Current Law *is* The Safeguard

Why the BMA Should Remain Opposed to Physician-Assisted Dying

Our **duty** of **care**

CONTENTS

Executive Summary

- On 14 September, a motion will be considered by the BMA ARM aiming to weaken the BMA policy from opposing 'physician-assisted dying' to adopting neutrality on the issue. BMA represents doctors and must responsibly recall that its decisions will influence politicians.
- Representatives at the BMA 2021 Annual Representative Meeting (ARM) on 14th September should choose to retain the World Medical Association's long-standing position against assisted suicide and euthanasia because evidence of overseas jurisdictions which have licensed these practices shows that they:
    - Undermine vital protections for vulnerable patients
    - Demoralise those with compromised autonomy due to their physician and mental condition
    - Lead to a worsening system of enabled suicide and incremental extension to wider cohorts of patients
    - Compromise and corrupt the doctor-patient relationship
- Laws send social messages, including those who may feel pressure to end their own lives. In Oregon, Washington State, and Canada, consistently high numbers of those who opt for assisted suicide do because they feel a burden on their family, friends, and caregivers. The alleged 'right to die' translates in practical experience to a 'duty to die'.
- Prognosis is unreliable, and assisted suicide / euthanasia laws which try to limit application to those prognosed with (e.g.) six months to live, risk premature deaths for patients who have years left of life.
- Evidence from Belgium indicates worrying proportions of involuntary euthanasia, and given the already existing problem of elder abuse, concerns exist that assisted suicide / euthanasia would provide another avenue for abuse of the elderly, which safeguards fail to obviate.
- Data on assisted suicide and euthanasia in American States and Benelux countries that have licensed assisted suicide / euthanasia show increasing number of deaths from both practices, with significant proportions of those who opt for assisted suicide suffering from depression and other mental illness. Very few patients in Oregon are referred for psychiatric help, due to the lack of time and medical expertise to recognise mental ill-health.

We cannot be neutral about the integrity of the medical mission, and of public or patient safety

- An emerging area of research is looking at the association between licensing of assisted suicide / euthanasia and rates of suicide by other means in certain jurisdictions, which implies that those practices directly undermine society's attempts at suicide prevention.
- Belgium, Holland, and Canada, all show incremental extension of euthanasia to cohorts of people beyond the terminally ill, including those who are chronically ill, in poor mental health, or who have disabilities. This is due to the logical implications of a 'right to die', which cannot rationally be limited to only one sort of person. Such a situation is not so much a 'slippery slope', but a *logical cliff*.
- Academic literature and the medical-political reality in Canada and Belgium show that assisted suicide and euthanasia allow for patients to be dehumanised both as a drain on resources and as a potential source for organ retrieval.
- The above problems contribute to concerns that perennial financial pressures applied to end-of-life care due to chronic under-funding of the NHS by central government, and a worsened postcode lottery in areas where palliative care and social care budgets are under strain, could lead to systematic abuse of patients if assisted suicide / euthanasia were implemented.
- Reports from the United States and other jurisdictions indicate psychological damage on up to half of those doctors who participate in assisted suicide, with long-term persisting consequences to up to a fifth of the same cohort. Canadian medical objectors to euthanasia there base their objection in fear to their mental health due to involvement in that practice.
- Palliative care reform widening access to proper palliative care across the country, proposals for which are already subject of a Private Member's Bill in Parliament, would be a better subject of advocacy, and use of resources, than moving to a system of assisted suicide under which patients could so much more easily be abused.
- No legal situation is perfect, but **current law is the safeguard** for patient welfare and safety, and the probity of the doctor-patient relationship.
- Whatever individual opinions on the morality of assisted suicide and euthanasia, too much is at stake for the BMA to drop its opposition to those practices. We cannot be neutral about the integrity of the medical mission, and of public or patient safety.

Introduction

On 14 September, representatives at the BMA 2021 Annual Representative Meeting (ARM) will debate and then vote on whether the BMA should change its opposition on 'physician-assisted dying' to a position of neutrality.

'Assisted Dying' is a euphemism used by the proponents of two distinct practices:

- **Physician-Assisted Suicide (PAS), or 'Assisted Suicide'.**
  This is prescription of a lethal dose of drugs, such as barbiturates, at the request of a patient, for them to self-administer.
- **Physician-Administered Euthanasia (PAE), or 'Euthanasia'.**
  This is prescription and administration of a lethal dose to a patient, typically because the patient is unable, or does not wish, to do so themselves.

There are good reasons for BMA representative members to reject this motion and to continue to follow the World Medical Association's position:

WMA WORLD MEDICAL ASSOCIATION

"The WMA reiterates its strong commitment to the principles of medical ethics and that utmost respect has to be maintained for human life. Therefore, the WMA is firmly opposed to euthanasia and physician-assisted suicide. No physician should be forced to participate in euthanasia or assisted suicide, nor should any physician be obliged to make referral decisions to this end". [1]

[1] WMA Declaration On Euthanasia And Physician-Assisted Suicide, adopted by the 70th WMA General Assembly, Tbilisi, Georgia, October 2019 https://www.wma.net/policies-post/declaration-on-euthanasia-and-physician-assisted-suicide/

The current law is the protection for the vulnerable. The prohibition of killing is the safeguard.

Our Duty Of Care is a group of health-care professionals across the UK, financed and administered by the Care Not Killing alliance.[2] We oppose the intentional killing of patients by assisted suicide or euthanasia. This briefing document will outline our concerns, with reference to experience in other countries, about physician-assisted dying, and the reasons why the BMA should remain opposed at the 2021 ARM.

BMA policy is just that; it does not change the law. Nonetheless, lawmakers will soberly consider the position of doctors, as represented by the BMA, on this complex and sensitive matter. The responsibility of the ARM is to ensure that the BMA does represent, support and protect doctors. Many, especially GPs, Palliative Care Specialists, Oncologists and Geriatricians have significant experience in caring for those at the end of life. These specialties were the most opposed to assisted dying in the poll that the BMA conducted in 2020. [3]

This briefing document will outline the concerns of these doctors.

- **It would threaten society's ability to safeguard vulnerable patients from abuse and demoralisation**
- **It would undermine the trust the public places in physicians**
- **It would send a clear message to our frail, elderly and disabled patients about the value that society places on them as people**

Instead we affirm our commitment to high quality Palliative Care for all.

It is impossible for any government to draft assisted suicide laws which include legal protection from future expansion of those laws. Canada has demonstrated that safeguards can be eroded in a matter of five years.

The current law is the protection for the vulnerable. The prohibition of killing is the safeguard.

[2] Care Not Killing https://www.carenotkilling.org.uk/

[3] BMA: Physician-Assisted Dying Survey https://www.bma.org.uk/advice-andsupport/ethics/end-of-life/physician-assisted-dying-survey

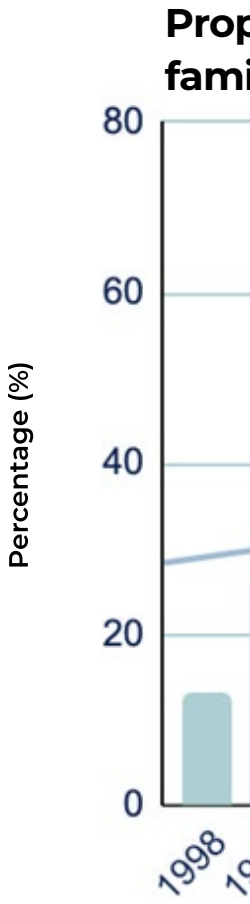
Pressuring The Most Demoralised And Vulnerable Patients

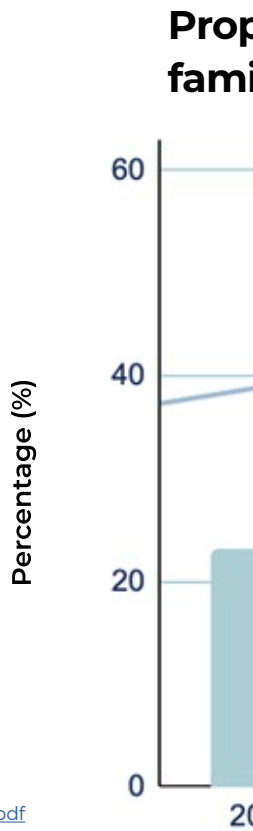
Laws Send Social Messages

Terminally ill and disabled individuals may begin to devalue themselves because they feel a burden. Legislation on assisted suicide, designed to empower, may erode the choices of the most vulnerable. Pressure is subtle and may be exerted by families and clinicians. Patients feel a burden in all sorts of spoken and unspoken ways.

The Oregon Health Authority annual report for 2019 shows 59% of those choosing assisted suicide mentioned the fear of being a burden on family, friends or caregivers as a factor in their decision, with 51% reporting the same concern in the latest figures for Washington state, which adopted the Oregon model which is taken as exemplary by most advocates of assisted suicide around the world. In Canada, the first two annual reports on their system of joint assisted suicide / euthanasia ('MAiD', short for 'medical assistance in dying') recorded the same reason given by 34% of patients in 2019, and 35.9% in 2020. [4]

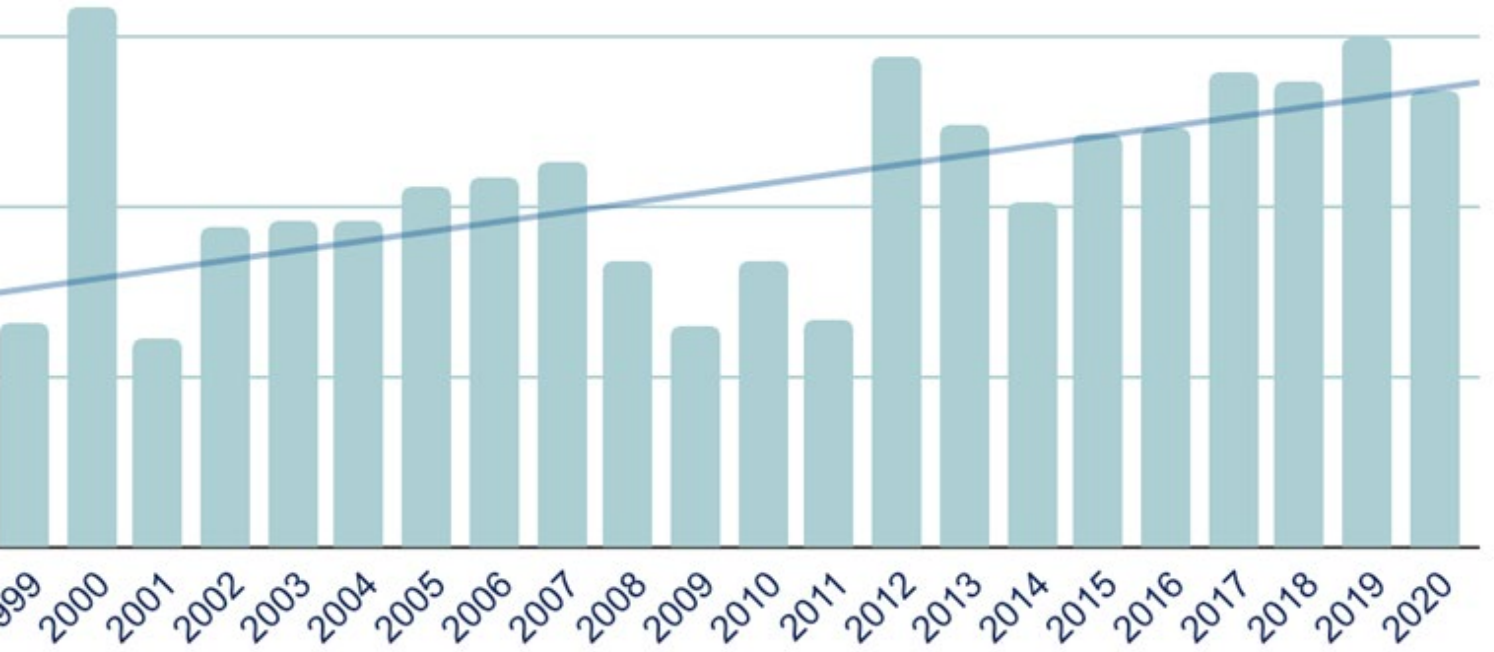
The alleged 'right to die' translates in practical experience to a 'duty to die'.



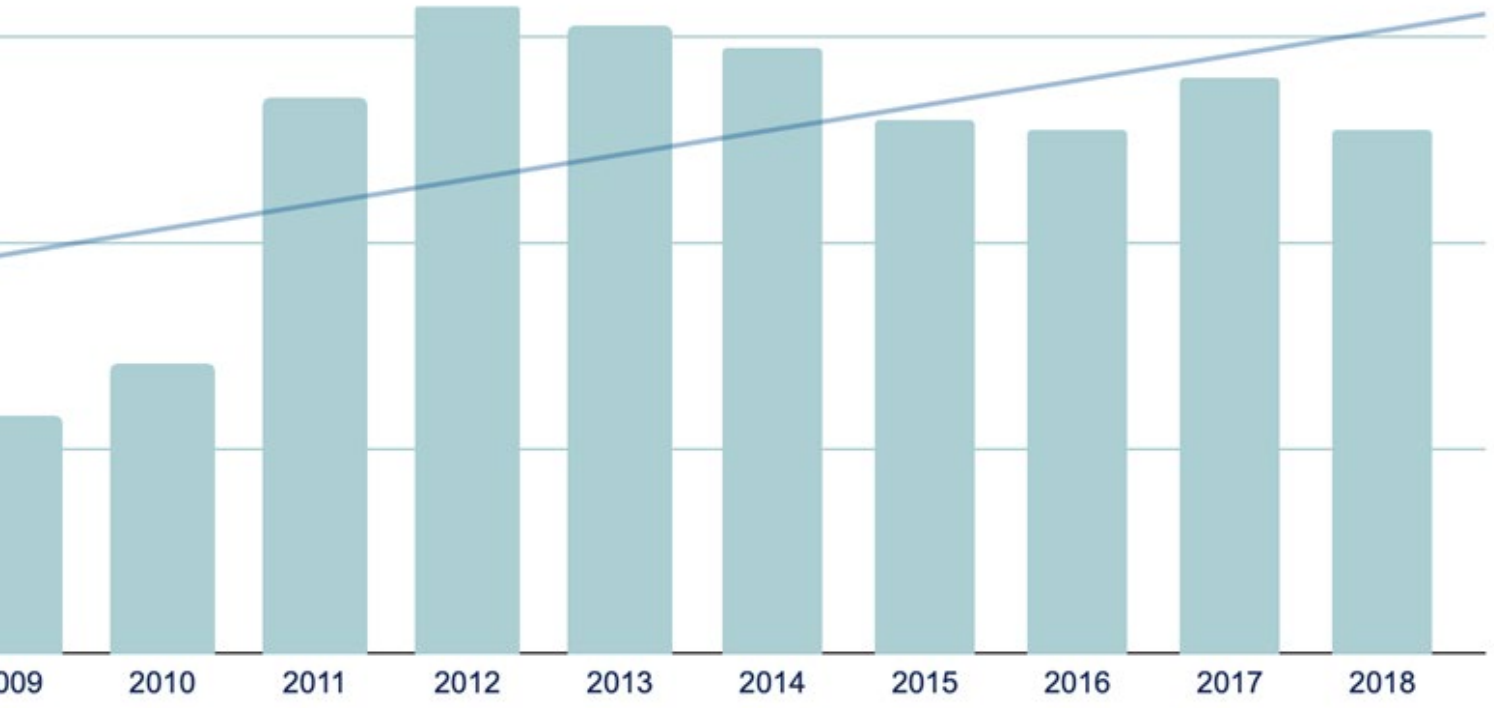


[4] First Annual Report on Medical Assistance in Dying 2019 (Health Canada): https://www.canada.ca/content/dam/hc-sc/documents/services/medical-assistance-dying-annual-report-2019/maid-annual-report-eng.pdf
Second Annual Report on Medical Assistance in Dying 2020 (Health Canada): https://www.canada.ca/content/dam/hc-sc/documents/services/medical-assistance-dying/annual-report-2020/annual-report-2020-eng.pdf

portion of those seeking PAS who reported feeling a burden on friends, ily and caregivers, et al (Oregon, 1998 - 2020)



portion of those seeking PAS who reported feeling a burden on friends, ily and caregivers, et al (Washington State, 2009 - 2018)



Failure of ‘Safeguards’ To Avoid Abuse

Proposed ’safeguards’, such as the requirement for two doctors, a cooling off period, and restrictions to terminal illness, are insufficient to protect patients in busy NHS care.

It is difficult to determine that a patient is not depressed, not being coerced and has capacity, beyond reasonable doubt. Our record in the UK is poor – we continue to fail vulnerable groups. [5] After 15 years, the Mental Capacity Act is still not fully implemented. [6]

PROGNOSIS

Proposals to include a six-month prognosis assume doctors can accurately predict this, but doctors become more inaccurate the longer the survival. [7]

- One fifth of predictions in motor neurone disease are wrong. [8]
- half of predictions in heart failure are wrong. [9]
- 5% of terminal diagnoses are wrong. [10]

[5] Confidential Inquiry into Premature Deaths of People with Learning Disabilities: http://www.bristol.ac.uk/cipold/
Cf. Protect, respect, connect – decisions about living and dying well during COVID-19, Care Quality Commision (2021): https://www.cqc.org.uk/publications/themed-work/protect-respect-connect-decisions-about-living-dying-well-during-covid-19

[6] Select Committee on Mental Capacity Act 2005- Report 78.

[7] Glare P et al. A systematic review of physician’s survival predictions in terminally ill patients. BMJ, 2003; 327: 195-8

[8] Agosta F et al, Survival prediction models in motor neurone disease. European Journal of Neurology, 2019; 26(9): 1143-52.

[9] Warriach HJ et al. Accuracy of physician prognosis in heart failure and lung cancer: comparison between physician estimates and model predicted survival. Palliative Medicine, 2016; 30(7): 684-9

[10] House of Lords Report 86-II (Session 2004-05).

NON-VOLUNTARY EUTHANASIA

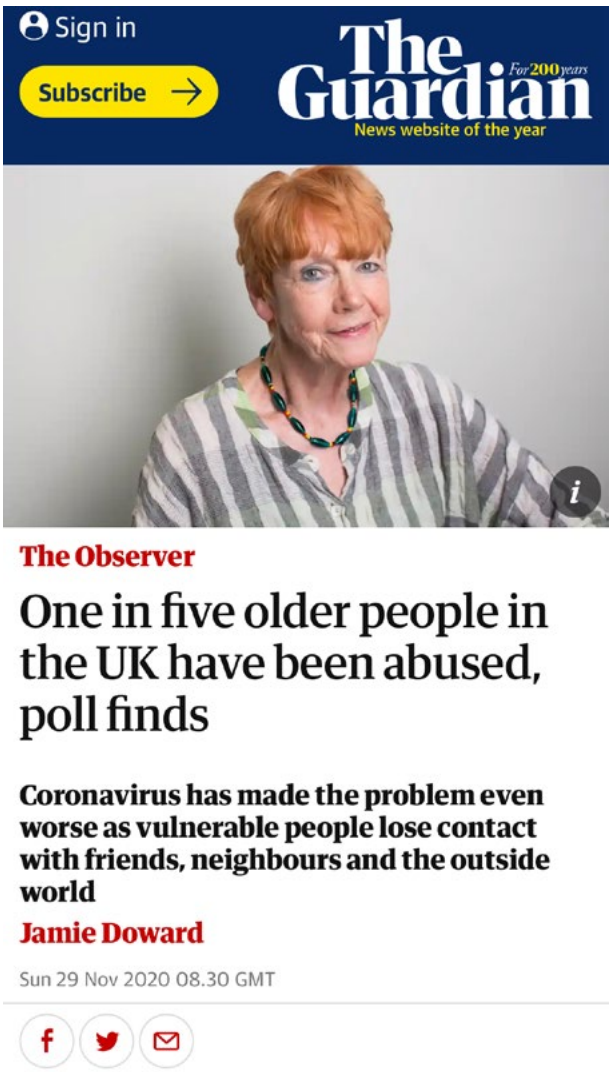
More than 1 in 60 deaths in Belgium occured with no consent from the patient – those in coma, confused, or the elderly are euthanised because their lives are considered not 'worth living'. [11] In 2013, 6.3% of total annual deaths in Flanders were a result of 'physician assisted-dying', of which 25% constituted "hastening of death without explicit request from patient". [12]

The cruel irony of this path is that legislation introduced with the good intention of enhancing patient choice actually diminishes or disregards choice for the most vulnerable.

1 in 4 physician-assisted deaths in Flanders occurred without patients' consent

POTENTIAL FOR ABUSE

Given the vulnerability of those most likely to be pushed towards assisted suicide, and given the high incidence of elder abuse across the UK' revealed by a poll,[13] which found that almost 10% of older people say that they are being abused and closer to 20% have been abused previously, this failure of safeguards which proponents of assisted suicide wish to introduce into UK law should be deeply concerning.



[11] Cohen-Almagor R. First do no harm: intentionally shortening lives of patients without their explicit request in Belgium, J Med Ethics 2015;41:625– 629. DOI: 10.1136/medethics-2014-102387

[12] Ibid., cf. Chambaere et al, Recent Trends in Euthanasia and Other End-of-Life Practices in Belgium, N Eng J Med 2015; 372:1179-1181: DOI: 10.1056/NEJMc1414527.

[13] One in five older people in the UK have been abused, poll finds, Jamie Doward, The Guardian, 29th November 2020: https://www.theguardian.com/society/2020/nov/29/one-in-five-older-people-in-the-uk-have-been-abused-poll-finds

[14] Poole, M., Bond, J., Emmett, C., Greener, H., Louw, S.J., Robinson, L. and Hughes, J.C. (2014). Going home? An ethnographic study of assessment of capacity and best interests in people with dementia being discharged from hospital. BMC Geriatrics, 14:56.

'If anyone were in any doubt about the risk of covert or silent coercion of vulnerable adults, they should look at the placement of older people, including those with dementia, in care homes.

Many older people give up their homes to live in institutions because they perceive (rightly or wrongly) that others wish them to do so. Some regret the decision; and those with dementia (where the assessment of capacity can be difficult) are often hardly involved in such decisions.[14]

Lonely, sick and disabled older people may well succumb (especially where the resources to care are scarce) to the suggestion that they should accept physician-assisted suicide or euthanasia, but this may well not reflect their true choices'.

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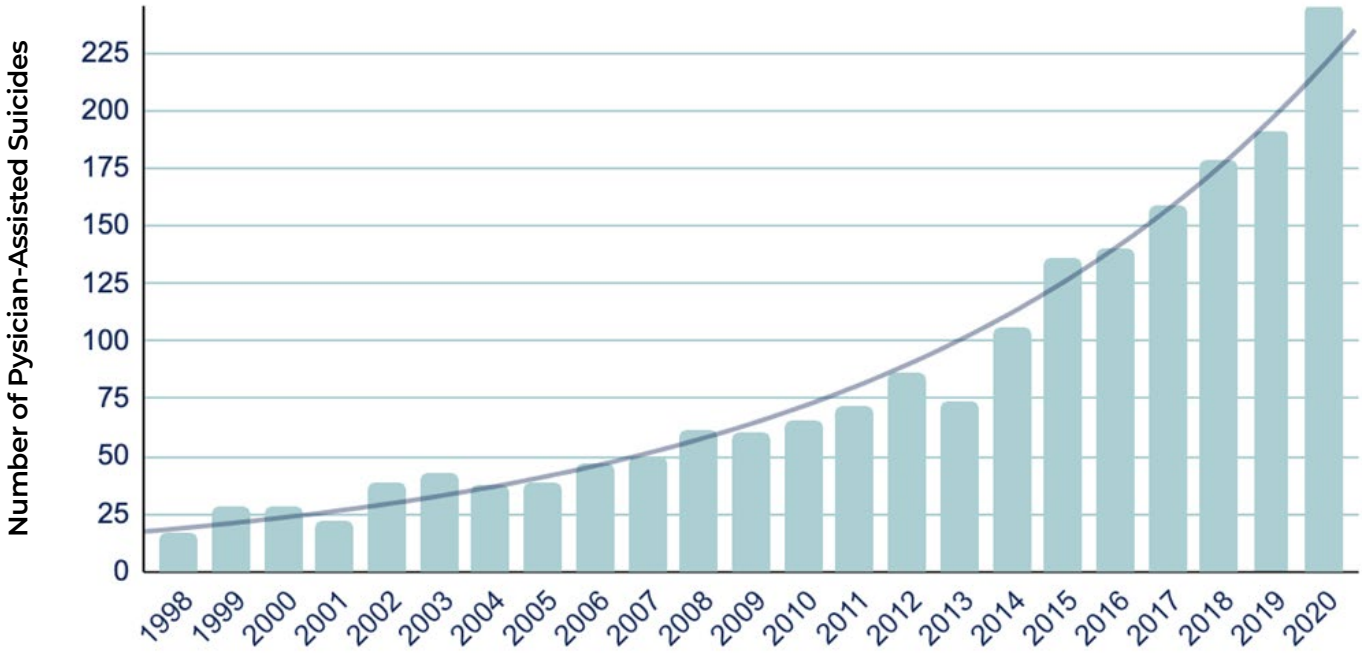
Bristol

Rising Numbers And Suicide

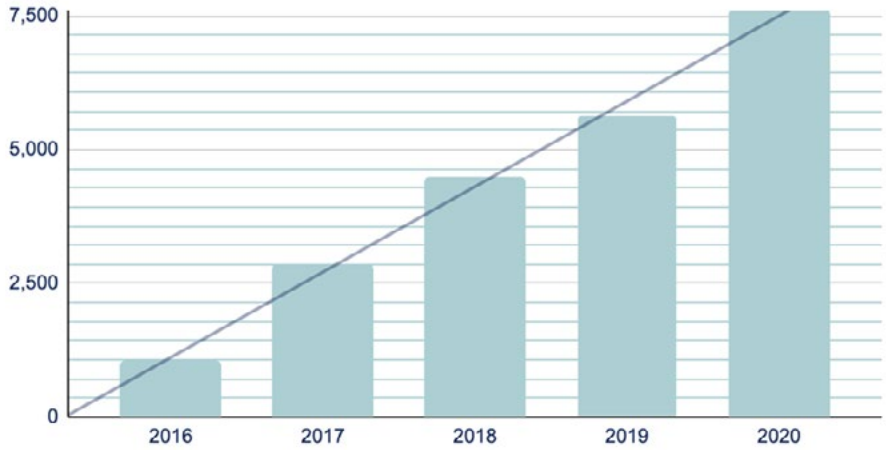
Assisted suicide coarsens attitudes to suicide, normalising it in societies that have introduced it and drastically undermines suicide prevention campaigns.

The rates of patients ending their own lives this way have increased exponentially wherever they have been introduced. The statistics gathered by the Oregon State Public Health Division show that the numbers of assisted suicides rose from 16 in 1998, to 191 in 2019. The latest 2020 figures show this has now increased to 245, an increase in one year of 28%.

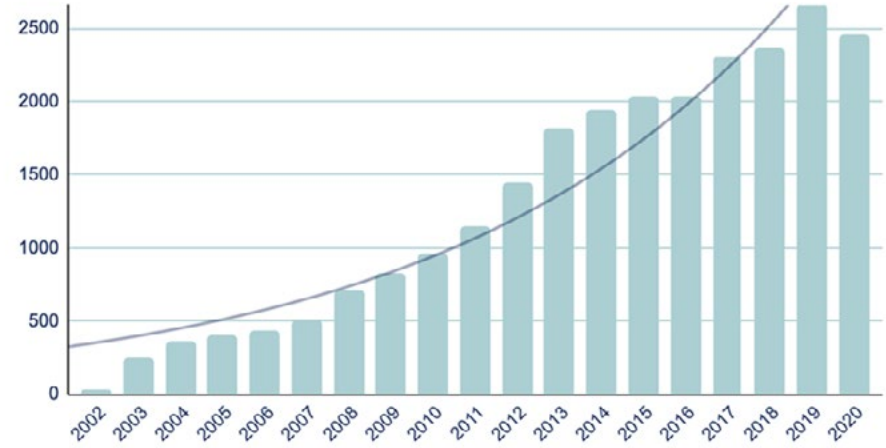
Assisted Suicides, Oregon (1998 - 2020)



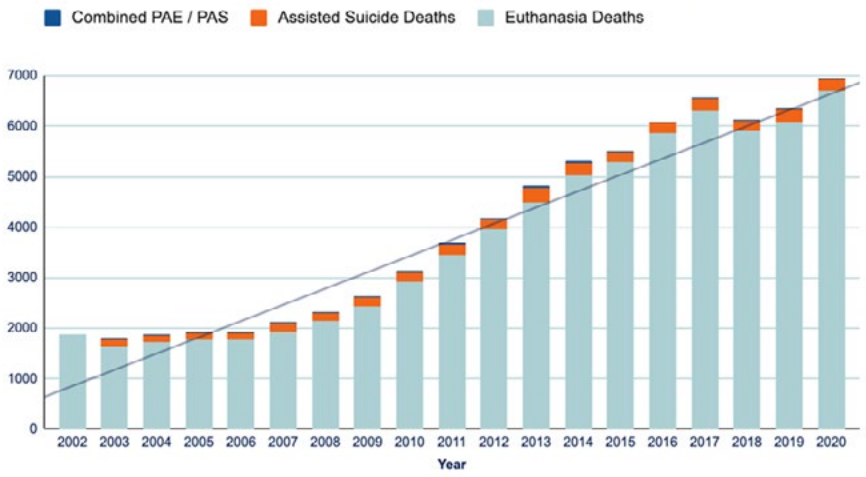
Reported 'MAiD' Deaths in Canada (2016 - 2020)



Euthanasia / Assisted Suicide Numbers, Belgium (2002 - 2020)



Euthanasia / Assisted Suicide Numbers, Netherlands (2002 - 2020)



DEPRESSION

In the context of terminal illness, a wish to die is often transient [15] due to depression caused by illness.

In the general population, suicidal thoughts and urges are common symptoms of depression, and serious suicidal thoughts rarely arise apart from depression.[16]

Correspondingly reports of individual assisted suicide cases show that patients who suffer from depression and dementia are receiving assisted suicide in Oregon.

A 2008 study published in the British Medical Journal examined 58 Oregonians who sought information on assisted suicide. Of them, 26% met the criteria for depressive disorder, and 22% for anxiety disorder. Three of the depressed individuals received and ingested the lethal drugs, dying within two months of being interviewed. The study's authors concluded that Oregon's law **"may not adequately protect all mentally ill patients"**.[17]

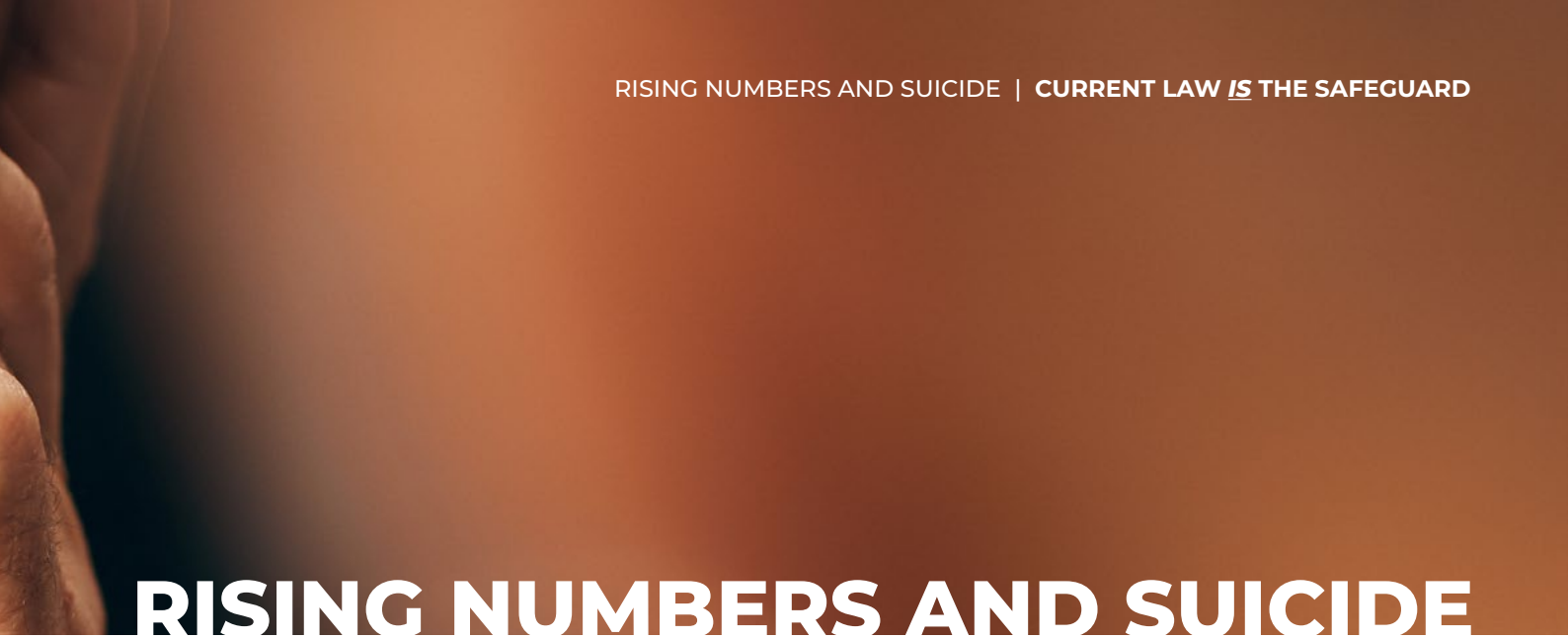
The latest annual *Death with Dignity Report* issued by the State's Public Health Division states that only 3.6% of patients dying by assisted suicide since 1998 have been referred for psychiatric evaluation. Based on the 26% figure above, 60 people should have been so referred in 2020 rather than the 3 (1.2%) who were, and only 1 (0.5%) in 2019.

We would expect such a low referral rate. In 2006, having compiled the available evidence, the UK's Royal College of Psychiatrists advised that **"many doctors do not recognise depression or know how to assess for its presence in terminally ill patients".** [18]

[15] Monteforte-Royo C, et al. What lies behind the wish to hasten death? A systematic review and meta-ethnography from the perspective of patients. PLoSOne, 2017; 7(5): e37117 6.

[16] See, e.g., Non-fatal suicidal behaviour among adults aged 16 to 74 in Great Britain, Office of National Statistics (2002), especially pp. 44-59: http://www.ons.gov.uk/ons/rel/psychiatric-morbidity/non-fatal-suicidal-behaviour-among-adults/aged-16-74-in-great-britain/aged-16-74-in-great-britain.pdf

[17] Prevalence of depression and anxiety in patients requesting physicians' aid in dying: cross sectional survey, Ganzini, Goy, and Dobscha, BMJ 2008;337:a1682: https://www.bmj.com/content/337/bmj.a1682



RISING NUMBERS AND SUICIDE

In the two doctor certification system proposed in the Oregon model, nothing establishes how the attending or consultant physicians would be able to overcome this, and even requiring one or both to possess mental health training, or the involvement of a mental health professional, would fail to address the insufficient time that would be had in only a few meetings with the patient to properly diagnose mental illness where it exists.

SUICIDE

In 2015, Jones and Paton [19] examined the association between the license of PAS in individual American States, and suicide rates of those States, between 1990 and 2013.

Introduction of assisted suicide was associated with a 6.3% increase in total suicides (including assisted suicides), with a 14.5% effect in those over 65. The study concluded that States which had introduced PAS saw an increased rate of total suicides relative to other States that had not done so, and that the same saw no decrease in non-assisted suicides.

The implication of this was that licensing assisted suicide not only does not inhibit suicide more generally but is associated with an increased inclination to suicide in some individuals. Such a reality would directly entail that PAS **directly undermines society's attempts at suicide prevention.**

This is an emerging area of discussion needing far more research, which attempts to license assisted suicide would pre-empt.

[18] Statement from the Royal College of Psychiatrists on Physician-Assisted Suicide (2006), para. 2.4

[19] Jones, D. A., & Paton, D. (2015). How does legalization of physician assisted suicide affect rates of suicide?. Southern Medical Journal, 180(10), doi:10.14423/SMJ.0000000000000349 https://nottingham-repository.worktribe.com/output/981903/how-does-legalization-of-physician-assisted-suicide-affect-rates-of-suicide

Incremental Extension To Non-Terminal Patients

Canada introduced assisted dying for the terminally ill in 2016. This has since been extended to those who are disabled but not dying in 2021 and to those who are mentally ill in 2023.[20]

The Canadian Government website states that: "New changes to the legislation have allowed a broader group of people to be eligible to request and receive MAID. These changes came into effect on March 17, 2021".[21]

LEGAL INEVITABILITY

The legal inevitability of the incremental extension of assisted suicide and euthanasia to non-terminal patients is due to the universal applicability of human rights: we do not usually restrict basic obligations to one group of people.

If the provision of something is a human right, this applies to everyone. If there is a human right to die, then there can be no restrictions on access to assisted suicide and euthanasia only to those who are dying. It must be available for all. This will eventually include those not at the end of life,[22] who cannot consent,[23] or are too young to consent,[24] or who suffer from psychiatric disorders[25] such as Alzheimer's.[26]

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[20] & [21] https://www.canada.ca/en/health-canada/services/medical-assistance-dying.html

[22] Montrealers file legal action contesting restrictions on medical aid in dying, Global News (14th June 2017): https://globalnews.ca/news/3526916/montrealers-file-legal-action-contesting-restrictions-on-medical-aid-in-dying/

[23] Quebec appoints experts to weigh in on expanding assisted-dying law, Global News (24th March 2017): https://globalnews.ca/news/3333418/quebec-appoints-experts-to-weigh-in-on-expanding-assisted-dying-law/

[24] Young patients, their parents now asking for medical aid in dying: pediatricians' group, Keith Gerein, Edmonton Journal (26th October 2017) http://edmontonjournal.com/news/local-news/embargoed-pediatricians-group-weighs-in-on-extending-medical-aid-in-dying-to-minors

[25] Adam Maier-Clayton's death renews debate on assisted-dying access for those with mental illness, Catrina Franzoi, Globe and Mail, 16th April 2017 https://www.theglobeandmail.com/news/national/adam-maier-claytons-death-renews-debate-on-assisted-dying-access-for-those-with-mental-illness/article34718194/

[26] Most caregivers favour assisted dying for Alzheimer's patients: survey, Aaron Derfel, Montreal Gazette (22nd September 2017): https://montrealgazette.com/news/local-news/most-caregivers-favour-assisted-dying-for-alzheimers-patients-survey

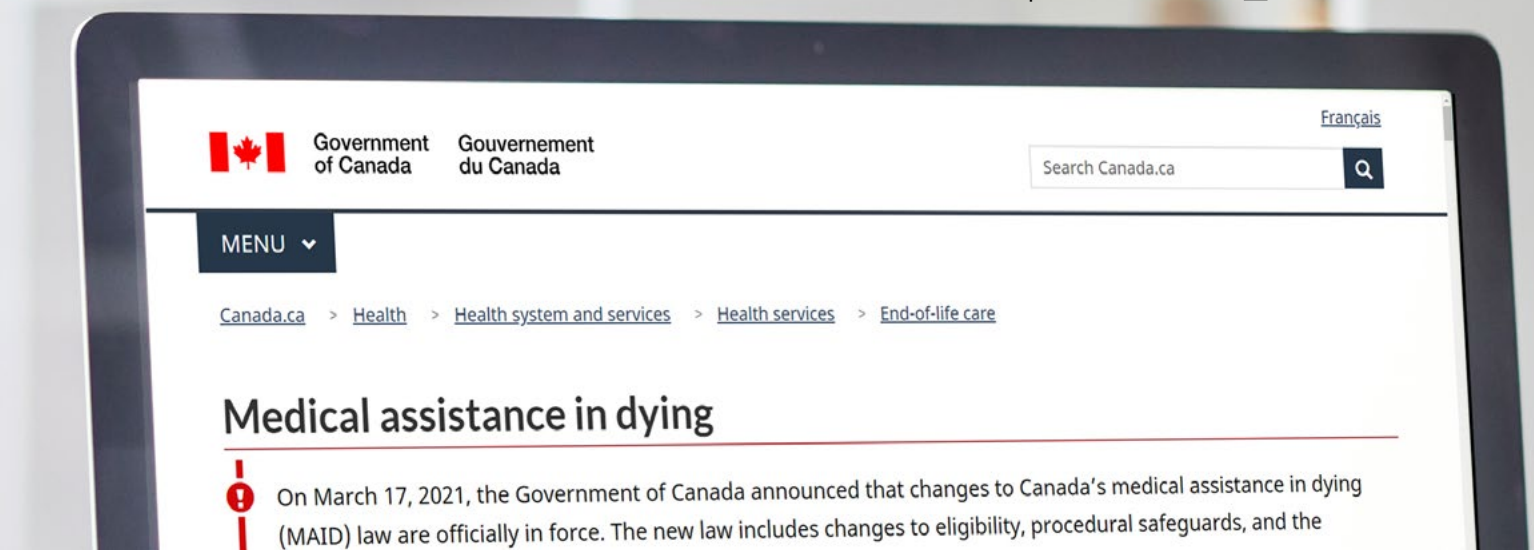


Illustration of this reality can be found in the Netherlands[27] and Belgium,[28] both of which licensed assisted suicide and euthanasia in the early 2000s.

TINE NYS (38), depressed after the break-up of a relationship, and who had suffered domestic violence and worked in prostitution, was euthanised in 2009 on the basis that she had autism.[29] Her parents and two sisters succeeded, after nine years of effort, in having charges of 'unlawful poisoning' laid against the psychiatrist and two doctors who certified her euthanasia, but despite evidence one of the doctors fraudulently obtained the certification, all three were acquitted in 2020.[30] A new trial against the doctor who committed the fraud is ongoing.[31]

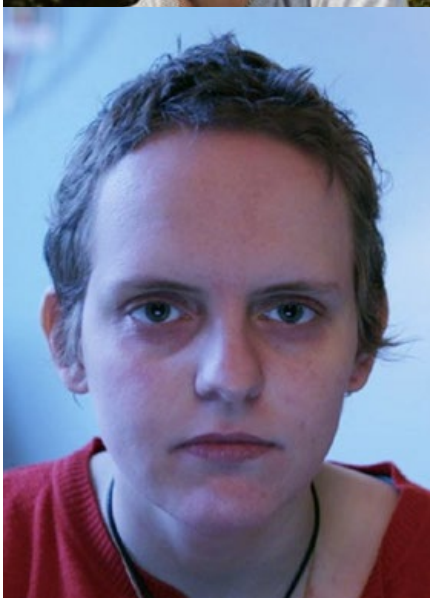
[27] Government of the Netherlands, Euthanasia, assisted suicide and non-resuscitation on request
https://www.government.nl/topics/euthanasia/euthanasia-assisted-suicide-and-non-resuscitation-on-request

[28] Euthanasia Act 2002 (Belgium)
https://apmonline.org/wp-content/uploads/2019/01/belgium-act-on-euthanasia.pdf

[29] Controversial case re-opens euthanasia debate, Andy Furniere, Flanders Today, 04th February 2016
http://www.flanderstoday.eu/politics/controversial-case-re-opens-euthanasia-debate

[30] Belgium Acquits Three Doctors in Landmark Euthanasia Case, Elian Peltier, New York Times, 31st January 2020
https://www.nytimes.com/2020/01/31/world/europe/doctors-belgium-euthanasia.html

[31] New trial for doctor who carried out euthanasia on Tine Nys, Alan Hope, Brussels Times, 12th May 2021
https://www.brusselstimes.com/news/belgium-all-news/169151/new-trial-for-doctor-who-carried-out-euthanasia-on-tine-nys-dendermonde-2010-psychological-pain-joris-van-hove-family-court/



GODELIEVA DE TROYER (64), an otherwise healthy Belgian woman living with depression, was killed by lethal injection at her own request in a Brussels hospital in 2012,[32] despite at least two of the experts who assessed not agreeing that she was beyond treatment. Her son was not contacted until after his mother had been euthanised, when a hospital rang asking him to retrieve her body from the morgue.

MARC AND EDDY VERBESSEM (45), a pair of deaf twins, were euthanised in 2013[33] due to the fear that with the onset of blindness they would be unable to communicate with each other.

NATHAN (44), born Nancy, was euthanised in 2013, after a series of failed gender reassignment surgeries.[34]

AURELIA BROUWERS (29), committed assisted suicide in the Netherlands in 2018 due to psychiatric suffering. She said, "When I was 12, I suffered from depression. And when I was first diagnosed, they told me I had Borderline Personality Disorder… Other diagnoses followed – attachment disorder, chronic depression, I'm chronically suicidal, I have anxiety, psychoses, and I hear voices".

The BBC report on her case[35] mentions another woman, Monique Arend, who suffered from serious mental health issues after sexual abuse, but avoided committing assisted suicide, having found a therapist specialising in trauma.

[32] Son challenges Belgian law after mother's 'mercy killing', Bruno Waterfield, Daily Telegraph, 02nd February 2015: https://www.telegraph.co.uk/news/worldnews/europe/belgium/11382843/Son-challenges-Belgian-law-after-mothers-mercy-killing.html
See also The Death Treatment, Rachel Aviv, The New Yorker, 22nd June 2015: https://www.newyorker.com/magazine/2015/06/22/the-death-treatment

[33] Marc And Eddy Verbessem, Deaf Belgian Twins, Euthanised After Starting To Turn Blind, Eline Gordts Huffington Post (14th January 2013): https://www.huffingtonpost.co.uk/entry/marc-eddy-verbessem-belgium-euthanasia_n_2472320

[34] Nathan Verhelst Chooses Euthanasia After Failed Gender Reassignment Surgeries, Eline Gordst, Huffington Post (10th May 2013): https://www.huffingtonpost.co.uk/entry/nathan-verhelst-euthanasia-belgium_n_4046106

[35] The troubled 29-year-old helped to die by Dutch doctors, Linda Pressly, BBC News (08th August 2018): https://www.bbc.co.uk/news/stories-45117163

Correspondingly, in 2021, the Canadian Parliament passed Bill C-7,[36] which extended the law beyond those whose death is "reasonably foreseeable" (the terminally ill, to whom the original limitation of the Canadian legislation was limited) to those whose death is not foreseeable, opening up euthanasia to patients who are chronically ill, or who have disabilities.

This act has been described as a **"stunning reversal of the central role of the medical and legal concept of the standard of care"**.[37]

The pressure for, and actual effecting of, incremental extension of such laws illustrates the fundamental problem with laws permitting medicalised killing. If we grant that there exists a 'right to die' based on personal 'dignity' and 'autonomy', such that people have the right to have their doctors involved in their suicide, then it is rationally impossible to limit that right only to one sort of person. Such a situation is not so much a 'slippery slope', but a *logical cliff*.

The current law is the only probative safeguard against the assisted suicide and euthanasia of wider cohorts of vulnerable patients.

...not so much a 'slippery slope', but a logical cliff.

[36] Bill C-7, March 2021
https://parl.ca/DocumentViewer/en/43-2/bill/C-7/royal-assent

[37] How Bill C-7 will sacrifice the medical profession's Standard of Care, Policy Options, IRPP (11th February 2021)
https://policyoptions.irpp.org/magazines/february-2021/how-bill-c7-will-sacrifice-the-medical-professions-standard-of-care/

The Doctor-Patient Relationship

CONCERNS FOR PATIENTS

Trust is the foundation of the clinician-patient relationship. The fact that a doctor might instigate death changes the relationship when a patient is ill and seeking care. There must be clarity that a doctor will never intentionally cause harm to a patient.

Continued pressure on NHS resources. however, could lead to decisions being taken that would undermine that trust, as medical decisions would be made not in the best interests of the patient, but of the health system.

Last year, a paper was published in the journal Clinical Ethics[38] which argued that granting terminally-ill patients help to die would both save money and potentially release organs for transplant. One of the authors, the ethicist David Shaw, described the potential savings of allowing assisted suicide as **"the elephant in the room"**, and the paper went on to assess the extent to which licensing euthanasia could help patients using the same formula which bodies such as NICE deploy to weigh up the expense and benefits of new drugs.

Recent research suggests that such attitudes are not merely hypothetical, but already part of clinical practice. One study showed that organ donors in Belgium (including 23.5% of all lung donors) had been euthanised, raising concerns that patients may be given an emotional inducement to be killed, believing that they can be better use being euthanised and harvested.[39]

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This prospect of voluntary euthanasia as a source of organ donation, despite the instrumentalisation and exploitation of patients this may often involve, has prompted concerns from north American doctors,[40] as the possibility opens up in Canada (the CMAJ having released guidance on the issue),[41] just as others have anticipated this new source.[42]

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[38] Shaw and Morton, Counting the cost of denying assisted dying, Clinical Ethics, Vol 15, Issue 2, 2020 https://doi.org/10.1177/1477750920907996

[39] Initial experience with transplantation of lungs recovered from donors after euthanasia, Van Raemdonck et al, Applied Cardiopulmonary Pathophysiology 15:38-48 (2011) http://www.applied-cardiopulmonary-pathophysiology.com/fileadmin/downloads/acp-2011-1_20110329/05_vanraemdonck.pdf

[40] See for example, Ely, E.W. Death by organ donation: euthanizing patients for their organs gains frightening traction. Intensive Care Med 45, 1309–1311 (2019). https://doi.org/10.1007/s00134-019-05702-1

[41] Downar et al, Deceased organ and tissue donation after medical assistance in dying and other conscious and competent donors: guidance for policy, CMAJ 2019 June 3;191:E604-13. doi: 10.1503/cmaj.181648

[42] Ball et al, Voluntary Euthanasia — Implications for Organ Donation, N Engl J Med 2018; 379:909-911 DOI: 10.1056/NEJMp1804276

Similarly, in October 2020, the Canadian Parliamentary Budget Officer (PBO) released a Cost Estimate Report[43] for Bill C-7, which expanded euthanasia and assisted suicide in Canada beyond the temrinally-ill (see previous section). This looked at projected 'Medical Assistance in Dying' (MAiD) deaths in 2021, as well as likely costs and savings due to them, estimating that under the law as it stood, 6,465 people would die by MAiD in 2021 – 2.2% of all deaths – with net healthcare savings of $86.9 million, and that expanding the law would add 1,164 deaths in the first year alone, leading to increased healthcare savings in 2021 of $149 million. An extra almost £87 million.

$149 million is almost exactly ten times the annual value of the official funding which was withdrawn from the Delta Hospice Society in British Columbia, after it refused to offer euthanasia and assisted suicide. The funding met 94% 'of the society's costs to operate 10 beds at the Irene Thomas Hospice'.[44] This illustrated the corruption of the medical system in Canada, in which economic efficiency and institutional discrimination against those with conscientious objection to euthanasia combined to undermine genuine patient choice and palliative care.

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The PBO went on to acknowledge that: 'Our estimates have only taken into consideration the health care costs from the perspective of provincial governments. Therefore, out-of-pocket costs paid by patients or their relatives have not been considered. For example, palliative care is usually free of charge when provided in a hospital or a government funded hospice, but there could be costs billed to patients in nursing homes or wanting to receive palliative care at home'.

Not only in academic theory, but in public policy practice, assisted suicide and euthanasia risks dehumanising patients by treating the ending of their lives as an economic and medical benefit.

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[43] Cost Estimate For Bill C-7 "Medical Assistance In Dying", Officer of the Parliamentary Budget Officer, 20th October 2020
https://www.pbo-dpb.gc.ca/web/default/files/Documents/Reports/RP-2021-025-M/RP-2021-025-M_en.pdf

[44] Government ends Delta Hospice Society service agreement, BC News, 25th February 2020
https://news.gov.bc.ca/releases/2020HLTH0047-000328

The Doctor-Patient Relationship

CONCERNS FOR DOCTORS

The act of deliberately causing death can have serious negative mental consequences on doctors who involve themselves in those practices.

Evidence from the United States and other jurisdictions indicates psychological damage on up to half of those doctors who participate in assisted suicide, with long-term persisting consequences to up to a fifth of the same cohort. Factors contributing to this include the emotional burden and discomfort with being involved in the process of causing the death of a patient, assessing their capacity to make the decision, and having to judge if they fit legally required criteria.[45]

In Canada, a majority of those doctors who have refused to participate in assisted suicide did so not based on religious or moral grounds, but because of fear of the repercussions on their mental health.[46]

In the BMA's own recent poll of practicing UK doctors, the majority (58%) of those who expressed an opinion were unwilling to prescribe lethal drugs.[47]

Whereas in Belgium, only 13% of psychiatrists were prepared to participate in the assisted suicide process.[48] One study found that of 52 GPs interviewed only 9 (17%) had performed an assisted death.[49]

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[45] Kelly B et al. "An indelible mark" The response to participation in euthanasia and physician-assisted suicide among doctors: a review of research findings. Palliative and Supportive Care, 2019; 18(1): 82-8. https://doi.org/10.1017/S1478951519000518

[46] Bouthillier ME, Opatrny L. A qualitative study of physicians' conscientious objections to medical aid in dying. Palliat Med. 2019 Oct;33(9):1212-1220. doi: 10.1177/0269216319861921.

[47] BMA: Physician-Assisted Dying Survey https://www.bma.org.uk/advice-andsupport/ethics/end-of-life/physician-assisted-dying-survey

[48] Verhofstadt M et al. Belgian psychiatrists' attitudes towards, and readiness to engage in, euthanasia assessment procedures with adults with psychiatric conditions: a survey. BMC Psychiatry 2020 https://doi.org/10.1186/s12888-020-02775-x

[49] Sercu M, Pype P, Christiaens T, Grypdonck M, Derese A, Deveugele M. Are general practitioners prepared to end life on request in a country where euthanasia is legalised? J Med Ethics. 2012 May;38(5):274-80. doi: 10.1136/medethics-2011-100048.

The Alternative: Excellent, Accessible Palliative Care

Those who wish to change the law are doing so from humane motives of compassion.

Yet with perennial financial pressures being applied to end-of-life care due to chronic under-funding of the NHS by central government, and a worsened postcode lottery in areas where palliative care and social care budgets are under strain, introducing assisted suicide could corrupt medical culture here as it has in other jurisdictions, leading to pressure for patients to be die by PAS for the sake of institutional convenience.

We must listen and respond to the cases of poor care and difficult symptom control, to which the response need not be assisted suicide. Everyone has the right to specialist palliative care and this is not being delivered in the UK. Palliative care services must be resourced, prioritised and funded.

- **Each day in the UK, over 320 patients fail to get the specialist palliative care they need.[50]**
- **Referrals to hospice are often very late in the illness.[51]**
- **Current UK policies lack clear priorities on how to improve palliative or end of life care.[52]**

Efforts have been introduced in Parliament to ensure country-wide access to specialist and generalist palliative care and support services, such as Baroness Finaly's current Access to Palliative Care and Treatment of Children Bill,[53] which also seeks to enable hospices to access pharmaceutical services on the same basis as other services commissioned by a clinical commissioning group, and to make provision for treatment of children with a life-limiting illness.

Let the result of this important debate be a drive to excellence in palliative care, not a move to assisted suicide under which patients could so much more easily be abused.

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[50] Hospice care in the UK. London: Hospice UK (2016) https://www.hospiceuk.org/docs/default-source/WhatWe-Offer/publications-documents-and-files/hospice-care-in-the-uk-2016.pdf

[51] Allsop MJ et al. Duration and determinants of hospice-based specialist palliative care: a national retrospective cohort study. Palliative Medicine, 2018; 32(8): 1322-3.

[52] Sleeman K et al. Priorities and opportunities for palliative and end of life care in United Kingdom health policies: a national documentary analysis. BMC Palliative Care, 2021; 20, 108.

[53] Access to Palliative Care and Treatment of Children Bill 2021 https://bills.parliament.uk/bills/2536

Conclusion

Assisted suicide and euthanasia have harmful consequences on patients and doctors.

The two principles of dignity and autonomy are actively compromised by:

- **Premature death due to compromised personal autonomy, particularly poor mental health.**
- **Premature death due to elder abuse or other forms of social pressure for monetary gain.**
- **Socio-psychological pressure of being a 'burden'.**

The effect on medical and general culture of normalising ending life in Oregon, the Netherlands and Belgium, has also been:

- **Increased numbers of patients opting for assisted suicide alongside increased suicides in the general society.**
- **An increasing number of mentally unwell people who have been euthanised rather than given the psychological assistance they have needed.**

Consequences on medical professionals are also serious, with profound psychological damage due to moral hazard, pressure to act against patient interests or the law by families, material pressure on resources, and similar cultural attitudes that would cause pressure on patients themselves if we saw the introduction into UK medicine of physician involvement in causing the death of those under their care.

No system or situation is perfect, but current laws and medical practice allow for reforms that will bring palliative care and psychological help to all those who need it, whilst providing protection for the most vulnerable members of society. Removing current legal protections would introduce abuses that would undermine the medical mission, and worsen rather than enhance the doctor-patient relationship.

For all these reasons, proposals to accept physician assisted suicide or physician-administered euthanasia should be rejected, and a realistic and authentically compassionate approach reaffirmed.

Whatever our personal views on the morality of assisted suicide and euthanasia, there is too much at stake here for the BMA to drop its opposition to either of those practices. We cannot be neutral about safety.

We cannot be neutral about safety

Current Law *is* The Safegaurd
is publication of the Our Duty of Care campaign

www.ourdutyofcare.org.uk

Our Duty Of Care is a group of UK healthcare workers who oppose the intentional killing of patients by assisted suicide or euthanasia. The campaign is financed by the Care Not Killing Alliance and administered by David Randall, a specialty registrar in renal medicine working London, and Gillian Wright, a former palliative care doctor based in Scotland.

It is supported by a wide range of healthcare professionals, and has campaigned during the membership polls run by the Royal College of Physicians, Royal College of General Practitioners and British Medical Association to maintain medical opposition to assisted suicide.

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Our duty of care