

Responding to patient requests for assisted dying: guidance for doctors

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Key points

- All forms of assisted dying are illegal in the UK.
- A decision about whether to prosecute someone is taken on a case-by-case basis by the Crown Prosecution Service (CPS) in England and Wales; the Public Prosecution Service (PPS) in Northern Ireland; and the Crown Office and Procurator Fiscal Service (COPFS) in Scotland.
- When faced with a request from a patient for assisted dying, doctors must respond professionally and compassionately, and continue to support patients in their ongoing care and treatment.
- Doctors should avoid any action that the law might consider to be assisting, facilitating, or encouraging suicide.
- Doctors who are unsure as to how a particular action might be construed by the law should seek up-to-date legal advice.



What is this guidance about?

All forms of assisted dying are illegal in all parts of the UK. A decision about whether to prosecute somebody is taken on a case-by-case basis by the relevant prosecutorial authorities in each of the four nations.

We receive some enquiries from members who have been asked by a patient for information, advice, or assistance in ending their lives, and who are unclear as to where the boundary lies between what behaviour is or is not permissible. It can be challenging to respond sensitively and compassionately to such patient requests, whilst ensuring that response does not contravene the law.

This document addresses situations where patients make an explicit request for your assistance in, or information about, ending their life or hastening their death. It is split into two parts: the first provides guidance to support doctors when faced with an explicit request from patients for assistance to die; and the second sets out more detailed information about the law in each of the four nations.

The terminology used in the assisted dying debate is open to different interpretations. Throughout this document, we use **physician-assisted dying** as an overarching term to describe physician-involvement in measures intentionally designed to terminate a person's life. This covers both **physician-assisted suicide** (where the final act is carried out by the individual themselves) and **euthanasia** (where the final act is carried out by a physician or another third party). Where we refer to assisted suicide in this document, it is in specific reference to its use in the law in the UK.

What does this guidance not cover?

If you are looking for guidance on the following situations, please see other BMA guidance, available at: www.bma.org.uk/ethics

- **Advance decisions to refuse treatment (ADRT):** a valid and applicable advance decision to refuse treatment must be respected. You can find more information on ADRTs in our Mental Capacity Act Toolkit.
- **Competent, contemporaneous refusals of care and treatment:** an informed refusal by a competent adult must be respected, even if it will result in serious injury or death. This includes a competent refusal of food and fluids. In these cases, it would be appropriate to discuss with the patient in advance what pain and symptom relief will be available at such a point in time that it becomes necessary.
- **Withdrawing or withholding life-sustaining treatment:** in the UK, the courts have been clear that there is a fundamental distinction between assisted suicide and a decision not to provide, or to not to continue life-sustaining treatment.¹ We have dedicated guidance, [Withholding and Withdrawing Life-prolonging Medical Treatment: Guidance for decision-making](#), which is now in its 3rd edition, alongside detailed guidance specifically on [decisions about clinically-assisted nutrition and hydration \(CANH\) and adults who lack capacity in England and Wales](#).
- **Pain and symptom relief:** timely and appropriate relief of pain and other symptoms are an essential part of the care of dying patients. Doctors can provide strong pain relief, even if that might risk hastening death, provided the intention is to relieve the patient's suffering, and the dosage is proportionate to that intention. This is often referred to as 'the doctrine of double effect'. Although the legal and ethical situation is clear, some doctors remain anxious about the degree of pain relief they can provide. More information can be found in [Chapter 10 of Medical Ethics Today](#) and in the BMA's report [Improving analgesic use to support pain management at the end of life](#).
- **'Continuous' or 'palliative sedation':** continuous or palliative sedation may be offered to patients who are very close to death and experience distressing symptoms which cannot be effectively controlled by other measures. This is a serious decision which requires careful examination of doctors' motives and the availability of possible alternatives.

It would be inappropriate, for example, to provide sedation, or to offer to or agree to provide sedation before such a point in time that it becomes necessary. To do so may in some circumstances, e.g. when combined with a refusal of food and fluids, be construed as indistinguishable from assisted suicide. This would not prevent a doctor from agreeing [in advance](#) to palliate pain and discomfort should the need for symptom management arise.

More information on appropriate and inappropriate use of deep sedation can be found in [Chapter 10 of Medical Ethics Today](#), and doctors should also refer to the most up-to-date clinical guidelines.

Part one: Guidance for doctors

What counts as 'assisting suicide'?

The law does not provide a clear definition of which actions might constitute assisting or encouraging suicide. We recommend that doctors do not:

- advise patients on what constitutes a fatal dose;
- advise patients on anti-emetics in relation to a planned overdose;
- suggest the option of suicide abroad;
- write medical reports specifically to facilitate assisted suicide abroad;
- provide literature to patients on aspects of assisted suicide;
- disseminate information via the media (including the internet) which would be likely to encourage people to end their lives;²
- put patients in touch with other individuals or groups who may be able to assist or organisations who promote assisted dying; and
- facilitate any other aspects of planning a suicide.

Doctors who are unsure as to how a particular action might be viewed in law should seek up-to-date legal advice.

What if a patient wishes to travel abroad for assisted dying?

While the act of travelling abroad to receive assisted suicide is not illegal, assisting, facilitating or encouraging someone to do so is a criminal offence. Although to date there has been no prosecution for people accompanying others abroad to end their lives, doctors need to be aware of the possibility of legal and professional sanctions if they were to do so.

This applies both to accompanying a patient abroad to receive assisted dying in a professional capacity, or in a personal capacity with a friend or family member. The prosecutorial authorities will consider the same factors for both in making a decision to prosecute.

The prosecutorial guidelines for England and Wales, and Northern Ireland, specifically identify the fact that someone was acting in his or her capacity as a medical doctor as a factor tending in favour of prosecution. This point was clarified in England and Wales in 2014, when the Director of Public Prosecutions (DPP) stated that this factor 'does not apply merely because someone was acting in a capacity described within it: it applies only where there was, in addition, a relationship of care between the suspect and the victim, such that it will be necessary to consider whether the suspect may have exerted some influence on the victim' (for more information, see below).³

The GMC's *Guidance for the Investigation Committee and case examiners when considering allegations about a doctor's involvement in encouraging or assisting suicide* notes various factors which will influence their consideration of a doctor's conduct, including that if a doctor's actions concern a close relative or partner, 'it is less likely they would repeat their actions or pose a danger to patient safety.' It goes on to note, however, that 'such actions may still undermine public confidence in the profession or contravene the proper standards of conduct expected of a doctor'.⁴

Can a patient request their medical records to seek assisted dying abroad?

Patients with capacity have the right to access their own health records via a subject access request, subject to certain exemptions, under the General Data Protection Regulation (GDPR).⁵ It is not necessary for patients to give reasons as to why they wish to access their records.

Where a patient makes a subject access request doctors are obliged to provide the requested information in order to satisfy their obligations under the GDPR. This is so regardless of whether the doctor knows or suspects that the medical records may be used abroad for assisted dying.

The GMC's *Guidance for the Investigation Committee and case examiners when considering allegations about a doctor's involvement in encouraging or assisting suicide* is clear that providing access to a patient's record, where a subject access request has been made in accordance with the GDPR, is an act that is 'lawful, or too distant from the encouragement or assistance' to raise a question about fitness to practise.⁶

How should I respond to a patient request for assistance in dying?

Doctors who receive a request from a patient to assist them in hastening their death should respond sensitively, compassionately, and non-judgmentally.

At the same time, you must ensure that your response does not contravene the law by encouraging or assisting suicide. This means limiting any advice or information about assisted dying to an explanation that it is a criminal offence to encourage or assist another person to commit or attempt suicide.

The following points may be helpful:

- **Listen to the patient and acknowledge the request:** it is important that you listen to what the patient is telling you; acknowledge their request; and respond honestly to their questions. You should not ignore or brush past what they wish to talk to you about. These conversations can be in-depth, and it is important that you allocate sufficient time in which to have them.
- **Be clear about the law:** you should explain the legal situation in the UK, and that there could be serious consequences for you or anyone else who might assist them in ending their life. You can explore the range of other interventions available to them, within the law, which might be able to help – but you should be clear that you cannot do or say anything that might be interpreted as assisting them to end their life.
- **Provide objective advice about the lawful clinical options available:** you can and should discuss with patients their treatment options (including the option of no treatment); provide objective advice about the lawful clinical options available to them at the end of life (including pain relief and symptom control); and create opportunities for patients to express their fears and concerns and explore how those might be addressed.⁷

We have already made clear in this guidance that a patient with capacity can make an informed and contemporaneous refusal of medical treatment and/or food and fluids, which must be respected. Where terminally ill patients have reached a settled intention to hasten their death in this way, you can provide objective advice about the lawful clinical options that would be available to them at that point and agree in advance to provide them should the need arise.⁸ You should not agree to, or actually provide that symptom relief before such a point in time that it becomes necessary – to do so may be construed as indistinguishable from assisted suicide.

- **Explore the patient's feelings, emotions and thoughts:** the expression of a desire or wish to die from a patient can indicate that there are underlying physical, practical, or emotional issues that need to be explored. It might be helpful to discuss their understanding of their condition or their fears and concerns, or those of people close to them. If you feel that the patient is depressed or suffering from another mental health condition, or would benefit from more support, therapy or counselling should be offered.

- **Use the opportunity to address those concerns:** you should also investigate whether other practical arrangements could help improve the patient’s quality of life. It is also an opportunity to review the patient’s current care and treatment; to explore whether there are other options for investigations, treatment or management that might help the patient; or to revisit advance care planning and the recording of their future wishes in the event that they might lose capacity.
- **Involve a colleague:** you might like to involve a more experienced colleague – making clear to the patient that this is what you will be doing.
- **Involve other sources of support:** you might like to seek support and input from other members of the healthcare team, such as a specialist palliative care team, colleagues from mental health, or the chaplaincy or voluntary services.
- **Be non-judgmental and non-partisan:** it is important that you continue to maintain a professional relationship with the patient and make them aware that they can continue to speak to you and express their feelings. Whatever your views are, it would be inappropriate to discuss these with the patient or let them influence the care and treatment you provide.
- **Do not abandon the patient:** in some cases, it may be that there is not an underlying problem or concern that can be identified and remedied, and the patient continues to feel as though assisted dying is the only option for them. These circumstances can be particularly challenging but, even though you are unable to meet their request, you must not abandon the patient. It is important that you continue to acknowledge and address concerns; provide assurances about the care you can provide; and continue to support the patient.

Part two: The law on assisted dying in the UK

All forms of assisted dying are currently illegal in the UK.

Euthanasia – where a doctor or another person deliberately ends a patient's life – is illegal and, depending on the circumstances, could be prosecuted as either murder or manslaughter.⁹

Assisted suicide – where a doctor or another person assists or encourages a person to end their own life – is also illegal. Assisting or encouraging suicide is an explicit criminal offence in England, Wales and Northern Ireland. In Scotland, where there is no legislation that addresses assisted suicide, it falls under the law relating to homicide.¹⁰ The current legal position on assisted suicide in all four nations is set out below.

For more detailed information on the law on assisted suicide in the UK, how it has developed, and to expand on some of the cases mentioned below, please see Chapter 3 of *End-of-life care and physician-assisted dying: Volume 1 – Setting the Scene*, available at www.bma.org.uk/endoflifecare.

England and Wales

Section 2 of the Suicide Act 1961 prohibits any act that 'encourages or assists the suicide of another, or an attempt by another to commit suicide'. Such an act carries a maximum penalty of 14 years' imprisonment.

Prosecution for assisting or encouraging a suicide requires the agreement of the Director of Public Prosecutions (DPP).

In 2010, following the ruling of the House of Lords in the case of Debbie Purdy,¹¹ the DPP published specific guidance for prosecutors on dealing with suspected cases of assisted suicide. *Policy for Prosecutors in Respect of Cases of Encouraging or Assisting Suicide* sets out guidelines for prosecutors when considering whether or not it is in the public interest to prosecute.¹²

It includes a list of public interest factors tending in favour of, and against, prosecution in suspected cases of assisted suicide:

A prosecution is more likely to be required if:	A prosecution is less likely to be required if:
<ol style="list-style-type: none"> 1. the victim was under 18 years of age; 2. the victim did not have the capacity (as defined by the Mental Capacity Act 2005) to reach an informed decision to commit suicide; 3. the victim had not reached a voluntary, clear, settled and informed decision to commit suicide; 4. the victim had not clearly and unequivocally communicated his or her decision to commit suicide to the suspect; 5. the victim did not seek the encouragement or assistance of the suspect personally or on his or her own initiative; 6. the suspect was not wholly motivated by compassion; for example, the suspect was motivated by the prospect that he or she or a person closely connected to him or her stood to gain in some way from the death of the victim; 7. the suspect pressured the victim to commit suicide; 8. the suspect did not take reasonable steps to ensure that any other person had not pressured the victim to commit suicide; 9. the suspect had a history of violence or abuse against the victim; 10. the victim was physically able to undertake the act that constituted the assistance him or herself; 11. the suspect was unknown to the victim and encouraged or assisted the victim to commit or attempt to commit suicide by providing specific information via, for example, a website or publication; 12. the suspect gave encouragement or assistance to more than one victim who were not known to each other; 13. the suspect was paid by the victim or those close to the victim for his or her encouragement or assistance; 14. the suspect was acting in his or her capacity as a medical doctor, nurse, other healthcare professional [whether for payment or not], or as a person in authority, such as a prison officer, and the victim was in his or her care;* 15. the suspect was aware that the victim intended to commit suicide in a public place where it was reasonable to think that members of the public may be present; 16. the suspect was acting in his or her capacity as a person involved in the management or as an employee (whether for payment or not) of an organisation or group, a purpose of which is to provide a physical environment (whether for payment or not) in which to allow another to commit suicide. 	<ol style="list-style-type: none"> 1. the victim had reached a voluntary, clear, settled and informed decision to commit suicide; 2. the suspect was wholly motivated by compassion; 3. the actions of the suspect, although sufficient to come within the definition of the offence, were of only minor encouragement or assistance; 4. the suspect had sought to dissuade the victim from taking the course of action which resulted in his or her suicide; 5. the actions of the suspect may be characterised as reluctant encouragement or assistance in the face of a determined wish on the part of the victim to commit suicide; 6. the suspect reported the victim's suicide to the police and fully assisted them in their enquiries into the circumstances of the suicide or the attempt and his or her part in providing encouragement or assistance.
<p><i>* Footnote [1]: For the avoidance of doubt, the words 'and the victim was in his or her care' qualify all of the preceding parts of this paragraph. This factor does not apply merely because someone was acting in a capacity described within it: it applies only where there was, in addition, a relationship of care between the suspect and the victim, such that it will be necessary to consider whether the suspect may have exerted some influence on the victim.</i></p>	

Upon publication of the guidelines, Keir Starmer QC, then DPP for England and Wales, was clear that the policy did not change the law on assisted suicide, but provided a framework for prosecutors to decide which cases should go to court. He stressed that the factors would not be used in a tick box fashion, and that the decision of whether to prosecute would be a matter of considering each case on its own facts.¹³

The words in **bold** in the above excerpt are the result of an amendment made in October 2014, following the judgment of the Supreme Court in the case of Tony Nicklinson.¹⁴ At an earlier stage of the appeal, the Lord Chief Justice at the Court of Appeal interpreted section 14 to mean that if a person operating in one of the listed professions had cared for the victim, to the extent that they were in a position of authority and able to exert undue influence over the victim, then this may be considered as factor tending in favour of prosecution. The DPP highlighted the words 'and the victim was in his or her care' and added the accompanying footnote to clarify how this factor should be applied.

In publishing this clarification, the DPP for England and Wales, Alison Saunders, stated that 'each case must be considered on its own facts and merits, and prosecutors must weigh each public interest factor depending on the circumstances of each case and go on to make an overall assessment.'¹⁵ She emphasised that assisting or encouraging suicide remains illegal, and that nothing in the updated guidance offers immunity from prosecution.

Northern Ireland

Assisting in another person's suicide is illegal in Northern Ireland under s.13 of the Criminal Justice (Northern Ireland) Act 1966, which extends s.2 of the Suicide Act 1961 to Northern Ireland.

The Public Prosecution Service (PPS) examines individual cases to ascertain whether a prosecution should be brought. The Director of Public Prosecutions for Northern Ireland published guidelines on prosecuting suspected cases of assisted suicide at the same time as the DPP for England and Wales.¹⁶ It lists the same factors tending in favour of, and against, prosecution as the England and Wales guidance, but does not incorporate the same changes made to the England and Wales policy after the case of Tony Nicklinson.

Scotland

The Suicide Act 1961 does not apply in Scotland, and there is no specific criminal offence of assisting or encouraging a person's suicide. The legal position has not been clarified through case law.

It is extremely likely, however, that assisting a suicide would give rise to a prosecution under homicide law. In a letter to MSPs ahead of the debate on the Assisted Suicide (Scotland) Bill in 2015, Scotland's then Lord Advocate, Frank Mulholland QC, noted that: 'if someone assisted another to take their own life, such cases would be reported to the procurator fiscal as a deliberate killing of another and it would be dealt with under the law relating to homicide'.¹⁷

The Crown Office and Procurator Fiscal Service (COPFS) has not published specific guidelines on prosecuting cases of suspected assisted suicide, and any decision to prosecute will be made using the same criteria as for all other criminal cases.¹⁸ In his written submission to the Assisted Suicide (Scotland) Bill in 2015, Mr Mulholland QC further stated that there is a high public interest in prosecuting all cases of homicide where there is sufficient, credible and reliable evidence, but that every case will be considered on its own facts and circumstances.¹⁹

At the time of publication of the DPP's policy for prosecuting assisted suicide in England and Wales, Scotland's Lord Advocate made clear that they would not be publishing detailed guidelines.²⁰ A legal challenge to the COPFS to publish specific guidelines was rejected in 2016, on the basis that the current prosecutorial code is sufficiently clear.²¹

Further reading

You might find the following resources helpful:

- [End-of-life care and physician-assisted dying](#) (2015): This is a three-volume report of research work carried out by the BMA with doctors and members of the public about aspects of end-of-life care and physician-assisted dying. Chapter 3 of Volume 1 explores the development of the law in the UK in more detail.
- [Patients seeking advice or information about assistance to die](#) (2015): Guidance from the GMC which summarises doctors' obligations under *Good Medical Practice* in relation to requests from patients for assistance in dying.
- [When Someone Asks for Your Assistance to Die: RCN guidance on responding to a request to hasten death](#) (2nd ed. 2016): Guidance from the Royal College of Nursing which provides more in-depth guidance about responding to patient requests for assisted dying.

Members are advised to contact their medical defence body for more guidance on this issue when faced with specific cases.

BMA members can contact BMA Ethics for further advice on this issue, or to discuss specific requests from patients about which they have concerns at ethics@bma.org.uk, or by phone via the BMA's First Point of Contact service, on 0300 123 1233.

References

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