

Changes in BMA policy on assisted dying

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In June 2005, the BMA became the third UK medical organisation to withdraw its opposition to the legalisation of assisted dying. Despite its history of opposition, delegates at the annual representative meeting voted narrowly to leave the matter to parliament. The royal colleges of general practitioners and physicians withdrew opposition in October 2004, saying it was a matter for society but stressing that neutrality was not support for assisted dying.^{1 2} However, the colleges are reviewing their stance because of criticism from members. This paper considers the events leading up to the change in BMA policy and its implications for future work surrounding the issue.

Barometer of changing views?

Only months before the debate at the annual representative meeting that changed BMA policy, the BMA gave evidence to the House of Lords Select Committee on the Assisted Dying for the Terminally Ill Bill in which it firmly opposed any change in the law.³ The vote thus may seem like a sudden reversal of policy, but cracks in BMA opposition had been gradually developing.

Recent BMA policy has acknowledged a wide spectrum of views within the profession. A debate at the annual representative meeting in 1997 approved a policy opposing any legal change "for the time being." That rider indicated that the matter was not closed and, despite being repeatedly knocked back, opponents of the status quo continued to raise it at annual meetings (box 1). In 2005, 13 motions were submitted on assisted dying. They can be summarised as five in favour, four against, one urging neutrality, and three calling for more discussion. The growing split within the



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membership was perhaps epitomised by the Lothian division of the BMA, which submitted two motions: one calling on the BMA to support the Scottish consultation paper on assisted dying⁴ and one opposing it.

The different motions alerted BMA representatives at the 2005 meeting that, whatever the outcome of the debate, it was becoming impossible to satisfy everyone. It may have contributed to the perception that organisational neutrality was the best option.

The diversity of medical opinion is backed up by research commissioned by the House of Lords select committee on assisted dying. This research examined 12 polls of doctors' opinion on assisted suicide carried out between 1987 and 2004. Reported support among doctors for the legalisation of assisted dying ranged from 30% to 60%. The select committee's conclusion was that the attitudes of doctors to assisted dying are not easily summarised accurately. Doctors, it said, have a more complex take on the issue than the general public but some evidence suggests that "the closer their experience of end-of-life patients, the less sure professionals are about the prospect of a change of the law in favour of euthanasia."⁵ The practical experience of those who currently provide end of life care clearly needs to be taken fully into account in any assessment of the law.

A shift has occurred but it is hard to assess the extent of change in the views of the elected representatives. Before electronic voting was introduced at the annual meeting, policy decisions were made on the basis of a majority vote by a show of voting cards; numbers were counted only if the vote seemed very close. More recently, the routine use of electronic voting has made it clear how split medical opinion is on some issues, including assisted dying. At the 2005 annual meeting, to assess whether there was any support at all for the BMA lobbying in favour of assisted dying, delegates voted to take this proposal first. It was rejected but by a far narrower margin than most had expected (58% against and 42% in favour). In other words, support among the voters was appreciable for the BMA making a complete volte face.

Box 1: Evolution of BMA policy on assisted dying

- 1969: BMA policy opposing euthanasia established at the annual representative meeting
- 1971: BMA issues a report rejecting medical participation in euthanasia
- 1988: BMA report recommends that euthanasia should remain illegal
- 1997: Annual meeting discusses physician assisted suicide for the first time. It opposes any change in the law "for the time being" but recognises a diversity of views in the profession
- 1998: Annual meeting calls for a national conference of BMA members to discuss physician assisted suicide
- 2000: National two day conference on physician assisted suicide rejects any legal change
- 2000: Annual meeting endorses the call for no legal change to allow assisted suicide
- 2003: Annual meeting notes "grass roots concern against euthanasia"
- 2005: Annual meeting votes to let parliament and society decide the issue of assisted dying

The subsequent vote was on whether the BMA should withdraw opposition to assisted dying but campaign for robust safeguards if any legislation was proposed. This was passed by a narrow majority (53% in favour and 47% against). In hard figures, this was 93 votes against 82. No count was taken of abstentions and so it is unclear how many present were “don't know.”

Areas of consensus

If proposals for legal change arise, the main area of consensus for the BMA seems to be on the matter of safeguards. A preoccupation with vulnerable people and safeguards to protect them from pressure has always been important in BMA policies. In 2000, the annual meeting called for a national conference on physician assisted suicide. In response, 50 doctors nominated by local BMA divisions examined the arguments and the evidence from other countries and tried to reach a workable consensus. This conference was held in parallel with an electronic debate on the BMA website with 200 more contributors. Despite the wide diversity of views, concern was shared about the risks for seriously ill or dependent individuals if assisted suicide were legalised.

The conference agreed to oppose change but largely on pragmatic rather than solely on moral grounds. Participants were unconvinced that sufficient safeguards could be put in place and feared a slippery slope situation, where the claimed rights of strong willed people to control their death would put pressure on people who were weak and uncertain. The main model participants were analysing was the Netherlands, which was beset by allegations of doctors acting outside the rules and ending some patients' lives without their consent.^{5 6} This concern for the vulnerable has been the bedrock of the BMA's opposition to the legalisation of assisted dying.

The lurking question, however, has been what would happen if any jurisdiction that allowed assisted dying could show that slippery slopes could be avoided? The US state of Oregon seems to have an assisted dying system without appreciable problems. Compared with other people dying in Oregon, patients applying for assisted suicide are younger with above average educational attainment.⁷ They are not marginalised people but individuals who prioritise having control over their death. Those treating them do not see depression, lack of social support, and fear of being a financial drain on family members as factors in their choice.⁸ Does this mean that the slippery slope can be avoided? Only time will tell.

Nevertheless, the spotlight in assisted dying debates seems to be shifting from proposals for doctor administered euthanasia, such as operated in the Netherlands, to models which emphasise patients controlling their own dying process, such as in Oregon. Each year some Oregon patients who obtain a lethal prescription choose not to use it, giving some reassurance about the absence of pressure. In 2004, for example, 60 patients obtained prescriptions but only 35 used them.⁹ In 2003, 67 lethal prescriptions were issued but 28 people did not use the drug; 18 died of their illness and 10 were still alive at the year's end.¹⁰ In 2002, 16 of the 58

Box 2: Oregon model of assisted suicide

Under the Death with Dignity Act, terminally ill adults can obtain a prescription for a self administered lethal medication (barbiturates). Doctors can write but not administer lethal prescriptions. Patients must ingest the drugs unaided. Assisting suicide outside the act is a crime.

- Patients must make two oral requests and a witnessed written request
- Two doctors must confirm the diagnosis and prognosis
- If doctors suspect that the patient's judgment is impaired, a psychological examination should take place
- Doctors must tell the patient about feasible alternatives, including palliative care
- Doctors must ask, but not oblige, patients to tell their next of kin
- Doctors must report all lethal prescriptions and inform pharmacists

patients who obtained a lethal prescription died without taking it and six remained alive.⁷

Lessons from Oregon

The Oregon Death with Dignity Act, which has been operational since 1997, is controversial (box 2).⁵ The Oregon Medical Association takes a neutral stance but estimates that relatively few Oregon doctors consider physician assisted suicide to be the best solution and perhaps as many as 85% are ambivalent.⁵ Dobscha and colleagues' survey of doctors highlighted the gulf between theoretically supporting the concept of assisted dying and actually participating in it.¹¹ Oregon doctors worry about being insufficiently prepared, making an error, or being damaged in some way by the experience.¹¹ Some have interpreted requests for assisted suicide as a rejection of their care or have felt relieved when patients died of causes other than suicide. Training, preparation, counselling, and clear rights of conscientious objection (including whether doctors have a duty to refer on) all need to be attended to in any jurisdiction with this type of legislation.

Doctors also worry that helping patients to commit suicide could affect their reputation or relationships with colleagues. Nevertheless, regardless of whether they issued a lethal prescription, Oregon doctors did not regret their decisions although they sometimes regretted not having communicated with the patient well enough.¹¹ They reported feeling better able to deal with patients at the end of life. For some it seemed a logical extension of the care already given and a chance to see patients through their whole illness. Some hospice nurses also thought that the knowledge that lethal medication was available would diminish patients' anxiety and desire for assisted suicide. “It may be that within the context of compassionate palliative care, the vast majority of requests disappear after some time.”⁸

What does neutrality mean?

If new draft legislation is proposed in the UK, the BMA cannot campaign for or against it but must focus on

the safeguards for doctors as well as for patients. In terms of patient protection, this clearly entails mechanisms for ensuring patients are competent, informed, unpressured, and able to change their mind at any stage. As part of the bigger picture, safeguards for patients must also include the availability of alternatives, especially good palliative care. Calls for legalisation of assisted dying lack credibility if patients have no proper alternative, and Lord Joffe has repeatedly emphasised how unsatisfactory are the current gaps in availability of palliative care.

Safeguards for doctors must include clear rights of conscientious objection, and for doctors working in the pharmaceutical industry if products designed solely for suicide are produced. Doctors' contracts must allow scope for dissension without prejudice. New kinds of training and support will be required. Also the BMA needs to continue to be open to the voices of doctors who oppose its new policy. The BMA change of policy came as new debating procedures, designed to promote wider discussion, were used. The open debates allowed more audience participation but some frustrated opponents of the new policy alleged manipulation of the meeting. Two confused early day motions were laid in parliament,^{12 13} indicating some misunderstandings about the BMA's policy making mechanisms (box 3). Clearly, clarity, and transparency about how policy is made and changed is essential, and this is something which the annual meeting has been tackling in its modernisation programme.

Conclusion

The medical profession is divided on assisted suicide, but it has been for some years. Arguably, it can be seen as a sign of the BMA's maturity that it now

Box 3: How the BMA makes policy

Policy making procedures are set out in the BMA's articles and byelaws. Policy is made at annual representative meetings by the representative body consisting of doctors nominated to take decisions on the membership's behalf. The BMA's 202 local divisions appoint about half of these representatives. The remainder are elected by craft conferences and other BMA bodies. Thus a small group of elected representatives determine policy as long as a quorum (one third of the registered representatives) is present. In 2005, 370 BMA representatives registered and the quorum was 123.

All BMA members can submit views to local divisions and suggest motions. Annually, BMA constituencies submit these motions for national debate. The number and relevance of motions on a topic determine the priority assigned to it for debate at the annual representative meeting. Past practice was for some speakers for and against each motion to be heard and then a vote taken. In 2005, a new process of open debate allowed more audience participation on four topics, including assisted dying. The debate was broadcast live and was accessible for a month on the BMA's website. Policy options were voted on electronically. As the BMA's sovereign policy making body, the annual representative meeting has sole power to overturn existing policies.

Summary points

Assisted dying is an issue which increasingly divides the profession

The BMA has adopted a neutral policy to allow parliament to decide

The adequacy of safeguards in any proposed legislation will be a BMA priority

Research from Oregon helps identify the safeguards needed.

acknowledges that this controversial issue can no longer be addressed in black and white terms. Surveys of medical opinion may be flawed but cannot be entirely dismissed. A 2004 Medix poll of 1000 doctors, for example, indicated that 56% favoured legalisation of physician assisted suicide with stringent safeguards.¹⁴ Oregon doctors warn us, however, that it is one thing to support the concept of assisted dying and another to implement it. Any country that embarks on such legislation needs to consider the potential effect on all its citizens, including care providers, patients, and their families. From the BMA's perspective, a neutral position entails a campaign for better palliative care, robust safeguards for patients, training and support for health professionals, and clear conscientious objection clauses.

Contributors and sources: AS has written extensively on ethical issues for the BMA and drafted the BMA's response to House of Lords select committee on the assisted dying bill.

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