End-of-life decisions

Views of the BMA

Contemporaneous and advance refusal of treatment

Withholding and withdrawing life-prolonging medical treatment

Assisted dying: euthanasia & assisted suicide
The British Medical Association has several publications dealing in detail with aspects of end-of-life decisions. These include chapters in its general textbook, *Medical Ethics Today* (2nd edition 2004), *Withdrawing and Withholding Life Prolonging Medical Treatment* (3rd edition available 2007) and *Advance Statements about Medical Treatment* (1994 currently under revision). This guideline summarises the BMA’s views on three main issues:

- Contemporaneous and advance refusal of treatment
- Withholding and withdrawing life-prolonging medical treatment
- Assisted dying: euthanasia & assisted suicide

### Background to BMA policies
The British Medical Association is a professional association for doctors. Its policies are formulated at its annual representative meeting where motions submitted by the BMA membership are debated. If approved, they become BMA policy.

End-of-life issues are frequently a matter of such debate, including concerns about the availability of good quality palliative care. In its policies, the BMA distinguishes between the right that every person has to be supported and cared for during the process of dying and requests that patients sometimes make that the doctor should deliberately hasten their death. The Association emphasises patients’ clear and indisputable right to care and assistance while dying but does not believe that patients have a right to assistance to end their lives.

Many doctors worry that high profile media interest in other aspects of end-of-life treatment may detract attention from issues such as palliative care provision. In 2005, a House of Lords Select Committee criticised the gaps in palliative care provision. It said services were inadequately resourced and unevenly spread. BMA members echoed this point. In 2006, the Government acknowledged that more investment was needed and pledged to double funds for palliative care services. Nevertheless, a continuing matter of concern for the Association remains the uneven availability of good quality palliative care for patients who want it.

### Contemporaneous requests for & refusal of treatment
Patients with a terminal or degenerative condition are likely to be anxious about how their care will be managed and how choices are made. Sensitive discussion of their views about the options is useful in enabling those treating them to act in accordance with patients’ wishes. While competent, patients decide for themselves what is in their best interests in terms of medical care. They may request or decline certain procedures or refuse life-prolonging treatment generally in certain circumstances. Requests should be taken into account but ultimately the clinician in charge of the patient’s care decides which options are clinically appropriate to offer. Patients or their families cannot insist upon clinically inappropriate treatment being provided. It should be borne in mind, however, that the Appeal Court has said that it is always appropriate for doctors to comply with a request for artificial nutrition and hydration (ANH) from patients with mental capacity who are unable to accept nourishment in other ways. The court made clear that this does not imply that patients can more generally insist upon receiving particular forms of treatment but that, as part of their duty of care, doctors must take reasonable steps to keep patients alive when this is patients’ known wish.

In terms of treatment refusal, the law and codes of ethical practice emphasise that adults with mental capacity can refuse medical treatment, including life-prolonging procedures. Where adult patients refuse procedures which are likely to benefit them, the BMA advises health professionals to ensure that there is no misunderstanding and provide information in a sensitive manner about the implications of refusal. Good communication is essential and may include exploration of alternative treatment options that might be acceptable to the patient. Ultimately, however, a refusal made by an adult with mental capacity must be respected.

### Advance refusals & requests
Advance decisions about medical treatment are a facet of patient choice. The recording of such decisions provides a mechanism for individuals with capacity to say what they would like to happen in the future if their mental capacity becomes impaired. Advance decisions only come into consideration once patients lose their mental capacity, are unconscious or otherwise unable to communicate. In that situation, doctors must act in the incapacitated patient’s best interests. Evidence of an informed advance decision, whether oral or written, should be taken into account when deciding what is in the individual patient’s best interests.

Patients cannot demand or refuse anything in advance that they cannot demand or refuse when conscious and competent. Therefore, patients cannot refuse in advance compulsory treatment provided under the mental health legislation or
advance requests or authorisation of specific treatment can be helpful, they lack legal weight if clinicians assess that treatment to be inappropriate.

Advance directives or "living wills" are one form of anticipatory refusal that some individuals with capacity choose in anticipation of future mental incapacity. Health professionals must abide by the terms of a patient's valid advance refusal but care is needed to ensure that the refusal of medical treatment is applicable to the circumstances which have subsequently occurred. The legally binding nature of clear and valid advance refusals which address the particular circumstances which later arise is well established in common law. (In England and Wales, statutory support for the common law position will be provided by the Mental Capacity Act which is due to come into force from April 2007). In Northern Ireland, advance refusals are also likely to be legally binding if they meet the criteria for validity established by common law. In Scotland, the only specific legislation on advance decision making relates to mental health but the code of practice issued under the Adults with Incapacity (Scotland) Act makes clear that advance refusals of treatment (except for treatment that can be given compulsorily under the mental health law) are potentially binding. In all cases, doctors need to look at the available evidence of the scope of the patient’s refusal.

In 1995, the BMA published Advance Statements about Medical Treatment which was endorsed by the Conference of Royal Colleges. (This is now being revised to reflect legal changes and a brief note is on the website). Although there was no legislation at that time, the common law throughout the UK made clear that people with mental capacity could legally and ethically decide for themselves about accepting or declining medical treatment offered to them.

While the BMA recognises the advantages of advance statements in terms of encouraging openness, dialogue and forward planning, it also draws attention to potential disadvantages. Health professionals and the public should be aware that treatment decisions are complex and practice is constantly evolving. If advance decisions are made a long time before capacity is lost, treatment options may have significantly changed. Over time, patients' views can also change about what constitutes a tolerable existence. Advance decisions cannot encompass unforeseen possibilities and options. Therefore, while upholding patients' rights to decide in advance, the BMA also emphasises that patients need to think carefully about the risks associated with committing themselves in advance.

When it comes to implementation of an advance refusal of treatment and the patient has lost mental capacity, health professionals will need to assess the validity of the refusal. There is an assumption that the patient was competent at the time of making the decision unless there is evidence to the contrary. Doctors also need to consider whether the statement fits the circumstances that now arise or if there is a major difference or has been a significant change from the scenario the patient anticipated. For example if the advance refusal was made a long time ago, not updated and treatment options have altered, its validity should be questioned. In case of doubt, legal opinion should be sought.

Further guidance is available in the BMA’s separate guidance note on advance decision making.

**Withholding and withdrawing life-prolonging medical treatment**

Medical treatment can legally and ethically be withdrawn when it is futile or that it cannot accomplish any improvement, when it would not be in the patient’s best interest to continue treatment (because, for example, it is simply prolonging the dying process) or when the patient has refused further treatment.

This is, however, a profoundly difficult area, as medical technology increasingly appears to blur the boundaries between life and death. This was illustrated in 1993 by the House of Lords deliberations in the case of Tony Bland
d. In a persistent vegetative state (PVS) with no awareness of the world and no hope of recovery, Bland was not terminally ill but withdrawal of artificial nutrition would inevitably result in his death. Following judgments made in other jurisdictions and confirming that artificial nutrition constitutes a medical treatment, the House of Lords agreed that it could be withdrawn.

The BMA receives many enquiries about when to give, and when to stop giving, medical treatment which has the potential to prolong life. These enquiries prompted the Association to undertake a consultation in 1998 and subsequently publish guidance for health professionals. The issues are difficult and complex, and doctors, patients and their families need reassurance that each individual decision is carefully thought through, is based on the best quality information available and follows a widely agreed procedure.

Medicine aims to restore or maintain patients’ health by maximising benefit and minimising harm. When medical treatment or intervention fails, or ceases, to provide a net benefit to the patient, this
primary goal of medicine cannot be realised and the justification for intervening is gone. Unless some other justification can be demonstrated, most people would accept that treatment should not be prolonged. The BMA does not believe that it is appropriate to prolong life at all costs, with no regard to its quality or the burdens of the intervention.

Technological developments continually extend the range of treatment options available to prolong life when organ or system failure would naturally result in death. Patients with progressive, degenerative conditions can have their lives prolonged considerably but this will not necessarily reverse a patient’s disease. Other patients, for example those with very severe brain damage, may remain stable for many years if life-prolonging treatment is provided, but this may be with no hope of recovering more than very minimal levels of awareness of their surroundings. They may lack the ability to interact with others or the capacity for self-directed action. In such severely damaged patients, treatment or intervention to prolong life by artificial means may fail to provide sufficient benefit to justify the intervention and the proper course of action may be to withhold or withdraw further treatment.

The guiding principles underlying any such decision must be to protect the dignity, comfort and rights of the patient; to take into account any known wishes of the patient and the views of people close to patients who lack capacity. Communication and consultation are essential. A thorough clinical evaluation, including the initiation of treatment for a trial period if appropriate, must take place, so that the decision is based on as accurate as possible an assessment of the benefits, risks and burdens of the treatment for that particular patient. Where the treatment to be withheld or withdrawn is artificial nutrition and hydration, the General Medical Council requires that a second clinical opinion be sought before treatment is withdrawn or withheld from a patient who is not imminently dying. Furthermore, in England, Wales and Northern Ireland, the withdrawal or withholding of ANH from a patient in persistent vegetative state needs to be subject to court review. In Scotland, this is not obligatory but it is advisable to seek legal advice.

The BMA’s guidance, contained in Withholding and withdrawing life-prolonging medical treatment, gives advice on the ethical, legal and clinical issues, and sets out safeguards for decision making. It indicates how the human rights legislation applies to the sphere. It also seeks to provide a coherent and comprehensive set of principles which apply to all decisions to withhold or withdraw life-prolonging treatment, which it is hoped will stimulate the development of local policies and guidelines.

Doctors considering withholding or withdrawing life-prolonging treatment can find detailed guidance in the BMA booklet. In any cases of doubt, legal advice should be sought. In England and Wales, legal advice can be sought from the Official Solicitor. Northern Ireland has its own Official Solicitor.

**Assisted dying**

“Assisted dying” is a general term covering both euthanasia (where someone other than the patient administers a fatal dose) and assisted suicide (where patients are assisted to end their own lives).

Traditionally, the BMA opposed any form of assisted dying but in 2005 its annual representative meeting (its policy-making body) recognised that there were diverse opinions within society and the profession. It agreed that Parliament and society at large should decide the issue of possible legalisation. This meant that the BMA took a neutral stance on assisted dying, (euthanasia and assisted suicide) agreeing not to oppose legislation which might alter the criminal law. If legal change occurred, the BMA was mandated to press for robust safeguards for patients and for doctors who did not wish to be involved in assisted dying. In 2006, however, BMA members voting at the annual meeting made clear that the majority opposed such legislation. Therefore the BMA dropped its neutral stance and again opposes all forms of assisted dying.

The current policy is that the BMA:

(i) believes that the ongoing improvement in palliative care allows patients to die with dignity;

(ii) insists that physician-assisted suicide should not be made legal in the UK;

(iii) insists that voluntary euthanasia should not be made legal in the UK;

(iv) insists that non-voluntary euthanasia should not be made legal in the UK; and,

(v) insists that if euthanasia were legalised, there should be a clear demarcation between those doctors who would be involved in it and those who would not.

**Euthanasia**

Active and intentional termination of another person’s life is morally and legally different to the withholding or withdrawal of treatment. Arguments for legalisation of euthanasia are generally based on arguments about competent individuals’ rights to choose the manner of their demise or about cases where medicine is unable to
control distressing terminal symptoms. Although the BMA respects the concept of individual autonomy, it argues that there are limits to what patients can choose if their choice will impact on other people.

Arguments against legalisation often focus on practical points. If euthanasia were an option, there might be pressure for all seriously ill people to consider it even if they would not otherwise entertain such an idea. Health professionals explaining options for the management of terminal illness would have to include an explanation of assisted dying. Patients might feel obliged to choose it for the wrong reasons, if they were worried about being a burden or concerned about the financial implications of a long terminal illness. Legalisation could generate anxiety for vulnerable, elderly, disabled or very ill patients.

**Physician-assisted Suicide**

The arguments for and against assisted suicide and physician assisted suicide are similar to those made in relation to euthanasia. Assisted suicide differs from euthanasia in that the individual retains control of the process, rather than the doctor or anyone else assisting.

In the past, the BMA made no attempt to distinguish between euthanasia and physician assisted suicide. The two were assumed to be the same, and BMA policy opposing the involvement of doctors in the intentional killing of patients was believed to cover the illegal act of assisting their suicide too. Only in 1997 did BMA policy make specific reference to both physician assisted suicide and euthanasia. It recognised that there was a wide spectrum of views about both but opposed any changes in law to permit either.

In 1998 the BMA’s Medical Ethics Department published a discussion paper asking whether the moral arguments about physician assisted suicide and euthanasia differ, and whether it is morally relevant that in physician assisted suicide the patient, not the doctor, is the main actor. The same year, the BMA was mandated by its representative body to hold a conference “to promote the development of a consensus on physician assisted suicide”. In March 2000, 50 BMA members, representing a range of medical specialties and professional seniority, met for two days of debate. They produced a consensus statement opposing physician assisted suicide, whilst recognising that the views of individuals within the profession covered a wide spectrum. In Parliament between 2003-6, there were attempts to change the law prohibiting physician-assisted suicide. In 2003 Lord Joffe brought forward the first of three bills attempting to legalise assisted dying in England and Wales. None have progressed to become law. The most recent was the 2005 Assisted Dying for the Terminally Ill Bill. In May 2006 this Bill received its second reading and Peers voted to delay it for six months. Lord Joffe pledged to reintroduce the Bill at a later date and the Government said it would not block a further hearing. In Scotland, a proposed similar Bill on Assisted Dying for which MSP Jeremy Purvis had sought support fell through lack of Parliamentary support in November 2005.

Like the arguments for euthanasia, the issue of physician assisted suicide is often portrayed as a question of “patient rights”, “free choice” or “liberty of action”. The BMA considers that this language of choice may belie the real pressures from family members or society in general which may be exerted if assisted suicide were legalised.

**Effects on health professionals**

While it is difficult, if not impossible, to predict the long-term effect of major social changes, the BMA would be concerned if health professionals were expected to participate in euthanasia or assisted suicide as a result of legal changes. Even if robust conscientious objection clauses were enacted, such a change could give rise to demoralisation among health professionals and ambiguity about their role. If it were part of a health professional’s role and duty to assist with suicide and provide advice and counselling for people wishing to carry it out, the underpinning of much of medicine’s efforts to improve individual quality of life might be undermined.

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References

1. Report of the House of Lords Select Committee on the Assisted Dying for the Terminally Ill Bill

2. 2006, White paper, *Our health, our care, our say*, (para 4.102)

3. *R(on the application of Burke) v General Medical Council* [2005] 2 FLR 1223


6. It is unlawful to aid, abet, counsel or procure a suicide under the Suicide Act 1961.