

Physician Assisted Suicide

The British Geriatrics Society's position

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Within the British Geriatrics Society (BGS) membership, there is a range of strongly held views on this issue; however, on balance our position as a society is as follows.

1. The BGS accepts individuals' right to determine the choice of treatment and care they receive provided they have the capacity to do so. We further accept that sometimes, some symptoms are difficult to control and that even if they are controlled people may still find their life unbearable. However a policy which allows physicians to assist patients to die is not acceptable to us. We believe instead that the most vulnerable should be enabled to access the services and care they need to lead as independent and symptom free a life as is possible and, when the time comes, to die in the setting of their choice with dignity.
2. Members of the BGS look after many older people with frailty, disability and those who are dying. We accept life has a natural end and that our job is not to prolong life at all costs but to improve quality of life whilst accepting that death is inevitable. Our members have long experience of conversations with patients about ending their life. Often these are phrased as "Can't you just let me go?" However our experience shows us these are more often a cry for help than a genuine desire for death. Often, listening to our patients' wishes, concerns and fears, and taking time to address their needs significantly diminishes their wish for death. We also believe older people may feel despair as a direct result of the reaction of others to their frailty and the care and treatment they are afforded. The BGS considers the best way for physicians to help these vulnerable people is to maximise their independence and health, rather than assisting with their expressed wish to die.
3. We know that older people are often strongly influenced by their families and carers- the vast majority, but not all, will have their well-being at heart. Even so, many requests to end life – made either directly or indirectly to us as geriatricians - come from the patients' families and not the older person themselves. Often such requests are then forgotten if such degrading symptoms as urinary and faecal incontinence, depression and unremitting pain are relieved.
4. Much of the public demand for assisted dying seems to stem from the fear of a prolonged death with increasing disability sometimes associated with unwanted burdensome medical care. This suffering at the end of life can be prevented by a change in the focus of care – from prolonging life to addressing the individuals own priorities and symptoms , and by the involvement of medical professionals skilled in palliative and end of life care.
5. The BGS does not accept that legalising physician assisted suicide is in the broader interests of society. We recognise that some people feel their life is unbearable; however, law makers should consider not only the rights of individuals in society but also society itself and the impact the legislation will have on all members of our communities. The BGS is

concerned with protecting the interests of vulnerable older and disabled people who already feel pressure to give up their lives to reduce the burden they feel they cause to others.

6. Campaigners for physician assisted dying argue that curing disease and bringing about death are not mutually exclusive roles, the intention in both cases being the relief of suffering. It is further argued that the primary role of the physician is to care for his/her patient, which must therefore entail respecting their autonomous wish to die. However, the BGS believes that crossing the boundary between acknowledging that death is inevitable and taking active steps to assist the patient to die changes fundamentally the role of the physician, changes the doctor-patient relationship and changes the role of medicine in society. Once quality of life becomes the yardstick by which the value of human life is judged, the protection offered to the most vulnerable members of society is weakened.
7. The right of any individual, whether terminally ill or not, to have their symptoms controlled is undisputed. In our opinion it is crucial to distinguish in clinical practice between actions primarily intended to control symptoms and actions primarily intended to assist the patient to die. In the same vein, the BGS would emphasise that the right of a patient to choose or decline treatment and or intervention whatever the consequences, supersedes all other guidance and wishes. This equally applies to those who express their wishes regarding their future care using an appropriately constituted advance directive who can be assured that such wishes will be respected.
8. The BGS is concerned that 'assisted dying', while it does not apply directly and solely to older people, will lead to a change in attitude to death in society and also within the medical profession. The prohibition on intentional killing is the cornerstone of society and it is worth preserving the notion that all lives are precious. The BGS accepts that this denies a very small number of persons the right to have their life ended by their physician if it is their autonomous wish. However it must be noted that every society puts some limits on respect for autonomy, which must be balanced against the greater good of society. The BGS urges improvement in the medical and social care of older people, placing them back in the centre of a society which respects their wisdom and experience.
9. The BGS accepts that society is changing, with a shift toward more emphasis on the rights of the individual, including the right to choose the manner and timing of their death. If this leads in time to a change in the law to allow physician assisted suicide, the BGS will aim to play a constructive role in the discussions with law makers and officials to develop an implementation code with robust safeguards in place to mitigate as far as possible any adverse impact and to protect the interests of older people and those who are vulnerable.

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