

BMA written evidence
Bill Committee on the Terminally Ill Adults (End of Life) Bill

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.

1. Summary: BMA position on assisted dying

1.1 Policy position

Our membership holds a wide range of views on physician-assisted dying. In 2021, the BMA's annual policy-making conference (ARM) [voted to adopt a neutral position on whether the law should be changed to permit physician-assisted dying](#): the BMA neither supports nor opposes a change in the law.

1.2 Views on legislation

1.3 Our Medical Ethics Committee (MEC) considered how we can best protect and represent our members in response to legislative proposals to permit assisted dying. Within the context of our neutral position on whether the law should change, we have identified those issues that would significantly impact on doctors, if the law were to change. [The views arising from this work](#) have been approved by the four BMA Councils across the UK.

1.4 Member survey

1.5 The [BMA's 2020 all-member survey on physician-assisted dying](#)¹ is one of the largest surveys of medical professional opinion on physician-assisted dying ever conducted. It informed the policy-making vote at our 2021 ARM and our MEC's work.

2 The Terminally Ill Adults (End of Life) Bill: BMA views to inform the Bill

2.1 The BMA is neutral on whether or not the Bill should pass, but [our views](#) on what we would want to see in the Bill, should it pass, are outlined below under thematic headings. Additional issues we have considered are listed at (7).

3 [General approach](#)

3.1 An 'opt-in' model for doctors to provide assisted dying:

The Bill 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 (e.g. assessing eligibility and/or prescribing for eligible patients).

3.1 An opt-in model is not explicit in the Bill. However, given only those doctors who meet the required training, qualifications, and experience would be able to participate, and no doctor would be under any duty to participate, it is our understanding that it would only be those doctors who actively choose to do the training who would, in effect, be opting in to provide the service.

3.2 We urge the committee to make it explicit in the Bill that this is an opt-in arrangement for doctors. Furthermore, references to 'training' should be more clearly defined in the Bill as specialised training to provide assisted dying.

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

¹ The survey was conducted on our behalf by Kantar, an independent research organisation. The results of our survey can be viewed here: www.bma.org.uk/advice-and-support/ethics/end-of-life/physician-assisted-dying/physician-assisted-dying-survey

We welcome the Bill's inclusion of a right to refuse to carry out activities directly related to assisted dying for any reason (such as assessing capacity or determining life-expectancy specifically to assess eligibility)². This is vital – our survey revealed that some doctors do not oppose the legalisation of assisted dying but would not want to participate themselves; these doctors would not be covered by a conscientious objection clause. A number of other medical bodies are also calling for this.

3.4 There is, however, an inconsistency with the Bill's provision that a doctor, who is unwilling or unable to conduct the preliminary discussion, must refer the patient to another doctor who would be willing to do so.

3.5 We urge the committee to remove the referral requirement and, instead, make it clear that the doctor's duty is to direct patients to where they can obtain information and have that discussion. We suggest elsewhere that this should be an official body set up to provide individual information and advice to patients, to which patients could be referred or directed to, or could self-refer.

3.6 Secondly, we are concerned that using the word 'assistance' in the titles of Clauses 18 + 19 could be interpreted (by a court, for example) as narrowing the right to refuse in Clause 23(1). We would be very concerned if doctors only had the right to refuse to carry out the activities detailed in Clauses 18 + 19 which are the process of providing the approved substance for the individual to self-administer and remaining with the patient until they have died.

3.7 We urge the committee to review the use of the word 'assistance' throughout the Bill; Clauses 18 + 19 might be better titled as 'Providing assisted dying' and 'Authorising another doctor to provide assisted dying', or similar, to avoid confusion over multiple uses of (and meanings associated with) 'assistance' in the Bill. It is essential that the right to refuse is not (unintentionally) narrowed in any way.

4 [Measures to protect doctors from discrimination and abuse](#)

4.1 **Statutory protection from discrimination:**

We welcome the Bill's specific provision stating that an employer must not subject an employee to detriment for deciding to participate, or not, in assisted dying.

4.2 We urge the committee to clarify whether this provision would cover potential, as well as existing, employees (e.g. job applicants), unpaid volunteers, and self-employed doctors (including GPs). Clearly, there would need to be scope for some exceptions to allow, for example, an assisted dying service to only employ people willing to actively participate in the provision of assisted dying, without falling foul of this provision.

4.3 **Provision for safe access zones:**

4.4 We urge the committee to consider adding a provision for safe access zones (to be invoked should the need arise) to protect staff and patients from harassment and/or abuse.

5 [Delivering an assisted dying service](#)

5.1 **Assisted dying as a separate service (but not necessarily separate from the NHS):**

There is nothing in the Bill about how an assisted dying service might be delivered, although the possibility of a separate service is mentioned in the explanatory notes. Whilst it is not for the BMA to determine how any assisted dying service should be delivered, our view is that assisted dying should not be part of the standard role of doctors or integrated into existing care pathways – it is not something that a doctor can just add to their usual role. It is likely that most doctors would rarely receive such requests, making it difficult for them to build up the knowledge, experience, and confidence to provide the service to a high standard, which is what all patients would deserve.

² It states that no doctor is under any obligation to provide or assist an assisted death, and no doctor would be under any duty to raise the subject of assisted death.

5.2 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.

5.3 [The model proposed in Jersey](#)³, whereby the Jersey Assisted Dying Service would ‘coordinate and deploy the professionals’ who would provide the service, provides an example of how this separate service could work.

5.4 There should be no duty to raise the issue of assisted dying with patients:

5.5 We welcome the Bill’s provision that a doctor is not under a duty to raise assisted dying. This is necessary to avoid any suggestion that doctors have a legal duty to raise it.

5.6 There should be no prohibition on doctors initiating discussion with patients about assisted dying:

5.7 We welcome clause 4(2). 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. 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.

5.8 A prohibition would also create uncertainty and legal risks for doctors, which may inhibit effective doctor/patient communication and understanding. Some patients find it difficult to bring up sensitive subjects in their consultations, and doctors are skilled at reading between the lines of what patients say and working out what has been left unsaid. It may be clear to the doctor that the patient wishes to explore the topic without them actually mentioning assisted dying. In this situation, a doctor who responded by gently exploring whether this was an issue the patient wished to discuss, could subsequently be open to legal challenge (for example, if a family member argued that the doctor, rather than the patient, had initiated the discussion).

5.9 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.

5.10 An official body to provide information for patients:

5.11 Clause 31 reflects the need for accurate, impartial information and advice for patients, but gives no indication of how this might be delivered. Generic published information would not be sufficient – patients would need individual advice, guidance, and support.

5.12 We would support the establishment of an official body (with legal accountability) to provide factual information to patients about the 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. Patients should be able to access this service directly or via a health professional.

5.13 Adequate funding and equitable access:

5.14 If this Bill is approved by Parliament, the Government would need to ensure that additional funds are made available so that the service is properly resourced, and that funding and workforce are not diverted from other, already overstretched, healthcare services. They would also need to

³ A separate assisted dying service – ‘the Jersey model’ – can be viewed on the BMA’s website here: www.bma.org.uk/media/c4qhenaf/bma-flow-chart-jersey-model.pdf

ensure that the service is available to all those who meet the eligibility criteria on an equitable basis.

6 [Establishing proper oversight and regulation](#)

6.1 **The collection and publication of data:**

6.2 The Bill only states that the Secretary of State *may*, by Regulations, specify the information that registered medical practitioners must provide to the relevant CMO.

6.3 Data collection and publication is essential for transparency and developing trust in the system – therefore, a requirement for data about all assisted deaths to be collected centrally, and for aggregated data to be published on a regular basis, should not be optional. We urge the committee to ensure that the Bill requires (rather than permits) the Secretary of State to make such Regulations.

6.4 **A detailed review of all assisted deaths:**

6.5 We urge the committee to ensure that the Bill requires a process for the routine review of all individual assisted deaths – including identifying the time from taking the drugs to death, and any complications or unforeseen circumstances that arose and how they were managed. Review committees are common in other jurisdictions. Such a process can lead to improvements in how cases are managed from a medical perspective, and help to identify learning points for those delivering the service. It would also enable checks to be made in all cases to ensure that the proper process had been followed, and any necessary action taken if it has not been.

7 [Additional issues we have considered](#)

7.1 **Definitions – ‘registered medical practitioner’ and ‘doctor’:**

7.2 The use of both the term ‘registered medical practitioner’ and ‘doctor’ at different places in the Bill introduces uncertainty. The easiest way to avoid any confusion would be to use a single term and then define it within the Bill. We urge the committee to consider this potential point of confusion/ambiguity.

7.3 **Definitions – ‘terminal illness’**

7.4 The BMA has not taken a position on the eligibility criteria for assisted dying but is aware that some questions have been raised about how the current definition of terminal illness should be interpreted. It is essential for doctors that there is no ambiguity about who would be eligible under the Bill.

7.5 **Protection for doctors who treat patients from other parts of the UK and/or Crown Dependencies**

7.6 Clause 24 gives protection for doctors who provide assistance to patients under this Bill but does not extend that protection to doctors who treat patients from elsewhere in the UK or Crown Dependencies, should assisted dying be legalised in those jurisdictions. Given the extent of formal, and informal, shared care arrangements between jurisdictions, this would leave our members at risk.

7.7 We would, therefore, hope to see an amendment to extend this clause to include an exemption for activities covered by assisted dying legislation in the rest of the UK and/or Crown Dependencies.

7.8 **Protecting doctors from pressure to approve a request for assisted dying**

7.9 The BMA is concerned that doctors could be put under pressure to approve assisted dying, and would welcome some consideration being given to what, if any, provisions exist in other legislation to protect doctors in this situation.