



Association for
Palliative Medicine
Of Great Britain and Ireland

Trainees'
NEWS UPDATE

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APM Trainees' News

Dear Trainees,

Welcome to our June newsletter. This weather has reflected this summer's status as being very changeable – the pandemic is still ongoing with both positive and concerning reports. In parallel many of us are continuing with the familiarity of doing our best for our patients and their loved ones whilst developing ourselves through training. We recognise it is still not an easy time for us all and we will continue to support trainees as much as we can. We want to thank our committee members for their continued efforts in doing this alongside other commitments.

June newsletter

- **Post of the Month:** Update on Assisted Dying - National media outlets reported this month that a new bill is being lodged at Scottish parliament regarding assisting dying. This bill has been outlined as being to propose assisted dying specifically for individuals with terminal illnesses. It will prompt discussion and debate on this ethical dilemma. If changed this legislation will impact us as palliative care clinicians, we will encounter it in our clinical practice perhaps in our discussions with patients and families or our observed experiences of patients' health journeys. I encourage you to take time to foster your own knowledge and engage in the discussion and we thank Prof Sleeman for her article here that will help as a starting point for this.
- **Committee Update:** Upcoming Regional Representatives meeting in July, 2 new committee members Lizzie and Dan.
- **Article of the month:** The experience of delirium in palliative care settings

In July we will be holding our regional representative meeting. If there are any suggestions or thoughts on how the APMT can help trainees, please speak with your regional representative or contact us.

Best wishes,

Jasmine and Simon
APMT Co-Chairs

Post of the Month - Update on Assisted Dying

Professor Katherine Sleeman
King's College London

Conflict of interest: I am a palliative medicine clinician and academic. My position on assisted dying is that I believe that the risk of harm of changing the law outweighs the risk of harm of leaving the law where it is. For this reason, and some others included below, I oppose legalisation of Assisted Dying. I have written about assisted dying [here](#), [here](#), [here](#) and [here](#). I spoke at the APPG for Dying Well [here](#).

On 26th May 2021 [Baroness Meacher's Assisted Dying Bill](#) had its First Reading in the House of Lords. Interviewed subsequently in the Telegraph, Baroness Meacher said that she believes that assisted dying is likely to become legal within 18 months.

What does Baroness Meacher's Assisted Dying Bill specify?

The Meacher Bill is almost identical one tabled in 2014 by Lord Falconer and another tabled in 2015 by Rob Marris MP (which was rejected by a substantial majority in the House of Commons). The bill would legalise 'assisted dying' for terminally ill, mentally competent adults. A person is defined as terminally ill if they have an inevitably progressive condition which cannot be reversed by treatment, and are reasonably expected to die within six months.

The Bill in its current form stipulates that two doctors, working independently, need to be satisfied that the person is (a) terminally ill; (b) has the capacity to make the decision to end their own life; and (c) has a clear and settled intention to end their own life which has been reached voluntarily, on an informed basis and without coercion or duress.

Assisting suicide is currently unlawful under Section 2(1) of the 1961 Suicide Act. The Meacher Bill is proposing is that doctors who consider a patient meets the conditions laid down should supply lethal drugs to the person in order to enable him/her to take his/her own life.

What is the process now for Baroness Meacher's Assisted Dying Bill?

The Bill will have its second reading, probably early this Autumn. This will be the first opportunity for members of the Lords to debate the key principles and purpose of the Bill and to flag any concerns or areas where they think amendments are needed. After the second reading, the Bill will go to committee stage, where detailed line by line examination and discussion of amendments takes place.

What are the arguments for changing the law?

In general, arguments in favour come down to individuals and autonomy: "it's my right, my choice". Proponents cite instances of failure of palliative care to relieve all suffering (for example this [Dignity in Dying campaign](#)). They highlight unsafe practices where terminally ill people choose to die by suicide (often alone and under distressing circumstances). They highlight inequalities, because going to Dignitas is only available to people who have the financial means. They also say that this often means people travel to Dignitas before they are ready to die, aware that they will become too unwell to travel over time. They draw on overseas experience, particularly from the US State of Oregon, to make the case that such legislation can work without risk of abuse to vulnerable people.

What are the arguments against changing the law?

In general, arguments against focus on the need to protect the vulnerable, and concern about widening of eligibility (the so-called slippery slope). Opponents highlight the limitations of suggested safeguards, for example the six month rule as being arbitrary (why six months?), impossible to predict accurately, and discriminatory (because it denies access to those with arguably the greatest need). Opponents highlight the limitations of safeguards to protect individuals from coercion, as well as wider societal concerns about the messaging that an 'assisted dying' law sends – that the 'right to die' becomes an obligation. Concerns are raised about the difficulty of embedding such practices within clinical care, particularly the conflict with 'do no harm'. While few (if any) argue that palliative care is a panacea to all suffering, opponents worry that legalising assisted dying in the absence of widely available and equitable palliative care sends a dangerous message to the terminally ill.

What do we know from other jurisdictions?

Assisted dying is now legal in 16 jurisdictions, covering around 2% of the world population. The precise nature of the law differs, from Oregon where the Death with Dignity Act allows the supply of lethal drugs to patients with a six-month prognosis (but not euthanasia - ie the injection of such drugs by a doctor), to Belgium where euthanasia is available to people with unbearable and unrelievable mental or physical suffering, regardless of predicted life expectancy.

Understanding the safety of existing laws is complex. Oregon is often given as an example where there is no evidence of abuse. However, the only data on safety in Oregon comes from a form filled out by the doctor who wrote the lethal prescription, and there is no data on people whose request for assisted dying was declined, meaning conclusions about safety are hard to draw. In Belgium it is estimated that half of assisted deaths are unreported.

There are concerns about rising death rates – the number of assisted dying deaths in Oregon has risen 15-fold since legalisation and the (still rising) death rate there is the equivalent of nearly 4,000 such deaths in Britain. In The Netherlands 1 in every 24 deaths is now the result of legalised euthanasia.

There are also important considerations around doctors' refusals to consider requests, which may lead to the practice of 'doctor shopping'.

It is notable that in almost every nation that has legalised assisted dying/suicide, eligibility has expanded over time. In Canada, following the 2016 Medical Aid in Dying Bill, those with mental illness will become eligible in 2023.

Why is this relevant to palliative medicine trainees?

If Baroness Meacher's prediction is correct and assisted dying becomes legal within eighteen months, there will be profound implications for our clinical practice. Therefore, whatever your views on legalisation, as experts in care for people with life-limiting illness, you can make important and valuable contributions to the debate.

Arguments in favour of assisted dying are relatively simple to make, drawing on autonomy and examples of 'bad' deaths. Arguments against assisted dying are harder; not because they are weaker but because they are more complex and require us to look beyond autonomy towards society. As we face once again the prospect of legalisation of assisted dying, it is essential that the public debate highlights not only the former but also allows scrutiny of the latter.

Assisted dying has been described as one of the great moral questions of our time. Please do not underestimate your expertise and potential to contribute to this complex societal conversation. As the next generation of palliative care leaders, it is important that your voices are heard.

Further reading / listening:

[APPG Dying Well website All Party parliamentary Group](#), website has useful opinion pieces and a template for writing to your MP

[Living and Dying Well website](#) has useful articles, podcasts, and analyses of data

[My Death My Decision website](#) - this is a pro-assisted dying campaigning group who believe that assisted dying should be available to all, not just people with a 6 month prognosis

[The Economist podcast](#) – this is an interesting and balanced podcast / debate from 2015 that airs some less commonly considered perspectives

[Series of articles in The Economist 2018](#) on assisted dying (for and against)

Book: Death by Appointment by Ilora Finlay and Robert Preston. This succinct book covers UK law, medical practice, models of assisted dying, safety and society, and is recommended for those interested in the arguments against.

Trainee Committee Update

Committee Update – Spring

Our team attended the APM Research and Ethics committee meeting, BMA meeting and APMT committee meeting this quarter.

Upcoming meetings include SAC meeting, Regional Representatives APMT meeting and APMT update at the APM Executive meeting.

Shielding trainees facebook group to become APMT Keeping in touch OOP Trainees facebook group

The shielding trainees facebook group will be changed to a group for OOP palliative medicine trainees to keep in touch with events and other trainees. It will aim to be a forum of informal peer support whilst trainees are OOP including those on OOPEs, parental leave, sick leave and academic programmes.

APMT Facebook Group

If you are a new ST3 trainee or not yet in our Facebook group please do join to share educational events, discuss topics and for latest APMT news.

Wellbeing Resource List

Our website has been updated throughout this year. You'll find links to the curriculum including the Covid amended curriculum. Our recent addition is our Wellbeing Resource List compiled by our SAC team.

<https://apmonline.org/trainees-committee/>

New Committee Members

We are pleased to welcome two new members to our committee - Lizzie Woods joins us as the Education and training representative and Daniel Soutar as the Communications representative.

We thank our outgoing Education representative Felicity for all her support and great work with the APMT, thank you!

Meet the Committee

Hello! My name is Isobel, and I am an Internal Medicine Trainee (IMT) currently working in the North East London region. I am the Careers and Mentorship Co-coordinator of the APM Junior Committee and as part of my role I liaise between the Junior and Trainee committee. Over the next few months I hope to work with both committees to establish a mentorship program to try and help support those interested in the specialty- please get in contact if you would like to get involved!



Palliative Care Formulary Access

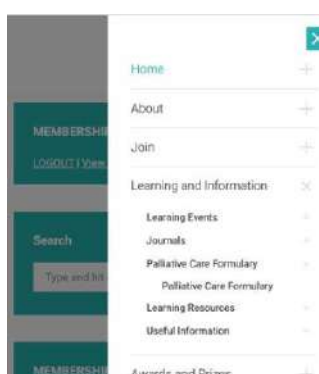
New to 2020, eligible APM members i.e. full members (including reduced subscription) now have access to Palliative Care Formulary Online through MedicinesComplete. Access is via the APM website by logging in and accessing PCF through the learning tab.



1. Login on to the APM website apmonline.org



2. From the list icon (top right corner) select 'Palliative Care Formulary'



COVID-19 Guidance

The APM has issued guidance regarding COVID-19 and Palliative, End of Life and Bereavement Care. The latest guidance can be found on the website: <https://apmonline.org/>



If there is anything else that you have found useful in preparing for the SCE, or for CPD in general, then please contact us and we will endeavour to add this to the next News Update.

Contact the APM Trainees' Committee

We're here to support trainees and our development.

Contact us:

- Via your regional APM Trainees' Representative
- Email us directly via apmtraineescommittee@gmail.com
- On our Facebook page 'APM Trainees'
- On Twitter @apm_trainees



The APM is the world's largest representative body for doctors practicing or interested in palliative medicine.

If you are not already a member join today! <https://apmonline.org/join-pages/join/>

Please remember to upgrade your membership to 'full membership' on commencement of your first consultant post. This can be done by emailing the APM at office@compleat-online.co.uk

This newsletter is for trainees by trainees. We want to hear from you, allow trainees to connect nationally and have a platform to feature your contributions in the upcoming newsletters.

Please contact us at apmtraineescommittee@gmail.com to contribute with a feature article, journal summaries or trainee reflections.

Research and Journals

Journals

The following journals can be accessed via your login through the APM website:

- Palliative Medicine Journal
- BMJ Supportive & Palliative Care Journal
- EAPC Journal (at a reduced subscription rate)

Publications may also be available through the BMA website, for those with membership. A list of these can be found at: <https://www.bma.org.uk/library/e-resources/e-journals>.

Article of the month:

The Experience of delirium in palliative care settings for patients, family, clinicians and volunteers: A qualitative systematic review and thematic synthesis

Featherstone, I et al Volume 35 Issue 6 Pages 988-1004 March 2021 Palliative Medicine

<https://doi.org/10.1177/02692163211006313>

Delirium is common in palliative care settings and can be very distressing for patients, relatives and clinicians. This paper synthesizes the evidence base of the qualitative evidence of the experiences of palliative care patients, their families, clinicians and volunteers of delirium in palliative care settings with a view to informing clinical practice and the development of interventions to prevent and manage delirium.

They found 16 studies that were relevant to their research question with provenance from all over the world including Australia, Canada, UK, USA Japan, Israel and New Zealand. These studies were based in hospice inpatient units, hospital inpatients, and community settings. Themes that were identified included interpretations of delirium and their influence on care, palliative care clinicians' responses to the suffering of patients with delirium and the role of family in care.

The authors found that there was a limited understanding of delirium as a medical condition, that delirium was seen as a normal part of dying. Patients suffering from delirium experienced a great deal of suffering. Clinicians responded to delirium either via a patient centred approach or by using medication to control symptoms.

The family was found to be very distressed by patients suffering from delirium, but that they also played a vital role in caregiving. The importance of caring for the family of patients with delirium was stressed.

Responding to these findings the reviewers concluded that opportunities should be taken to increase palliative care nursing staff recognition of delirium as a medical condition and understanding of its prevention and management. There should be an increased emphasis on preventing delirium and recognizing it early. A patient centred approach should be taken to deal with delirium. Staff may need support to be able to increase use of non-pharmacological approaches to care. Families play a vital role in identifying and caring for patients with delirium and they also should be supported. Further research is needed on delirium interventions, and delirium prevention in palliative care, as well as patient perspectives of delirium.

This article therefore gives us a better understanding of different perspectives on delirium and has highlighted some areas where care should be focused and improved, as well as some important targets for future research. This should encourage us as clinicians to ensure that we are seizing reflective learning opportunities from our day to day work and has highlighted the need for emotional support for staff.