Briefing | Royal College of Psychiatrists
Second Reading of The Terminally Ill Adults (End of Life) Bill 2024-25

House of Commons, 29 November 2024

Key messages

A decision to pass legislation to permit the practice of assisted dying/assisted suicide[1] ("AD/AS") would represent a significant societal shift and, as such, we recognise that it should be made by parliaments for their respective jurisdictions. In coming to a decision, MPs in Westminster should give careful consideration to the safeguarding of patients and their doctors and, in particular, the reliability of the consent procedures, including:

- the assessment of the capacity to end one's own life;
- whether consent can adequately act as a safeguard against both internal and external forms of coercion;
- potential implications for people with mental disorders, intellectual disabilities and neurodevelopmental conditions, who do not always have adequate access to palliative care; and
- impacts on suicide prevention efforts, palliative care and the NHS more broadly.

Our views are based on extensive consideration by our cross-College working group, surveys of members, a debate held for members, and engagement with members on proposals in Scotland, England, Wales and Jersey. There are a range of views among our members, which reflects the complexity and sensitivity of this issue. Our survey of members in England, Wales, Northern Ireland and the Crown Dependencies[2] showed:

- **An equal number of psychiatrists oppose and support AD/AS proposals for people with terminal illness[3]**
  Of those who responded to our survey, almost half (45%) opposed or strongly opposed, and an equal proportion (45%) supported or strongly supported proposed AD/AS legislation that requires a person to have a terminal illness, valid consent, be 18+ and where life ending medication is self-administered.
- **Majority of psychiatrists are not confident that consent can act as an adequate safeguard**
  Almost two thirds (65%) of respondents were not confident that consent can act as a safeguard against people making unfree choices, including, for example, those made due to lack of information, coercion or the effects of psychopathology on decision making. Almost one third (31%) were confident.
- **Majority of psychiatrists would not be willing to participate in an AD/AS service**
  Over half (58%) of respondents said they would not be willing to participate as a medical professional in an AD/AS service, including determinations of capacity or assessing for mental disorder, if it became law in the UK. 30% of respondents said they would be willing to participate.
- **Majority of psychiatrists oppose widening eligibility to include suffering in mental disorder**
  A majority (64%) of respondents opposed policies that widen eligibility to include suffering in mental disorder, while 18% supported such policies.

It is the Royal College of Psychiatrists' view that there are questions which remain outstanding about whether it is possible to provide adequate protections and safeguards for people and, if so, what those necessary measures would be. These details must not be left to the relevant professions to deal with through amendments to existing or new codes of practice.

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[1] There is no consensus within or without the RCPsych about a single term that should be used when discussing the practice of assisting people to end their own lives. Terms vary in meaning and interpretation, and include 'assisted dying,' 'assisted suicide,' 'medical assistance in dying,' 'physician assisted suicide,' 'voluntary assisted dying' and 'voluntary euthanasia.' We have elected to use the term 'assisted dying/assisted suicide,' or 'AD/AS' hereafter. The use of this term is intended to reflect the lack of consensus on the most appropriate description of the practice.

[2] The RCPsych has surveyed members in England, Wales, Northern Ireland and the Crown Dependencies on this topic. This was open from 18 October to 4 November 2024. The total response rate was 10.5% (1,474 responses out of 14,091 members).

[3] Note, our survey closed before the wording of *The Terminally Ill Adults (End of Life) Bill* was first introduced on 11 November 2024.

Consent procedures

The Terminally Ill Adults (End of Life) Bill 2024-25 ("Bill") requires a person to have the ability to give valid consent, which comprises relevant information on options, mental capacity to decide to end one's own life, and for there to be no coercion.

Mental capacity

The Bill defines capacity in accordance with the Mental Capacity Act 2005 ("MCA"). Whether or not a person has capacity is a legal determination made at a specific point in time for a particular intervention. These decisions are opinions with a margin of error and are time specific (a person's capacity can fluctuate over the course of a given day and as their illness progresses). Decisions can be particularly complex for people with a physical terminal illness and mental disorder. While we are of the view that a person's capacity to decide treatment[4] can be reliably assessed, an assessment of a person's mental capacity to decide to end their own life is an entirely different determination.

The MCA requires assessors to assume capacity as a starting point; incapacity must be proven. Assessing clinicians are also under a duty to support a person to make the decision in question. The presumption of capacity may be problematic in the context of AD/AS given the consequence, if the person is deemed capacitous and meets all other eligibility criteria, would result in their death.

Members have expressed to us that decisions about mental capacity should always reflect the weight of the consequences of that decision. Some have said that a higher threshold for capacity than is currently in law would therefore be needed, while others have questioned whether there can be a threshold at which someone can be deemed as having capacity to decide to end their own life.

Coercion

The Bill focuses on external coercion. That is, for example, coercion from family members with personal or financial motivations to hasten death. While this type of coercion may not always be clear, internal and societal pressures that may reach the threshold of coercion can be even more difficult to detect. This Bill does not address these more subtle forms of coercion such as where a person may internalise a feeling of being a burden to others. How might such internalised pressure be identified or responded to in this context? At what level would implicit or internal pressures amount to coercion? At what point would supporting a person to have capacity to make a decision to request assistance to die constitute coercion?

The Human Tissue Authority ("HTA") trains and oversees a network of independent assessors who interview potential organ donors and recipients to confirm that they have capacity, a full understanding of the choice before them, and are not subject to coercion. In this regard, the HTA provides regulatory oversight of capacity, understanding and coercion in the context of life-changing choices; it may also serve as a model for comparable oversight in this area.

Information on options (including palliative care, social care, and mental healthcare)

In any assessment of capacity, we must also consider whether a person is making the request because they consider that they are a burden or because they do not consider that they have access to effective treatments or good-quality palliative care. At a population level, palliative care, social care and mental health service provision may impact the demand for an AD/AS service.

In an initial or preliminary discussion on the subject of AD/AS with a person, the Bill requires a registered medical practitioner to explain and discuss alternative options with them, including palliative care, management of symptoms and psychological support. It is not clear, however, what

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[4] The Bill is not only proposing a model about legalising AD/AS, but one in which there would be active provision by the state, including as part of the NHS. In our survey of members in England, Wales, Northern Ireland and the Crown Dependencies, when respondents were asked whether they consider AD/AS to be a medical treatment option, over half (57.0%) of respondents thought it was not, while 32.2% thought it was. If AD/AS legislation were to be passed in the UK, over half (54.5%) of respondents said they did not believe that such a service should be provided by the NHS, while 28.8% did.

the registered medical practitioner should do if the person declines to accept any recommendation about their care.

Although the provision of psychological care is a fundamental part of good palliative care, we know that adult patients' access to such support in UK hospices is limited. People at end of life deserve high quality psychiatric treatment and research suggests that if depression is treated in people with a physical terminal illness, their wish to hasten death is significantly altered, usually diminishing. Until the provision of such care is improved, it is difficult to see how a person could be determined to be making a choice between options on AD/AS. We do wish to note that access to psychological care for people with palliative care needs is required whether or not AD/AS is legislated.

Other considerations

While we understand the Bill's intention is to only make eligible those with a physical terminal illness, there are a range of potential implications for people with mental disorders (including dementia and other brain changes that may profoundly affect decision making), intellectual disabilities, and neurodevelopmental conditions; psychiatry; and the services in which psychiatrists work. It should also be noted that, in some jurisdictions where AD/AS has been legalised, there have been subsequent changes or challenges which have resulted in the broadening of eligibility to include those for whom the service was not initially intended.

Co-occurring mental and terminal physical illness

A person who has a terminal physical illness is more likely to have a mental illness. Emotional distress is also common in people with life limiting illness and is associated with a wish to hasten death. In fact, it would be unusual for a person with a terminal physical illness to not be impacted mentally.

Assessment of mental disorder in those who are physically ill requires considerable medical and psychological expertise and should be carried out by professionals with sufficient training and experience in conducting such assessments. The difference between symptoms of mental illness and the psychological distress associated with terminal illness can be difficult to distinguish, as can ensuring that any decisions made are free from the influence of untreated mental health issues. Liaison psychiatrists, who work in general hospitals, can struggle to have confidence in whether their patients are depressed, physically ailing, or both. Assessments for mental disorder can take many weeks, trials of treatment and pragmatic conversations.

In addition to determining whether a mental disorder is impairing a person's ability to make a decision to end their own life, an assessment of capacity in this context may also include a determination of whether the presence of a mental disorder is the cause for, or contributing to, a person's desire to die. Presumably, such a determination would also include an assessment of whether the person had undergone appropriate treatments for any identified mental disorder that may alleviate a person's wish to hasten their death.

Under the Bill as introduced, a person with a co-occurring mental disorder that is impacting their wish to end their own life would not necessarily be deemed ineligible; only those whose mental disorder was deemed to impair their capacity to make a decision to end their own life would be excluded. For example, a person with terminal cancer may have clinical depression which is influencing their wish to die but be determined in accordance with the MCA as having capacity to decide to end their own life and therefore eligible for AD/AS. Separate to whether a decision is capacitous, this is also further complicated by the uncertainty of whether a patient might feel differently at a future time if provided with appropriate interventions and support to treat a co-occurring mental disorder.

Additionally, the wording of the Bill could also be interpreted to include those whose sole underlying medical condition is a mental disorder. While anorexia nervosa, for example, does not itself meet the criteria for terminal illness as it is not an "inevitably progressive illness, disease or medical condition which cannot be reversed by treatment," its effects (malnutrition) in severe cases could be deemed by some as a terminal physical illness, even though eating disorders are treatable conditions and recovery is possible even after decades of illness.

Role of psychiatry & psychiatrists

The Bill states that the assessing doctor "may, if they have doubt as to the capacity of the person being assessed, refer the person for assessment by a registered medical practitioner who is registered in the specialism of psychiatry in the Specialist Register kept by the General Medical Council or who otherwise holds qualifications in or has experience of the assessment of capability…" There is a question here about whether psychiatrists should be involved in every application process or only when a person is suspected to have a mental disorder and in particularly complex cases.

Regardless, given the ethical and moral complexities involved, the moral burden of making critical decisions in this context could be profound, raising concerns about the vulnerability of clinicians and psychological impacts on those involved in the process. A single psychiatrist or professional should not be required to navigate such complex decisions alone.

A determination of someone's capacity to decide to end their own lives is complex and multi-faceted, requiring deep understanding, collaboration and input from multiple perspectives. The input of a multiprofessional team would better ensure a balanced, reflective approach, reducing the burden on individual psychiatrists and other clinicians, improving the care provided, and keeping the patient and those around them at the heart of the process.

All clinicians, including psychiatrists, must be afforded the right to not take part in an AD/AS service for any reason, should legislation pass, such as those who conscientiously object on moral, religious or spiritual grounds or those who do not wish to take part for professional reasons. An AD/AS service should operate on an opt-in model, and set out which part of a service professionals are willing to take part in. Professionals should not be required to provide justification for not opting in.

Under the current Bill, it is not clear whether psychiatrists and other medical professionals will be required to refer a person on for an assessment by a coordinating doctor, even if they do not wish to take part or in instances where patients do not meet the eligibility criteria. For some, doing so would constitute participation in a process to which they personally object. Additionally, if a psychiatrist is asked to make a referral by a suicidal adult they are treating, and they are required to refer that person on for assessment, then this may impact a psychiatrist's ability to establish a therapeutic relationship with the patient and continue to treat the person.

There would also need to be consideration given to the additional demands this would place on mental health services (both in terms of training and service provision) where one or more staff members do not opt-in to participate in the process. In areas with limited specialist staffing, this could create significant issues in providing capacity assessments in a timely fashion.

Conclusion

It is the Royal College of Psychiatrists' view that whatever decision is made, there are unanswered questions about whether patients and doctors can be adequately protected and, in particular, the reliability of the consent procedures in the Bill.

MPs should carefully consider the unanswered questions about the reliability of assessments of capacity to end one's own life and the adequacy of consent as a safeguard against coercion in this context. It is also important to consider potential implications for those with mental disorders, intellectual disabilities and neurodevelopmental conditions, as well as suicide prevention efforts, palliative care and the NHS.

More information

If you have any questions or require further information please contact Gregory Kay, Public Affairs and Media Officer at gregory.kay@rcpsych.ac.uk. We would also be delighted to arrange a meeting at a convenient time for you, either in person or virtually, if you would like to discuss any issues raised in this briefing in more detail, now and in the future.