

# Position Statement Physician Assisted Dying



**nottinghamshire hospice**

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# **Nottinghamshire Hospice**

## **Position Statement on physician assisted dying**

### **Introduction**

Assisted dying remains highly topical and debated, both in the public and medical arena.

Physician assisted death is a legal activity in certain parts of the world but not presently in the UK (for example, the state of Oregon following the 1997 Death with dignity Act and in the Netherlands under the 2001 Termination of Life on Request and Assisted Suicide Act).<sup>1</sup>

The debate regarding physician assisted death is complex involving many legal, ethical, medical, socio-cultural and religious issues.

It is a highly contentious topic, with concerns regarding mercy, uncontrolled suffering, patient autonomy, care-provider autonomy, concern for the potential of coercion and abuse, the vulnerability of people with disabilities and the implications for palliative and hospice care.

### **Definition of terms**

#### **Physician assisted death:**

As far as this document is concerned the term ‘physician assisted dying’ refers to both ‘euthanasia’ and ‘physician-assisted suicide’

#### **Euthanasia:**

The term euthanasia describes a situation in which a doctor intentionally kills a person by the administration of drugs, at the person’s voluntary and competent request.<sup>2</sup>

The term ‘non-voluntary euthanasia’ is sometimes used to describe instances in which the person has been unable to ask for this to happen.

All forms of euthanasia are illegal in all parts of the UK

#### **Physician-assisted suicide:**

This is when a doctor intentionally helps a person to commit suicide by providing drugs for self-administration, at that person’s voluntary and

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<sup>1</sup> D Harris, B Richard and P Khanna ‘Assisted dying: the ongoing debate’ Postgraduate Medical Journal, 2006 August,; 82(970): 479-482 (A)

<sup>2</sup> Help the Hospices ‘Statement on hospice care and assisted dying’  
[www.helpthehospices.org.uk/media-centre/campaigns/assisted-dying](http://www.helpthehospices.org.uk/media-centre/campaigns/assisted-dying) accessed 23/3/2010

competent request<sup>2</sup>. The doctor does not administer the drug. The person must be able to act to administer the drug themselves.

Physician-assisted suicide is illegal in all parts of the UK.

It is also important to note the legal and ethical 'distinction' between a physician assisted death and other end-of-life issues such as withdrawing and withholding life prolonging treatment, do not attempt resuscitation orders and the appropriate provision of medication to relieve pain that may (but not necessarily and extremely rarely) incidentally hastens death (the doctrine of double-effect)<sup>3,4</sup>

**Double effect:**

The principle of double effect means that treatment can be provided with the intention of alleviating symptoms which may have, as an additional unintended consequence, a shortening of life. This happens very rarely in reality.<sup>3</sup>

**Non-Treatment decisions:**

A non-treatment decision is where doctors, in consultation with patients and families, believe that the withdrawal or withholding of a particular treatment is in the best interest of the patients for reasons of comfort; assessing distress versus benefit. For example, discontinuing chemotherapy, or deciding not to set intravenous antibiotics for a patient.<sup>2</sup>

## **Assisted Dying for the Terminally Ill Bill**

### **Background**

Lord Joffe introduced The Patient (Assisted Dying) Bill of 2003 to The House of Lords, which if enacted would have legalised assisted dying. This bill did not proceed further.

The Assisted Dying for the Terminally Ill (ADTI) Bill was submitted in March 2004<sup>5</sup>, but defeated in the House of Lords.

A second reading (current version) of the bill was again defeated in the House of Lords in May 2006.

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<sup>3</sup>A Thorns (1998) 'A review of the doctrine of double effect' European Journal of Palliative Care; 5(4): 117-120

<sup>4</sup> J Gilbert and S Kirkham (1999) 'Double effect, double bind or double speak' Palliative Medicine; 13 : 365-366

<sup>5</sup> Assisted Dying for the Terminally Ill Bill  
[www.publications.parliament.uk/pa/ld200304/ldbills/017/2004017.pdf](http://www.publications.parliament.uk/pa/ld200304/ldbills/017/2004017.pdf)

It is a revised version with important amendments, in particular, the current proposed legislation will only legalise physician assisted suicide and not euthanasia, and physicians who conscientiously object would **not** now be under an obligation to refer a patient requesting assisted suicide to another physician who would agree to do so.

### **The aim of the Bill**

The proposed bill will enable ‘a competent adult who is suffering unbearably as a result of a terminal illness to receive medical assistance to die at his own considered and persistent request; and for connected purposes.’<sup>5</sup>

In summary, the proposed legislation would mean that:

1. any patient considering assisted suicide would inform their physician in writing of their request
2. the patient must be fully informed of their medical diagnosis, their prognosis and the process of being assisted to die
3. the patient must also be informed (but not necessarily have experience) of the alternatives to assisted dying “included, but not limited to palliative care, care in a hospice and the control of pain” by a palliative care doctor or nurse
4. the physician must be satisfied that the patient does not lack capacity, that they have a terminal illness, and are “suffering unbearably” as a result
5. The patient must also have been seen by a second “independent” physician who agrees these criteria are met
6. If there is doubt about capacity then an opinion from a psychiatrist or psychologist is also required.
7. If the above criteria are met the patient would then sign an independently witnessed declaration
8. A period of 14 days must pass before assistance to die is made during which time that patient may revoke their declaration

This Assisted Dying for the Terminally Ill Bill is opposed by a number of key organisations:

- Royal College of Physicians<sup>6</sup>
- The Association for Palliative Medicine (Great Britain and Ireland)<sup>7</sup>
- Help the Hospices<sup>2</sup>
- National Council for Palliative Care<sup>8</sup>
- Royal College of General Practitioners<sup>9</sup>
- British Medical Association<sup>10</sup>
- Royal College of Psychiatrists<sup>11</sup>

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<sup>6</sup> [www.rcplondon.ac.uk/news/news.asp?pr\\_id=310](http://www.rcplondon.ac.uk/news/news.asp?pr_id=310) accessed 16/3/2010

<sup>7</sup> The Association for Palliative Medicine of Great Britain and Ireland

<sup>8</sup> [www.ncpc.org.uk](http://www.ncpc.org.uk) accessed 16/3/2010

<sup>9</sup> The Royal College of General Practitioners [www.rcgp.org.uk](http://www.rcgp.org.uk) accessed 26/2/2010

<sup>10</sup> [www.bma.org.uk/ethics/end\\_life\\_issues/Euthanasiaphysicianassistedsuicide.jsp](http://www.bma.org.uk/ethics/end_life_issues/Euthanasiaphysicianassistedsuicide.jsp) accessed 9/3/2010

<sup>11</sup> Statement from the Royal College of Psychiatrists on Physician Assisted Suicide [www.rcpsych.ac.uk/press/collegeresponses/physicianassistedsuicide.aspx](http://www.rcpsych.ac.uk/press/collegeresponses/physicianassistedsuicide.aspx) accessed 23/3/2010

## **Policy for Prosecutors in Respect of Cases of Encouraging or Assisting Suicide.**

On 25 February 2010 the Director of Public Prosecution (DPP) launched the Policy for Prosecutors in Respect of Cases of Encouraging or Assisting Suicide. Section 2 of the Suicide act of 1961 was amended with effect from 1 February 2010. According to Keir Starmer QC (DPP) the policy is now more focused on the motivation of the suspect (If compassion was the driving force behind assisting the victim) than the characteristics of the victim. The policy does not change the law on assisted suicide. It does not change the will of Parliament. The policy provides a framework for prosecutors to decide which cases should proceed to court and which should not.<sup>12</sup> The Crown Prosecution Service will now only carry out prosecutions against those who assist a person's suicide when the 'public interest' requirement is satisfied.<sup>12</sup> For public interest factors tending in favour or against prosecution see Appendix 1.<sup>12</sup>

## **The values of Hospice and Palliative Care**

### **Palliative Care:**

This is active care for people with advanced progressive illness, designed to address pain and other physical symptoms and to provide psychological, social and spiritual support. The ultimate goal is to provide the best quality of life for the person with the illness and support their family.

Nottinghamshire Hospice recognises the World Health Organization's definition that palliative care:<sup>13</sup>

- Affirms life and regards dying as a normal process
- Neither hastens nor postpones death (This philosophy is a corner stone for hospice care in the UK)
- Provides relief from pain and other distressing symptoms
- Integrates the physical, psychological, social, emotional and spiritual aspects of care, with coordinated assessment and management of each person's needs (Placing equal weight on those needs)
- Offers a support system to help people live as actively as possible until death ('Adding life to days')

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<sup>12</sup> Policy for Prosecutors in Respect of Cases of Encouraging or Assisting Suicide. Issued by the Director of Public Prosecutions - The Crown Prosecution Service. February 2010  
[www.cps.gov.uk](http://www.cps.gov.uk) accessed 25/2/2010

<sup>13</sup> [www.who.int/cancer/palliative](http://www.who.int/cancer/palliative) accessed 22/3/2010

- Offers a support system to help the family cope during the patient's illness and in bereavement

The central aim is to achieve the best quality of life, both for the person who is dying and for their family while upholding patients' and families' values and goals.

The General Medical Council guidance reminds doctors that 'it is important to ensure that the patient's palliative care or terminal care needs are identified and met appropriately'.<sup>2</sup>

Nottinghamshire Hospice, as an organisation has a responsibility to ensure that all staff involved in providing care to patients at the hospice have the knowledge (including alternatives to physician assisted dying), attitude and skill to help people at the end of life manage physical, emotional, spiritual and psychological suffering and to support family members. We also have a responsibility to ensure that patients seeking physician assisted dying (however rare) are aware of other options.

However, we recognise that even with comprehensive, compassionate end-of-life care, a very small number of patients may still ask for assistance to end their lives. We at Nottinghamshire Hospice have the responsibility to respect these patients' views and respond to these patients in a way that still respects our own values and principles.

## Position Statement

This statement attempts to capture our fundamental concern regarding issues related to physician assisted dying.

As an organisation Nottinghamshire Hospice do not support any change in the law to legalise assisted dying in any form. We do not consider a change in the law to be in the best interests of the people we care for. At the same time we want to show respect for those who hold a different view.

***Nottinghamshire Hospice is committed to do what we can to enhance the quality of living and the quality of dying for patients we care for at the end of life and to support their families. We do not view physician assisted dying as part of quality end of life care.***

***Good end-of-life care will include assistance with pain and symptom management as well as giving psychological, emotional and spiritual support. For most patients high quality palliative care will be a better option than physician assisted dying.***

***However, despite access to high quality end-of-life care a small number of patients may still choose to have control over their own death.***

***Nottinghamshire Hospice, as an organisation will respect their right to choose and will not abandon them. We will continue to provide the same***



*compassionate care to these individuals and their families, but we also have a choice not to participate or to be expected to assist in any efforts that intentionally hasten death if physician assisted suicide may become legal in the United Kingdom in the future.*

## Concerns regarding the proposed legislation

- To value peoples' lives is fundamental to every aspect of palliative care and is at the heart of our day-to-day work with patients in our care at Nottinghamshire Hospice. There is the potential for such legislation to reinforce in society the attitude that 'suffering should not be a part of life, that interdependency is a burden and that the lives of disabled people are not worth living.'<sup>1</sup>
- To define 'unbearable suffering' is difficult and in its nature subjective and can mean something very different to different people.
- There is concern for the protection of vulnerable people (e.g. the elderly, disabled and mentally incompetent.) Coercion and abuse are possibilities. There is the ethical conflict between meeting individuals' demands for therapeutic death and ensuring that incapable, vulnerable or voiceless patients will not have lethal treatment prescribed as their best interest.<sup>14</sup>
- Patients can feel a burden to their families and to society. A right to die can become a duty to die.<sup>7</sup>
- The most vulnerable members of society may feel this sort of legislation would compromise their trust in the medical profession.<sup>1</sup> These concerns may build to the 'slippery slope' argument whereby voluntary requests for assisted death may evolve into involuntary euthanasia of vulnerable people.<sup>1</sup>
- Central to the argument for assisted dying is respect for patients' autonomy, but how far does patients' autonomy go in modern society? If assisted dying is legalised could a non-terminal patient autonomously request assisted death?<sup>1</sup>
- Equally, the argument of patient autonomy has to be balanced against a respect for human dignity and the reverence for life.<sup>1</sup>
- A further important concern is the potential impact a change in legislation will have on the doctor-patient (any health care professional and patient) relationship and the relationship between the medical profession and the British society in general.<sup>1</sup>
- Concerns about the logistical aspects of the proposed legislation:

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<sup>14</sup> R George, I Finlay and D Jeffrey, 'Legalised euthanasia will violate the rights of vulnerable patients' BMJ, Vol 331, 21 September 2005 : 684-685

- Accurately estimating prognosis (particularly in non-malignant diseases) is difficult
- The ‘independence’ of the second physician( If they are selected by the first physician they will probably share the same opinion)
- Excluding depression in those requesting assisted dying. (Distinguishing depression from a natural reaction to terminal illness is often difficult.)<sup>1</sup>
- Contrary to belief, most patients requesting physician assisted dying do not do so because of physical symptoms such as pain or nausea. Rather depression, psychological distress and fear of loss of control are identified as the key end of life issues. A study in Canada showed no correlation between physical symptoms (pain, nausea, loss of appetite) and the patient’s expressed desire or support for assisted dying. In the same study the patients suffering from depression or anxiety, but not somatic symptoms such as pain demonstrated support for or requested assisted dying.<sup>15</sup>
- There is little information about frequency of complications or unsuccessful assisted suicide and should either occur there is the potential to diminish the quality of end of life care (and of dying) and not improve it.<sup>1</sup>
- In reviewing the publicly available report of assisted suicide in Oregon, loss of autonomy and decreased ability to engage in pleasurable activities were cited in excess of 78% of cases.<sup>15</sup> What percentage of these cases might have been helped by psychiatric intervention or spiritual counselling?
- Instead of allowing natural death this will mean ‘death by appointment’ which is an alien concept for health professionals.
- We must solve the real issues and pressing problems of inadequate care, not avoid them through solutions such as physician assisted dying.<sup>12</sup>
- If assisted dying is legalised, there is no conscience clause to protect health care professionals.<sup>16</sup>

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<sup>15</sup> Position Statement on Physician Assisted Suicide. Association of Northern Californian Oncologists and Medical Oncology Association of Southern California. 16 April 2007

<sup>16</sup> 8<sup>th</sup> Palliative Care Congress, March 2010, ‘Analysis of Oregon Health Department reports on the Death with Dignity Act. Lecture by Baroness Illora Finley, Professor in Palliative Medicine, Cardiff University.

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## **Appendix 1**

### **Policy for Prosecutors in Respect of Cases of Encouraging or Assisting Suicide.**

#### **Public interest factors in favour of prosecution.**

A prosecution is more likely to be required if:

- 1 - The victim was under 18 years of age
- 2 - The victim did not have the capacity 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, a professional carer, 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

### **Public interest factors tending against prosecution**

A prosecution is less likely to be required if:

1 - The victim had reached a voluntary, clear, settled and informed decision to commit suicide

2 - The suspect was motivated wholly 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 and his or her part in providing encouragement or assistance