Terminally Ill Adults (End of Life) Second Reading Briefing: multidisciplinary consideration

Introduction

This briefing is prepared by Professor Gareth Owen, Professor Alex Ruck Keene KC (Hon) and Professor Katherine Sleeman, all members of the Complex Life and Death Decisions Group (CLADD). CLADD is a King's College London based group with expertise in psychiatry, palliative care, bioethics, public policy and law. We are neutral as to whether assisted dying / assisted suicide should be made law. We are committed to the principle that it is for Parliament to decide. We are equally committed, however, to the principle that any law that is passed must function as a workable framework which protects the interests of patients, professionals and wider society.

In our broader briefing, we set out why the Terminally Ill Adults (End of Life) Bill ('the TIA Bill') as it stands is not good law. We have prepared a version of the Bill which remedies the key problems that we identify in that briefing. This briefing looks in more detail at the issue of multidisciplinary consideration of eligibility, and explains our recommended amendments.

Multidisciplinary consideration

As initially drafted, the Bill contained no requirement for multidisciplinary consideration of eligibility. Two doctors had to be involved, with eligibility confirmed by a High Court judge. A considerable body of evidence was put before the Public Bill Committee, however, making clear the importance of multidisciplinary consideration. In moving the amendments which replaced the High Court with the Panel, Kim Leadbeater MP explained that this was to bring about multidisciplinary consideration, and specifically referenced how this was a response to the "evidence about the benefits of a multidisciplinary approach to choice at the end of life." (Public Bill Committee, 11 March 2025, 976).

That evidence was, however, addressed to multidisciplinary consideration at the stage of assessment, not at the stage of confirmation. Parliament has recognised in other contexts involving personal autonomy under pressure that multidisciplinary consideration must take place at the earliest possible stage: admission under the Mental Health Act 1983, for instance, requires consideration by professionals of more than one discipline as the point of initial assessment. Furthermore, time, money and emotional energy will have been expended unnecessarily if Panels show that the person is ineligible when multidisciplinary consideration earlier would have done so.

Amendments to secure earlier multidisciplinary consideration

The recommended amendments that we propose to clauses 10 to 15 (in particular) are designed to ensure two key matters.

First: that the coordinating professional and the independent professional have different professional training, and can be of different disciplines. The effect of our recommended amendments to clause 12 would be to ensure that in any given case the person is considered by at least one doctor, together with either

(1) A doctor with different specialist training (so, for instance, a general practitioner and a palliative care doctor, or a palliative care doctor and a psychiatrist).
(2) A professional from a different discipline, to be specified in regulations. The most obvious such discipline would be social work, but enabling the discipline to be specified in regulations would give the flexibility to calibrate the framework of the Bill to evolving circumstances.

Second: that the assessing professional must take all practicable steps to consult with those involved in the person's health or social care. Our recommended amendments to clause 12 seek to bring this about, whilst recognising that there may be circumstances in which such consultation is not practicable.

While these two changes do not ensure multidisciplinary decision making in its true sense (i.e. a collaborative approach where professionals from different fields work together to make consensus-based decisions), they do ensure multidisciplinary consideration.

A further effect of our recommended amendments would be to change the role from coordinating / independent "doctor" to coordinating / independent "professional" and also from administering doctor to "assisting professional" (albeit that the latter, we recommend, could only ever be a registered medical practitioner). We suggest that this has a further benefit in terms of making clear that a doctor who is discharging functions under the Bill is discharging a role within a process whereby a patient is deciding to end their own life, rather than a role relating to a medical treatment. This would have the following benefits:

1. It would minimise the potential for 'role confusion,' so that a doctor is clear at any given point during their potential involvement in the process provided for under the TIA Bill whether they are (a) discharging the conventional functions of a doctor, such as assessing a patient's treatment needs; or (b) assessing, instead, a patient's eligibility to receive assistance in ending their own life, or providing that assistance;
2. It would reaffirm the policy intent confirmed by Kim Leadbeater MP of an 'opt-in' system, whereby doctors who wish to take part in the provision of assistance have actively to take steps to that end, and can suffer no adverse effects if they choose not to.

Further information

For more detail about any of the matters set out above, please contact alexander.ruck_keene@kcl.ac.uk.

More information about CLADD can be found here.

Alex Ruck Keene maintains a resources page on the TIA Bill here.