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Breaching the stalemate on assisted dying: it's time to move beyond a medicalised approach

Despite growing legal and medical support for assisted dying, many healthcare professionals do not want to be directly involved. Could a de-medicalised approach help to overcome this? **Nancy Preston, Sheila Payne, and Suzanne Ost** discuss

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Assisted dying involves a patient receiving drugs to end their life. These drugs are either self-administered (assisted suicide) or administered by someone else (euthanasia). Various countries, including Austria, Germany, Italy, New Zealand, Portugal, Spain, and some Australian states, have changed laws to permit assisted dying.¹ But debate about whether assisted dying is morally justified tends to assume that, were it legalised, it would be part of healthcare. The possibility of situating assisted dying outside healthcare would significantly reposition the debate.

Many doctors who support legal reform on assisted dying in the UK acknowledge they do not wish to be directly involved.^{2,3} In most countries providing assisted dying, only a minority of doctors are involved,⁴ with some healthcare professionals reporting that it was “stressful to kill somebody.”⁵ Pharmacists may be unwilling to dispense drugs as they fear being “complicit” and hospitals are also reluctant to be associated with assisted dying, preferring to discharge patients. Unsurprisingly, bereaved relatives report difficulties in navigating healthcare systems to find a doctor to assist by assessing a patient’s capacity, prognosis, and prescribing the required drugs. Is there another option that reduces healthcare involvement?

A de-medicalised approach

When members of the public talk about an assisted death they envisage a doctor they know, sitting at their bedside and assisting them in their last moments. With so few doctors willing to be involved, this is unrealistic. There needs to be a balance between what the public want and what is best for the NHS and the people working in it.

Several countries have adopted de-medicalised approaches. In Switzerland assisted dying is considered a civil rather than a medical act.⁶ Doctors volunteer, predominantly with right to die associations, to perform the necessary measures. Palliative care doctors are rarely involved in writing prescriptions or assessing capacity.⁴ Austria has a similarly de-medicalised approach and we propose that a similar model could work in the UK.

An enhanced de-medicalised model⁷ would reduce the responsibility of healthcare professionals in assisting someone to die. Oversight could occur prospectively, with a requirement for a review board’s approval of the request for an assisted death before it can occur. These boards could include a lawyer, healthcare professional, and ethicist. This might

cause delays, but offers greater support for potentially vulnerable people, and removes sole decision making from doctors. Delays could be mitigated by the panel providing lists of doctors willing to be involved and pharmacies that will dispense drugs. Some oversight of applications for assisted dying would be required as it is in Austria, where the entire process is monitored. In most other countries, reviews only happen after a death, which can mean some are not recorded. In Belgium it is estimated that up to 50% of cases are never recorded.¹

Crucial to this approach is assessment of the mental capacity of the person seeking an assisted death and assurance that all options, including palliative care, have been explored. Assessment of capacity could include a consultation with a palliative care specialist with an attached report, as we know that if doctors explore a patient’s desire for a hastened death, an assisted death or suicide is less likely.⁸ Mental capacity could be assessed by the review board or a doctor working with a right to die organisation. The panel could check for any undue influence by way of a screening tool or other means.⁹ Also, even once a request for an assisted death is approved, this does not mean that it will take place. In Canada, about 40% of people with approved requests felt palliative care was enough.¹⁰

A realistic compromise

An enhanced de-medicalised model⁷ may be preferable for the UK as it would remove the involvement of the healthcare service and there would be no loss of trust or confidence in NHS staff—which is a fear repeatedly expressed in parliamentary debates.^{11,12}

To patients and families navigating the system, there would need to be clear messaging about how to access an assisted death. This process could be supported by right to die associations as in other countries.

If there is a change in the law, an enhanced de-medicalised approach has much to offer. Doctors could instead focus on becoming more confident in having compassionate conversations when responding to requests for assisted dying and better support patients in a holistic manner. A de-medicalised approach to assisted dying should be carefully considered in the UK.

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- 1 Riley S. Watching the watchmen: changing tides in the oversight of medical assistance in dying. *J Med Ethics* 2023;49:-7. doi: 10.1136/jme-2022-108470 pmid: 36150893
- 2 BMA. Physician-assisted dying survey. 2021. www.bma.org.uk/media/3367/bma-physician-assisted-dying-survey-report-oct-2020.pdf.
- 3 Mahase E. Royal College of Surgeons of England moves to neutral position on assisted dying. *BMJ* 2023;381:. doi: 10.1136/bmj.p1397 pmid: 37336555
- 4 Gamondi C, Borasio GD, Oliver P, Preston N, Payne S. Responses to assisted suicide requests: an interview study with Swiss palliative care physicians. *BMJ Support Palliat Care* 2019;9:e7. doi: 10.1136/bmjspcare-2016-001291 pmid: 28801317
- 5 Lewis D, Preston N. Dutch healthcare professionals experiences of assisted dying: a constructivist qualitative study conducted in a chronic disease care centre and hospice. *Research Square*. 2019. doi: 10.21203/rs.2.11826/v1.
- 6 Gamondi C, Pott M, Preston N, Payne S. Family caregivers' reflections on experiences of assisted suicide in Switzerland: a qualitative interview study. *J Pain Symptom Manage* 2018;55:-94. doi: 10.1016/j.jpainsymman.2017.12.482 pmid: 29288877
- 7 Ost S. The de-medicalisation of assisted dying: is a less medicalised model the way forward? *Med Law Rev* 2010;18:-540. doi: 10.1093/medlaw/fwq025 pmid: 21098047
- 8 Porta-Sales J, Crespo I, Monforte-Royo C, Marín M, Abenia-Chavarria S, Balaguer A. The clinical evaluation of the wish to hasten death is not upsetting for advanced cancer patients: A cross-sectional study. *Palliat Med* 2019;33:-7. doi: 10.1177/0269216318824526 pmid: 30688146
- 9 Ost S, Biggs H. *Exploitation, ethics, and law: violating the ethos of the doctor-patient relationship*. Routledge, 2021;doi: 10.4324/9781315296890.
- 10 Health Canada. Second annual report on medical assistance in dying in Canada 2020. www.canada.ca/en/health-canada/services/publications/health-system-services/annual-report-medical-assistance-dying-2020.html.
- 11 Hansard. Assisted Dying Bill. 18 July 2014, vol 755, col 827: 'I do not want our trusted NHS to turn from being the National Health Service into the national death service' (Baroness Nicolson) <https://publications.parliament.uk/pa/ld201415/ldhansrd/text/140718-0001.htm>.
- 12 Hansard. Assisted Dying Bill. [https://hansard.parliament.uk/commons/2015-09-11/debates/15091126000003/AssistedDying\(No2\)BillHC](https://hansard.parliament.uk/commons/2015-09-11/debates/15091126000003/AssistedDying(No2)BillHC) Deb 11 September 2015, vol 599, cols 677, 705, 708, 713