

1 May 2024

Dear Mr McArthur,

Assisted Dying for Terminally Ill Adult (Scotland) Bill

You may be aware that since 2021 the BMA has taken a position of neutrality on assisted dying, including physician-assisted dying. This means that the BMA neither supports nor opposes a change in the law. We have been clear, however, that we have a responsibility to represent the views of our members in discussions on any legislative proposals. In order to do this, the BMA's Medical Ethics Committee (MEC) – which has a UK-wide remit and includes members from Scotland - has undertaken a significant piece of work to consider how we can best represent our members in debates across the UK and Crown Dependencies on assisted dying.

To develop these positions, the MEC reviewed what we already knew about our members' views (from previous engagement work including our member [survey](#) and [dialogue events](#)); communicated with other national medical associations about the issues their members were concerned about and how they were engaging in the debates; spoke with individuals working in jurisdictions where assisted dying is lawful (both providers and opponents); and carried out a literature review. With these considerations in mind, the MEC identified those issues that would significantly impact on our members, should the law change, and considered what, if any, view the BMA should take on those issues. As the work developed, the MEC sought views from other BMA committees – across all branches of practice – and our patient liaison group. This work was then approved and agreed by BMA Scottish Council and the three other national Councils across the UK.

As was evident from our survey of BMA members, conducted in 2020, we represent members with a diverse range of views; as doctors we also have responsibilities to our patients. Central to the MEC's work, therefore, was the need to balance the different, and sometimes competing, interests of three different groups:

- BMA members who, for whatever reasons, would not be willing to participate in assisted dying;

National director (Scotland): John Robertson**Co-chief executive officers:** Neeta Major & Rachel Podolak

Registered as a Company limited by Guarantee. Registered No. 8848 England.

Registered office: BMA House, Tavistock Square, London, WC1H 9JP.

Listed as a Trade Union under the Trade Union and Labour Relations Act 1974.



- BMA members who would be willing to provide assisted dying if it were legalised; and
- patients who may wish to access a lawful assisted dying service.

We have now reviewed your Assisted Dying for Terminally Ill Adults (Scotland) Bill alongside the work we have conducted and wish to offer the comments below. By commenting on your Bill, we are not supporting or opposing a change in the law. These comments are provided solely to inform you of the BMA's views on some key issues if the law were to change. Where we have not commented on your proposals, this is because it is not an issue that we have currently taken a position on – it should not be interpreted as support for or acceptance of those provisions.

General approach in the Bill

The Bill, as drafted, is based on the premise that any doctor could be expected to participate in assisted dying, if requested by a patient, unless they have claimed a conscientious objection. At various points in the supporting documentation, you refer to your expectation that the coordinating doctor will usually be the terminally ill adult's GP or specialist doctor and, in the financial memorandum, that 'it is anticipated that the registered medical practitioners (RMPs) would undertake the role as part of their existing employment and thus that costs would be absorbed by existing budgets'. We believe that these are both unrealistic and concerning assumptions and we would urge you to look again both at the practicalities of how your proposals would work and how any assisted dying service would be funded.

If assisted dying were to be legalised, the BMA would want to see a completely different approach which gives doctors greater choice about whether and, if so to what extent, they are willing to participate, and which does not divert already over-stretched staff and other resources from existing care services. BMA Scotland does not believe our health service is sustainable with the current resources not able to match or keep up with the expectation and demand being placed on it. NHS Scotland is understaffed, under-resourced and under-funded. Additional services cannot be placed on doctors without adequate resourcing and funding. If the Scottish Parliament decides to change the law on assisted dying, the Scottish Government must make sufficient additional funds available to ensure that the service is properly resourced without adversely impacting on existing care services.

An opt-in model of delivery

The BMA believes that any legislation to permit physician-assisted dying 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 drugs to eligible patients).

From the information we have gathered about other jurisdictions, it appears that *in practice* assisted dying is usually only provided by those who positively choose to participate, even though it is not explicitly presented in this way. (In some jurisdictions for example, only those who choose to undertake the required mandatory training, or to register with a central body, are eligible to participate.) Making this explicit in any legislation would provide reassurance to both doctors and patients. From our members' perspective, if assisted dying were to be legalised, having an opt-in model would:

- give doctors the greatest amount of choice about whether, and if so the extent to which, they were involved;

- provide reassurance to those doctors who did not want to participate that they would not face pressure to do so;
- ensure that those who wanted to participate had the proper training and experience to do so;
- make it easy for patients seeking assisted dying to identify a doctor willing to help them; and
- make the service easier to audit, which would help to build confidence and maintain trust.

Although not included in its recommendations, your medical advisory group (at page 16 of its [report](#)) appeared to support a similar approach, saying ‘The group discussed the practicalities of conscientious objection and *decided that assisted dying should be an opt-in process...*’ [emphasis added]. It is disappointing that this was not pursued and we would urge you to reconsider this approach.

A separate service

In the BMA’s view, assisted dying should be set up as a separate service that would accept referrals from other professionals and/or self-referrals. 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 BMA does not support the proposal in the documentation accompanying your Bill that assisted dying would be provided by the patient’s own GP, or specialist doctor, as part of the standard care and treatment they provide.

There are different ways that a separate service could be organised (including, for example, the model proposed in Jersey), and it is not for the BMA to comment on the details of this, but the advantages of having this separation include that it would:

- help to reassure those doctors who did not want to participate that there would be no pressure on them to do so;
- give patients a clear pathway to access the service that would not be dependent on the views of their treating doctor;
- ensure that those doctors participating in assisted dying would have the necessary training, experience and both practical and emotional support; and
- help to ensure consistency and facilitate oversight, research, and audit of the service.

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

The Bill currently includes a conscientious objection clause similar to that found in legislation on abortion and assisted reproduction, but with a higher burden of proof for those wishing to rely on it. The BMA believes that, if assisted dying were legalised, doctors should be able to refuse to carry out any activities that are directly related to assisted dying (such as assessing capacity, or determining life-expectancy, specifically to assess eligibility for assisted dying) for any reason. Therefore, there should be a general right to object which does not need to be based on matters of conscience.

Doctors who do not choose to provide assisted dying themselves may, nonetheless, receive requests from patients or other health professionals for actions that are an intrinsic part of the assisted dying process. These are activities that would require them to use their professional skills and judgement to facilitate a request for assisted dying. This could include, for example, a request

to assess an individual's capacity, or make a judgement about their life-expectancy, specifically in order to assess their eligibility for assisted dying.

We are aware (including from responses to our survey) that there are some doctors who do not oppose assisted dying in principle (and so do not have a 'conscientious' objection in the way that is normally understood) but who would not personally want to participate in the process. It is important, therefore, that if assisted dying were legalised, doctors should be able to object to taking any part in the process itself, for *any reason* and, as such, any right to object should not be framed as, or limited to, matters of conscience. There is some evidence from Quebec that supports this position; many doctors who claimed a conscientious objection did not cite moral or religious objections to assisted dying but expressed other reasons for not wanting to participate such as the emotional impact of participation, lack of time, and lack of confidence in their competence to carry it out.¹

In terms of moral complicity, there is a difference between requests for doctors to use their professional skills as part of the process of assisted dying, which the BMA believes doctors should be able to refuse for any reason, and requests to provide existing information from the medical record, which the BMA believes all doctors should comply with, without delay. Irrespective of their personal views, if approached about assisted dying, the BMA believes that all doctors should also inform patients about where and how to obtain information about assisted dying (see comments below on information for patients).

We are also aware of the need for Westminster to give its approval to the inclusion of a conscientious objection clause in Scottish legislation which, as far as we can tell from the documentation accompanying the Bill, has not yet been given. Having an opt in system combined with a general right to refuse may also help to address some of these technical legal challenges.

Protection from discrimination and abuse

The Bill does not currently provide any protection for doctors from discrimination or abuse as a result of their views and actions in relation to assisted dying.

Statutory protection from discrimination

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.

Through the work we undertook with our members, it became clear that some doctors were concerned about how their decision to participate, or not to participate, in assisted dying (if it were legalised) might impact on them both personally and professionally. This included concerns that they might be ostracised by colleagues, or their career prospects might be jeopardised, because of their decision. We also heard anecdotally about some healthcare institutions in other countries, that are opposed to assisted dying, using contractual terms to prevent their doctors from participating in assisted dying in their own time. Any discrimination, or detriment to doctors, as a result of their views, and/or intentions, regarding assisted dying is unacceptable to the BMA and should be prohibited.

¹ [A qualitative study of physicians' conscientious objections to medical aid in dying - Marie-Eve Bouthillier, Lucie Opatrny, 2019 \(sagepub.com\)](#) Palliative Medicine Vol 33(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.

The BMA has for many years campaigned for safe access zones (formerly known as ‘buffer zones’) around abortion clinics to protect patients and staff from harassment by protesters – an issue that is currently under consideration by the Scottish Parliament. Given the strong views around assisted dying, it is possible that similar protests could take place close to facilities providing assisted dying.

Although there is no evidence of harassment outside establishments in other countries, the BMA strongly supports the need to protect both staff and patients in the event of any harassment taking place. Safe-access zones can only be put in place if the relevant legal powers exist. Therefore, if legislation were to be passed, it should include legal provision for safe access zones that could be invoked if the need arose.

Providing information to patients

If assisted dying were to be legalised, 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.

If assisted dying were legalised, it is important that doctors who do not wish, or do not feel confident, to provide information to patients about assisted dying have somewhere they can direct patients to, in the knowledge that they will receive accurate and objective information. It is also important for patients who may meet the eligibility criteria to know where and how to obtain the information they need without the requirement to go through their doctor. The policy memorandum suggests that organisations such as Friends at the End and the Humanist Society Scotland have indicated that they would provide ‘guidance, support, counselling and other navigation for patients’ but the BMA believes that something much more formal and centralised is needed for this vital role. We therefore believe there should be an official body (with legal accountability) to provide this information to patients and to help them to navigate the process.

Oversight and monitoringRegulation

The BMA strongly supports the establishment of an independent and transparent system of oversight, monitoring and regulation of assisted dying if it were legalised. This is essential to ensure appropriate standard-setting, quality assurance and to maintain public confidence.

There is currently no mention in the Bill or accompanying documents of any form of oversight, monitoring or regulation of assisted dying.

Post-death review

If assisted dying were legalised, the BMA would support the introduction of a system for routinely reviewing all assisted deaths as an important part of oversight and monitoring, to maintain trust and confidence in the service.

Review committees, to assess all deaths following assisted dying, have been set up in a number of countries including New Zealand, Australia, the Netherlands and Canada. Their role is to

retrospectively review each individual case after a death has occurred, to ensure that the correct process had been followed. Any problems or breaches identified and requiring further investigation or action are then referred on to the relevant organisations. Reviewing the details of individual deaths – including identifying the time to death and any complications or unforeseen circumstances that arose – can also lead to improvements in how cases are managed from a medical perspective and help to identify learning points for those delivering the service.

Whilst the Bill refers to the collection and publication of data, it does not include provisions for individual review of the detail of every assisted death.

We will be sharing these views with the Health, Social Care and Sport Committee when it puts out its call for evidence, but we were keen to share this information with you first. We would welcome the opportunity to discuss these issues with you and to know whether you would support the changes we have suggested which, we believe, would be better for both doctors and patients in the event of a change in the law. If you would find such a meeting helpful, please contact [Erin Robertson](#) so that we can find a mutually convenient date.

Yours sincerely



Dr Iain Kennedy
Chair, BMA Scottish Council