



Association for Palliative Medicine

PUBLIC BRIEFING ON THE APM'S POSITION ON ASSISTED SUICIDE

The Association for Palliative Medicine represents over a 1000 specialist doctors in the UK working in hospices and the NHS. We remain overwhelmingly opposed to a change in the law on Assisted Suicide (AS) as proposed by current Bills before Parliament. We seek to stand between our many vulnerable and voiceless patients and the dangers of such proposed legislation for them, the profession and society in general. There are three sections:

- Clarity about palliative care and its distinction from Assisted Suicide,
- The Association's specific concerns over legislative change and
- The broader societal issues.

PALLIATIVE CARE:

The people who use our services

- We start with the needs of a patient as a person in their social and cultural context;
- We promote people's freedoms within their mental capacity to choose between the relevant treatments and care they receive. This includes their freedoms to refuse treatment and or intervention whatever the consequences, in line with the Mental Capacity Act 2005.
- We seek to enable and serve the most vulnerable, through the services and care that we provide, to lead as independent and symptom free a life as is possible. We also promote the right for a person, when their time comes to die, to choose as far as possible the setting of their death and for this to be dignified.
- The universally accepted philosophy of palliative care does not see assisting suicide or euthanasia to be part of its purpose. Rather, we see dying as a natural process and seek neither to shorten nor prolong life as someone dies. In other words, we care for people whilst they die and not in order that they die.

Our role

- In this context, palliative care professionals are expert in caring for people, and the families and friends who care for them, who have advanced, progressive or life-limiting disease and co-existing chronic conditions. Our objective is to help them to live and conclude their lives as well as possible:
- We seek to view clinical priorities through their eyes;

- We train and support colleagues explicitly to fulfil their particular duties of care towards their dying or suffering patients;
- We work in multidisciplinary services that span the NHS, voluntary Hospices and social care because the care we offer is complex, holistic and beyond the skills of a single discipline or individual.
- Someone's suffering is unique and what a person says it is. However, that person's perception always has the potential to change and with expert care it usually does;
- Whilst most dying people, with expert care, should be comfortable and free of distress and pain, not all symptoms can be controlled completely all of the time and even if they are, a very small minority of people may still feel the necessary palliative medications or interventions unacceptably intrusive, their remaining life unbearable, excessively burdensome or worthless.

DIRECT ISSUES TO DO WITH LEGISLATION

We understand that change in the law is a matter for Parliament through the democratic process, but so far legislation has always rested responsibility upon doctors. It is this expert voice we are expressing and not our individual views as citizens, which may differ. As a key group of doctors expected in such Bills to be directly involved in assisting suicide (AS), we are most anxious that the debate is as well-informed as possible and engages our five principal and interconnected questions and concerns. Patient safety is our main worry.

1. How much error is society prepared to tolerate from legalisation of AS?

- People are fallible and no safeguards can eliminate errors in assessment; even as experts, we find it impossible to separate those who might want to die from those who feel they ought to die;
- Views that appear to be fixed or unchangeable seldom are. So a person who feels a particular kind of life is unbearable before they reach that state may feel that it is a life worth living when they get there.
- Coercion, real or imagined, may be undetectable and feeling burdensome is a prominent and rising reason for requesting assisted suicide. Some people not now at risk will be put at risk were the Law to change;
- When left to doctors, ample and reputable evidence exists that assessment of people's capacity to make these irreversible decisions, or determining whether they are influenced by a mental illness, is unreliable and flawed. In fact, mental illness is now a legitimate indication for AS in Belgium and Holland, where some legislators are reported to consider the rise in AS and euthanasia to be out of control. Leaving the process to doctors may feel safer, but the evidence shows it is not;

- Official polls by medical professional bodies across the board show that the majority of doctors oppose such a Bill, many from a fundamental abhorrence of a doctor being complicit with deliberately foreshortening life by months or years, but most because of worries over safety.

For the vulnerable dying, laws that make doctors the decision makers are unsafe.

2. Why should AS be the province of doctors?

- Current Bills propose that doctors will estimate prognosis, assess capacity, detect coercion, determine a settled wish, then prescribe, supervise or implement administration of lethal drugs with a Court simply to run the rule over the decisions and not to make the judgments.
- Doctors' expertise lies in diagnosis of illness, estimating its likely course and managing its effects. Despite this training, clinicians are seldom able to predict prognosis accurately.
- The judiciary has the training, established expertise and authority in dispassionate consideration of complex issues such as the settled nature of a request, the weight of personal or domestic issues that might influence the request and the person's capacity to make such a serious and irreversible decision. It is the proper province of Courts;
- A doctor's role should be limited to the provision of information to the Court on the strictly medical aspects of a request:
 - Over 90% of the APM members who have responded to our consultation say that if such a Bill were passed they would be willing to provide factual information to the Courts;
 - Only 4% would be willing to decide suitability, recommend to the Court and prescribe lethal medication as currently envisaged;
 - Decision-making by the Court allows medicine to focus on care and the relief of suffering without this dangerous distraction.

Were the law to change, and protagonists and legislators truly focussed on protecting the newly vulnerable, moving executive authority and responsibility from medicine to an appropriate judicial process with specialist non-clinical technicians will be least harmful and most transparent.

3. Does a prognosis have any real meaning, and if not, why is it there?

- We know that prognostication, even with the full medical facts, is very unreliable and the Oregon data support this;

- It is unjust and a potential infringement of human rights to make AS available to those purported to be dying within 6 months, whilst denying it to those potentially facing a much longer time to suffer their distress;
- Were society really to accept that AS should be available for this arbitrary group, it assumes falsely that the last 6 months of life is somehow a distinct and special period. This is incoherent and unfair either by limiting its availability unreasonably to them, or discriminating against the vast majority of dying people, and said to be in their last 6 months, who will not want AS by exposing them to its dangers.
- It seems that the only purpose in confining an initial law to the dying is that it is more likely to be acceptable to Parliament.

Prognosis is misleading and unsafe.

4. How might this affect palliative care for the majority?

- The UK is recognised as an international leader in this field.
- Hospices' and specialists' critical and enduring roles are to provide patients with a safe environment. Here they are able to explore and express their fears and anxieties without worrying that speaking openly of a desire to die will set them on a course to assisted suicide.
- The Association's membership is concerned that the passing of such Bills will damage and compromise the delivery of palliative care including the care given by Hospices.
- We are concerned that the public perception of hospices and palliative care would no longer be to care for and value people as they die, but to bring about their death. This misconception is already too prevalent in some patients' minds and makes some people who are in need of specialist care fearful of being admitted to a hospice.

We believe that legal change will exacerbate this problem by distorting, confusing and contaminating clinical care of the vulnerable dying who are in need of expert palliative care, and is unsafe.

5. Can the law distinguish Assisted Suicide and Euthanasia coherently?

- Bills to date have sought to present a line between Assisted Suicide and Euthanasia, but the inherent ambiguity is misleading and paves the way for future wider legislation.
- This is inevitable since the distinction, alongside prognosis, is technical and not moral. For example, the decision to prescribe an antibiotic is when a judgment is made, how it is then to be administered is practical – if someone is unable to swallow, then an injection will be both better and more reliable. Assisted suicide is euthanasia by mouth, euthanasia is assisted suicide by injection. They are the same.

- Proponents are open about their pragmatism in confining the Bill to Assisted Suicide (framed as Assisted Dying) to maximise its chance to pass into Law: one has said recently *“This should be a part of the normal process of health care”*.

We disagree. The doctor’s role is to avoid futile and harmful interventions, maximise quality of life and relieve the suffering of both the person and their loved ones as she or he dies. Licensing doctors explicitly to prescribe or administer lethal drugs is not health care and must remain distinct.

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BROADER ISSUES TO DO WITH SOCIETY

Coercion

- People are relational: we respond to others, seek affirmation, approval and generally avoid upset and never more so than when we depend on others for care. We are all vulnerable to confuse our emotions and feelings with those of others, thinking that their distress, helplessness, suffering, etc., is ours or our suffering is theirs. In this way a sense of being a burden can be felt or projected subconsciously and then expressed by either the person or their carer as a genuinely felt belief about the state of affairs.
- Clinicians are not immune from this either and the literature bears this out. Furthermore, these feelings and requests may be very transient or a ‘cry for help’ and yet their consequences may not, should the law change.

Fractures in the doctor - patient relationship

- In our survey, this has been one of the most common concerns by the membership. Many life-saving treatments and medications are potentially lethal even when protocols are followed. Any oncologist will admit that justification from ‘double-effect’ is often in mind as they seek to kill a cancer without killing the patient. However, the bright line that forbids doctors to administer lethal drugs with the sole purpose of ending the person’s life is there to reassure all that doctors have the undivided commitment to the life and health of their patients and not some covert intent to kill. It also protects us from misplaced compassion that may end up with a mistaken assisted suicide;
- Palliative care and the Hospice Movement have still to protest the safety of opioids and sedation and withdrawal of burdensome treatments at the end of life due to the misunderstandings of the public and misinformation that seeks to align palliation and symptom management falsely with assisted suicide and euthanasia.

Legal change without firewalling health care will make these claims impossible to correct and patients will suffer from poorer symptom control.

Economic pressures

- If AS is part of health care, then it ranks alongside all other treatments and will be an increasing pressure on clinicians. There was evidence emerging on this in the Netherlands in the mid 2000s before they stopped asking the question.

A changing demography: the elderly care perspective

We are facing an ageing population and the challenges that this brings in terms of frailty and patterns of dying that may be prolonged and dwindling. The British Geriatric Society (BGS) statement opposing Assisted Suicide (July 2015) is to be found here. http://www.bgs.org.uk/pdfs/2015_bgs_on_assisted_suicide.pdf

The ambient climate of care

- The law doesn't just reflect society, it also influences it. For society to set in law a permissible threshold below which a life is better off ended changes the whole climate of equality and solidarity that holds civil society together.
- This may mean that a very few will have to forgo a lethal solution in favour of the best care available as they die. This must be a civil responsibility: otherwise it begs the question as to what is worse: not to kill people who want to die or to kill people who might want still to live?
- No one in favour of AS can give a categorical guarantee that no one will die 'by mistake' with this planned law. As Lady Butler-Schloss, former president of the High Court has said:

'Laws, like nation states, are more secure when their boundaries rest on natural frontiers. The law that we have rests on just such a frontier... The law is there to protect us all. We tinker with it at our peril'.

Professor Rob George, President
on behalf of The Association for Palliative Medicine of Great Britain
and Ireland.
July 2015