



# **Assisted Dying for the Terminally Ill Bill [HL]**

**Written evidence collated by  
The Royal College *of* Physicians of London**

**On behalf of  
The Academy of Medical Royal Colleges**

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## **Background**

The Royal College of Physicians of London (RCP) has considered this Bill both in its original 2003 version, and in the amended version of 2004. It has been considered by RCP's Committee on Ethical Issues in Medicine, and its Council.

Throughout what has been extensive discussion, there has been considerable sympathy for the considerations that have informed the proposed Bill: humane concern for the possible unnecessary suffering of patients; respect for the autonomy of patients in this most important area of decision making; and the need to protect doctors who may be uncertain of their duties in an unclear legal situation or who may be driven to activities that are currently illegal by their wish to serve what they perceive to be the best interests of their patients.

The first version of the Bill was unanimously rejected both within RCP's Committee on Ethical Issues in Medicine and within our Council on a variety of grounds including the fact that there were serious ambiguities in the formulation of the Bill. Many concerns were also raised about the impact the Bill would have, if enacted, on the relationship between individual patients and their doctors, between the medical profession and society and also upon society itself.

The College reconsidered the Bill in detail when it was proposed in an amended form, which had addressed some of its concerns. Moreover, the initial response elicited some extremely useful, and in part reassuring, information on the impact of comparable legislation in other countries on the relationship between doctors and patients and the medical profession and society as a whole.

When the amended Bill was considered, there was no longer a unanimous opinion. Setting aside empirical issues regarding the impact on society, there was a clear division of views as to its desirability from the ethical point of view. Extensive debate both within the Committee -including presentations from the Lord Joffe and Ms Deborah Annetts (in favour of the Bill) and Baroness Ilora Finlay and Dr Rob George (against the Bill) - and within Council did not bring agreement any closer.

One area where there was strong and overwhelming agreement, was that the Bill was essentially a matter for society as a whole to decide and that the College should not assume a position for or against.

The comments in our submission are therefore confined to areas in which the medical profession could claim to have a special understanding and expertise. It does not signal support for, or opposition against the Bill, but instead highlights those issues for practising doctors which would have to be carefully thought through both within the Bill and any subsequent Code of Practice, if assisted dying were legalised under the terms of the proposed legislation.

Members of the Select Committee should note that our submission incorporates the views of the Academy of Medical Royal Colleges (AMRC) whose members were consulted in the course of our deliberations.

## Medical issues

### *Diagnosis*

1. When a patient seeks assistance in dying, it is important to diagnose the reasons for this before discussing this option. In many cases unbearable suffering may be due to remediable symptoms. These should be identified and adequately addressed. Doing so requires considerable expertise and this expertise is unfortunately at present not available to all dying patients.
2. Many dying patients, are, for entirely understandable reasons, depressed. This depression may not simply be a reflection of their medical condition and may be amenable to treatment by antidepressant drugs or by counselling. It is essential, therefore, that a treatable depression should have been identified and managed. This again requires considerable expertise.
3. It has to be recognised that autopsy studies have shown that in a small minority of cases people who are thought to have had terminal cancer turn out to have had a treatable non-cancerous cause of death. This places the onus on the clinical team to make an accurate diagnosis before even considering assisted dying.
4. The request for assisted dying may be the reflection of a fear of the process of dying: these fears should be identified and in many cases may be allayed by discussion and reassurance.
5. Palliative care specialists have noted that unbearable suffering prompting the request for assisted dying is often a reflection of unresolved psychosocial issues. These should be identified and resolution attempted.

6. Finally, it is important to ensure that the request for assisted dying, and the decision to grant it, is not the result of external pressures; for example the feeling that one is a burden to others or that one is pointlessly consuming resources.

There should be clear documentation that all these concerns have been identified and addressed as far as possible.

### *Training*

It will be evident from the foregoing that the management of the dying patient, and, more specifically a clear understanding of the issues surrounding the request for assisted dying, both require a high level of competence in making the complex diagnoses. Anyone involved in the assisted dying process should have received rigorous training in how to discuss these issues with patients and with their supporters; in the legal framework of assisted dying; in the appropriate methods of assisting patients to die; and in the context and settings in which this should take place.

Any facility where it is likely that patients will be requesting assisted dying should have a team of doctors and allied professionals, who have willingly opted to belong to the team and who could be well trained and might even be "on call" when their specialised decision making assistance was required. This of course would be necessary only if the Bill were enacted.

## *Implementation*

Consideration should be given as to who would be responsible for assisting a patient to die. Not all physicians will wish to be involved and this is acknowledged in the ‘conscientious objection’ component of the Bill. This should be clearly supported in practice as well as in theory.

It follows from this that, other attendants than those usually overseeing the patient’s care (eg hospital consultant, general practitioner) may be involved in assisted dying. Co-opting others to assist in dying should be the subject of careful consideration and even more careful scrutiny. The extension of a nurse’s role to encompass this assisted dying, for example, would be a major step. Involving others less directly concerned with patient care, such as pharmacists, is an even greater step. How will this be arranged and how will this be perceived? How will those requested to assist in dying cope with the impact on themselves? As care is increasingly delivered in multidisciplinary teams it is imperative that there are clear lines of responsibility.

Finally, we ask that the Committee give careful consideration to the current recommendation to have two co-signatories to sanction an assisted dying procedure, as a number of people have questioned whether this constitutes a sufficient safeguard against potential abuse of the law.

### *Audit and documentation*

Many believe that the enactment of the Bill would be a leap into the dark. There have been widely expressed concerns about a 'slippery slope'; that assisted dying may be extended beyond those groups envisaged in the Bill to those who seek euthanasia voluntarily while not terminally ill; or, more worryingly, to those whose request for assisted dying is not truly informed or even truly voluntary. There have been additional worries that these concerns could have an adverse impact on the doctor patient relationship and the relationship between the profession and society as a whole.

There should therefore be sufficiently detailed documentation and audit of the uptake of assisted dying in order to address purposefully, rather than merely incidentally, the concerns expressed with respect to 'slippery slopes'. Audit should include a clear examination of the availability of palliative care services to patients who have received assisted dying to make sure this was genuinely a comprehensive service and was truly accessible. In addition there should be proper evaluation of the impact of the availability of assisted dying on the attitudes of patients who have a terminal illness and on the relatives of those who have died with and without assistance. Finally, there should be regular surveys of public opinion about the impact of the Bill in the areas indicated.

We also seek clarification as to whether assisted deaths would require notification to the coroner. Since the immediate event resulting in death would be unnatural, we presume that notification would be required and that each individual death would be subject to medico-legal scrutiny.

## *Campaigning for palliative care services*

Even those who are opposed to the Bill welcome the acknowledgement that there are patients who have unacceptable deaths with unalleviated, prolonged and unbearable and pointless suffering. Irrespective of whether the Bill is or is not enacted, it should be seen as a trigger to campaign for better care for dying patients. This includes not only an extension of first-class palliative care services to all patients beyond those who have traditionally received such care, but also a more rational, human and intelligent discussion of a wide range of end-of-life issues. The medical profession is not alone in experiencing increasing uncertainty as to the proper approach to decision making in this area. Technological advances, changing values and increasing ethnic diversity of viewpoint have left many clinicians feeling bewildered and at times unprotected when they wish to do what they see is their human best for their patients.

## **Conclusion**

The Royal College of Physicians and the Academy of Medical Royal Colleges very much hopes that these essentially medical consequences of a change in law should receive at least as much attention as the ethical debate.