ROYAL
COLLEGE OF
PHYSICIANS
OF IRELAND

Assisted Suicide

Supplementary key updates & literature review for RCPI Position Paper on Assisted Suicide (2017) relating to Assisted Suicide and Euthanasia 2017-2020

October 2020

Key updates to 2017 RCPI position paper on physician assisted suicide and euthanasia (PAS-E) since 2017

1. Section 1, Background, and Section 8, Issues and concerns

Since the report in 2017: the state of Victoria in Australia has introduced PAS in 2019; New Zealand is putting PAS-E to a popular referendum on 17 October 2020 in conjunction with the 2020 general election and a cannabis referendum. The referendum will be on the question of whether PAS-E legislation passed by the New Zealand parliament in 2019 should come into force.

2. Section 5, Position of professional bodies

RCP London clarified that it does not support a change in the law to permit assisted dying at the present time.

The RCP noted the following points as relevant to a survey of its membership and its position:

- The RCP has an important role in informing the societal debate on this issue, and is keen to do so;
- Whilst the ultimate decision on assisted dying rests with society through Parliament, professional and clinical issues pose significant challenges to the success of any future legislation;
- There remain many shortcomings in the provision of palliative care, and physicians of all shades of opinion in the current debate share a commitment to the improvement of care at the end of life;
- There is a plurality of views within the RCP membership on the issue of assisted dying;
- Whilst a significant minority of its fellows and members support a change in the law, a greater number remain opposed;
- The majority of doctors would be unwilling to participate actively in assisted dying if the law were changed to permit it, with only 25% indicating a willingness to do so.

https://www.rcplondon.ac.uk/news/rcp-clarifies-its-position-assisted-dying

3. Section 6, International legislation

The UK supreme court dismissed an emergency application to hear a right-to-die case challenging the legal ban on assisted dying in Nov 2018.

Updated literature review for 2017 RCPI Position paper on PAS-E since 2017

Background

In 2017, following extensive consultation with Fellows of the College, the Council of RCPI (which included lay representation) adopted a Position Paper on Assisted Suicide. In the light of a Private Member's Bill introduced to the Oireachtas in September 2020, Council reaffirmed that the 2017 Position Paper represented the RCPI position on assisted suicide, confirmed the Chair of the Working Group – Dr Feargal Twomey, Consultant Physician in Palliative Medicine – as RCPI spokesperson on the College's position, and requested that the Working Group that prepared the original paper would undertake a literature review of Physician-Assisted Suicide and Euthanasia (PAS-E) of the time period which had elapsed since the 2017 Position Paper.

Process

A MedLine search was undertaken using the MeSH terms ((("Euthanasia/classification"[Mesh] OR "Euthanasia/economics"[Mesh] OR "Euthanasia/ethics"[Mesh] OR "Euthanasia/history"[Mesh] OR "Euthanasia/legislation and jurisprudence"[Mesh] OR "Euthanasia/methods"[Mesh] OR "Euthanasia/organization and administration"[Mesh] OR "Euthanasia/psychology"[Mesh] OR "Euthanasia/standards"[Mesh] OR "Euthanasia/statistics and numerical data"[Mesh] OR "Euthanasia/trends"[Mesh])) OR "Euthanasia, Involuntary"[Mesh]) OR "Suicide, Assisted"[Mesh] for the time period 1 Jan 2017 to 20 Sept 2020.

The 465 papers were reviewed by the Working Group, and the following discussion points arose.

A) Expansion of groups included in PAS-E

The process of extension of PAS-E to age groups and conditions is noted, with extension to:

- *Newborn infants*: newborn infants in the Netherlands four years after the introduction of Assisted Suicide/Euthanasia (Tedesco, 2017),

- *Children*: over the age of 12 in the Netherlands and any age in Belgium (Cohen-Almagor, 2018),
- *Psychiatric patients*: euthanasia of patients with psychiatric illness with an increase in the estimated number of requests from 320 in 1995 to 500 in 2008 and then to 1,100 in 2016 in the Netherlands (Denys, 2018) and Belgium (Verhofstadt, Van Assche, Sterckx, Audenaert, & Chambaere, 2019). This creates enormous ethical dissonance with the ethos and practice of suicide prevention (Kious & Battin, 2019).
- *Intellectual disability and/or autism spectrum disorder*: There was a lack of detail on social circumstances and how patients were informed about their prognosis: capacity tests in these cases did not appear sufficiently stringent (Tuffrey-Wijne, Curfs, Finlay, & Hollins, 2018).
- *Tired of living*: The Dutch government intends to create a separate legal framework for PAS-E for those who are "tired of living" (Florijn, 2018).
- *Chronic disease*: Ongoing court challenges in Canada to legislative requirements for PAS-E have resulted in its approval for individuals with chronic illnesses such as osteoarthritis, dementia, and physical disability (Herx, Cottle, & Scott, 2020).
- *Advance directives for dementia*: The inclusion of requests for euthanasia in advance directives for dementia in the Netherlands has been of concern in terms of over-riding patients' right to change their mind characterized in a particularly troubling case (Miller, Dresser, & Kim, 2019) where a woman was euthanized after indicating that she did not want to be euthanized, and was sedated covertly and physically restrained for the euthanasia to be carried out.

B) Jurisdictions

Since 2017, PAS-E has been introduced to the state of Victoria in Australia: individuals whose life expectancy is 6 months or less can seek assisted PAS-E. Patients with certain progressive neurodegenerative conditions, such as multiple sclerosis or motor neuron disease, can apply within 1 year of their expected death. People with conditions that might hinder their decision-making capacity, such as advanced Alzheimer's disease, are excluded, as are people who have a mental illness or disability, without a terminal illness: healthcare practitioners

must not initiate or suggest discussion of assisted suicide/euthanasia to patients (Kirby, 2020).

Germany's supreme court in 2020 lifted a law which outlawed the provision of assisted-suicide services. These services could range from signing a prescription for a lethal overdose of sedatives, to providing consultation to terminally ill patients on how they could travel outside of Germany to end their lives legally (Hyde, 2020).

C) Economic case for PAS-E

A Canadian study estimated that PAS-E could reduce annual health care spending across Canada by between $34.7 million and $138.8 million, exceeding the $1.5-$14.8 million in direct costs associated with its implementation. (Trachtenberg & Manns, 2017)

D) Overview and regulation

Concerns have been raised about the overview process in the Netherlands: in substantive criteria cases, the focus regional ethics overview was procedural. The cases were more about unorthodox, unprofessional or overconfident physician behaviours and not whether patients should have received Assisted Suicide/Euthanasia (Miller & Kim, 2017).

E) The phenomenology of PAS-E

Data from the Dutch protocols, and other similar methods used elsewhere, suggest that after oral drug sedative ingestion, patients usually lose consciousness within 5 min. However, death takes considerably longer. Although cardiopulmonary collapse occurs within 90 min in two-thirds of cases, in a third of cases death can take up to 30 h. Other complications include difficulty in swallowing the prescribed dose (in up to 9%) and vomiting thereafter (in up to 10%), both of which prevent suitable dosing, and re-emergence from coma (in up to 2%). Each of these potentially constitutes a failure to achieve unconsciousness, with its own psychological consequences, and it would seem important explicitly to acknowledge this in suitable consent processes. Complications are still reported: difficulties with intravenous access which preclude proceeding (3%); prolonged time to death (up to 7 days from drug administration in up to 4%); and failure to induce coma (with patients re-awakening, even sitting up, in up to 1.3%), and are more common in those who are not frail. The incidence of 'failure of unconsciousness' is approximately 190 times higher when it is intended that the patient is unconscious at the time of death as when it is

intended they later awaken and recover after surgery (when accidental awareness is approximately 1:19,000) (Sinmyee et al., 2019).

Nurse practitioners can assess and implement assisted PAS-E in Canada (Schiller, Pesut, Roussel, & Greig, 2019).

F) Relationship to palliative care

It has been noted that while PAS-E was determined as a right in Canada, no similar right was determined for access to palliative care, and less than 30% of Canadians have access to any form of palliative care and less than 15% have access to specialized palliative care (Herx et al., 2020). A Quebec study found that in patients requesting euthanasia, 32% of those who received a palliative care consultation had it requested less than seven days before euthanasia provision and another 25% of palliative care consults were requested the day of or the day after the euthanasia request (Seller, Bouthillier, & Fraser, 2019).

The use of the euphemistic terminology of Medical Assistance in Dying (MAID) to refer to PAS-E in Canada is considered by palliative care physicians to have exacerbated this confusion in both the public and health care spheres. Canadian palliative care organizations have argued against the use of such language, affirming that palliative care provides support or “assistance» in dying to help people live as fully as possible until their natural death, but does not intentionally hasten death (Canadian Hospice Palliative Care Association and the Canadian Society of Palliative Care Physicians, 2019). This assertion is also supported by the longstanding World Health Organization definition of palliative care.

Fear of being a burden to others is a real concern in terms of seeking assisted suicide/euthanasia and should be addressed by relieving it through positive pro-active palliative measures to address and remedy this fear (Braswell, 2019).

Hospices that do not engage with assisted suicide/euthanasia are being defunded in Canada (Levia, Cottle, & Ferrier, 2018).

The number of registrars entering palliative care in Quebec dropped after MAID legalisation (Levia et al., 2018).

G) Organ donation and PAS-E

Organ donation in in the context of PAS-E raises ethical issues regarding respect for autonomy, societal pressure, conscientious objections and the dead-donor rule (Allard &

Fortin, 2017). A number of proposals have been made suggesting reversing the accepted principle of organ donation after death to 'death by donation' (Ball, Sibbald, & Truog, 2018) (J. A. M. Bollen et al., 2019). Belgian physicians have noted that an estimated maximum of 10.1% of all patients undergoing euthanasia could potentially donate at least 1 organ, and that if even if only a small percentage of the patients undergoing euthanasia donated an organ, donation after euthanasia could potentially help reduce the waitlists for organ donation (J. Bollen et al., 2017).

H) Challenges in ethics

Schiller and colleagues note that a legislated approach to assisted death has proven challenging in a number of areas. Although it facilitates a degree of accountability, precision and accessibility, it has also resulted in particular challenges negotiating the diverse perspectives of such a morally contentious act. One of these challenges is the tendency to conflate what is legal and what is moral in a modern liberal constitutionalism that places supreme value on autonomy and choice. Such a conflation tends to render invisible the legal and moral/ethical considerations necessary for nurses and nurse practitioners to remain ethical actors (Schiller et al., 2019).

Conscientious objection has been circumscribed under threat of sanction by the College of Physicians and Surgeons in Ontario (Carpenter & Vivas, 2020): Physicians who decline to do this could face disciplinary action such as the loss of the license to practice medicine: The Ontario courts have agreed that the requirement for referral violates the conscience/religious rights of physicians (which are protected under the Canadian Charter of Rights and Freedoms) but justifies the referral requirement to "ensure access" to euthanasia for patients, despite no documented lack of access in Ontario (Herx et al., 2020).

Vulnerability and persons with disabilities in relation to PAS-E: This commentary draws on both the literature and on case examples from Canada. Specifically, it considers the issue of assisted suicide/euthanasia as an alternative to, or substituted for, appropriate disability supports. Secondly, it considers the issue of the devaluation of disabled lives in general and within health care practice and ethics. It concludes that current safeguards are inadequate and that as PAS-E regimes become more permissive the risk to disabled persons will increase (Stainton, 2019).

A useful paper emphasizes the importance of reasoning over empirical research in ethical issues and highlights the underlying reason for positive publication bias for PAS-E in the medical literature (Sulmasy, 2019).

A Dutch paper notes how that the concept of autonomy 'as a right,' which can be distinguished from autonomy 'as an ideal,' narrows the physician's window of opportunity to offer end-of-life care other than euthanasia (Kouwenhoven, van Thiel, van der Heide, Rietjens, & van Delden, 2019).

I) Public perceptions

The paradox of individuals wanting to have control whilst preferring not to know that they are dying. (Sanderson, Miller-Lewis, Rawlings, Parker, & Tieman, 2019)

J) Global perspective

A helpful summary from a global perspective arises from a multi-disciplinary grouping from four continents (Sprung et al., 2018): Medical professional societies have traditionally opposed physician-assisted suicide and euthanasia (PAS-E), but this opposition may be shifting. They present 5 reasons why physicians shouldn't be involved in PAS-E. 1. Slippery slopes: There is evidence that safeguards in the Netherlands and Belgium are ineffective and violated, including administering lethal drugs without patient consent, absence of terminal illness, untreated psychiatric diagnoses, and nonreporting; 2. Lack of self-determination: Psychological and social motives characterize requests for PAS-E more than physical symptoms or rational choices; many requests disappear with improved symptom control and psychological support; 3. Inadequate palliative care: Better palliative care makes most patients physically comfortable. Many individuals requesting PAS-E don't want to die but to escape their suffering. Adequate treatment for depression and pain decreases the desire for death; 4. Medical professionalism: PAS-E transgresses the inviolable rule that physicians heal and palliate suffering but never intentionally inflict death; 5. Differences between means and ends: Pro-euthanasia advocates look to the ends (the patient's death) and say the ends justify the means; opponents disagree and believe that killing patients to relieve suffering is different from allowing natural death and is not acceptable. Physicians have a duty to eliminate pain and suffering, not the person with the pain and suffering. Solutions for suffering lie in improving palliative care and social conditions and addressing the reasons for PAS-E requests. They should not include changing medical practice to allow PAS-E.

K) Impact on physicians and medicine

An overview of the impact on physicians ends with this analysis – *'The request for PAS-E may represent a complex dynamic within the patient, their family and his/her social structures. It also has complex ramifications for the physician and the wider medical community. Our aim should be to elicit the underlying causes driving any request and undertake the necessary steps to address them. This requires clinicians to discuss patient concerns, particularly the dimensions of psychological distress at the end of life including existential dilemmas and anxieties. A prime driver for PAS-E requests is the effort to exert control. The reality is we are not in control of all our circumstances during life; why pretend this is so in death? In the same way physical pain is a signal to the body to pay attention to something, the psychic pain of existential distress is a prompt to the individual to face transcendent eternal questions: What did it all mean? What I am leaving behind? Is there anything more? We do a greater service to our patients by helping them tackle these important questions rather than ignore them. Considering the real (and potential) adverse effects of PAS-E on families, physicians and the palliative and healthcare systems, our vocation rather should stimulate us to have the time and courage to open these potentially difficult and challenging conversations.'*

Working Group Summary

A review of the literature of PAS-E from 2017-2020 strengthens the reservations and concerns expressed in the Position Paper adopted by RCPI Council in 2017 and supports the position of emphasising positive and therapeutic approaches to worries and concerns of patients and the public, and guidance away from approaches and measures that promote Physician Assisted Suicide and Euthanasia.

References

Allard, J., & Fortin, M. C. (2017). Organ donation after medical assistance in dying or cessation of life-sustaining treatment requested by conscious patients: the Canadian context. J Med Ethics, 43(9), 601-605. doi: 10.1136/medethics-2016-103460

Ball, I. M., Sibbald, R., & Truog, R. D. (2018). Voluntary Euthanasia - Implications for Organ Donation. N Engl J Med, 379(10), 909-911. doi: 10.1056/NEJMp1804276

Bollen, J., van Smaalen, T., Ten Hoopen, R., van Heurn, E., Ysebaert, D., & van Mook, W. (2017). Potential Number of Organ Donors After Euthanasia in Belgium. Jama, 317(14), 1476-1477. doi: 10.1001/jama.2017.0729

Bollen, J. A. M., Shaw, D., de Wert, G., Ten Hoopen, R., Ysebaert, D., van Heurn, E., & van Mook, W. (2019). Euthanasia through living organ donation: Ethical, legal, and medical challenges. J Heart Lung Transplant, 38(2), 111-113. doi: 10.1016/j.healun.2018.07.014

Braswell, H. (2019). US Hospice Structure and its Implications for the "Right to Die" Debate : An Interdisciplinary Study of the "Feeling of Being a Burden to Others". J Bioeth Inq, 16(4), 525-534. doi: 10.1007/s11673-019-09938-w

Canadian Hospice Palliative Care Association and the Canadian Society of Palliative Care Physicians. (2019). CHPCA and CSPCP - Joint Call to Action. Ontario: Canadian Hospice Palliative Care Association and the Canadian Society of Palliative Care Physicians.

Carpenter, T., & Vivas, L. (2020). Ethical arguments against coercing provider participation in MAiD (medical assistance in dying) in Ontario, Canada. BMC Med Ethics, 21(1), 46. doi: 10.1186/s12910-020-00486-2

Cohen-Almagor, R. (2018). Should the Euthanasia Act in Belgium Include Minors? Perspect Biol Med, 61(2), 230-248. doi: 10.1353/pbm.2018.0039

Denys, D. (2018). Is Euthanasia Psychiatric Treatment? The Struggle With Death on Request in the Netherlands. Am J Psychiatry, 175(9), 822-823. doi: 10.1176/appi.ajp.2018.18060725

Florijn, B. W. (2018). Extending' euthanasia to those 'tired of living' in the Netherlands could jeopardize a well-functioning practice of physicians' assessment of a patient's request for death. Health Policy, 122(3), 315-319. doi: 10.1016/j.healthpol.2018.01.007

Herx, L., Cottle, M., & Scott, J. (2020). The “Normalization” of Euthanasia in Canada: the Cautionary Tale Continues. World Medical Journal, 66(2), 28-37.

Hyde, R. (2020). Germany overturns ban on assisted suicide. Lancet, 395(10226), 774. doi: 10.1016/s0140-6736(20)30533-x

Kious, B. M., & Battin, M. P. (2019). Physician Aid-in-Dying and Suicide Prevention in Psychiatry: A Moral Crisis? Am J Bioeth, 19(10), 29-39. doi: 10.1080/15265161.2019.1653397

Kirby, T. (2020). Gag clause prevents discussion of assisted dying in Victoria, Australia. Lancet Respir Med, 8(4), 341-342. doi: 10.1016/s2213-2600(20)30108-9

Kouwenhoven, P. S. C., van Thiel, G., van der Heide, A., Rietjens, J. A. C., & van Delden, J. J. M. (2019). Developments in euthanasia practice in the Netherlands: Balancing professional responsibility and the patient's autonomy. Eur J Gen Pract, 25(1), 44-48. doi: 10.1080/13814788.2018.1517154

Levia, R., Cottle, M., & Ferrier, C. (2018). Euthanasia in Canada: a cautionary tale. World Med J, 64(3), 17-23.

Miller, D. G., Dresser, R., & Kim, S. Y. H. (2019). Advance euthanasia directives: a controversial case and its ethical implications. J Med Ethics, 45(2), 84-89. doi: 10.1136/medethics-2017-104644

Miller, D. G., & Kim, S. Y. H. (2017). Euthanasia and physician-assisted suicide not meeting due care criteria in the Netherlands: a qualitative review of review committee judgements. BMJ Open, 7(10), e017628. doi: 10.1136/bmjopen-2017-017628

Sanderson, C., Miller-Lewis, L., Rawlings, D., Parker, D., & Tieman, J. (2019). "I want to die in my sleep"-how people think about death, choice, and control: findings from a Massive Open Online Course. Ann Palliat Med, 8(4), 411-419. doi: 10.21037/apm.2019.03.07

Schiller, C. J., Pesut, B., Roussel, J., & Greig, M. (2019). But it's legal, isn't it? Law and ethics in nursing practice related to medical assistance in dying. Nurs Philos, 20(4), e12277. doi: 10.1111/nup.12277

Seller, L., Bouthillier, M., & Fraser, V. (2019). Situating requests for medical aid in dying within the broader context of end-of-life care: ethical considerations. J Med Ethics, 45(2), 106-111. doi: 10.1136/medethics-2018-104982

Sinmyee, S., Pandit, V. J., Pascual, J. M., Dahan, A., Heidegger, T., Kreienbühl, G., . . . Pandit, J. J. (2019). Legal and ethical implications of defining an optimum means of achieving unconsciousness in assisted dying. Anaesthesia, 74(5), 630-637. doi: 10.1111/anae.14532

Sprung, C. L., Somerville, M. A., Radbruch, L., Collet, N. S., Duttge, G., Piva, J. P., . . . Ely, E. W. (2018). Physician-Assisted Suicide and Euthanasia: Emerging Issues From a Global Perspective. J Palliat Care, 33(4), 197-203. doi: 10.1177/0825859718777325

Stainton, T. (2019). Disability, vulnerability and assisted death: commentary on Tuffrey-Wijne, Curfs, Finlay and Hollins. BMC Med Ethics, 20(1), 89. doi: 10.1186/s12910-019-0426-2

Sulmasy, D. P. (2019). Physician-Assisted Suicide and the Perils of Empirical Ethical Research. JAMA Netw Open, 2(8), e198628. doi: 10.1001/jamanetworkopen.2019.8628

Tedesco, M. (2017). Dutch Protocols for Deliberately Ending the Life of Newborns: A Defence. J Bioeth Inq, 14(2), 251-259. doi: 10.1007/s11673-017-9772-2

Trachtenberg, A. J., & Manns, B. (2017). Cost analysis of medical assistance in dying in Canada. Cmaj, 189(3), E101-e105. doi: 10.1503/cmaj.160650

Tuffrey-Wijne, I., Curfs, L., Finlay, I., & Hollins, S. (2018). Euthanasia and assisted suicide for people with an intellectual disability and/or autism spectrum disorder: an examination of nine relevant euthanasia cases in the Netherlands (2012-2016). BMC Med Ethics, 19(1), 17. doi: 10.1186/s12910-018-0257-6

Verhofstadt, M., Van Assche, K., Sterckx, S., Audenaert, K., & Chambaere, K. (2019). Psychiatric patients requesting euthanasia: Guidelines for sound clinical and ethical decision making. Int J Law Psychiatry, 64, 150-161. doi: 10.1016/j.ijlp.2019.04.004

Appendix 1 - Membership of Working Group

- Dr Feargal Twomey, Consultant in Palliative Medicine, Milford Hospice & UL Hospitals, University Hospital Limerick.
- Dr Shaun O'Keefe, Consultant in Geriatric Medicine at Merlin Park Hospital Galway.
- Dr Regina McQuillan, Medical Director of St Francis Hospice and Consultant in Palliative Medicine at St Francis Hospice and Beaumont Hospital
- Dr Siobhan MacHale, Consultant Liaison Psychiatrist, Dept of Psychiatry, Beaumont Hospital & Senior Lecturer RCSI
- Dr Raymond Carson, Consultant in Rehabilitation Medicine at the Mater Misericordiae University Hospital / Clinical Lecturer at University College Dublin
- Prof Des O'Neill, Consultant in Geriatric Medicine, Tallaght University Hospital
- Prof Michael Keane, Consultant Respiratory Physician, St Vincent's University Hospital
- Dr Diarmuid O'Shea, Consultant in Geriatric Medicine, St Vincent's University Hospital