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BMA

Physician-assisted dying
2020 BMA member survey

In February 2020, we will be going out to all BMA members for their views on what the BMA's position on physician-assisted dying should be. The results from the survey will not determine policy – but they will be published ahead of this year's annual representative meeting (ARM – the organisation's main policy-making body) and provided to those attending to help them make an informed decision about the BMA's policy position.

We represent doctors and medical students with a wide range of views on this issue. We want to hear from as many of our members as possible to ensure that any decision on our policy position takes account of the views of our wider membership.

This briefing has been put together by the Medical Ethics team at the British Medical Association, working with the Medical Ethics Committee. It provides an overview of some information about physician-assisted dying in the UK and internationally that you might want to consider before you participate in the survey.

For more detailed information on some of the issues covered in this briefing pack, you should refer to the reports of the BMA research on end-of-life care and physician-assisted dying from 2015, available at **bma.org.uk/endoflifecare**

You can find out more about the survey and how to get involved at **bma.org.uk/PAD**

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What is physician-assisted dying?

Physician-assisted dying refers to doctors' involvement in measures intentionally designed to end a patient's life. It covers situations:

- where doctors would prescribe lethal drugs at the voluntary request of an adult patient with capacity, who meets defined eligibility criteria, to enable that patient to self-administer the drugs to end their own life. This is sometimes referred to as **physician-assisted dying** or **physician-assisted suicide**; and

- where doctors would administer lethal drugs at the voluntary request of an adult patient with capacity, who meets defined eligibility criteria, with the intention of ending that patient's life. This is often referred to as **voluntary euthanasia**.

Eligibility for physician-assisted dying would be set out in any piece of legislation brought forward in the future, but for the purposes of this survey we are assuming that the criteria would fall between the following boundaries to cover patients who:

- are adults
- have the mental capacity to make the decision
- have made a voluntary request and
- have either a terminal illness or serious physical illness causing intolerable suffering that cannot be relieved.

We have made a deliberate decision not to tie our definition of physician-assisted dying to any specific model that has been proposed in the UK, or any model that is currently used overseas. This is because we want to ensure that the information we gather through this work has lasting relevance and can be used to respond to whatever eventuality may arise.

Why is the BMA consulting on this issue?

We are carrying out this work because a motion was passed at last year's annual representative meeting (ARM) which asked us to poll our members for their views on whether the BMA should shift its position from opposing a change in the law on physician-assisted dying, to adopting a neutral position.

We want to hear from as many of our members as possible to ensure that any decision on our policy position can be informed by the views of our wider membership.

How will the results be used?

Your answers will be kept confidential by the company conducting the survey on our behalf. The results will be analysed and the cumulative results will be published ahead of the ARM in June 2020.

The results of the survey will not make BMA policy. They will be shared with representatives attending the ARM and will feed into a discussion and debate on the BMA's position. You can find out more about how BMA policy is made here.

The information that you provide in the survey will help us in responding to any future legislative proposals and put us in a much stronger position to engage on your behalf in the event of any future legal change.

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What would each position mean for the BMA's work?

A decision on the BMA's policy position will guide how we will engage with or respond to any future proposals for a change in the law.

- A decision to remain **opposed** would mean that we would **actively oppose** attempts to change the law.

- A decision to adopt a **supportive** position would mean that we would **actively support** attempts to change the law.

- A decision to adopt a **neutral** position with respect to a change in the law to permit physician-assisted dying would mean that we would not take a view on whether or not the law should be changed.

It does not, however, mean that we would be silent on this issue. In any future legislative proposals we will continue to represent our members' professional interests and concerns.

How can I take part?

Keep checking **www.bma.org.uk/PAD**, and keep an eye on your emails and other BMA communications, for the most up-to-date information about the survey and how to participate.

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What is the law on physician-assisted dying in the UK?

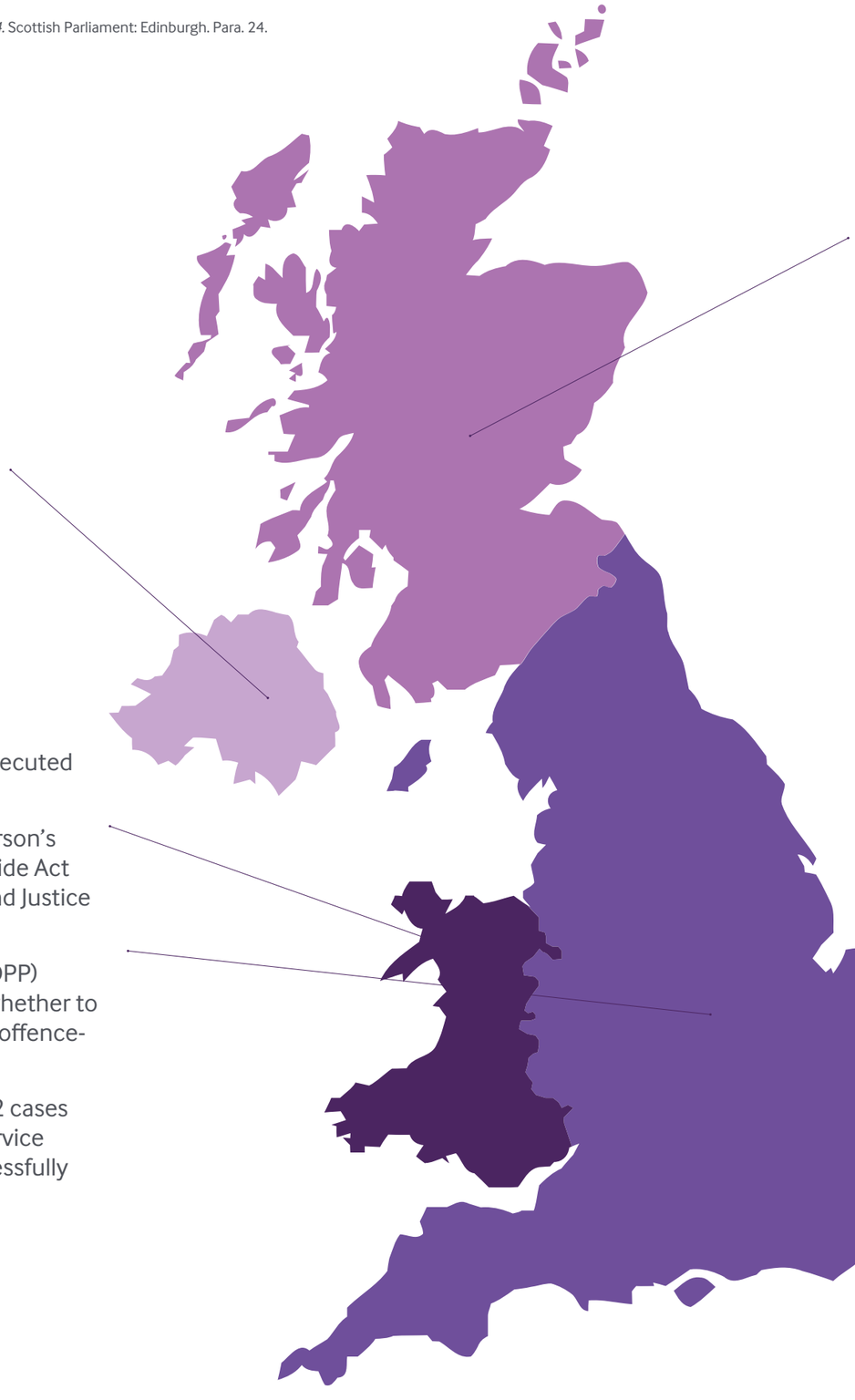
1. Lord Advocate, Frank Mulholland QC. Written evidence on the Assisted Suicide (Scotland) Bill (ASB 178).
2. Scottish Parliament (2015) *Official Report: Health and Sport Committee, Tuesday 13 January 2015. Session 4.* Scottish Parliament: Edinburgh. Para. 24.
3. Crown Prosecution Service (2019) Latest Assisted Suicide Figures, Update as of 31 July 2019.

Northern Ireland

Euthanasia is illegal and could be prosecuted as murder or manslaughter.

'Assisting or encouraging' another person's suicide is illegal under s.13 of the Criminal Justice (Northern Ireland) Act 1966, which extends the Suicide Act 1961 to Northern Ireland.

The Public Prosecution Service (PPS) examines individual cases to decide whether to prosecute. That decision is guided by offence-specific guidelines published in 2010.



Scotland

Euthanasia is illegal and could be prosecuted as murder or manslaughter.

There is no specific offence of assisting or encouraging suicide in Scotland. Any suspected offence would be dealt with under homicide law. (1)

The Crown Office and Procurator Fiscal Service (COPFS) makes the decision whether to prosecute. There are no offence-specific guidelines in Scotland and the decision will be taken on the basis of the general prosecution code. A legal challenge to compel the COPFS to produce offence-specific guidelines failed in 2015.

The last known prosecution was taken in 2006, in an unreported case. (2)

England and Wales

Euthanasia is illegal and could be prosecuted as murder or manslaughter.

'Assisting or encouraging' another person's suicide is prohibited by s.2 of the Suicide Act 1961, as amended by the Coroners and Justice Act 2009.

The Director of Public Prosecutions (DPP) examines individual cases to decide whether to prosecute. That decision is guided by offence-specific guidelines published in 2010.

Since April 2009, there have been 152 cases referred to the Crown Prosecution Service (CPS), three of which have been successfully prosecuted.(3)

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How has the law and BMA policy developed over the past twenty years?

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The Joffe Bill

Lord Joffe's Assisted Dying for the Terminally Ill Bill reached Committee Stage in the House of Lords. It would allow doctors to prescribe lethal drugs to terminally ill adults (with 6 months or less to live) for them to self-administer.

The Bill did not progress further after the 2005 General Election was called.

Diane Pretty

Diane Pretty had motor neurone disease, and asked for a guarantee that her husband would not be prosecuted if he assisted her to die.

Her case was rejected by the House of Lords, who held that the 'right to life' did not confer a 'right to die'. They also held that the 'right to a private life' did not include a right to choose the timing and manner of death.

Pretty v UK

Diane Pretty took her case to the European Court of Human Rights, which also rejected her case.

The Court did hold, however, that a right to choose how to end her life was part of a right to private life – but that the UK's ban on assisted dying could be justified to protect vulnerable people.

Debbie Purdy

Debbie Purdy had multiple sclerosis and argued that the law in the UK was insufficiently clear as to when someone will be prosecuted for assisting another person's death. She argued that the Director of Public Prosecutions (DPP) must publish guidelines on how a decision to prosecute a case of assisted dying will be made.

She won her case at the House of Lords and the DPP was compelled to publish guidelines.

Margo MacDonald's End of Life Assistance (Scotland) Bill

Margo MacDonald's End of Life Assistance (Scotland) Bill reached First Stage debate in the Scottish Parliament. It would allow doctors to provide lethal drugs to terminally ill adults or those who were "permanently physically incapacitated" for them to either self-administer or for a third party to administer to them.

It was defeated by 85 votes to 16.

The DPP publishes guidelines for prosecutors in England and Wales

Similar guidelines were published in Northern Ireland; Scottish Lord Advocate is clear that the guidelines do not apply in Scotland and that Scottish-specific guidelines will not be published.

The Falconer Bill

Lord Falconer's Assisted Dying Bill passed Second Reading in the House of Lords. It would allow doctors to prescribe lethal drugs to terminally ill adults (with 6 months or less to live) for them to self-administer.

The Bill did not progress further after the 2015 General Election was called.

Tony Nicklinson and Paul Lamb

Tony Nicklinson, who had locked-in syndrome following a stroke and Paul Lamb, who is paralysed from the neck down sought a declaration that the UK law was incompatible with their right to a private life.

The Supreme Court rejected the case and held that an issue of this importance was for Parliament to decide.

'Martin'

'Martin', who was paralysed following a stroke, joined the Nicklinson/Lamb appeal. He argued that the DPP's guidance was not sufficiently clear as to whether healthcare professionals who might accompany him to Switzerland would be prosecuted.

The Supreme Court rejected his claim – but the DPP did add a new footnote to the guidelines to clarify that the involvement of a healthcare professional, with a specific and professional duty of care to the individual, will be a factor tending in favour of prosecution.

Margo MacDonald's Bill

Margo MacDonald's Assisted Suicide (Scotland) Bill reached First Stage debate in the Scottish Parliament. It would allow doctors to prescribe lethal drugs to people with terminal, life-limiting, or life-shortening disease for them to self-administer.

It was defeated by 82 votes to 36.

The Marris Bill

Rob Marris came first in the ballot for Private Members' Bills in the House of Commons and introduced a Bill modelled on the Falconer Bill – with an additional requirement for a High Court judge to approve each application for assistance.

The Bill was defeated at Second Reading by 330 votes to 118.

Gordon Ross

Gordon Ross had Parkinson's Disease and brought a claim arguing that the Lord Advocate in Scotland should be compelled to publish guidance for prosecutors, similar to the DPP's guidelines in England and Wales.

His case was rejected by the Scottish Court of Session, which held that the law in Scotland is sufficiently clear.

Noel Conway

Noel Conway, who has motor neurone disease, brought a legal challenge arguing that the UK's ban on assisted suicide is incompatible with his right to a private life. He proposes a model where a High Court judge would have to agree that someone meets the eligibility criteria.

His claim was rejected by the High Court and the Court of Appeal, and his request to appeal was rejected by the Supreme Court. They reaffirmed the decision in *Nicklinson*, that Parliament was best placed to consider this issue.

Phil Newby and Paul Lamb

Phil Newby and Paul Lamb
In two separate applications, Phil Newby, who has motor neurone disease, and Paul Lamb, who had previously joined Tony Nicklinson's appeal, sought to challenge the current law on assisted suicide in the UK.

In both cases, the High Court refused permission for their cases to proceed to a full hearing, holding that Nicklinson was still the authoritative case on this issue.

2001
The BMA's annual representative meeting (ARM) debated and adopted a neutral position on assisted dying.
This was reversed the following year.

2002
BMA gave oral evidence to the House of Lords Committee examining Lord Joffe's bill.

2005
ARM debated and adopted current position of opposition to assisted dying.

2006
ARM debated and rejected a motion calling for the BMA to support a change in the law to allow the choice of an assisted death by patients who are terminally ill.

2007
BMA gave oral evidence to the special committee set up to consider the End of Life Assistance (Scotland) Bill.

2008
ARM debated and rejected a motion calling for the BMA to adopt a neutral position on physician-assisted dying.

2009
BMA carried out extensive engagement project on end-of-life care and physician-assisted dying.

2010
BMA gave oral evidence to the Health and Sport Committee considering the Assisted Suicide (Scotland) Bill.

2011
ARM debated and reaffirmed current position of opposition to assisted dying.

2012
ARM debated and passed a motion calling on the BMA to survey members on assisted dying.

2013
2014
2015
2016
2018
2019
2020

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For more detailed information on the cases and legislation mentioned here, please see Chapter 3 of Volume 1 of the end-of-life care and physician-assisted dying report, available at **www.bma.org.uk/endoflifecare**

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Map of international jurisdictions

Physician-assisted dying
2020 BMA member survey

- **Doctors permitted to prescribe lethal drugs for self-administration**
- **Doctors permitted to prescribe lethal drugs for self-administration AND to administer**
- **Court rulings create a defence for doctors**
- **Legislation pending public referendum**

Canada
Canadian Supreme Court ruled that Canada's ban on assisted dying violated citizens' rights in 2015; the Federal Government passed legislation on 'Medical Aid in Dying' in 2016. Doctors are permitted to prescribe drugs for self-administration **and** to administer.

Montana, USA
Doctors may have a defence to assisting in a person's suicide under a 2009 Court ruling.

Vermont, USA
Patient Choice and Control at the End of Life Act 2013 permits doctors to prescribe drugs for self-administration.

Maine, USA
Death with Dignity Act 2019 permits doctors to prescribe drugs for self-administration.

Oregon, USA
Death with Dignity Act 1994 permits doctors to prescribe drugs for self-administration.

Washington, USA
Death with Dignity Act 2008 permits doctors to prescribe drugs for self-administration.

Belgium
Belgian Act on Euthanasia 2002 permits doctors to prescribe drugs for self-administration **and** to administer.

The Netherlands
Termination of Life on Request and Assisted Suicide Act 2001 permits doctors to prescribe drugs for self-administration **and** to administer.

California, USA
End of Life Option Act 2015 permits doctors to prescribe drugs for self-administration.

Luxembourg
Right to Die with Dignity Act 2009 permits doctors to prescribe drugs for self-administration **and** to administer.

Switzerland
Swiss Criminal Code 1942 permits individuals to assist in another's suicide as long as the motive for doing so is not 'selfish'.

Colorado, USA
End of Life Options Act 2016 permits doctors to prescribe drugs for self-administration.

Italy
In 2019, the Italian Constitutional Court ruled that it is not always a crime to assist terminally ill patients experiencing 'intolerable suffering' to die. Work is ongoing in Italy to explore what this ruling means for the law more generally.

Washington DC, USA
Death with Dignity Act 2017 permits doctors to prescribe drugs for self-administration.

Victoria, Australia
Voluntary Assisted Dying Act 2017 permits doctors to prescribe drugs for self-administration **and**, in cases where an individual is physically unable to self-administer, to administer the drugs.

Hawaii, USA
Our Care, Our Choice Act 2019 permits doctors to prescribe drugs for self-administration.

New Jersey, USA
Aid in Dying for the Terminally Ill Act 2019 permits doctors to prescribe drugs for self-administration.

Colombia
In 1997, the Colombian Constitutional Court ruled that a doctor could not be prosecuted for assisting a terminally ill, consenting adult to die.

Western Australia, Australia
Voluntary Assisted Dying Act 2019 permits doctors to prescribe drugs for self-administration **and**, in cases where an individual is physically unable to self-administer, to administer the drugs. The Act will come into force in 2021.

New Zealand
End of Life Choice Bill, which permits doctors to prescribe drugs for self-administration **and**, in cases where an individual is physically unable to self-administer, to administer the drugs, was passed by the New Zealand Parliament in 2019. It will now go to a public referendum in November 2020, the results of which will be binding.

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What does the law look like in some of those places?

This comparative table outlines information about how the law operates in jurisdictions which permit some form of physician-assisted dying. For ease of reference we have selected information about the law in four jurisdictions where physician-assisted dying has been permitted for the longest time (Switzerland, Oregon USA, The Netherlands and Belgium) and the law in Canada, where the law has changed more recently.

	Switzerland Since 1942		Oregon Since 1997		The Netherlands Since 2001		Belgium Since 2002		Canada Since 2015	
Supply of lethal drugs for self-administration	✓	Permitted as long as the motive for doing so is not 'selfish'. There is not a centrally regulated process. Almost all assisted suicide takes place within frameworks set up by individual non-profit groups.	✓	Permitted by Death with Dignity Act 1994.	✓	Permitted by the Termination of Life on Request and Assisted Suicide Act 2001.	✓	Not explicitly regulated for – but it is not prohibited. The Federal Control and Evaluation Commission has accepted that cases of assisted suicide fall under the law.	✓	Permitted by an Act amending the Canadian Criminal Code. Referred to as 'medical assistance in dying' or MAID. This Act followed a ruling from the Supreme Court of Canada that the country's ban on assisted dying was unconstitutional.
Administration of lethal drugs by a third party	✗	Final act must be carried out by the individual themselves.	✗	Final act must be carried out by the individual themselves.	✓	Permitted by the Termination of Life on Request and Assisted Suicide Act 2001.	✓	Permitted by Belgian Act on Euthanasia 2002.	✓	Permitted by an Act amending the Canadian Criminal Code. Referred to as "medical assistance in dying" or MAID.
Adults only	✓		✓		✗	Must be at least 12 years old; parental consent required for those aged 12-16.	✗	Since 2014 there are no age restrictions; parental consent required for all those under the age of 18.	✓	
Terminal illness	✓	In principle, assisted suicide is lawful irrespective of the condition of the person who requests it. Individual organisations have their own internal policies which set out eligibility criteria. In practice, however, there are some limits. Individual organisations have their own internal policies which set out eligibility criteria. Additionally, doctors are only allowed to prescribe lethal drugs within the limits of accepted professional practice – which, as defined by the Swiss Academy of Medical Sciences is when an individual is "approaching the end of life".	✓	Individuals must have an incurable and irreversible disease that is likely to cause death within six months.	✓	The law covers physical and psychiatric conditions. Individuals must be experiencing constant and unbearable physical or psychological suffering with no prospect of improvement.	✓	The law covers physical and psychiatric conditions. Individuals must be suffering from constant and unbearable physical or psychological suffering which cannot be cured. Where death is not expected within the short-term, there is an additional application process. A third doctor must be consulted, and there must be a one-month waiting period between the request and the act itself.	✓	Individuals must have a serious and incurable illness, disease or disability which is causing enduring physical or psychological suffering that is intolerable to them. The requirement in the statute that death be 'reasonably foreseeable' has been successfully challenged in the courts, and change in the law by the federal government is now pending. The psychological suffering must stem from the underlying physical illness, disease or disability – MAID is not permitted for individuals for whom a psychiatric condition is their sole underlying medical condition.
Non terminal illness	✓		✗		✓		✓		✓	
Psychiatric illness	✗				✓		✓		✗	
Citizens/residents only	✗	Foreign citizens can receive assisted suicide through membership of organisations such as Dignitas.	✓		✓		✓		✓	
Voluntary request from a patient with capacity	✓	Individual organisations have their own internal processes for making a request. Professional guidance for doctors is clear that the person must have made a voluntary, persistent, and well considered request.	✓	Request must be made orally, then in writing, signed by two independent witnesses.	✓	Request must have persisted over time. There is no requirement for a request to be made in writing.	✓	Request must have persisted over time and be made in writing.	✓	Request must be made in writing and witnessed by two independent persons. There must be a 10-day waiting period between making the request and receiving assistance.
Advance decisions recognised	✗	Request must be contemporaneous.	✗	Request must be contemporaneous	✓	In April 2020, the Dutch Supreme Court ruled that patients with advanced dementia who have made a written advance request for euthanasia can receive it.	✓		✗	Request must be contemporaneous
Medical involvement	✓	Swiss law does not require doctors to be involved – but as they are the only persons who can prescribe lethal substances, in practice they are involved in every case.	✓	– Two doctors (one of whom is the doctor with primary responsibility for the patient's care; the other of whom must be a specialist in the patient's condition) must confirm that the individual meets the eligibility criteria. – One doctor must prescribe the lethal drugs. – The law does not require the presence of a doctor at the time a patient self-administers the drugs.	✓	– Two doctors (independent of one another) must confirm that the individual meets the eligibility criteria. – One doctor must 'carry out the death in a medically appropriate fashion' and be present at the time of death.	✓	– Two doctors (independent of one another) must confirm that the individual meets the eligibility criteria. – Where death is not expected in the short-term, an additional doctor must also be consulted.	✓	– Two doctors or nurse practitioners (independent of one another) must confirm the individual meets the eligibility criteria.
Conscientious objection	✓	Doctors are not compelled to participate in the process.	✓	Protected in statute; objecting doctors must transfer patient's medical records, upon request, to a new health care provider.	✓	Professional guidance is clear that doctors do not have an obligation to be involved.	✓	Protected in statute; conscientiously objecting doctors must handover care to another doctor.	✓	Statute is clear that no one is 'compelled' to provide or assist in MAID; the courts have made clear that conscientiously objecting doctors must make an 'effective referral'.
Regulation and reporting	✗	No central regulatory body; police must be notified of all "unnatural deaths" and can examine those deaths.	✓	Doctors must inform the Oregon Health Authority of any prescription they write. The Authority notifies the Oregon Medical Board of any suspicions of non-compliance with the law.	✓	Doctors must report the death to the municipal coroner. The coroner will inform one of five regional review committees, which will assess compliance with the law. Cases of non-compliance are referred to the public prosecutor.	✓	Doctors must report the death to the Federal Control and Evaluation Commission, which will assess compliance with the law. Cases of non-compliance are referred to the public prosecutor.	✓	Doctors and nurses must report all written requests of MAID either to their provincial or territorial health departments, or the federal health department, depending on their location.
Data	✗	Recorded causes of death do not differentiate between suicide and assisted suicide.	✓	Data are published annually. The 2018 Annual Report can be accessed here.	✓	Regional review committees publish a joint report annually. The 2018 annual report can be accessed here.	✓	Data are published every two years. The last report translated to English was published in 2016 and is available here.	✓	The federal government publishes data annually. The annual report for 2018 can be found here.

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Key arguments used in the debate on physician-assisted dying

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Key arguments used in the debate on physician-assisted dying

There are many strongly held views on both sides of the debate on physician-assisted dying, and a huge range of materials and literature has been published on the topic. Here we outline some of the key arguments used by those who support and oppose physician-assisted dying. These are not intended to be comprehensive but to provide an overview of the range of views and opinions expressed in the debate. Some people may disagree with some of these arguments or have different reasons to support their position.

Additionally, we set out some of the arguments used by those who support the BMA adopting a neutral position on physician-assisted dying, and those who oppose it. Again, these are not intended to be comprehensive, and individuals may have other reasons for their views.

Key arguments for and against physician-assisted dying

Those who oppose physician-assisted dying often use the following arguments.

1. Laws send social messages. An assisted dying law, however well intended, would alter society's attitude towards the elderly, seriously ill and disabled, and send the subliminal message that assisted dying is an option they 'ought' to consider.
2. So-called 'safeguards' are simply statements of what should happen in an ideal world. They do not reflect the real-world stresses of clinical practice, terminal illness and family dynamics. It is impossible to ensure that decisions are truly voluntary, and that any coercion or family pressure is detected.
3. For most patients, high-quality palliative care can effectively alleviate distressing symptoms associated with the dying process. We should be calling for universal access to high quality generalist and specialist palliative care, rather than legalising physician-assisted dying.
4. Licensing doctors to provide lethal drugs to patients is fundamentally different from withdrawing ineffective life-sustaining treatment, and crosses a Rubicon in medicine. The role of doctors is to support patients to live as well, and as comfortably, as possible until they die, not to deliberately bring about their deaths.
5. Currently, seriously ill patients can raise their fears, secure in the knowledge that their doctor will not participate in bringing about their death. If doctors were to have the power to provide lethal drugs to patients to end their lives, this would undermine trust in the doctor-patient relationship. Some patients (particularly those who are elderly, disabled or see themselves as 'a burden') already feel that their lives are undervalued and would fear that health professionals will simply 'give up' their efforts to relieve distress, seeing death as an easy solution.
6. Once the principle of assisted dying has been accepted, the process becomes normalised and it becomes easier to accept wider eligibility criteria or to widen eligibility through the use of anti-discrimination legislation.
7. In modern clinical practice many doctors know little of patients' lives beyond what the busy doctor may gather in the consulting room or hospital ward. Yet the factors behind a request for assisted dying are predominantly personal or social rather than clinical. Assisted dying is not a role for hard-pressed doctors.

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Those who support physician-assisted dying often use the following arguments.

1. Even with universal access to specialist palliative care, some dying people will still experience severe, unbearable physical or emotional distress that cannot be relieved. Forcing dying people to suffer against their wishes is incompatible with the values of 21st century medicine.
2. Physician-assisted dying is a legal option for over 150 million people around the world. In jurisdictions where it is lawful, there are eligibility criteria, safeguards and regulation in place to protect patients.
3. Guidance in the UK for end-of-life practices, such as the withdrawal of life-sustaining treatment, already contains safeguards to ensure decisions are made voluntarily, coercion is detected and potentially vulnerable people are protected. There is no reason why these safeguards could not be used effectively in assisted dying legislation.
4. The current law is not working. UK citizens travel to Switzerland, to facilities like Dignitas, to avail themselves of physician-assisted dying, but this option is only available to those who have the funds to do so. This often leads to people ending their lives sooner than they would have wished because they need to be well enough to travel. There is no oversight under UK law about who travels abroad for an assisted death; anyone who provides assistance – doctors, family or friends – is breaking the law, which can lead to criminal investigations.
5. There is widespread public support for, and tacit acceptance of, physician-assisted dying within society. Given this, it would be fairer and safer to have a properly controlled and regulated system within the UK.
6. Some people, knowing that they are dying, want to be able to exercise their autonomy and determine for themselves when and how they die, but need medical advice and support to achieve this. Doctors should not be able to impose their personal beliefs on competent, informed adults who wish to exercise this voluntary choice. Legislation would contain a conscientious objection clause to protect those healthcare professionals who did not want to participate.
7. The existence of legislation allowing assisted dying brings reassurance and peace of mind for many people with terminal illness and their loved ones, even though only a small percentage actually use it when the time comes.

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Key arguments for and against the BMA moving to a position of neutrality on physician-assisted dying

Those who support the BMA adopting a neutral position often use the following arguments.

1. The BMA represents doctors with a wide range of views on physician-assisted dying; adopting a neutral position would reflect this diversity and allow the BMA to represent the views of its membership more accurately.
2. The BMA taking a position 'for' or 'against' a change in the law erroneously implies that this represents 'the view' of the medical profession whereas in fact no such consensus exists.
3. This is an issue for society, not just for doctors – the BMA should not therefore seek to disproportionately influence the debate. Rather, the BMA should focus on ensuring that doctors' and patients' interests are protected in any proposed legislation.
4. Some argue that the BMA should focus on its trade union functions and should not take a public stance on any of these broader public policy issues.

Those who oppose the BMA adopting a neutral position often use the following arguments.

1. A decision by the BMA to move to a position of neutrality would be interpreted as the BMA dropping its opposition to physician-assisted dying, and could be seen as implicit acceptance of a change in the law.
2. Legislators look to professional bodies for their views on matters affecting them and the BMA's opposition to physician-assisted dying has been persuasive in Parliamentary debates in the past. A shift by the BMA to a position of neutrality would make a change in the law more likely.
3. The BMA cannot be neutral on an issue that will have a significant impact on doctors' clinical practice and could put vulnerable and disabled patients at risk.
4. The BMA is both a trade union and a professional association and as such must take a stance in important public policy debates that directly affect doctors and patients.

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Public and professional opinion on physician-assisted dying

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Public and professional opinion on physician-assisted dying

Within society, as well as within the medical profession, there is a range of views on physician-assisted dying. In 2015, as part of our end-of-life care and physician-assisted dying (ELCPAD) project, we reviewed the academic literature on doctors' views on assisted dying and some of the main polls, surveys and research on public opinion. This information is available on our website,[1] and is not repeated here.

Here we outline some of the surveys of public and professional opinion carried out since the ELCPAD work concluded. This includes:

- updated information on the British Social Attitudes Survey data provided in the ELCPAD report to include the results of questions asked in its 2017 survey;
- the 2019 survey carried out by the Royal College of Physicians;
- the 2019 survey carried out by the Royal College of Radiologists' Faculty of Clinical Oncology; and
- the 2019 survey carried out by the Royal College of General Practitioners.

We have also included details of the World Medical Association's declaration on this topic which was agreed in October 2019.

We have not included details of any of the recent polls commissioned by other organisations, but these can easily be found through online search engines.

British Social Attitudes Survey

The British Social Attitudes Survey is generally regarded as one of the most reliable surveys of public opinion as it uses a large and diverse sample and is regularly repeated. At varying intervals, a question is included about whether the law should allow active voluntary euthanasia performed by a doctor for a patient with a 'painful incurable disease'. The most recent survey to address this question was in 2017 and the results are set out in the table below, together with those from previous years when this question has been asked.

British Social Attitudes Surveys 1984-2017 – Attitudes to voluntary euthanasia

Should the law allow a doctor to end the life of a patient with painful incurable disease?	1984	1989	1994	2005	2010	2017
Yes	75	79	82	80	82	79**
No	24	20	15	18	n/a*	20***
Base	1,562	1,274	1,000	1,786	2,250	1,928

* Figure not provided in the report
** Definitely or probably should change the law to end the life of a patient with a painful incurable disease from which they will die.
*** Definitely or probably should not change the law to end the life of a patient with a painful incurable disease from which they will die.

In 2017, the BSA looked in more detail at euthanasia, considering public opinion on a range of different scenarios. The study analysed the levels of support across five different scenarios and assessed whether people thought voluntary euthanasia (administered by a third party) should 'definitely' or 'probably' be allowed for each scenario. The results are provided in the table below. More analysis and discussion of these results can be found in the report itself.[2]

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British Social Attitudes Survey 2017 – Attitudes towards voluntary euthanasia

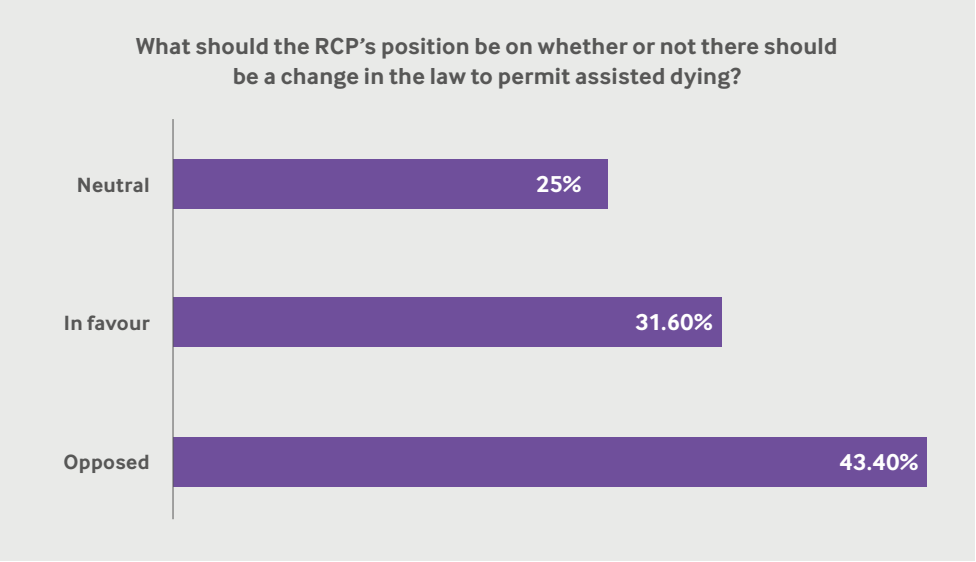
	By a doctor for someone with an incurable and painful illness from which they will die	By a close relative for someone with an incurable and painful illness from which they will die	By a doctor for someone with an incurable and painful illness from which they will not die	By a doctor for someone who is dependent, but not in pain or danger of death
Should the law allow voluntary euthanasia in this situation?	%	%	%	%
Definitely should	50	16	20	19
Probably should	29	23	30	31
Probably should not	8	26	22	21
Definitely should not	12	33	25	26
Unweighted base	*1928*	*1928*	*1928*	*1928*

Medical bodies

Royal College of Physicians (RCP)

The RCP polled its 36,000 members on what the College's position on physician-assisted dying should be in early 2019. A total of 6,885 responses were received and the results are set out below.

Royal College of Physicians – Assisted dying survey results 2019



The survey asked additional questions about whether the law should be changed in the UK to permit assisted dying, and whether, regardless of personal views, doctors would be prepared to participate in assisted dying should it become legal.[3]

The Council of the Royal College of Physicians had decided, in advance of the poll being conducted, that it would adopt a neutral position unless 60% of respondents said the RCP should be in favour of, or opposed to, a change in the law. As this 'supermajority' was not reached, the RCP moved from opposing a change in the law, to a position of neutrality. In October 2019, the High Court gave permission for this decision to be judicially reviewed. For more information see: https://www.rcplondon.ac.uk/news/update-legal-proceedings-related-assisted-dying-survey

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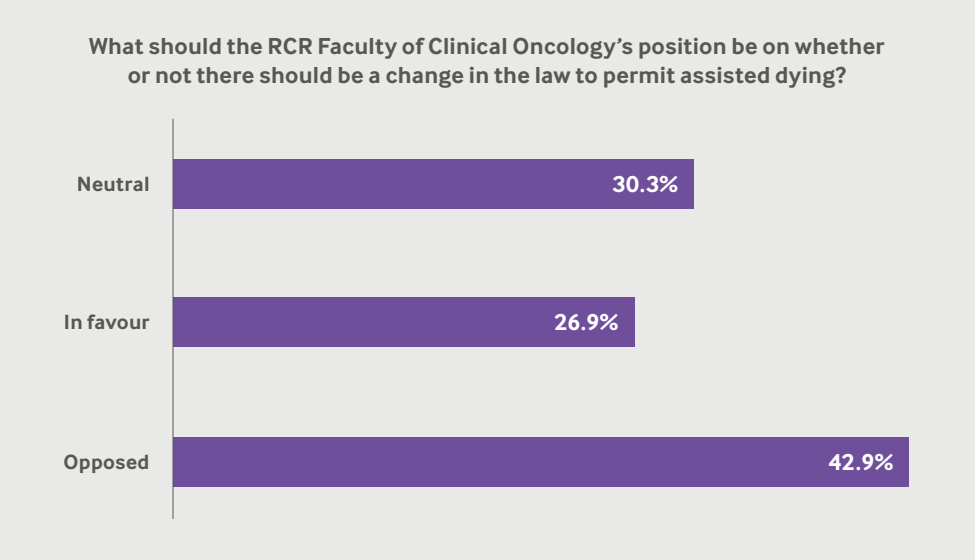
Royal College of Radiologists' (RCR) Faculty of Clinical Oncology

In February 2019 the Royal College of Radiologists surveyed the 1,572 members of its Faculty of Clinical Oncology on what its position should be on a change in the law to permit assisted dying. A total of 532 valid responses were received. The results are set out below.

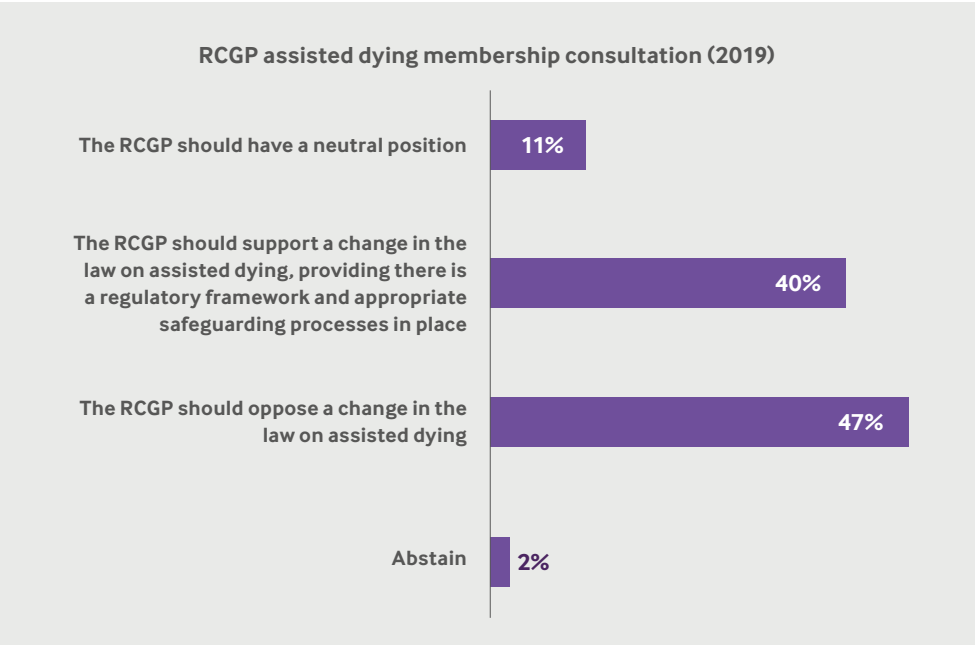
Royal College of Radiologists' Faculty of Clinical Oncology – Assisted dying survey results 2019



The survey asked additional questions about the respondents' personal views about a change in the law and whether, regardless of their personal views, they would be prepared to actively participate in assisted dying if the law changed to make it lawful.[4] The Royal College of Radiologists' Faculty of Clinical Oncology does not hold an official position on assisted dying.

Royal College of General Practitioners (RCGP)

The RCGP polled its members in late 2019 about what the College's position on the law on assisted dying should be. Of the 49,539 members who were invited to participate, a total of 6,674 members from across the UK responded.



Following the all-member consultation, the RCGP Council announced its decision to retain the College's opposition to a change in the law on assisted dying on 21 February 2020.

World Medical Association (WMA)
In October 2019 the WMA reaffirmed its long-standing policy of opposition to all forms of physician-assisted dying.[5] The revised declaration continues to state that no doctor should be forced to participate in assisted dying or be obliged to make referrals. The statement, in the previous declaration, that doctors who participate in assisted dying are acting 'unethically' has now been removed.

References

1 British Medical Association (2015) *End-of-life care and physician-assisted dying. Volume 1 – setting the scene, pp.76-96*. Available at: www.bma.org.uk/endoflifecare

2 National Centre for Social Research (2017) *British Social Attitudes 34 – Moral Issues* (available at: https://www.bsa.natcen.ac.uk/media/39147/bsa34_moral_issues_final.pdf)

3 The full results of the RCP's survey can be found online at: https://www.rcplondon.ac.uk/news/no-majority-view-assisted-dying-moves-rcp-position-neutral

4 The full results of the RCR Faculty of Clinical Oncology's survey can be found online at: https://www.rcr.ac.uk/posts/uk-clinical-oncology-members-and-fellows-poll-assisted-dying

5 World Medical Association (2019) *WMA Declaration on Euthanasia and Physician-assisted Suicide*. Available at: https://www.wma.net/news-post/world-medical-association-reaffirms-opposition-to-euthanasia-and-physician-assisted-suicide/

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