

Key arguments used in the debate on physician-assisted dying

There are many strongly held views on both sides of the debate on physician-assisted dying, and a huge range of materials and literature has been published on the topic. Here we outline some of the key arguments used by those who support and oppose physician-assisted dying. These are not intended to be comprehensive but to provide an overview of the range of views and opinions expressed in the debate. Some people may disagree with some of these arguments or have different reasons to support their position.

Additionally, we set out some of the arguments used by those who support the BMA adopting a neutral position on physician-assisted dying, and those who oppose it. Again, these are not intended to be comprehensive, and individuals may have other reasons for their views.

Key arguments for and against physician-assisted dying

Those who oppose physician-assisted dying often use the following arguments.

1. Laws send social messages. An assisted dying law, however well intended, would alter society's attitude towards the elderly, seriously ill and disabled, and send the subliminal message that assisted dying is an option they 'ought' to consider.
2. So-called 'safeguards' are simply statements of what should happen in an ideal world. They do not reflect the real-world stresses of clinical practice, terminal illness and family dynamics. It is impossible to ensure that decisions are truly voluntary, and that any coercion or family pressure is detected.
3. For most patients, high-quality palliative care can effectively alleviate distressing symptoms associated with the dying process. We should be calling for universal access to high quality generalist and specialist palliative care, rather than legalising physician-assisted dying.
4. Licensing doctors to provide lethal drugs to patients is fundamentally different from withdrawing ineffective life-sustaining treatment, and crosses a Rubicon in medicine. The role of doctors is to support patients to live as well, and as comfortably, as possible until they die, not to deliberately bring about their deaths.
5. Currently, seriously ill patients can raise their fears, secure in the knowledge that their doctor will not participate in bringing about their death. If doctors were to have the power to provide lethal drugs to patients to end their lives, this would undermine trust in the doctor-patient relationship. Some patients (particularly those who are elderly, disabled or see themselves as 'a burden') already feel that their lives are undervalued and would fear that health professionals will simply 'give up' their efforts to relieve distress, seeing death as an easy solution.
6. Once the principle of assisted dying has been accepted, the process becomes normalised and it becomes easier to accept wider eligibility criteria or to widen eligibility through the use of anti-discrimination legislation.
7. In modern clinical practice many doctors know little of patients' lives beyond what the busy doctor may gather in the consulting room or hospital ward. Yet the factors behind a request for assisted dying are predominantly personal or social rather than clinical. Assisted dying is not a role for hard-pressed doctors.



Those who support physician-assisted dying often use the following arguments.

1. Even with universal access to specialist palliative care, some dying people will still experience severe, unbearable physical or emotional distress that cannot be relieved. Forcing dying people to suffer against their wishes is incompatible with the values of 21st century medicine.
2. Physician-assisted dying is a legal option for over 150 million people around the world. In jurisdictions where it is lawful, there are eligibility criteria, safeguards and regulation in place to protect patients.
3. Guidance in the UK for end-of-life practices, such as the withdrawal of life-sustaining treatment, already contains safeguards to ensure decisions are made voluntarily, coercion is detected and potentially vulnerable people are protected. There is no reason why these safeguards could not be used effectively in assisted dying legislation.
4. The current law is not working. UK citizens travel to Switzerland, to facilities like Dignitas, to avail themselves of physician-assisted dying, but this option is only available to those who have the funds to do so. This often leads to people ending their lives sooner than they would have wished because they need to be well enough to travel. There is no oversight under UK law about who travels abroad for an assisted death; anyone who provides assistance – doctors, family or friends – is breaking the law, which can lead to criminal investigations.
5. There is widespread public support for, and tacit acceptance of, physician-assisted dying within society. Given this, it would be fairer and safer to have a properly controlled and regulated system within the UK.
6. Some people, knowing that they are dying, want to be able to exercise their autonomy and determine for themselves when and how they die, but need medical advice and support to achieve this. Doctors should not be able to impose their personal beliefs on competent, informed adults who wish to exercise this voluntary choice. Legislation would contain a conscientious objection clause to protect those healthcare professionals who did not want to participate.
7. The existence of legislation allowing assisted dying brings reassurance and peace of mind for many people with terminal illness and their loved ones, even though only a small percentage actually use it when the time comes.

Key arguments for and against the BMA moving to a position of neutrality on physician-assisted dying

Those who support the BMA adopting a neutral position often use the following arguments.

1. The BMA represents doctors with a wide range of views on physician-assisted dying; adopting a neutral position would reflect this diversity and allow the BMA to represent the views of its membership more accurately.
2. The BMA taking a position 'for' or 'against' a change in the law erroneously implies that this represents 'the view' of the medical profession whereas in fact no such consensus exists.
3. This is an issue for society, not just for doctors – the BMA should not therefore seek to disproportionately influence the debate. Rather, the BMA should focus on ensuring that doctors' and patients' interests are protected in any proposed legislation.
4. Some argue that the BMA should focus on its trade union functions and should not take a public stance on any of these broader public policy issues.

Those who oppose the BMA adopting a neutral position often use the following arguments.

1. A decision by the BMA to move to a position of neutrality would be interpreted as the BMA dropping its opposition to physician-assisted dying, and could be seen as implicit acceptance of a change in the law.
2. Legislators look to professional bodies for their views on matters affecting them and the BMA's opposition to physician-assisted dying has been persuasive in Parliamentary debates in the past. A shift by the BMA to a position of neutrality would make a change in the law more likely.
3. The BMA cannot be neutral on an issue that will have a significant impact on doctors' clinical practice and could put vulnerable and disabled patients at risk.
4. The BMA is both a trade union and a professional association and as such must take a stance in important public policy debates that directly affect doctors and patients.

BMA

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