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## Assisted Dying Bill 2023

**Dear Dr Allinson**

Thank you very much for your letter to Professor Banfield which has been passed to the BMA's medical ethics team to respond.

As you know, since 2021 the BMA has taken a position of neutrality on assisted dying, including physician-assisted dying. This means that we neither support nor oppose a change in the law. We have been clear, however, that this does not mean that we will be silent on the issue, and that we have a responsibility to represent the views of our members in discussions on any legislative proposals.

Our Medical Ethics Committee (MEC) has just completed a significant piece of work to ensure the BMA is in a good position to represent our members as and when the need arises. As part of this work, we reviewed what we already knew about our members' views (from previous engagement work including our member survey and dialogue events); communicated with other national medical associations about the issues their members were concerned about and how they were engaging in the debates; spoke with individuals working in jurisdictions where assisted dying is lawful (both providers and opponents); and reviewed some of the vast literature on this subject. With these considerations in mind, we identified those issues that would significantly impact on our members, should the law change, and considered what, if any, view the BMA should take on those issues. As the work developed, the MEC sought views from other BMA committees – across all branches of practice – and our patient liaison group. This work has now been approved by the four BMA Councils across the UK. To be clear, by doing this work, the BMA is not pre-empting the outcome of attempts to change the law, but rather it allows us to engage constructively with law and policy makers such as yourself, on behalf of our members, regarding the specifics of any proposals that are brought forward.

As was evident from our survey of BMA members, conducted in 2020, we represent members with a diverse range of views; as doctors we also have responsibilities to our patients. Central

to the MEC's work therefore, was the need to balance the different, and sometimes competing, interests of three different groups:

- BMA members who would be willing to provide assisted dying if it were legalised;
- BMA members who, for whatever reasons, would not be willing to participate in assisted dying; and
- patients who may wish to access a lawful assisted dying service.

We have now reviewed your Bill, alongside the work we have conducted, and wish to offer the comments below. By commenting on your Bill, we are not providing support for a change in the law. These comments are provided solely to inform you of the BMA's views on some key issues *if* the law were to change. Where we have not commented on aspects of the Bill, this is because it is not an issue that we have currently taken a position on – it should not be interpreted as support for or acceptance of those provisions.

**General approach in the Bill**

The Bill, as drafted, is based on the premise that any doctor could be expected to participate in assisted dying, if requested by a patient, unless they have claimed a conscientious objection. If assisted dying were to be legalised, however, the BMA would want to see a different approach which gives doctors greater choice about whether and, if so to what extent, they are willing to participate.

An opt-in model of delivery

*The BMA believes that any legislation to permit physician-assisted dying should be based on an 'opt-in' model, so that only those doctors who positively choose to participate are able to do so. Doctors who opt in to provide the service should also be able to choose which parts of the service they are willing to provide (eg assessing eligibility and/or prescribing and/or administering drugs to eligible patients).*

From the information we have gathered about other jurisdictions, it appears that *in practice* assisted dying is usually only provided by those who positively choose to participate, even though it is not explicitly presented in this way. (In some jurisdictions for example, only those who choose to undertake the required mandatory training, or to register with a central body, are eligible to participate.) Making this explicit in any legislation would provide reassurance to both doctors and patients. From our members' perspective, if assisted dying were to be legalised, having an opt-in model would:

- give doctors the greatest amount of choice about whether, and if so the extent to which, they were involved;
- provide reassurance to those doctors who did not want to participate that they would not face pressure to do so;
- ensure that those who wanted to participate had the proper training and experience to do so; and
- make the service easier to audit which would help to build confidence and maintain trust.

Those doctors who chose to participate would need specialised training, guidance and both practical and emotional support.

A right to refuse to carry out activities directly related to assisted dying for any reason

*The Bill currently includes a standard conscientious objection clause as found in legislation on abortion and assisted reproduction. The BMA believes that, if assisted dying were legalised, doctors should be able to refuse to carry out any activities that are directly related to assisted dying (such as assessing capacity, or determining life-expectancy, specifically to assess eligibility for assisted dying) for any reason. Therefore, there should be a general right to object which does not need to be based on matters of conscience.*

Doctors who do not choose to provide assisted dying themselves may, nonetheless, receive requests from patients or other health professionals for actions that are an intrinsic part of the assisted dying process. These are activities that would require them to use their professional skills and judgement to facilitate a request for assisted dying. This could include, for example, a request to assess an individual's capacity, or make a judgement about their life-expectancy, specifically in order to assess their eligibility for assisted dying.

We are aware (including from responses to our survey) that there are some doctors who do not oppose assisted dying in principle (and so do not have a 'conscientious' objection in the way that is normally understood) but who would not personally want to participate in the process. It is important, therefore, that if assisted dying were legalised, doctors should be able to object to taking any part in the process itself, for *any reason* and, as such, any right to object should not be framed as, or limited to, matters of conscience. There is some evidence from Quebec that supports this position; many doctors who claimed a conscientious objection did not cite moral or religious objections to assisted dying but expressed other reasons for not wanting to participate such as the emotional impact of participation, lack of time, and lack of confidence in their competence to carry it out. [1]

In terms of moral complicity, there is a difference between requests for doctors to use their professional skills as part of the process of assisted dying, which we believe they should be able to refuse for any reason, and requests to provide existing information from the medical record, which we believe all doctors should comply with, without delay. Irrespective of their personal views, if approached about assisted dying, we believe that all doctors should also inform patients about where and how to obtain information about assisted dying. Ideally there would be an independent service that doctors could direct patients to, which would provide accurate and objective information about the range of options available to them and, for those wishing to be considered for assisted dying, help them to navigate the system.

**Protection from discrimination and abuse**

The Bill does not currently provide any protection for doctors from discrimination or abuse as a result of their views and actions in relation to assisted dying.

[1] A qualitative study of physicians' conscientious objections to medical aid in dying - Marie-Eve Bouthillier, Lucie Opatrny, 2019 (sagepub.com) Palliative Medicine Vol 33(9)

Statutory protection from discrimination

*If assisted dying were to be legalised, the BMA would want to see specific provisions in the legislation making it unlawful to discriminate against, or cause detriment to, any doctor on the basis of their decision to either participate, or not participate, in assisted dying.*

Through the work we undertook with our members, it became clear that some doctors were concerned about how their decision to participate, or not to participate, in assisted dying (if it were legalised) might impact on them both personally and professionally. This included concerns that they might be ostracised by colleagues, or their career prospects might be jeopardised, because of their decision. We also heard anecdotally about some healthcare institutions in other countries, that are opposed to assisted dying, using contractual terms to prevent their doctors from participating in assisted dying in their own time. Any discrimination, or detriment to doctors, as a result of their views, and/or intentions, regarding assisted dying is unacceptable and should be prohibited.

Provision for safe access zones

*The BMA believes that any Bill to legalise assisted dying should include provision for safe access zones that could be invoked should the need arise, to protect staff and patients from harassment and/or abuse.*

The BMA has for many years campaigned for safe access zones (formerly known as 'buffer zones') around abortion clinics to protect patients and staff from harassment by protesters. Given the strong views around assisted dying, it is possible that similar protests could take place close to facilities providing assisted dying.

Although there is no evidence of harassment outside establishments in other countries, the BMA strongly supports the need to protect both staff and patients in the event of any harassment taking place. Safe-access zones can only be put in place if the relevant legal powers exist. Therefore, if legislation were to be passed, it should include legal provision for safe access zones that could be invoked if the need arose.

**Initiating discussions about assisted dying**

*The BMA does not support the Bill's provisions (at clause 9) that would prevent doctors from initiating discussions with patients about assisted dying.*

The BMA believes there should be guidance and training for those having discussions with patients about assisted dying, to ensure they are carried out in a sensitive and appropriate manner but does not support a prohibition on doctors initiating discussions with patients. Doctors should be able to talk to patients about all reasonable and legally available options. They should be trusted to use their professional judgement to decide when a discussion about assisted dying would be appropriate, taking their cue from the patient, as they do on all other issues. It would set a dangerous precedent to legislate for what doctors can, and cannot, say to patients.

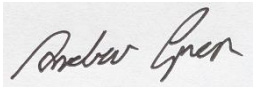
From a patient perspective, it cannot be assumed that all eligible patients would be aware that assisted dying might be an option for them and there is a risk that a prohibition may impact disproportionately on some minority groups who have unequal access to information.

Such a prohibition would also create uncertainty and legal risks for doctors. It may not always be clear, for example, whether a patient is asking about assisted dying – such as if a patient asks about the options open to them – leaving doctors at risk of inadvertently breaking the law.

I hope this is information is helpful.

I am copying this letter to Dr Ben Harris, President of the Isle of Man Medical Society.

Yours sincerely



**Dr Andrew Green**
Deputy Chair of Medical Ethics Committee
MEC lead on physician-assisted dying