

## Terminally Ill Adults (End of Life) Bill - Oral evidence

Terminally Ill Adults (End of Life) Bill Committee

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The oral evidence given to the committee considering the **Terminally Ill Adults (End of Life) Bill** revealed a range of nuanced positions, most of them focusing less on whether assisted dying should exist in principle and more on *how* such a system could be made safe, fair, and workable. Witnesses included senior medical officers, palliative-care clinicians, lawyers, disability-rights advocates, and representatives of professional bodies such as the British Medical Association.

A consistent theme across the sessions was the **difficulty of defining “terminal illness”** with sufficient precision for use in law. Sir Chris Whitty, the Chief Medical Officer, and other medical witnesses observed that prognoses are inherently uncertain: very few conditions follow predictable trajectories, and even experienced clinicians can rarely state with confidence that someone will die within a fixed period such as six months. This uncertainty, they argued, complicates any law that makes eligibility contingent upon a time-bound prognosis. Some witnesses also worried that people enduring severe, intractable suffering but without a strictly terminal condition might be excluded, while others warned that vague definitions could open the door to misuse.

Another strand of evidence concerned **safeguards and consent**. Medical and legal experts alike stressed that the protection of vulnerable individuals—particularly those who might feel subtle pressure to end their lives—must be paramount. Questions were raised about how coercion or undue influence could be identified and prevented, and whether the Bill’s mechanisms—such as assessments by two independent doctors and waiting periods—were sufficient. Disability organisations were especially cautious, warning that a “right to die” must not evolve into a “duty to die” for those who already feel burdensome to their families or to the care system. The importance of clear, independent oversight and the ability of healthcare professionals to conscientiously object without penalty were repeatedly emphasised.

The **impact on palliative care** was another recurrent concern. Clinicians and hospice representatives insisted that assisted dying cannot be viewed as a substitute for high-quality end-of-life care. They urged that any legislative change should proceed only alongside stronger guarantees of access to palliative services across England and Wales. Without that, some feared the Bill might create a perverse incentive to favour assisted dying simply because other forms of care remain under-resourced.

From a practical standpoint, witnesses discussed whether the health system was ready to implement such a regime. Sir Chris Whitty and others advised that, if Parliament were to approve the Bill, the system would need time—perhaps two years or more—to establish reliable training, protocols, data systems, and oversight bodies. Rushing implementation, they argued, could compromise safety and public trust.

There were also **legal and procedural questions** about the Bill’s drafting. Several witnesses pointed out that many operational details would be left to secondary legislation. They warned that this could reduce parliamentary scrutiny of crucial safeguards. Some argued for clearer

statutory definitions and for mechanisms ensuring that Parliament—not only ministers—retains control over how the law is applied.

The committee also heard **comparative evidence** from jurisdictions where assisted dying is already legal, including Canada, parts of Australia, and some European countries. These discussions revealed the importance of rigorous data collection, ongoing review, and transparent reporting. Some witnesses noted that even well-intentioned systems abroad have struggled with mission creep, inconsistent application, or poor monitoring, reinforcing the need for caution and continual evaluation if the UK proceeds down this path.

Across the evidence, one could sense both empathy for those who seek control over their dying and unease about the broader societal implications. Supporters of reform emphasised autonomy and compassion, arguing that terminally ill people should not be forced to endure unbearable suffering when they are mentally capable of choosing otherwise. Opponents and sceptics, meanwhile, focused on the risks of error, coercion, and erosion of trust between patients and doctors.

In summary, the oral evidence before the committee did not reveal a simple divide between approval and opposition. Instead, it illuminated a shared recognition of the gravity of the issue and the potential for unintended consequences. The dominant message was that, whatever Parliament decides, the law must be accompanied by stringent safeguards, clear definitions, and careful preparation. Sir Chris Whitty’s cautionary remark captured the prevailing sentiment: this is not a matter that should be “done at speed,” but one that demands deliberation, readiness, and respect for both autonomy and protection.