

## Written evidence submitted by The BMA (ADY0406)

### About the BMA

The BMA is a professional association and trade union representing and negotiating on behalf of all doctors and medical students in the UK. It is a leading voice advocating for outstanding health care and a healthy population. It is an association providing members with excellent individual services and support throughout their lives.

The BMA welcomes the opportunity to respond to the Health and Social Care Committee's inquiry into assisted dying.

### 1. Summary

1.1. The BMA represents members with a diverse range of views on this topic. Following a survey of our membership, the BMA changed its policy in September 2021 from opposition to one of neutrality, that is, we neither support nor oppose a change in the law on assisted dying. We have been clear, however, that we will continue to represent the professional interests and concerns of our members in any legislative proposals brought forward, using our professional knowledge and skills to advise on issues such as service provision and the protection of patients. The BMA is currently having internal discussions about some of the issues that would significantly impact on doctors if the law were to change in the future and, depending on the length of your inquiry, we may be able to provide some of the conclusions of that work at a later stage.

1.2. Members of the committee may find it helpful to read the following BMA reports in full:

- End-of-life care and physician-assisted dying (ELCPAD) volume 2: [dialogues events](#); and
- [BMA Survey](#) on Physician-assisted dying.

### 2. To what extent do people in England and Wales have access to good palliative care? a) How can palliative care be improved, and would such improvements negate some of the arguments for assisted dying/assisted suicide?

2.1. The BMA has long called for improved access to, and greater funding for, hospice and specialist palliative care services, to end the long-standing variability in access across the country. The requirement, in the Health and Care Act, for palliative and end-of-life care services to be commissioned across England, is welcome but this should be seen as a step in the right direction rather than an end to the problem of access.

2.2. The BMA strongly supports universal access to high quality generalist and specialist palliative care for all patients who need it, whether in hospitals, hospices, care homes or their own home, but recognised at its 2019 Annual Representative Meeting that 'not all patient suffering can be alleviated'.

2.3. Whether there is a connection between access to high-quality palliative care and requests for assisted dying is not clear-cut and is often linked to the views of the person making the assessment. In our own summary of the [key arguments for and against assisted dying](#), we have referred to palliative care on both sides, with a different emphasis based on the argument it is used to support:

FOR: 'For most patients, high-quality palliative care can effectively alleviate distressing symptoms associated with the dying process.'

AGAINST: 'Even with universal access to specialist palliative care, some dying people will still experience severe, unbearable physical or emotional distress that cannot be relieved.'

2.4. Where we believe there is agreement, however, is that people should not be driven to request assisted dying because of a lack of appropriate pain and symptom relief at the end of life. Any future change in the law, therefore, must not deter or delay investment in palliative care services.

### **3. What can be learnt from the evidence in countries where assisted dying/assisted suicide is legal?**

3.1. As with the question on palliative care, it is sometimes difficult to assess whether 'evidence' is presented in an entirely impartial way or is being used selectively to support a particular position (either intentionally or subconsciously) – whether that is in support of, or opposed to, a change in the law. Whilst it is possible to ascertain objectively, what the law states and how the system has been set up, and to assess the factual data collected, it is not so straightforward to objectively assess the impact and consequences of those laws or what the changes have meant in practice in those countries.

3.2. Where the BMA has found it helpful to look to the experience of other countries, however, is to look at how assisted dying services have been set up, the impact of that on doctors and the steps that have been taken to address some of the concerns doctors in those countries had. The BMA is liaising with medical associations in other countries to identify the issues that were of concern to their members and how, if at all, those concerns have been addressed. This work is currently ongoing and so we are not able to go into details at this stage, but some of the questions raised by doctors in other countries reflect those made by our own members in part 6 of our [all-BMA survey](#), which asked members about the issues they would want the BMA to comment on in the event of future legislation.

### **4. What are the professional and ethical considerations involved in allowing physicians to assist someone to end their life?**

4.1. In our 2020 all-BMA member survey, we invited our members to explain, in their own words, why they were supportive of or opposed to a change in the law. Half of respondents (a total of 14,436) responded to this, giving us some insight into the thinking of doctors about the professional and ethical considerations involved in assisted dying.

4.2. The reasons for supporting a change in the law, given by at least 5% of those who provided an answer, are listed below. (Percentages refer to the number of respondents who mentioned this issue - some respondents mentioned more than one reason).

- Patients should have the right to choose assisted dying as a treatment option in the same way as other treatments. These responses mentioned patients' 'right to die with dignity', that they should have choice and autonomy in the decisions surrounding their death and that the option of assisted dying would provide peace of mind (28%).
- Patients should not have to suffer unnecessarily if they want to end their lives. These responses mentioned that the role of the doctor is to 'relieve suffering', that this is morally and ethically the right thing to do and that they personally would want the option for themselves (23%).
- Would support a change in the law but on the condition that doctors are equipped with clear legislation and guidelines around how this would work in practice, including on issues such as eligibility, exploration of other options and that a second opinion would always be given (18%).
- Would support a change in the law provided that doctors were able to choose not to participate where they would not feel comfortable doing so (5%).
- Supportive of a change in the law but that prescribing life-ending drugs should be a specialist role only (5%).

4.3. The reasons for opposing a change in the law, given by at least 5% of those who provided an answer, are listed below.

- Assisted dying goes against their medical ethical beliefs around the role of doctors. These responses mentioned the Hippocratic Oath (specifically 'do no harm'), and that the role of doctors is to heal their patients and provide support and care rather than bring about their deaths (22%).
- Risks to vulnerable patients and concern around how certain groups of patients could be protected, for instance those who may feel a burden to their families, patients who might be coerced into making this decision and those suffering from mental health issues (18%).
- The focus should be placed on providing better quality palliative and end-of-life care, rather than on assisted dying. Responses indicated a concern that palliative care provision may worsen as a consequence of a change in the law and that if high-quality palliative care was already available for every patient who needs it, those patients may change their minds (14%).
- The negative consequences of assisted dying are yet unknown. These responses included views that a change in the law would be merely the starting point ('the thin end of the wedge') and that we would then be on a 'slippery slope' to, for example, a widening in eligibility criteria and the devaluing of the lives of older people and other groups in society (12%).
- Their own personal ethical or religious beliefs, a feeling that life is sacred or, for some, that to take part in assisted dying would be 'playing God' (9%).
- Prescribing life-ending drugs would negatively impact on the relationship between patient and doctor and would harm trust in the relationship (6%).
- Risks to doctors – legal liability as well as having adequate time to carry out the task of prescribing sufficiently well given doctors' already heavy workload (6%).

4.4. There was a very clear message throughout the survey that there must be no requirement on individual doctors to participate in assisted dying if the law were to change. Only 3% of the 27,907 who responded to a question on conscientious objection, selected 'all doctors should be expected to participate'. This was expanded in the free text answers where it was added that there must be 'no repercussions' for those who do not wish to participate.

4.5. The possible impact of legalising physician-assisted dying on the doctor-patient relationship was discussed in detail in our [2015 dialogue events](#). As mentioned above, some considered that legalising physician-assisted dying would have a negative impact on the doctor-patient relationship; others, however, believed that allowing doctors to provide this option would lead to improvements in the doctor-patient relationship. Views were mixed although overall doctors tended to be more negative and have greater fear about the potential impact of physician-assisted dying on doctor-patient relationships than the public.

## **5. What, if any, are the physical and mental health criteria which would make an individual eligible to access assisted dying/assisted suicide services?**

5.1. The BMA does not currently have a formal view on what the health criteria for eligibility should be in any future legislation although we do have some information about the views of our members from our 2020 survey.

5.2. A question about which patients should be eligible for assisted dying (should the law change in the future) was answered by 28,013 of our members (doctors and medical students). Respondents could choose only one of the options offered and:

- 59 % chose 'patients with a physical condition causing intolerable suffering which cannot be relieved'
- 24% chose 'patients with a terminal illness where death is expected within 6 months'
- 10% chose 'patients with a terminal illness where death is expected within 12 months'
- 8% chose 'patients with a terminal illness where death is not expected within 12 months' and
- 29% chose 'no patients should be eligible to access these drugs'.

In addition, 1,450 members provided a free text response, of which:

- 41% said the focus should be quality of life and not linked to prognosis/life expectancy
- 19% included patients with a mental health condition causing intolerable suffering which cannot be relieved
- 12% said patients with a condition that is expected to get worse and may choose this option before experiencing intolerable suffering
- 11% said patients with a terminal illness where death is expected within a shorter time frame than 6 months
- 7% would include patients who lack capacity but have made an advance request for this and
- 7% said consideration should take place on a case-by-case basis.

## **6. What protections could be put in place to protect people from coercion and how effective would these be?**

6.1. The BMA does not have a position on this issue. It was, however, discussed in some [dialogue events](#) on end-of-life care and physician-assisted dying we carried out with the public and doctors in 2015. Participants were asked to consider three different options for who should decide on eligibility – the patient's own doctor, an independent doctor or a High Court Judge. Although overall, members of the public were less supportive of the third option, they did nonetheless consider that judges would be able to assess coercion given that they are experienced in weighing up evidence. Many participants (doctors and public) thought the best way to assess coercion would be via a team assessing eligibility; counsellors, mental health professionals, family members, GPs, nurses or an ombudsman were other options suggested for assessing whether coercion had occurred.

## **7. What information, advice and guidance would people need in order to be able to make an informed decision about whether to access assisted dying/assisted suicide services?**

7.1. The BMA does not currently have a formal position on this.

## **8. What capabilities would a person need to be able to consent to assisted dying /assisted suicide?**

8.1. The BMA does not currently have a formal position on this.

## **9. What should the Government's role be in relation to the debate?**

9.1. It is for the Government to decide whether to initiate, or make Parliamentary time available, to debate this topic. If it becomes clear, however, that it is the will of Parliament to change the law to permit assisted dying, the Government must step in to ensure that any legislation is fit for purpose and that it is implemented in a way that protects patients, the public and health professionals, both those who wish to participate and those who do not. The Government should also ensure there is a rigorous, transparent equality impact assessment which is made available for public scrutiny.

9.2. In the BMA's view, if Parliament should decide to legislate for physician-assisted dying, there must be:

- 1) a robust legal and regulatory framework providing clarity about what is, and is not, permitted under the law, particularly in relation to eligibility criteria, process and any obligations placed on doctors;
- 2) robust conscience rights included in any future legislation on physician-assisted dying – these could be respected, for example, by allowing doctors to 'opt out' via a right to conscientious objection or by using an 'opt-in' model of delivery;
- 3) a formal mechanism for oversight of the process;
- 4) a national system for the collection and publication of data; and
- 5) clear guidance, training and both practical and emotional support for those involved.

While developing legislation or supporting materials, or considering how any such legislation should be implemented, the following should also be considered:

- the need to ensure patient access is not limited by locality/geography;
- the views and experiences of dying patients, their relatives, and their carers; and
- the evidence from countries in which physician-assisted dying has been legalised.

9.3. Although the BMA is neutral on whether or not the law should change, in the event of legislation becoming likely the BMA would expect to be consulted, and involved in discussions, in order to ensure that our members' views and concerns are represented.

9.4. If Parliament decides to change the law on assisted dying, the Government must ensure that additional funds are made available to ensure that the service is properly resourced, and that funding and workforce are not diverted from other services.

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