2025 Issue
ISSN 2514-3174
bsdj.org.uk
thebsdj.cardiffuniversitypress.org

The British Student Doctor Journal

BSDJ

British Student Doctor Journal: 2025 Issue

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Journal DOI
10.18573/issn.2514-3174

Issue DOI
10.18573/bsdj.v8i1

ACADEMY OF MEDICAL EDUCATORS

The **British Student Doctor** is published by **The Foundation for Medical Publishing**, a charitable incorporated organisation registered in England and Wales (Charity No. 1189006), and a subsidary of **The Academy of Medical Educators**.

Cardiff University Press
Gwasg Prifysgol Caerdydd

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The British Student Doctor, 2025:15
DOI: 10.18573/bsdj.413
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Physician-Assisted Dying: History, Changes in Law and Ethical Dilemmas

EDUCATION

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No conflicts of interest to declare.

Accepted for publication: 12.10.2025

ABSTRACT

Summary: Physician-assisted dying is an act where a patient can end their life by ingesting a medicine or any form of medication that has been prescribed to them by a medical practitioner. At the moment, all forms of assisted dying in the UK are illegal under Section 2 of the 1961 Suicide Act. However, the recent 'Terminally ill adults (End of Life) Bill' was backed by MPs which could result in assisted dying being made legal in the UK, provided that both Houses of Parliament approve it. This article analyses the history of physician assisted dying in the UK, the recent changes in law and its ethical dilemmas.

Relevance: The new developments surrounding assisted dying, which are currently being discussed in parliament, will alter the way medical students perceive physician roles. In medicine, there is a great emphasis placed on the Hippocratic Oath and the ethical pillar of non-maleficence but physician-assisted dying questions these teachings and how they should apply to modern clinical practice. Medical students must be aware of the evolving changes in law and its implications so that they can assist patients to make well-informed decisions about their own life when they graduate as doctors.

Take Home Messages: Physician-assisted dying could trigger the slippery slope and could put vulnerable members of society at risk due to mala fide intentions. There are limited statistics to support this as physician-assisted dying has never been legal in the UK but there are indications from other countries that laws could gradually change over time until a wide range of individuals, not just the terminally ill, are able to seek assisted dying to end their life. In addition, certain duties of a doctor could be deemed to be out-of-date and may need to be refined in the context of physician-assisted dying.

INTRODUCTION

'Physician-assisted dying' is defined as an act in which a terminally ill patient can end their life by ingesting a medicine or any form of medication handed over to them by a doctor. The final act of death will be taken by the patient themselves. (1) Proponents of the Assisted Dying Bill 2015 in England and Wales argue that this term best describes prescribing life ending drugs for terminally ill mentally competent adults to administer themselves after meeting strict legal safeguards. (2) The practice comes from 'euthanasia' which has ancient Greek origin: the word 'eu' means good while 'thanatos' refers to death. Therefore, euthanasia could be defined as an act leading to a 'good death'. All forms of assisted death or suicide were illegal in the UK under section 2 of the 1961 Suicide Act. (3) However, the 'Terminally ill adults (end of life) Bill' was recently introduced in the UK Parliament. Members of Parliament backed the bill by 330 to 275 votes in the House of Commons. (4) The bill is now proceeding through the various stages of reading and will receive the Royal Assent once it has been accepted by both the House of Commons and Lords.

Case histories

Diane Pretty persistently campaigned for one main reason – to have the ability to end her life when she desired with the aid from her husband provided, he wouldn't be convicted. When considering any defining movements that support physician-assisted dying in the UK, Diane Pretty's case notably stands out. She had an extremely low quality of life due to Motor Neurone Disease (MND) and was completely dependent on others given that she had no ability to move and was facing the prospect of dying by suffocation. (5) She argued that the UK laws (at the time) violated certain rights entitled to her under the European Convention on Human Rights. These included Article 2 (the right to life), Article 3 (freedom from torture), Article 8 (right to respect private life), Article 9 (freedom of thought and conscience) and Article 14 (freedom from discrimination). (5)

The Court quashed all her claims. Article 2 is concerned with 'protection of life'. It is the State's duty to protect life. Her claim against article 3 was rebutted as it was not a general sweeping fundamental right to be 'free from all suffering'. It protects from specific sufferings endured from intentional harm by or at the instigation of the State. The Court accepted that there was some self-determination on the period of dying but there was no protection for the specific liberty desired by her – receive assistance in dying. Article 9 could not be utilised as a substantial piece of evidence for Diane Pretty's sake because neither her free will nor choice were overruled by laws in place at the time. Therefore, any decisions that Diane Pretty made had to remain within the constraints of the law. There was no plausible argument in favour of Article 14 because assisted dying was always deemed illegal in the UK. As a result, she could not prove that she was being discriminated against.

Paul Lamb suffered from paralysis from the neck down for around 30 years and he needed 24-hour care as he was dependent on others. (6) He described being in pain all the time and wanted assisted dying to be legalised. Much like Diane Pretty, he believed that the laws at the time unfairly forced him to endure torture and that assisted dying would be a much calmer process. (6)

Noel Conway, an individual suffering from MND, was in a very similar position to both Diane Pretty and Paul Lamb. A proposition was put forward to grant him an exception to the law which would be applicable when he had a prognosis of six months or less to live. The proposal indicated that Conway would self-ingest medication before he lost control over his body. The mode of administration would likely to be a tablet or a liquid to fit his description. (7) It was evident that Conway had thought of the possible ways to end his life and had even gone on to say that he wanted medical advice to ensure that he was carrying out his last act properly.

Are some physician responsibilities outdated?

It is well known that physicians are obliged to the ethical rule of non-maleficence which briefly means, "first, do no harm". (3) Furthermore, they must be always beneficent and therefore act in the patients' best interests. Physician-assisted dying is a concept which causes controversy regarding non-maleficence and beneficence because it potentially goes against them.

The alternative to making patients feel more relaxed, if physician-assisted dying is not legalised in the UK, is palliative care. The WHO defines this as a process to improve the quality of life of terminally ill patients by utilising physical and psychological methods so that any pain is alleviated as best as possible. (3) This may seem as the most compassionate act available and doctors are known to promote this method because it can be the best possible course of action for certain patients – once again, the pillar of beneficence is duly abided by. In spite of this act of good gesture, there are times when such care doesn't seem to be fruitful and patients aren't rewarded. A study in the early 21st century in Oregon, USA (where assisted dying is legal) indicated that 80% to 89% of patients who died by assisted dying had received hospice care. (1) The overwhelming percentage of patients choosing this route could imply that they weren't satisfied with palliative care but according to a study by Gerson et al (8), some patients, who were already in palliative care, chose assisted dying instead

because it was made available to them by healthcare professionals and any reasons regarding inadequate end-of-life care were not provided. In an interview consisting of 20 hospice nurses, there were concerns that there would be a larger responsibility on doctors to make the correct choices when a patient is deciding between a hospice or assisted dying. Both these measures contradict one another but since the sample size is extremely small, the nurse's views will not be representative of an entire healthcare system. Since the study took place in Oregon, physicians and medical students in the UK can only use the findings as insight into what could happen in the future. (8)

Oregon has had assisted dying for many years and is cited as a stable example of assisted dying legislation. However, a 25-year analysis revealed missing data on many variables (decision making, drug efficacy, complications and the nature of palliative care support). The quality of the consultation process where the decision was made to prescribe life-ending medications was not monitored. Only 1% of physician assisted dying patients were referred for psychiatric evaluation. The percentage of patients who considered themselves as a burden or were concerned about their finances had increased and these were cited as reasons for choosing assisted death. (9)

Providing good palliative care is vital for patients who are terminally ill. It can improve a person's autonomy and reduce their distress. (10) Belgium is the only jurisdiction where palliative care has developed in tandem with assisted dying. (8) Access to palliative care is fragile in the UK. Marie Curie estimates that 'around 1 in 4' do not get the end of life care they deserve. Research from the recent King's Fund failed to identify data for monitoring quality in end-of-life services. (10) Many patients rely on family and friends to support them. Depression and hopelessness can influence a wish to die and elder abuse is becoming a major public health issue in the USA and UK. (11, 12, 13, 14)

This debate questions whether physicians should adapt their responsibilities to the modern world's requirements rather than stick to the convention that they have been following for centuries. If palliative care fails, the next reasonable solution may be to peacefully end patients' lives in a controlled manner so that the pain experienced isn't unbearable anymore. However, the literature suggests that actively ending a patient's life can result in adverse effects for participating physicians like shock and isolation. Moral injuries include disagreement with families, fears of accusation of coercion, guilt, legal wrangles and distrust between doctors and patients. (15, 16)

The BMA's position on physician-assisted dying

The British Medical Association (BMA) has a neutral position concerning physician-assisted dying. In 2020, they carried out a survey amongst its members which revealed some drastic results, further hinting that the UK was shifting away from the stigma surrounding ending lives via assisted means and whether the role of physicians may encompass this vocation in the future, possibly due to new perspectives being drawn upon.

Added below (Figure 1) is one of the questions from the survey which is an indirect way of asking whether physician-assisted dying should be legalised in the UK. (17)

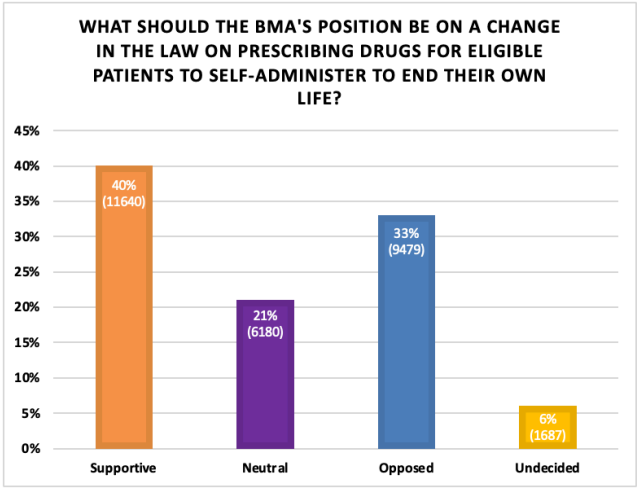

Figure 1: *The bar chart illustrates whether BMA members would support or oppose a 'change in the law' on prescribing drugs for eligible patients to self-administer to end their own life.*

The situation becomes more complicated as indicated in the following pie chart (Figure 2). (17)

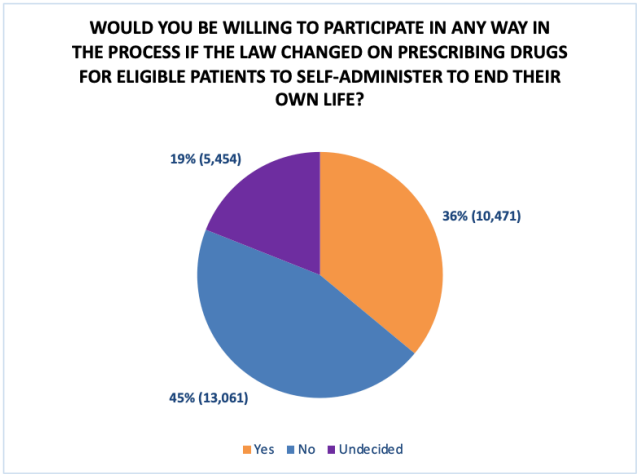

Figure 2: *The pie chart highlights the willingness from BMA members to 'actively participate' in prescribing life ending drugs to eligible patients.*

There is a clear contradiction in responses within these two questions; 40% of respondents supported a change in law that favoured the use of drugs to end patient lives if requested but 45% would not be willing to participate in the process. (17) It doesn't make sense for there to be support for legalisation but fewer healthcare professionals wishing to participate in physician-assisted dying. One possible explanation could be the responsibilities surrounding a physician's roles and how they are linked to the 'Hippocratic Oath' but at the same time, there may be a growing attitude towards dignity in dying which could result from generational developments within medicine. Another possibility could be that highly religious physicians were likely to oppose physician assisted dying (18).

The BMA's results do not represent the entire medical workforce of the UK as only 19% of members responded. This is a very low response rate. A typical survey should have a response rate of around 60% to decrease non-response bias as the survey represents the personal views of members. (19) Excluding medical students and non-practicing doctors, 41% of members would oppose a change in law to permit doctors to prescribe life-ending medications to eligible patients (vs 39%). (17) Another controversial statistic of the survey was a greater support received from members (47%) who had relinquished their licence to practice (supporting a change in law) against 38% who had a licence. Only 1 in 10 clinicians with the most experience and understanding of this cohort of patients would assist dying. (17) This includes clinicians from palliative medicine, oncology and geriatric medicine. The findings were not weighted for any differences in the specialties of members and GPs were over-represented.

53% of medical students supported a change in law compared to consultants (40%) and GPs (34%). A similar finding was replicated in a survey by the Royal College of Surgeons of England where 59% of respondents (medical students) were in favour for a change in law compared to consultants (51%). (20) There is no study done to say opinions can change as one gains more experience in their medical careers.

The New Bill

The Terminally ill Adults (end of life) Bill was proposed by the Labour MP Kim Leadbeater in the House of Commons. The Bill recommends assisted dying could be provided with lawful assistance to voluntarily end life for a terminally ill patient who –

- has the capacity to make a decision to end their own life
- is aged 18 or over at the time the person makes a first declaration
- is ordinarily resident in England and Wales and has been so resident for at least 12 months ending with the date of the first declaration and
- is registered as a patient with a general medical practice in England or Wales. (21)

The Bill defines a person is 'terminal ill' –
(a) if they have a progressive illness, disease or medical condition which cannot be reversed by treatment and
(b) the person's death in consequence of that illness, disease or medical condition can reasonably be expected within 6 months. (21)

The 'Slippery Slope' Analogy

One major problem which experts believe could happen if any mismanagement occurs is inducing a slippery slope. This argument states that if action X is legalised, then over time, society's attitude will change in favour of action Y which was previously deemed to be unfavourable. Eventually, there will be numerous consequences because of the relaxation of the laws that were once in place, possibly for safeguarding. This will make society reflect on their current circumstances and realise that a line in the sand should have never been crossed in the first place. The topic of physician-assisted dying can be applied here; if it is legalised in the UK, then assisted dying (without the need for physicians) could be permitted after a few years if there isn't an apparent issue. Another problem that is mentioned here is the gradual acceptance of the types of conditions which qualify for physician-assisted dying; first those who are terminally ill, then those with lots of pain and eventually, those who don't seem to have any apparent issue concerning their physical disability or mental health. (22) Both are unintended disasters. Evidence suggests that even experienced palliative medicine practitioners can find it difficult to predict life expectancy in someone with a terminal condition with total precision. (23, 24)

There is evidence to suggest that the slippery slope effect could be taking place in the Netherlands, the first country in the world to legalise euthanasia in 2002. A study in 2021 indicated that 10% of doctors terminated the lives of patients without an explicit request from patients. (25) Whilst this applies to voluntary euthanasia, which differs from physician-assisted dying, the outcomes of physician-assisted dying and voluntary euthanasia are similar. 10% may seem small but it is highly significant.

On the other hand, there is no evidence within the UK itself to indicate that the slippery slope argument will undoubtedly fall into place as the situation in Netherlands' can only be hypothetically applied to one possibility that could occur due to legalisation. Professor Emily Jackson, who is a British legal scholar and has specialised in medical law, made the case that not all laws

will be eradicated in the UK at first glance if physician-assisted dying is permitted. (26)

The Assisted Dying Bill (House of Lords)

The Assisted Dying Bill was introduced in the House of Lords in 2021. In this Bill, there is a clear clause stating that the patient must make a signed declaration that they have voluntarily decided to end their life without any coercion or mala fide intentions. (27) The Bill also requires a witness, who is not a relative or a healthcare professional so that there is no conflict of interest, to be present at the time of death. This declaration must be countersigned by –
(i) a suitably qualified registered medical practitioner from whom the person has requested assistance to end their life (the attending doctor); and
(ii) another suitably qualified registered medical practitioner (the independent doctor) who is not a relative, partner or colleague in the same practice or clinical team, of the attending doctor: neither of whom may also be the witness.

These steps may ensure that the slippery slope won't take place in the UK. They also suggest that there is a way to prevent the situation in the Netherlands from initiating where some cases, such as Aurelia Brouwers' death, allow patients who are not terminally ill to seek physician-assisted dying. (28)

The Oregon study indicates that out of the surveyed people who could end their life by assisted means, only 60% of them do so. (1) This implies that not every person will end their life, even if presented with the option, and possibly the thought of having the right to die reassures them that they can enjoy the rest of their life knowing that if their quality of life deteriorates uncharacteristically, there is a way to stop undue agony from happening. The 2023 Oregon Death with Dignity Act said the three most frequently reported end-of-life concerns were loss of autonomy (92%), decreasing ability to participate in activities that made life enjoyable (88%) and loss of dignity (64%). (29)

Worldwide

Assisted dying is now legal in 11 countries and some states of the USA. Table 1 illustrates the different criteria applied by each jurisdiction. Variations in assisted dying legislation across the world has implications for patients, physicians and healthcare systems thereby making it difficult to compare practices. (30) Despite these variabilities, every jurisdiction has its own procedural safeguards. The Netherlands and Belgium are the only jurisdictions which currently permit assisted dying in children. The Dutch use a stage-based model (minors aged 12-15 years can request assisted death only after parental consent while 16–17-year-olds can request without parental consent, but parental involvement is encouraged). Belgium has a case-based model in which every minor's context, experiences and perceptions shape the degree and rate at which capacities develop. (31) The Canadian government is currently debating on the legalities around physician-assisted dying in children. (31)

CONCLUSION

On one hand, legalising physician-assisted dying may allow those like Diane Pretty and Paul Lamb to have potentially pain-free deaths but it may create unwanted uncertainty based on the slippery slope argument. The slippery slope argument could pose challenges in the future and any law that is passed to support physician assisted dying must have appropriate safeguards in place so that over time it is not misused. There should be provisions made in law to review the process regularly so that it is tightly regulated. Most importantly as things currently stand, the Bills do not explore the views of the physicians on whether the concerned attending or independent doctor would want to be part of the process. It will be incumbent on the General Medical Council and the UK Parliament to define who is a 'suitably qualified registered medical practitioner' as proposed in the Assisted Dying Bill (House of Lords).

	Self-administer only	Self/Medical assistance	Terminal condition	Severe chronic physical condition	Severe chronic mental condition	Advance directive (physical)	Advance directive (dementia)	Year introduced
Europe								
Austria	✓		✓	✓		✓		2021
Belgium		✓	✓	✓	✓	✓		2002
Luxembourg		✓	✓	✓	✓			2009
Netherlands		✓	✓	✓	✓	✓	✓	2002
Spain		✓	✓	✓	✓			2021
Switzerland	✓		✓	✓	✓			1942/1980s
Americas								
Canada		✓	✓	✓	✓			2016
Colombia		✓	✓	✓	✓			2015
11 US States	✓		✓					Various
Australasia								
Australia		✓	✓					2022
New Zealand		✓	✓					2021

Table 1: *The table shows the differing criteria of physician assisted dying across the globe. (32)*

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