The assisted dying bill continues through UK parliament with legal momentum but also lingering questions

Standfirst: Assisted dying laws must be transparent, ethically sound, and sensitive to the concerns of patients and practitioners, write Nancy Preston and Suzanne Ost

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The Terminally Ill Adults (End of Life) Bill is set to continue its report stage on Friday 13 June before the crucial vote at third reading that will determine its fate[1]. If the bill passes third reading, it will go to the House of Lords to proceed through the parliamentary stages there. The bill has had a rocky road, perhaps not surprisingly as a Private Member's Bill on such a complex issue [2].

If it continues to progress, both houses must agree on the final version of the bill before it can become law. There are strong voices of opposition in the House of Lords. Concerns about how much of the implementation of assisted dying would be left to ministerial discretion — through the creation of delegated legislation after the bill becomes law — may resurface in the Lords [3, 4].

The implementation of the bill has been extended from two to four years to ensure robust safeguards and public confidence in the process. However, without the operational detail of what "commissioned assisted dying services" [1] will look like in practice, a number of important questions remain.

First and foremost, it remains unstated whether assisted dying will be integrated into the NHS or if it will be an aligned, but separate service as favoured by the British Medical Association and the Royal College of General Practitioners [5, 6]. Minister of State for Care, Stephen Kinnock, has not ruled out a service outside of the health system. But with parallels of "going to the dentist" made by some news outlets, this approach has not been well received [7]. Such scaremongering may be unfounded.

Perhaps a better comparison might be how early medical abortion is managed in England. Although women may initially approach their GPs, ultimately they are largely cared for in abortion services. This is likely to be the case with assisted dying. In Oregon

— where the assisted dying model bears similarities to the bill in England and Wales — 88% of deaths occur in the person's own home. This would imply the possibility of a substantial role for GPs in assisted dying whether the service is within or outside of healthcare. If GPs do choose to be involved, they would need a higher level of training than currently anticipated in the government's impact assessment [8].

Choice is central to the Royal College of General Practitioners' concerns, given their preference of offering GPs the ability to "opt in" [9]. They have expressed concern that the wording of the bill implicitly puts pressure on GPs to be involved by putting the onus on them to "opt out". A clear opt in system seems sensible and could address this issue of pressure.

The Royal College of Psychiatry has adopted a neutral position on assisted dying, but opposes the bill. [10, 11] This could inform part of the debate if the bill progresses to the House of Lords. Their concerns include that someone with a treatable mental illness might be allowed to access assisted dying, that terminal illness is a "risk factor" for suicide, and that psychiatrists don't see assisted dying—or suicide—as a form of medical treatment [12].

The bill stipulates that the Secretary of State would be required to issue a code of practice on "recognising and taking account of the effects of depression or other mental disorders … that may impair a person's decision-making" [1]. This clause of the bill could be amended to make explicit reference to suicidality. But again, under the current version of the bill, this would be a matter that would be resolved through delegated legislation, without parliamentary debate and scrutiny.

Notwithstanding this, the four year implementation period in England and Wales offers valuable opportunities to consider the colleges' concerns. If the bill passes, ensuring that the system is transparent, ethically sound, and sensitive to the needs of patients and practitioners, will be critical.

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