11) Positions held on Assisted Dying by British medical organisations.

The ethical and moral debate.

The concept of a 'natural death', in view of modern medical intervention, is for many at best anachronistic and illusory. Strinic[1] observes that

> "Advances in medical technology means that people are living longer. The population is aging, and modern medicine has extended people's life span with the result that it is more likely now than in the past that the people will die of chronic degenerative diseases. Euthanasia has been a subject of controversy for more than three thousand years."

The original Hippocratic Oath, cited by opponents of AD, states, "I will follow that system of regimen which, according to my ability and judgment, I consider for the benefit of my patients, and abstain from whatever is deleterious and mischievous."

The original oath also states ""I will neither give a deadly drug to anybody if asked for it, nor will I make a suggestion to this effect". This is generally understood, but not without disagreement in some quarters, to be a reassurance that the doctor will be neither one of the many untrained 'quacks' and medical charlatans operating in that period, nor an assassin working for an enemy. The poison proviso has long since been removed from almost all modern oaths, along with other anachronistic maxims such as the restriction that only men should practice medicine, and the pledge to allow barbers to wield the scalpel and operate on the sick. After all, strict adherence to "no deadly drug" would bar any risky treatment involving anything with a possible lethal toxicity, and indeed any treatment that could be applied under the doctrine of 'double-effect'.

Euthanasia, a Greek word meaning "a good death" was practiced in ancient Greece before, during and after the introduction of the Hippocratic Oath. MacLeod, Wilson and Malpas observe that in Hippocrates' time and subsequently, self-administered deaths were permitted, and "some physicians were instrumental in helping terminally-ill or fatally injured individuals to die".[2]

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[1] Strinic, Visna (2015) *Arguments in Support and Against Euthanasia*, British Journal of Medicine & Medical Research 9(7): 1-12. http://geographical.openscholararchive.com/id/eprint/998/1/Strinic972015BJMMR19151.pdf

[2] Macleod et al (2012) *Assisted or Hastened Death: The Healthcare Practitioner's Dilemma*. Global Journal of Health Science; Vol. 4, No. 6; 2012. https://www.researchgate.net/publication/230817383_Assisted_or_Hastened_Death_The_Healthcare_Practitioner's_Dilemma

They note that “there is little doubt that throughout human history those charged with providing healthcare services have assisted very-ill individuals to die more rapidly than nature would have allowed”.[3]

As Rothschild[4] observes:

> “Medicine is a science that today would be incomprehensible to Hippocrates when he penned his oath so many years ago. Traditional medical ethics, as well as medical law, are lagging behind the progression of both medical science and patient autonomy, when they should be ahead or at least abreast of medical practice so that the medical profession has standards it can follow rather than improvise.”

The original Hippocratic Oath has seen multiple revisions over the centuries, with each new contemporary version reflecting changes in medical and ethical practice. As of 1993, only 14% of medical oaths prohibited euthanasia.[5]

The 1964 adaptation by Louis Lasagna, Academic Dean of the School of Medicine at Tufts University, and used in many medical schools today states:

> “I will apply, for the benefit of the sick, all measures [that] are required, avoiding those twin traps of over-treatment and therapeutic nihilism.”[6]

Since those ancient times science has advanced to the point that medical intervention can keep a person alive long beyond the natural death that would have occurred. The question persists: just because we can, should we keep those we love alive at all costs? Where does the notion of help stop and harm start? What do we do when continuing medical support and extending life is to the detriment of somebody who is incurably suffering? As Clarke & Egan[7] note:

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[3] ibid

[4] Rothschild, Alan. Physician-Assisted Death An Australian Perspective. From Giving Death a Helping Hand: Physician-Assisted Suicide and Public Policy. An International Perspective. Edited by DIETER BIRNBACHER and EDGAR DAHL 2008 Springer Science+Business Media B.V.

[5] Hajar, Rachel (2017) *The Physician's Oath: Historical Perspectives*. Heart Views 18(4):p 154-159, Oct–Dec. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5755201/

[6] Lasagna, Louis (1964) *The Hippocratic Oath: Modern Version*. https://www.pbs.org/wgbh/nova/doctors/oath_modern.html

[7] D L Clarke, A Egan. Euthanasia – is there a case? https://www.academia.edu/117086765/Euthanasia_is_there_a_case?email_work_card=view-paper

> "The traditional role of the physician has been to preserve human life. However, we have now reached a stage where physicians are often accused of preserving human life long after life itself has become a burden to the person living it."

Currently the World Medical Association's revised International Code of Medical Ethics operates by the four fundamental ethical principles of *beneficence*, *non-maleficence*, *respect for autonomy*, and *justice/fairness*, as defined by Beauchamp and Childress, augmented by the two additional core ethical principles of *respect for human life* and *respect for human dignity*.[8]

Opponents of AD argue that palliative care is sufficient for all patients, and that the right to AD for some threatens the autonomy of others. They argue that the patient may be deprived of a valued future, that vulnerable people may be coerced or put at risk, and that any legal change is the start of a slippery slope. They argue that ending a life even if it appears compassionate is against the will of their god.

Supporters of AD argue that AD falls within the scope medical ethics. AD supporters see a commitment to beneficence and non-maleficence including helping incurable patients where existing treatments prove insufficient or causing more harm than good, and continued living is no longer beneficial. They see it as a means to avoid unnecessary excessive suffering. AD supporters argue that to support a request by a patient to end unnecessary and incurable suffering is an act that benefits. They argue that choosing to ignore such pleas and insist that the suffering continues can be seen to be to the detriment of the patient and therefore an act of malice.

To supporters of AD, a commitment to autonomy and respect for human dignity includes prioritising the patient's wishes and not inflicting unwelcome treatment and unnecessary suffering upon them. Choices by patients who choose to cease treatment or further intake of food and water are already respected, in the certain knowledge that death will follow. In such cases, where a brief release may not be possible, the subsequent experience can be unnecessarily traumatic for both the patient and their loved ones.

In terms of respect for human life, for supporters of AD this requires a recognition that situations exist where an acceptable quality of life ends and a drawn out death characterised by misery and intractable suffering begins.

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[8] Parsa-Parsi et al (2024) *The revised International Code of Medical Ethics unites doctors under one global medical ethos*. BMJ 2024; 384 doi: https://doi.org/10.1136/bmj.q449

41% of Scots have witnessed a dying family member or friend suffer unbearably towards the end of their life.[9]

46% of Scottish healthcare professionals have experience of caring for someone who has suffered at the end of their life despite receiving high quality palliative care.[10]

50% of doctors personally support changing the law on assisted dying.[11]

58% of doctors also believe, if the law were to change, people experiencing unbearable suffering with no prospect of improvement should be eligible for an assisted death. Only a minority of doctors (24%) think assisted dying should be restricted to people with six months left to live.[12]

62% of Scottish healthcare professionals believe there are circumstances in the UK in which doctors or nurses have intentionally hastened death as a compassionate response to a patient's request to end their suffering.[13]

Only 29% of Scottish healthcare professionals think refusing treatment to bring about death is more ethical than giving people the option of an assisted death.[14]

Only 14% of Scottish healthcare professionals think that without an assisted dying law there are sufficient options available to give dying people meaningful control over their deaths.[15]

It can be argued that continuing to keep the incurably and excessively suffering patient alive is not extending life so much as extending a bad death. Later versions of the Hippocratic oath have placed primacy on "first do no harm" and "I will abstain from all intentional wrong-doing and harm", non-

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[9] https://www.dignityindyingscotland.org.uk/wp-content/uploads/sites/2/2025/02/DiD_Inescapable_Truth_Scotland_WEB.pdf

[10] https://www.dignityindyingscotland.org.uk/wp-content/uploads/sites/2/2025/02/DiD_Inescapable_Truth_Scotland_WEB.pdf

[11] https://www.mydeath-mydecision.org.uk/professional-and-public-opinion/

[12] https://www.mydeath-mydecision.org.uk/professional-and-public-opinion/

[13] https://features.dignityindying.org.uk/inescapable-truth-scotland/#:~:text=62% of Scottish healthcare professionals,at the end of life.

[14] ibid

[15] ibid

maleficence, and ensuring informed consent[16]. Respect for each patient's autonomy and dignity has become central to the treatment of patients.

Even back in 2001, throughout the BMA/RC/RCN guidance, there is an implicit concern with the concept of 'quality of life' and it is emphasised that life should not be prolonged at any cost:

> 'Prolonging a patient's life usually provides a health benefit to that patient. Nevertheless, it is not an appropriate goal of medicine to prolong life at all costs with no regard to its quality or the burdens of treatment on the patient.'[17]

The British Medical Association and almost all other Medical Royal Colleges (Nursing, Psychiatrists, Physicians & Royal Society of Medicine) have now dropped their previous opposition to assisted dying.

11.1 The General Medical Council

Key elements within the GMC guidance are "Respect every patient's dignity and treat them as an individual" and "Listen to patients and work in partnership with them, supporting them to make informed decisions about their care."[18]

While the type of advice and support for a patient's wishes remains limited by law, doctors are advised by the GMC to:

> "treat patients as individuals and respect their dignity and privacy; respect competent patients' right to make decisions about their care, including their right to refuse treatment, even if this will lead to their death".[19]

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[16] Hajar, Rachel (2017) ibid https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5755201/

[17] BMA/RC/RCN (2001) Decisions Relating to Cardiopulmonary Resuscitation: a joint statement from the British Medical Association, the Resuscitation Council (UK) and the Royal College of Nursing. Journal of Medical Ethics, October 2001: 7. https://jme.bmj.com/content/27/5/310

[18] General Medical Council (as at Nov 7 2024) *The duties of medical professionals registered with the GMC*. https://www.gmc-uk.org/professional-standards/professional-standards-for-doctors/good-medical-practice/the-duties-of-medical-professionals-registered-with-the-gmc

[19] General Medical Council (as at Nov 7 2024) *When a patient seeks advice or information about assistance to die*. https://www.gmc-uk.org/professional-standards/professional-standards-for-doctors/when-a-patient-seeks-advice-or-information-about-assistance-to-die/when-a-patient-seeks-advice-or-information-about-assistance-to-die

The General Medical Council adopted a neutral stance on physician-assisted dying in 2021.

11.2 The Royal College of Nursing

In 2009 the RCN adopted a neutral stance and an approach to be

> "committed to supporting its members provide high quality end of life care to ensure a comfortable and dignified death, with the intention of alleviating distress."[20]

11.3 The British Medical Association

In 2019 the BMA published updated guidelines[21] on responding to patient requests for assisted dying, despite it remaining illegal. The guidance noted that there was a degree of ambiguity if a doctor's involvement in encouraging or assisting suicide concerned a close relative or partner[22], and recognised the likelihood of continuous sedation contributing to death in patients who are starving themselves, as it may,

> "when combined with a refusal of food and fluids, be construed as indistinguishable from assisted suicide."[23]

The document notes, but seeks to exclude from a definition of assisted suicide, 'withdrawing or withholding life-sustaining treatment', and 'pain and symptom relief', noting that

> "doctors can provide strong pain relief, even if that might risk hastening death".[24]

The guidance also notes that

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[20] Royal College of Nursing (2009) *RCN position on assisted dying*. https://www.rcn.org.uk/About-us/Our-Influencing-work/Position-statements/rcn-position-on-assisted-dying

[21] British Medical Association (2019) *Responding to patient requests for assisted dying: guidance for doctors*. https://www.bma.org.uk/media/1424/bma-guidance-on-responding-to-patient-requests-for-assisted-dying-for-doctors.pdf

[22] ibid

[23] ibid

[24] ibid

> "a patient with capacity can make an informed and contemporaneous refusal of medical treatment and/or food and fluids, which must be respected."

This can include continuous sedation/induced coma. The document then goes on to offer guidance on the degree of involvement (in England and Wales) where "a prosecution is less likely to be required".[25]

Dr Andrew Green, the chair of the BMA's medical ethics committee, which leads on assisted dying, said that barring doctors from raising the option with patients would put unprecedented legal restriction on doctors – though he said no doctor should be obliged to mention the procedure.

> "After careful debate, we did conclude that there should be no requirement on doctors to raise the subject, but equally, they should be able to do so sensitively when they thought it was in the best interest of their patients."[26]

In 2021 the BMA adopted a neutral stance and published guidelines[27] on how they proposed Assisted Dying should operate.

Table 16[28] in section 146 of the Westminster Impact Assessment of the introduction of AD indicates the percentages of each type of BMA member willing to train and participate in AD.

Table 16 Proportion of BMA members who would actively participate in any way, if the law were to change so that doctors were permitted to prescribe drugs for patients to self-administer to end their own life, by profession (2020)[79]

Profession	Base %	yes %	no %	undecided
Palliative medicine	604	10%	76%	14%
Clinical oncology	205	23%	60%	17%
Geriatric medicine	725	26%	56%	18%
Medical oncology	149	30%	52%	18%
Respiratory medicine	376	30%	51%	19%
General practice	9,525	32%	50%	18%
Cardiology	301	37%	49%	14%

[25] ibid

[26] https://www.theguardian.com/society/2025/jan/15/doctors-to-speak-out-against-changes-to-proposed-assisted-dying-law-in-england-and-wales

[27] The BMA's views on legislation on physician-assisted dying (2021). https://www.bma.org.uk/advice-and-support/ethics/end-of-life/physician-assisted-dying

[28] Impact Assessment: Terminally Ill Adults (End of Life) Bill (as amended in the House of Commons Public Bill Committee) **IA No**: DHSCIA9682 https://publications.parliament.uk/pa/bills/cbill/59-01/0212/TIABImpactAssessment.pdf

Neurology	193	36%	48%	16%
Old age psychiatry	296	35%	47%	17%
General (internal) medicine	490	34%	46%	20%
Occupational medicine	141	35%	45%	20%
General surgery	683	39%	44%	17%
Public health medicine	330	41%	43%	16%
General psychiatry	927	37%	42%	20%
Emergency medicine	755	47%	35%	19%
Intensive care medicine	423	45%	35%	19%
Overall	**26,357**	**35%**	**47%**	**18%**

11.4 The Royal College of Physicians

In 2019 the Royal College of Physicians polled its 36,000 members on AD, and while 43.4% remained opposed, the majority of 56.6% were now neutral (25%) or supported AD (31.6%). The former Chair of the Committee on Ethical Issues in Medicine at the Royal College of Physicians has stated:

> "As a doctor I used to think palliative care was the answer. Now I realise that keeping people alive can be unspeakably cruel".[29]

11.5 The Royal College of Radiologists' (RCR) Faculty of Clinical Oncology

In 2019 the Royal College of Radiologists' (RCR) Faculty of Clinical Oncology polled its members and a minority (42.9%) opposed while the majority of 57.1% were now neutral (30.3%) or supported AD (26.9%).

11.6 The Royal College of General Practitioners

The Royal College of General Practitioners (RCGP) has also now moved from opposition to adopting a neutral position on assisted dying.[30] Also in 2019 the RCGP polled members, and the results were 2% abstain, 47%

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[29] Duckworth, Prof Stephen (2022) Written evidence submitted by Professor Stephen Duckworth OBE, DSc, PhD, FKC, MSc LRCP MRCS (ADY0002) https://committees.parliament.uk/writtenevidence/114065/pdf/

[30] https://www.theguardian.com/society/2025/mar/14/professional-body-for-uk-gps-softens-position-on-assisted-dying-to-neutral

opposed, but by a narrow margin a majority had 11% neutral and 40% support outright.[31]

11.7 the Royal College of Surgeons

In February 2023, the Royal College of Surgeons surveyed its 17,631 members, and found 52% supported AD, 20% were neutral and only 25% opposed.

11.8 the Royal College of Anaesthetists

In 2024 the Royal College of Anaesthetists moved to a neutral position on assisted dying.

[31] British Medical Association (2023) Public and professional opinion on physician-assisted dying. https://www.bma.org.uk/media/4403/public-and-professional-opinion-on-physician-assisted-dying-report-v2.pdf

12 Medical staff and legal liability

12.1 Will medical practitioners face legal liability issues if they provide support in Assisted Dying?

In the end, this is the crux of the matter in relation to the law and AD in Scotland. There remains ambiguity in existing precedents and the law.

Downie notes that "in Baxter v Montana, the Supreme Court of Montana held that physicians who provide 'aid in dying' (so termed and limited to assisted suicide by the court) to terminally ill, mentally competent adult patients are shielded from criminal liability by the patient's consent."[32] When assisted deaths are permissible by law, and a medical practitioner follows the procedures as prescribed by law, the threat of liability is null.

By comparison, currently Scots case law simply fails to offer sufficient clarity and guidance on the legality of providing and/or administering a lethal substance to patients where the purpose is a hastened and compassionate death, hence the need for legislation.

12.2 Is there a risk of malpractice?

Poor reporting in the early years in the Netherlands has also been cited by opponents[33], but this is a criticism of poor reporting administration and not proof of malfeasance by doctors. Opponents of AD have tried to cite cases in the Benelux countries pointing to cases of assisted dying without consent. These have tended to be cases of heavy (and ultimately terminal) sedation in futile cases where the patient was in a coma or suffering from Alzheimers, but also dealing with a comorbidity such as terminal cancer. The level of deterioration of the patient, and the level of suffering is judged to be irreversible and progressive, and heavy sedation leads to death. This application of double effect existed legally in those countries before assisted dying legislation was introduced. It exists now legally in Scotland.

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[32] Downie, Joyce (2016) *Permitting Voluntary Euthanasia and Assisted Suicide: Law Permitting Voluntary Euthanasia and Assisted Suicide: Law Reform Pathways for Common Law Jurisdictions Reform Pathways for Common Law Jurisdictions*. QUT Law Review Volume 16, Issue 1, pp 84-112. https://digitalcommons.schulichlaw.dal.ca/cgi/viewcontent.cgi?article=1906&context=scholarly_works

[33] https://www.academia.edu/49721225/Euthanasia_and_assisted_suicide_good_or_bad_public_policy?email_work_card=view-paper

Guidelines and procedures can be clearly set by legislation. Procedures can be monitored and subject to regular reporting. However it is unrealistic to suggest that any medical system is perfect.

Opponents regularly seek to hold AD to a standard that is impossibly high for any area of medicine. They cite the the possibility of mistakes, poor practice, even bad actors. It is an uncomfortable truth that isolated mistakes and poor practice, some fatal, exist in every area of medical treatment. Holding AD hostage to negative speculation or to standards that no other area of medicine can guarantee is at best partial in approach.

In recent years there have been serious issues identified in UK medicine in areas such as post-natal and children's care or general support for the elderly, but post-natal care or elderly care is not denied to everybody else - the system ensures the processes are better monitored, improved and regulated. Palliative care has not been banned in every jurisdiction because abuses in hospices and care homes have been reported. Deep sedation has not been denied to patients because deaths have been the result in many cases. No system can ever be guaranteed to be perfect. In the end we find the compromise that offers the greatest benefits and the greatest protections. That said, supporters of AD would argue emphatically that no slippery slope, no coercion, no abuse of the vulnerable has been proven in relation to AD in any state where AD is legal in the 84 years since it it was first available in Switzerland. In addition, no state that has legalised AD has subsequently banned it for those reasons or any other.

From the very start, according to the proposed Scottish legislation, assisted dying will be one of the most tightly regulated areas of medical support. Expert medical practitioners, multiple safeguards and multiple stages are proposed in the decision to approve an assisted death to protect against lone bad actors. As in all other areas of medicine, there will also be a process of constant monitoring, evaluation and improvement.

As the international expert panel commissioned by the Royal Society of Canada observed:

> "In countries with a restrictive regime for assisted suicide and euthanasia, the incidence of non-voluntary cases was higher than of voluntary ones, as opposed to countries with permissive regimes. Apparently, therefore, the incidence of non-voluntary cases of assisted death is independent of the permissibility of euthanasia and assisted

suicide. It may even be the case that an open and liberal policy leads to a reduction in non-voluntary assisted dying."[34]

12.3 Are there risks of choosing AD for the wrong reasons?

Some in opposition to AD seek to separate the concept of unbearable pain from a more general concept of overall unbearable suffering. The latter takes into account non-pain related experiences of a chronic condition which can include feelings of isolation and loss of mobility, loss of social connections, poor quality care/living conditions, depression and what Kissane et al[35] refer to as 'demoralisation syndrome'.

In some cases it can appear that sufferers cite these experiences as stronger motivators to end their lives than pain, which may be normalised and taken for granted within the equation. Critics of AD express concern that individuals may be motivated to end their lives before pain becomes too severe, as a result of these other factors.

The Social Care (Self-directed Support) Act 2013 was put in place in Scotland to ensure that care and support is delivered in a way that supports choice and autonomy in each disabled person's life, and the recommendations of the Feeley review[36] for the Scottish government of adult social care, which involved direct consultation with the Scottish disabled and chronically ill community, indicates a positive direction of travel in terms of protections and support for Scotland.

In Scotland, social care prioritises patients remaining in their own home for as long as their condition will allow and with support. Palliative care in Scotland, includes counselling and support.

Finally, it appears to make sense to place AD, as current Scottish proposals do, as a final additional option, after all other available social care resource, palliative and counselling support has been made available to the individual.

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[34] Royal Society of Canada Expert Panel (2011) *End-of-Life Decision Making*. Royal Society of Canada: 89 https://rsc-src.ca/en/end-life-decision-making

[35] https://www.researchgate.net/publication/12012374_Demoralization_syndrome-A_relevant_psychiatric_diagnosis

[36] https://www.gov.scot/publications/independent-review-adult-social-care-scotland/pages/2/

12.4 Will legalising AD undermine patient trust in doctors?

As to the argument that legalising medical aid in dying will undermine patient trust in the medical profession, this does not appear to be the case. Hall et a[37]l conclude that

> "despite the widespread concern that legalising physician aid in dying would seriously threaten or undermine trust in physicians, the weight of the evidence in the USA is to the contrary".

Anderson et al's study[38] of a highly diverse population

> "did not substantiate concerns that legalising medical aid in dying undermines patient trust in the medical profession."

12.5 Will medical staff be forced to administer an assisted death if it is in opposition to their personal beliefs?

MacLeod et al acknowledge that supporting an incurably suffering individual to achieve an assisted death may be a difficult or even insurmountable issue on a personal level for some staff.[39] Respect for personal autonomy is applied to all, including medical staff, in the current Scottish proposals. There is normally however a requirement in cases where medical staff are unwilling to participate that there is a mechanism to refer or transfer the individual's case. It is however generally agreed that nobody should be forced to participate unwillingly in the process, and there is a right to conscientious objection.

MacLeod et al[40] also cite various studies that indicate that providing a fatal prescription or administering a fatal dosage can place an emotional burden on some medical staff involved in AD, and this is a factor to consider in implementing a system that can include such support as counselling for

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[37] Hall et al (2005) *The impact on patient trust of legalising physician aid in dying.* J Med Ethics 2005;31:693–697. doi: 10.1136/jme.2004.011452 https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1734062/

[38] Anderson et al (2024) *The Impact of Legalizing Medical Aid in Dying on Patient Trust: A Randomized Controlled Survey Study*. Journal of Palliative Medicine. doi: 10.1089/jpm.2023.0706. Epub ahead of print. PMID: 39167528. https://pubmed.ncbi.nlm.nih.gov/39167528/

[39] Macleod, Rod (2012) *Assisted or hastened death: the healthcare practitioner's dilemma. Global journal of health science.* https://www.academia.edu/24606646/

[40] ibid

medical staff, as well as the choice to not participate. White[41] notes that the best outcome is a health policy that provides a duty of care and support for all involved.

12.6 Will patient autonomy and best interests be protected?

General medical guidance already stresses the need to respect the wishes and rights of patients.

An assisted death remains a final resort, after all other possibilities have been offered and found wanting by a fully-informed and competent sufferer. As Adedayo et[42] al note:

> "Patients also need to be educated regarding end-of-life decision-making and what current technologies or lifesaving treatments they are able to choose or reject. Friend (2011) asserts that personal autonomy is achieved when patients have sufficient information to understand both their illness and prepare for the dying process."

The current Scottish Bill introduced by Liam McArthur ensures that there will be recognition that it is the individual's life, the individual's death, and the individual's choice. Each individual seeking an assisted death will:

- receive information about their palliative/end of life choices.
- receive counselling and information of existing alternative treatments and support.
- act on this information in order achieve a peaceful death at a time of their choosing.
- request & be granted assistance with dying if still desired.
- any such request will be subject to checks and balances to confirm no coercion, and will involve confirmation and approval by independent expert health professionals. The individual's choice will be assessed and confirmed as voluntary, and the request must be maintained in all the steps in the process, and decision making capacity is reviewed right up to the final confirmation of choice.

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[41] https://www.academia.edu/82903746/Voluntary_assisted_dying_peak_bodies_must_provide_practical_guidance?email_work_card=view-paper

[42] https://www.academia.edu/9665663/Euthanasia_and_Physician_Assisted_Suicide_The_History_Ethics_and_Healthcare_Implications?email_work_card=view-paper

- after approval, the individual is under no obligation to ever initiate an assisted death, and can simply hold the option in reserve, which often offers reassurance and a better sense of agency and autonomy.