

The BMA's views on legislation on physician-assisted dying

Since September 2021, the BMA has taken a neutral position on assisted dying. This means that we neither support nor oppose a change in the law. The legalisation of assisted dying would, however, have a significant impact on doctors, and so we have a responsibility to protect and represent our members in any debates on legislation.

Through engagement with our members dating back to 2015, and an intensive piece of work by our Medical Ethics Committee, we have identified the issues that would significantly impact on doctors if the law changed, and developed views on what we would want to see in any future legislation. These views – which are summarised below – have been supported by members with very diverse views on the topic of assisted dying itself and have been approved by all four BMA Councils across the whole of the UK. We have subsequently engaged with legislators in the UK and Crown Dependencies to promote these views on behalf of our members. (for information see www.bma.org.uk/pad).

1. [An opt-in model for doctors to provide assisted dying](#)

Only those who positively choose to provide the service should be able to do so. This would give our members the maximum amount of choice about whether, and if so how, they are involved if assisted dying were legalised. It would also ensure that those who wanted to participate would receive the proper training and support and make the service easier to audit. This would also mean that patients would be assured that they will see a doctor who is supportive of their request and who has the knowledge, skills, experience and confidence to provide the care and support they need.

2. [A general right to decline to carry out activities directly related to assisted dying](#)

A standard conscientious objection clause is not sufficient for legislation on assisted dying. Doctors who do not opt-in to provide the service may, nonetheless, be asked to carry out tasks such as assessing capacity or life-expectancy to be used as part of the assessment of eligibility. If assisted dying were legalised, there should be a general right to decline to carry out these activities, which does not need to be based on matters of conscience.

3. [No duty to raise the issue of assisted dying with patients](#)

The BMA's view is that assisted dying is not a 'treatment option' in the conventional sense and so the Supreme Court judgments of [Mongomery](#) (concerning the scope of information that must be provided when seeking consent to treatment) and [McCulloch](#) (which covers doctors' duties to raise treatment options with patients) are not relevant to assisted dying. For the avoidance of any doubt, however, the BMA would want to see specific provision in any legislation to make clear that there is no duty on doctors to raise assisted dying with patients if it were legalised. Doctors should be trusted to use their professional judgement to decide when and if a discussion about assisted dying would be appropriate, taking their cue from the patient as they do on all other issues.

4. [No prohibition on raising assisted dying with patients](#)

The BMA would not support a prohibition on doctors raising the issue of assisted dying with patients. Doctors should be able to talk to patients about all reasonable and legally available options; a provision that limits or hinders open discussion about any aspect of death and dying is likely to be detrimental to patient care. A prohibition would also create uncertainty and legal risks for doctors, which may inhibit effective doctor/patient communication and understanding.

We note that official bodies in [New Zealand](#) (pages 7 and 10) and [Victoria](#) (page 34) have raised concerns about the impact of this provision in their legislation and have recommended that it is amended.

5. [Assisted dying should be provided as a separate service.](#)

If legalised, the BMA does not believe that assisted dying should be part of the standard role of doctors or integrated into existing care pathways. Rather, it should be arranged, but not necessarily delivered, through a separate service that would accept referrals from other professionals and/or self-referrals. (This does not necessarily mean separate from the NHS.) Doctors who wanted to do so could still assist their own patients, but this would be arranged, and potentially managed, through a different pathway. The [model proposed in Jersey](#), whereby the Jersey Assisted Dying Service would 'coordinate and deploy the professionals' who would provide the service, provides an example of how this could work.

The separate service could take the form of a professional network of specially trained doctors from across the country who have chosen to participate, who come together to receive specialised training, guidance, and both practical and emotional support. They would then provide the service within their own locality – for example, in the patient's usual hospital, or their home. Or it could be a combination of some specialist centres and an outreach facility. In our view, having this degree of separation would be better for doctors and for patients and would help to ensure consistency, and facilitate oversight, research and audit of the service.

6. [An official body to provide information for patients](#)

If assisted dying were to be legalised, the BMA would wish to see the establishment of an official body (with legal accountability) to provide factual information to patients about the full range of options available to them, so that they can make informed decisions. This would ensure that doctors who did not wish, or did not feel confident, to provide information to patients about assisted dying had somewhere they could direct patients to, in the knowledge that they would receive accurate and objective information. It would also ensure that patients who may meet the eligibility criteria would be able to access the information they need without the requirement to go through their doctor and would have support to navigate the process.

7. [Adequate funding and equitable access](#)

Governments must provide additional resources so that money and staff are not diverted from other, already over-stretched, services if assisted dying were to be legalised. The BMA has not taken a position on how assisted dying should be funded (and, in particular, whether it should be part of the NHS) but we are clear that it should be available to all those who meet the eligibility criteria on an equitable basis.

8. [Statutory protection from discrimination or detriment](#)

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.

9. [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.

10. A formal review of all assisted deaths

The BMA would want to see a system for routinely reviewing all assisted deaths to ensure that the correct process was followed, and to identify learning points to improve the management of cases, if assisted dying were legalised. Review committees are common in countries that have legalised assisted dying.

11. The collection and publication of data

If legalised, there should be a requirement for data about all assisted deaths to be collected centrally, and for aggregated data to be published on a regular basis, to ensure openness and transparency.

12. Open and transparent regulation

The BMA does not have a view on what form it should take but, if the law changed, we would strongly support the establishment of an independent and transparent system of oversight, monitoring and regulation.

More information about the BMA's views, and our engagement with legislative proposals across the UK and Crown Dependencies, can be found at www.bma.org.uk/pad.

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