Association of Hospice and Palliative Care Chaplains (2003) Statement on Assisted Dying

The Association recently held its annual conference at which the delegates debated the Patient (assisted dying) Bill which is to be presented in the House of Lords on June 6th, 2003. The delegates agreed the following statement:

The Patient (assisted dying) Bill, which is to be presented in the House of Lords on June 6th, appears to be an attempt to address the experience of patients living with pain and distress. As chaplains working in hospices and palliative care units we have much experience of patients and families living with very real and genuine pain and distress. As members of the multi-professional team we know that many staff also experience pain and distress in caring for patients and their families.

We are unable to support this Bill because:

* Whilst we acknowledge that the Bill is based on the experience of patients it is based on the experience of a limited number of patients. A number of patients are greatly helped in their pain by the provision of holistic palliative care, which can so often enable people to re-evaluate their feelings and give hope for the life that they are still able to live.
* Many patients living with an irremediable condition feel extremely vulnerable because they are facing death and can feel they have little or no control over what happens to them. We feel that this sense of vulnerability could lead to patients making ill-informed decisions under a perceived pressure to relieve the stress of those close to them, and not to be a burden to the team of health care workers looking after them.
* The criteria and words used in the Bill are too subjective and will lead to a variety of interpretation that will be impossible to check and verify. Given that the intensity of pain and unbearable suffering depends upon the patient self-reporting the way could be open for assisted death on demand.
* It is unacceptable that physicians or any profession should be given the power to assist anyone to actively end their life. This would be an unacceptable change of role for those working as health care providers.
* We believe that patients who consider they are experiencing unbearable suffering should experience holistic palliative care in order to give them the best quality of care that can be given to them and their families and those close to them.
* If some physicians in hospices and hospitals were legally able to assist patients in dying it would fundamentally change the purpose of both institutions.

The Patient (assisted dying) Bill raises for us the following issues:

* The Bill states that patients, following a process outlined in the Bill, will be able to request the assistance of a physician in order to die (Clause 1:1). However, many patients living with an irremediable condition will have been cared for – not just by a physician – but by a multi-professional team within a hospice or hospital unit. The knowledge that the physician and other members of the team (Clause 9:2) may assist a patient to die could compromise their relationship with the rest of the team who do not agree that a patient should be assisted to die. The relationship of the team with other patients could also be compromised, as patients could be anxious or confused as to the nature of care being offered. Patients and families frequently talk with each other about their illness and the care they are receiving.
* A number of words and phrases within the Bill are open to subjective interpretation such as ‘suffering unbearably.’ (Clause 2:2, d) and ‘terminal illness’. The interpretation of ‘suffering unbearably’ could vary from physician to physician and case to case. Patients may suffer unbearably in ways other than physical pain. The term ‘terminal illness’ is used in the Bill for when a physician has given a prognosis of death within six months. We know that so often such time scales prove to be wrong and more physicians seem reluctant to give them.
* Physicians may not be the appropriate people to make decisions on the criteria of suffering unbearably. It is our experience that patients, due to a number of factors, can frequently change their views as to how they feel; this can happen on a daily basis or even hour by hour.
* Physical pain is implied as a major criterion (Clause 2:2, d) contributing to a patient qualifying to request assistance to die. However, patients can experience emotional, social and spiritual pain. As the concept of pain is open to interpretation, this criterion could change.
* Active employment of physical pain control and palliative care is only mentioned as an alternative (Clause 2:2, e, iv) or that patients are “entitled to request…such medication” (Clause 14). Patients should be strongly encouraged to experience the range of pain control and palliative care available to them and which should not be seen as alternative care, or something a patient has to request.
* The process set out in the Bill in order for a patient to qualify for assistance in dying has several stages: ensuring that a patient has made an informed decision, alternatives have been discussed and the patient’s wishes to revoke their decision. This will be a lengthy process that physicians may feel they do not have adequate time to fully resource.
* The period of time from a patient becoming a ‘qualifying’ patient to the physician assisting the patient to die is not stated (Clause 4).
* The patient is advised to inform their next of kin if they have taken a decision to be assisted in their death (Clause 8). Next of kin and families could experience many strong emotions when they know that such a decision has been taken. The family could need support from the multi-professional team. This would require a team who supported assisting patients in dying and who will have time to spend with families and friends.

We would wish the following to be considered:

* Physicians who are prepared to assist patients to die could find that the relationship of trust that they have developed with both patients and other professionals may be compromised due to the power that they could be seen to have in assisting a patient to choose to die.
* A patient who considers that they are a burden to their family may feel under pressure to request assistance in dying.
* When a patient has taken a decision to request assistance in dying they may find it difficult to revoke the decision for a variety of reasons.
* The decision of what is and what is not unbearable suffering is too complex for any professional to judge. The Bill does not sufficiently address how this is to be interpreted.
* There is no acknowledgement as to the impact on family and friends, and the effects on other staff and units as a whole.