

Assisted Dying Bill

House of Lords Second Reading Briefing July 2014

The British Medical Association (BMA) is a voluntary professional association and independent trade union which represents doctors and medical students from all branches of medicine all over the UK. With a membership of over 153,000 worldwide, we promote the medical and allied sciences, seek to maintain the honour and interests of the medical profession and promote the achievement of high quality healthcare.

Executive Summary

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

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. Accordingly, the BMA opposes the Assisted Dying Bill in its entirety.

This briefing sets out the BMA's policy and the key reasons underlying the BMA's opposition to any change in the law which would permit assisted dying. Further information about 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 Lords Library.

The BMA's policy on assisted dying was agreed in 2006, and 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.¹**

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.)

People facing the effects of terminal illnesses and other incurable conditions should receive the best possible treatment and care. This should not extend to giving anyone a legal right to end their life with assistance.

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. The BMA's view is that the unique relationship between doctors and patients risks being undermined, and trust lost, if doctors were permitted to play a role in ending patients' lives. The doctor's role is one of improving health and welfare and minimising suffering. 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 – would fundamentally alter the ethos within which medical care is provided.

As doctors may legally withdraw life-sustaining treatment in certain circumstances, some question why they should not go further. It is the BMA's view that this is not fundamentally a question about whether there is a difference between commission and omission – killing and letting die – but rather about the intention behind a doctor's actions. When treatment is held or withdrawn, the intention is not to end the patient's life, but to refrain from providing an intervention that is burdensome and cannot benefit the patient. If doctors are authorised to kill deliberately, or help kill, however carefully circumscribed the situation, they acquire an additional role that the BMA believes is alien to 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 personal autonomy has 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 weak 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 put under pressure to end their lives. 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. A study of the first five years of Oregon's Death with Dignity Act found that 44 per cent of patients who had 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.² Whilst many of the choices we make in life are predicated upon doing the best we can for those close to us, the BMA believes that issues of life and death are in a different category from most other decisions. It would be an undesirable outcome if allowing assisted dying generated a perception that some lives are worth less than others, or made people consider assisted dying to be an option they *ought* to consider.

Vulnerable individuals may begin to fear that a premature death would 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."³ 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.⁴

A recent study conducted by King's College London's Institute of Psychiatry highlighted concerns about the assessment of mental capacity in relation to assisted dying, and the insufficient protection it offers patients.⁵ The study analysed the oral and written evidence submitted to the Commission on Assisted Dying and found that whilst there was agreement amongst stakeholders on the importance of mental capacity as a crucial component of any proposed legislation, there was no clear consensus on the definition of mental capacity;

what level of capacity was appropriate; or how it should be assessed. This followed the findings of the House of Lords Select Committee on the Mental Capacity Act, which concluded that the Act was frequently failing vulnerable adults, by virtue of the fact that healthcare professionals and others involved in their care were often unaware of the provisions of the Act and thus failed to implement it appropriately.⁶ Accordingly, the BMA has serious concerns about how robust the safeguards outlined by the Bill regarding mental capacity are in offering protection to the most vulnerable members of society.

The Supreme Court, in their recent judgment on the Tony Nicklinson, Paul Lamb, and Martin case, described the issue of vulnerability as a “formidable problem.”⁷ They noted that the Falconer Commission on Assisted Dying had not found evidence of abuse of the law in jurisdictions where assisting suicide is legal. However, they further noted that this could not be taken to mean that there is no risk whatsoever of abuse, due to the numerous problems in obtaining negative evidence, combined with the limited scope for information given the few countries where assisted suicide is permitted and the relatively short time for which it has been lawful. In the leading judgment, Lord Neuberger concluded that the concern of pressure on vulnerable individuals cannot be rejected outright as “fanciful or unrealistic.”⁸

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 suicide 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 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.⁹ The law in the Netherlands also permits ending the life of seriously disabled neonates. Earlier this year, the Belgian Parliament passed legislation allowing euthanasia for terminally ill children, a further example of a law being extended far beyond the limits originally envisaged at its inception.¹⁰

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

In the first five years of Oregon’s Death with Dignity Act 1994, patients cited not only a fear of inadequate pain control as a reason for seeking a lethal prescription, but also the fear of being a burden on family and friends; losing their autonomy; having less ability to participate in activities which made life enjoyable; and losing control of bodily functions.¹¹ Skilled and compassionate palliative care, with good communication and patient involvement, can help with these issues. People fear many aspects of the dying process, including the possibility of not being listened to, being neglected, or the opposite – that medical technology will take over and delay or prolong death. This does not mean that society has to reject the advances and palliation available at the end of life through modern medicine, but rather have more awareness of what can be provided by way of support.

In the BMA’s view, by focussing on assisted dying as a solution to people’s natural anxieties about end of life care society is having the wrong debate. Widespread availability of high quality palliative care services would be likely to diminish the demand for assisted dying. Patients and their families need to know about 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.

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 in palliative care; for better information to be made available to the public about what can be achieved by good palliative care; and better training in palliative medicine for all doctors involved in the care of dying patients.

For further information, please contact:

David Knowles, Senior Public Affairs Advisor

T: 0207 383 6520 **E:** dknowles@bma.org.uk

BMA House | Tavistock Square | London | WC1H 9JP |

References

¹ In light of this policy, the BMA declined to give evidence to Lord Falconer's Commission on Assisted Dying in 2010, which was established to investigate the circumstances under which it should be possible for people to be assisted to die in the UK. For similar reasons of inconsistency with BMA policy, it would be inappropriate to engage with the detailed proposals in the Assisted Dying Bill.

² Department of Human Services (2003) *Fifth Annual Report on Oregon's Death with Dignity Act*. Oregon: DHS at 20.

³ Legislative Assembly of the Northern Territory Select Committee on Euthanasia (1995) *Report of the Inquiry by the Select Committee on Euthanasia*. Vol. 2 Transcripts of Oral Evidence (Public Hearing, Thursday 6 April 1995). Legislative Assembly of the Northern Territory, Darwin, s.2.

⁴ Segers, JH. (1988) "Elderly persons on the subject of euthanasia." *Issues Law Med* 3, 429-37.

⁵ Price, A et al. "Concepts of mental capacity for patients requesting assisted suicide: a qualitative analysis of expert evidence presented to the Commission on Assisted Dying." *BMC Medical Ethics* 2014, 15:32.

⁶ House of Lords Select Committee on the Mental Capacity Act 2005 (2014) *Mental Capacity Act 2005: post-legislative scrutiny*. London: HL.

⁷ *R (on the application of Nicklinson and another) (Appellants) v Ministry of Justice (Respondent); R (on the application of AM) (AP) (Respondent) v The Director of Public Prosecutions (Appellant)* [2014] UKSC 38, at 228.

⁸ *Ibid.*, at 88.

⁹ Sheldon, T. (1994) "The doctor who prescribed suicide: Was the Dutch psychiatrist Dr Boudewijn Chabot right to help a sane, healthy woman to take her own life?" *The Independent*, 30 June 1994. Available at www.independent.co.uk (accessed 11 June 2014)

¹⁰ Law of 28 May 2002 on Euthanasia, amended by the Law of 13 February 2014. Unofficial translation available at <http://eol.law.dal.ca/wp-content/uploads/2014/02/Law-of-28-May-2002-on-Euthanasia-as-amended-by-the-Law-of-13-February-2014.pdf> (accessed 9 July 2014).

¹¹ Department of Human Services (2003) *Fifth Annual Report on Oregon's Death with Dignity Act*. Oregon: DHS at 20.