The British Medical Association (BMA) is an apolitical professional association and independent trade union, representing doctors and medical students from all branches of medicine across the UK and supporting them to deliver the highest standards of patient care. We have a membership of over 154,000, which continues to grow each year.

**Introduction**

The BMA opposes assisted dying in all its forms, and supports the current legal framework, which allows for compassionate and ethical care for the dying to enable them to die with dignity. We support the provision of comprehensive and high quality palliative care and believe that the public should be better informed about what is available.

This briefing sets out the BMA’s policy and the key reasons underlying the BMA’s opposition to any change in the law that would permit assisted dying. Further information about the BMA’s position, and the issues surrounding euthanasia and physician-assisted suicide, can be found in Chapter 11 of the BMA’s publication *Medical Ethics Today*, Third Edition, available in the House of Commons Library.

**Key points**

- The law should not be changed to permit assisted dying.
- Some doctors believe that legalising assisted dying could have a profound and detrimental effect on the doctor-patient relationship, even where medical involvement is limited to assessment, verification, or prescribing.
- Individual autonomy is important, but should be limited where it could cause harm to others. It would be unacceptable to put vulnerable people in a position where some of them felt that they had to consider precipitating the end of their lives.
- For most patients, effective palliative care can alleviate suffering and allay many of the fears associated with the process of dying. High quality palliative care services should be consistently and widely available for those who need it, and the public should be better informed about such services.

**BMA policy**

The BMA represents doctors who hold a wide range of views on assisted dying. However, BMA policy is set through a well-established democratic structure, where members’ views and opinions are aired and debated at the Annual Representative Meeting (ARM), the main policy-making body of the Association. The BMA’s policy on assisted dying was agreed at the BMA’s ARM in 2006, and reaffirmed in 2009 and 2012 when proposals to change this policy were rejected. It states that the BMA:
• Believes that the ongoing improvement in palliative care allows patients to die with dignity;
• Insists that physician-assisted suicide should not be made legal in the UK;
• Insists that voluntary euthanasia should not be made legal in the UK;
• Insists that involuntary euthanasia should not be made legal in the UK;
• Insists that if euthanasia were legalised, there should be a clear demarcation between those doctors who would be involved in it and those who would not.

Reasons for opposition

A change in the law would be contrary to the ethics of clinical practice
The principal purpose of medicine is to improve patients’ quality of life, not foreshorten it. A number of doctors have concerns that the trust found in the unique relationship between doctors and patients might be jeopardised if doctors were permitted to play a role in ending patients’ lives. Following debates on assisted dying at our representative meetings, the BMA remains concerned that permitting individuals to end their lives with physician assistance – even where that assistance is limited to assessment, verification, or prescribing – could fundamentally alter the ethos within which medical care is provided. If doctors are authorised to kill deliberately, or to help kill, however carefully circumscribed the situation, they acquire an additional role that the BMA believes is alien to the nature of the doctor-patient relationship.

Permitting assisted dying for some could put vulnerable people at risk of harm
People increasingly expect to be able to exercise control over certain aspects of their life, and over matters that affect them, but this autonomy has its limits. The crucial question is whether, in practice, allowing some people to choose death would be likely to harm others. It is the BMA’s view that, if there is even a suspicion that it will, society must exercise caution. The rights of one person or a group of people cannot be permitted to undermine disproportionately the rights of others. The BMA views doctors’ duties as part of a continuing obligation to try to help realise patient autonomy within a widely accepted moral framework that must protect the vulnerable as well as articulate and autonomous patients.

The BMA is concerned that a legislative change would alter society’s attitudes towards the vulnerable: old or disabled people might be seen as burdensome and might be put under pressure to end their lives. It would be an undesirable outcome if allowing assisted dying generated a perception that some lives are worth less than others, or made some people consider assisted dying to be an option they ought to consider.

Additionally, in the BMA’s view, legal safeguards designed to ensure the voluntary nature of assisted dying could fail to detect more insidious pressures, such as self-imposed pressure, or subtle emotional coercion from relatives. Since the enactment of Oregon’s Death with Dignity Act 1994, 40 per cent of patients who have made use of the law cited a fear of being a burden to their family, friends and carers as part of their reasoning for wanting to end their life.1

The Supreme Court, in its recent judgment on the case of Tony Nicklinson, described the issue of vulnerability as a “formidable problem.”2 It noted that the Falconer Commission on Assisted Dying had not found evidence of abuse of the law in jurisdictions where assisting suicide is legal, but that due to the various problems of obtaining negative evidence, this could not be taken to
mean there is no risk whatsoever of abuse. In the leading judgment, Lord Neuberger concluded that the concern of pressure on vulnerable individuals could not be rejected outright as “fanciful or unrealistic.”

Some vulnerable individuals may also begin to fear that a premature death will be selected for them. During the debate prior to the brief legalisation of euthanasia and physician-assisted suicide in Australia’s Northern Territory, there was evidence of disquiet from the indigenous Aboriginal population, who were afraid to attend health clinics and hospitals out of a fear of doctors “having the power to kill.” In the early years of euthanasia being tolerated in the Netherlands, it was also alleged that some older people feared their lives would be ended without their consent.

Legalising assisted dying could weaken society’s prohibition on killing and undermine the safeguards against non-voluntary euthanasia

It is the BMA’s view that if assisted dying is accepted as a reasonable choice for people with mental capacity and the ability to carry out the final act themselves, it could then be extended further, with undesirable results. The justification of death as a “benefit” underpinning claims for a right to assisted dying could, for example, be applied to people who are physically unable to carry out the final act themselves, leading to the acceptance of voluntary euthanasia. Once that line is crossed, this could lead to acceptance of non-voluntary euthanasia, for example, of those who lack mental capacity, such as patients with depression or dementia.

Some people view the Dutch practice of assisted dying as an example of such a “slippery slope”, where the requirements of due care that first applied to adults with capacity later encompassed other cases. In the mid-1990s the Dutch courts held that “unbearable and hopeless psychological suffering”, even in the absence of physical illness was legitimate grounds for a doctor to assist suicide. In 2014, the Belgian Parliament passed legislation allowing euthanasia for terminally ill children, a further example of a law being extended beyond the limits originally envisaged at its inception.

For most patients, effective and high quality palliative care could effectively alleviate distressing symptoms associated with the dying process and allay patients’ fears

People fear many aspects of the dying process. Since the enactment of Oregon’s Death with Dignity Act 1994, patients have cited a number of reasons for seeking a lethal prescription, including fear of inadequate pain control; fear of being a burden on family and friends; losing autonomy; losing control of bodily functions; and being unable to participate in activities that make life enjoyable. Skilled and compassionate palliative care, with good communication and patient involvement, can alleviate many of these fears.

In the BMA’s view, by focusing on assisted dying as a solution to people’s natural anxieties about end-of-life care, society is having the wrong debate, potentially risking a normalisation of one option towards the end of life without consideration of or access to other options or choices. Widespread and consistent availability of high quality palliative care services would be likely to diminish the demand for assisted dying, and patients and their families need to know about all the options available to them, both in hospice-type settings and also as part of outreach care to people who want to die at home with the necessary support to enable them to do so with compassion and dignity.
The BMA has repeatedly expressed concern that good quality palliative care is not always available and that some groups continue to have poor access to it. BMA policy calls for continuing improvements to be made in the provision of palliative care; for such a service to be universally available for all members of our society; for better information to be made available to the public about what good palliative care can achieve; and better training in palliative medicine for all doctors involved in the care of dying patients. Investing in such services would be not only a good thing in itself but would address some of the concerns that have led to calls for legalised assisted dying.

Ongoing BMA Work
In January 2015 the BMA launched a major new project examining end-of-life care and physician-assisted dying.

The project is not intended to assess the level of support for or opposition to assisted dying, but has involved engaging with doctors and members of the public across the spectrum of medicine and of society to explore concepts, perceptions, and understanding of a number of practical and ethical issues surrounding care and options at the end of life.

In carrying out this research, we aim to compile a thorough and comprehensive body of qualitative evidence around end-of-life care and physician-assisted dying which will not only inform our own discussions, but play a significant role in the ongoing public debate.

The project will conclude at the end of 2015.

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For further information, please contact:

David Knowles, Senior Public Affairs Advisor
T: 020 7383 6520 | M: 07917 041 018 | E dknowles@bma.org.uk

2 R (on the application of Nicklinson and another) v Ministry of Justice [2014] UKSC 38, at 228.
3 Ibid., at 88.