Association for Palliative Medicine

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APM 'Myth Buster' for MPs - in relation to the Terminally Ill Adults (End of Life) bill August 2026

This document collates some frequently raised claims about assisted dying (AD), and presents evidence to address them. It aims to broaden understanding of the complexities associated with the proposed TIA Bill.

Claim	Evidence
1. Rhetoric	
1.1 Assisted dying offers people choice at the end of life	True choice only exists when both options are equally available and accessible. It has been clearly established that access to high-quality palliative care is currently inequitable across the UK, and faces severe gaps. (Here) Creating an accessible and fully-funded model for assisted dying (AD) without addressing these known gaps will not leave dying people with true choice.
1.2 Assisted dying need not detract from palliative care.	There are many ways in which assisted dying can impair palliative care. Through competition for resources (funding, staff capacity – doctors in Australia estimate that a single assisted death takes around 60 hours of clinician time (Here), through moral distress and burnout (85% of palliative medicine doctors are opposed to AD), and through patients and families having fear of hospices and palliative care services.
1.3 This debate is simply about people facing terminal illness who want control over their deaths.	There are four groups of people who must be considered in this debate: 1- those who might want (and might benefit from) AD. This group receives the majority of media attention. 2- those who might be pushed towards it. For example, vulnerable groups pressured or coerced (by individuals or by their situation) to 'choose' an assisted death. 3- People for whom there has been mis-diagnosis, mis-prognosis, or mis-management that leads them to seek it. 4- those approaching the end of life for whom the very existence of this legislation changes the care landscape, potentially influencing choices, for example because they are reluctant to accept palliative care or because palliative care is less readily available.
1.4 The public overwhelmingly support assisted dying.	Surveys of public opinion generally demonstrate strong support for assisted dying, however only 43% are aware that this means 'providing people who have less than six months to live with lethal drugs to end their life'. Others polled didn't know what it meant, or thought it meant 'providing hospice type care to

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	people who are dying' or 'giving people who are dying the right to stop life-prolonging treatment'. (Here) Opinion polls also show that support is fragile. For example, half of supporters say they would switch to oppose if people had assisted deaths because they couldn't access the health and care they need. (Here) Experience of palliative care professionals is that the general public lack experience in 'normal dying' due to over-medicalisation in recent decades, and variable explanations of the process being offered. This can create a perception that the dying process primarily represents prolonged suffering at the end of life and, consequently, that it is something from which patients should seek escape or be spared.
1.5 We are not protecting vulnerable people now, this Bill is safer than the status quo	The most imminent threat to vulnerable people at the end of life in the UK is the limited availability and structural inequity in access to high-quality palliative and end of life care. In jurisdictions where AD is legal it is only chosen by a minority of the population (0.1-5.1% of all deaths). For them, whether AD offers 'convenience' or 'safety' can be debated.
1.6 Assisted dying is a medical treatment	A treatment is an intervention that improves a patient's health or quality of life. Assisted dying is an intervention with death as the outcome.' Assisted dying is an existential choice, not a treatment. (Here) The Bill itself is silent on the question of whether assisted dying is a treatment or not. This is a critical question because it has implications for healthcare, clinical practice and law. This opinion piece makes the case that assisted dying should not be considered a treatment and that it should be out-with medicine. There are alternate models available also (Here)
1.7 The Terminally Ill Adults Bill incorporates an 'MDT approach'.	A 3-person panel, at the end of the assessment process, will not allow for multi-disciplinary decision making in its true sense. To be meaningful, multi-disciplinary assessment needs to happen at the beginning of the process, not the end, and each multi-disciplinary team member should independently assess the patient in person.
1.8 Palliative care professionals are generally against assisted dying because they are very religious.	There is no evidence for this. It is notable that those doctors who are most anti-assisted dying are the ones who spend most of their time caring for dying people (palliative medicine, geriatrics, oncology).
1.9 20 people per day (or around 7,000 people per year) would die with unrelieved pain even if they received high quality palliative care.	This data comes from a report that has not been peer-reviewed, and it was based on a flawed assumption. See explainer blog. (Here).

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	However, Marie Curie highlighted that over 150,000 people last year who should have palliative care couldn't access it – this is one every 5 minutes. (Here)
2. Eligibility	
2.1 Doctors can reliably identify those who have only 6 months to live.	Research across thousands of prognosis assessments show that doctors' assessments of which patients are likely to die within 6 or 12 months are correct less than 50% of the time. (Here) and (Here). The implications of this in the context of the TIA bill might be: (1) people assessed as 'reasonably expected to die within 6 months' would have lived longer without assisted dying, and (2) people assessed as 'not reasonably expected to die within 6 months' die sooner without having had the opportunity to access assisted dying.
2.2 People won't be able to have an assisted death because they feel they are a burden.	The Bill does not require that patients are asked why they want to die. Thus any reason for wanting assisted dying, including feeling a burden, would be permitted. Around half of people in other jurisdictions choose AD because of feeling a burden on family and friends: in Oregon it is 40% (Here) in Canada 48.4% (Here)
2.3 The Mental Capacity Act is agreed to be the appropriate framework for testing capacity for the decision to have an assisted death	The Royal College of Psychiatrists have stated "The Mental Capacity Act does not provide a framework for assessing decisions about ending one's own life", see point 4: (Here)
2.4 Application of the Mental Capacity Act in the context of assisted dying would be straightforward.	Leading psychiatrists disagree. Dr Annabel Price (Royal College of Psychiatrists Lead on Assisted Dying) has said: "I'm a liaison psychiatrist with a PhD looking at capacity in assisted suicide. I know my way around the MCA and assess capacity regularly. Am I confident I would get the capacity assessment right for people requesting AD? No."
3. Vulnerable groups	
3.1 The TIA Bill adequately protects vulnerable people.	Support for the Bill by professional organisations, associations or regulatory body does not exist. The Royal College of Physicians, Royal College of Psychiatrists, Association for Palliative Medicine, Disability Rights UK, British Geriatric Society, MIND, BEAT, Liberty, Standing together against Domestic Abuse, KCL complex End of life and Death Decisions group, Gold Standards Framework Centre, and British Association of Social Workers **all have explicitly stated that the Bill fails to protect the vulnerable**. For examples see (Here) and (Here)
3.2 Assisted dying won't affect children.	This law will affect children in many ways. Professionals can bring AD up and discuss it with children. For children with life-limiting

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	conditions, this law may send societal messages that some lives are not worth living. See editorial (Here)
3.3 People with anorexia would not be eligible for assisted dying under the TIA Bill.	The Royal College of Psychiatrists are clear that there is a risk that people with anorexia – whose mental illness causes physical frailty – would be eligible (Here -p6) as is BEAT Eating disorders (Here). Furthermore, a robust thematic analysis of parliamentary debate relating to eating disorders and the TIA bill suggested that a seemingly disproportionate focus on eating disorders can in fact serve as a stress test of the eligibility criteria as a whole. (Here).
3.4 People from minoritised ethnic groups generally access assisted dying less than white people. Therefore there are no concerns around vulnerability of these groups.	To understand the risks to different groups we need to examine not just whether people access AD but why they access it. There is evidence from minority ethnic groups in England that the TIA bill may deepen mistrust and deter some individuals from accessing palliative care and healthcare in general, potentially worsening the already existing inequalities in end-of-life care. (Here) Further, the intersection with poverty and other factors relating to structural disadvantage may further disproportionately affect these communities.
3.5 Under this Bill, someone could not request an assisted death because they were depressed.	Having treatable depression will not exclude people from an assisted death within this Bill. Depression is common among people with terminal illness, is often treatable, and does not necessarily impair capacity. See evidence given by The Royal College of Psychiatrists to the House of Commons TIA Bill Committee. (Here) Clinicians are trained to prevent suicide in people suffering from depression. Where would the line be drawn? How would doctors know when it is right to move from suicide prevention to assisting suicide? Assessing mental capacity in a person suffering from depression and expressing suicidal thoughts is fraught with risk. The Bill makes no provisions to support this difficult transition or create safeguards around it.
3.6 Disabled people support assisted dying	It's correct that in some public opinion polls around 70% people who are disabled support AD. But **there is not a single disability rights organisation** – which tend to represent people with the most severe, life-long disabilities – **that supports assisted dying**.
3.7 Doctors are able to identify when a person requesting AD might be being coerced into the decision	It has been shown that healthcare professionals are poor at identifying when a person is being coerced (Here) More than 1 in 5 of the UK population have personally experienced abuse as an older person (65+) or know someone who has been abused (Hourglass 2020). Coercion can be subtle and difficult to detect. It may occur behind closed doors or be internalised and never

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	explicitly expressed by the person, particularly where they feel they are a burden on their loved ones. This is already a recognised source of distress at the end of life. For example, individuals may agree to hospice admission when their preference would be to remain at home, owing to concerns about the burden their care may place on family members and loved ones. In Canada and Oregon, up to half of those seeking assisted dying stated 'feeling like a burden' as a factor in their decision making. In addition, the doctor-patient power differential may compound the risk of subtle influence, as patients often regard clinicians as authority figures and may consciously or unconsciously align their decisions with what they believe their doctor considers appropriate.
4. Pain and morphine:	
4.1 Pain is inevitable at the end of life.	While some pain is common at the end of life, severe pain is much less common. Pain can be very well controlled in the vast majority of people when there is access to appropriate palliative and end of life care.
4.2 Assisted dying legalisation means people won't die in excruciating pain.	First, pain can be very well controlled through a combination of pharmacological and non-pharmacological approaches. Wider public education about this may reduce the fear of pain, which sometimes contributes to requests for AD (e.g. Oregon (Here) or Canada (Here). Second, The TIA Bill does not specify the nature of 'the approved substance' used to bring about death. It is important to know that robust testing has never taken place for any medications, or combinations of medications, used for AD in other jurisdictions, therefore their side effect profile, including pain, is largely unknown and unreported. The Netherlands has one of the world's most established and liberal assisted dying frameworks, yet significant unmet needs remain at the end of life, with up to 43% of patients experiencing at least one unresolved symptom in their final stages of life. (Here)
4.3 There is an upper limit to the amount of morphine dying patients are 'allowed'	There is no upper limit to morphine dose. Sometimes pain does not respond to morphine so other medications need to be used. The dose of drugs used at the end of life should be titrated according to the patient's symptoms and given regularly as the medication is metabolised. If people have side effects from one drug, or if the pain is less responsive, alternatives can be used to manage pain. In these more complex pain situations, appropriate input from specialists in palliative care is needed.
4.4 People with morphine allergy cannot receive pain relief.	True morphine allergy is very rare. What is more common is experiencing side effects such as nausea, which can be managed

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	with medication and does not mean the morphine must be stopped. People who are allergic to morphine can receive other opioids safely. There are also non-opioid medications, and non-drug approaches, that are used to manage pain.
4.5 Use of morphine when people are in their last phase of life hastens their death	There is no evidence that in appropriate doses, and titrated carefully to someone's pain, that giving morphine at the end of life hastens death (Here). The misunderstanding comes about because two things are true: (1) dying people often receive drugs such as morphine for pain relief, (2) dying people die. These facts are correlated, rather than causatively related.
5. Experiences at the end of life	
5.1 Vomiting faeces is something that commonly happens when people are dying.	Vomiting faeces is incredibly rare. Explainer blog (Here)
5.2 The rate of suicide in terminally ill people is twice the rate in non-terminally ill people.	It is correct that suicide risk is around twice as high among people diagnosed with severe physical illness. However, suicide risk is highest immediately after diagnosis and falls quickly within 3-6 months. There is no good evidence that suicide risk is higher in people who are in their last 6 months of life. This evidence suggests that better mental health support is needed at the time of diagnosis of severe physical illness. (Here) Additionally, non-assisted suicide rates in some countries where AD is legal remains consistently higher than the UK (Australia, Netherlands). Unassisted suicides in Victoria, Australia have gone up since the introduction of AD. (Here).
5.3 People approaching the end of life often resort to starving themselves to death.	Eating and drinking less is a natural part of dying. The body just doesn't need as much nutrition when someone is dying as it did when they were well. Voluntarily stopping eating and drinking is very unusual.