ROYAL PHARMACEUTICAL SOCIETY

Policy statement

ASSISTED SUICIDE

The Royal Pharmaceutical Society (RPS) is the new professional body for every pharmacist in Great Britain. We are the only body that represents all sectors of pharmacy in Great Britain.

The RPS leads and supports the development of the pharmacy profession within the context of the public benefit. This includes the advancement of science, practice, education and knowledge in pharmacy. In addition, it promotes the profession's policies and views to a range of external stakeholders in a number of different forums.

Its functions and services include:

- Leadership, representation and advocacy: promoting the status of the pharmacy profession and ensuring that pharmacy's voice is heard by governments, the media and the public.
- Professional development, education and support: helping pharmacists to advance their careers through professional advancement, career advice and guidance on good practice.
- Professional networking and publications: creating a series of communication channels to enable pharmacists to discuss areas of common interest.

BACKGROUND AND POLICY CONTEXT

In The Netherlands, assisted suicide and voluntary euthanasia have been legal since 2002.[1,2]. In the state of Oregon USA, the Death with Dignity Act was passed in 1997, legalising assisted suicide; Washington state followed in 2009. Euthanasia has been legal in Belgium since 2002[3]. In Switzerland assisted suicide is legal and over the last 10 years 160 Britons have travelled to the headquarters of Dignitas near Zurich to end their lives, while hundreds more have joined the organisation but will never take up their assisted suicide option as the knowledge that they may do so at some point is enough for them to continue their lives and explore other options.[1]

In recent years there have been several debates and attempts to change the legal position of assisted suicide in both the Westminster and Holyrood Parliaments. Most recently, the Commission for Assisted Dying, chaired by Lord Charles Falconer, reported to the Westminster Parliament in January 2012 and a draft bill and consultation have now been published by the All Party Parliamentary Group (APPG) on Choice at the End of Life[6]. In Scotland, Margo MacDonald MSP consulted on her proposed bill which will be placed before the Scottish Parliament[5]

The RPS therefore considered it timely to address this issue and the three National Pharmacy Boards, comprised of elected members from Scotland, England and Wales have been involved in preparing this policy statement. If legislation was passed in any of the GB countries every pharmacist would need to make a personal decision on whether or not they would wish to be involved in providing or supporting such a service.

The Royal Pharmaceutical Society (RPS) is the professional body representing pharmacists in all sectors of the pharmacy profession. As such there is a wide spectrum of members' views to be considered and respected. It is therefore important for the RPS to maintain a neutral position and we will therefore neither support nor oppose any proposals for changes in the governing legislation.

POLICY OBJECTIVES

This policy outlines our approach to the issues and challenges which the pharmacy profession would be presented with should assisted suicide be legalised. It respects the views of individual pharmacists by providing a suitable framework for those who wish to be involved, to work in partnership with their medical colleagues, whilst providing reassurance for those pharmacists opposed to assisted suicide. The suggested framework outlined below demonstrates that the views, expressed by those for and against the concept, have been acknowledged and considered in developing our position. The framework takes account of the issues that need to be addressed before

a prescription to end a person's life can be dispensed and seeks to ensure that patient access to the facility is not compromised by inadequate signposting or service provision.

This document is a policy statement and is not intended as practice guidance. It is not meant to be definitive or overly prescriptive as the finer details of practice and procedure will still need to be developed depending on the exact nature of any new legislation. Fuller debate will also be required to accommodate patients' needs in a variety of settings across all of the home countries.

The document seeks to provide information and a clear steer on the requirements of the pharmacy profession, to government policymakers, other professional bodies, health and social care colleagues, patients, the public and other key stakeholders in order to support pharmacist engagement.
If legislation is passed, pharmacists will have a key role in developing suitable protocols and guidance for prescribers. Policy makers need to recognise and be aware that the role of pharmacists goes far beyond supply of the required medication.

RPS will work closely with policy makers and legislators to ensure that any legislation and subsequent regulations give careful consideration to the principles outlined in this framework to ensure that the first considerations of patients are respected at all times; that pharmacists, sympathetic to any changes in the law, are engaged and that unnecessary anxiety amongst those who would not wish to be involved is prevented. Issues regarding personal, ethical and moral conscience, such as assisted suicide, can generate debate, but the views of the individual must be respected. In respecting personal viewpoints, professional responsibility requires clinicians to accommodate these issues in ways which combine compassion with legal and medical integrity.

Recent proposals for changes in the law have sought to address solely the situation of a mentally competent person suffering from a terminal condition, whose quality of life has deteriorated to the extent that they now determine it to be intolerable and that they wish to end their life at a time of their choosing, rather than by the natural course of their disease. It is therefore in this context that we are specifically examining the issues around assisted suicide from a pharmacy perspective and have not yet addressed the wider issue of either euthanasia or a broader patient group.

DEFINITIONS

Assisted dying - used as an umbrella term to encompass assisted suicide and voluntary euthanasia.[7]
Voluntary euthanasia - where one person causes another person's death with their consent (illegal in the UK at present and there are no moves to change this position).[7]
Involuntary or non voluntary euthanasia - ending another person's life 'when the individual is incompetent to consent to or refuse euthanasia and has made no prior decision'.[7]
Assisted suicide - providing someone with the means to end his or her own life'[7] (In some countries this is called Physician Assisted Suicide)
Mental capacity - A person is considered mentally capable if they fit with the definitions of the Mental Capacity Act (England and Wales) 2005 and the Adults with Incapacity (Scotland) Act 2000.

POLICY DRAFTING PROCESS

An expert working group was established with a cross-sector representation of pharmacists with expertise in many aspects of practice, including legal and ethical, palliative care, oncology, controlled drug accountable officers, hospices, education, primary care, community and hospital practice. Initial views from the working group were sought via a webinar and then disseminated to a wider reference group for feedback and comment. Members' views were also sought through a virtual network discussion and coverage in the Pharmaceutical Journal. We have attempted to be as inclusive as possible in the drafting process but recognise that this policy statement cannot fully encompass the breadth of opinions held, in good conscience, by all our membership. Feedback from our members is encouraged at all times and the policy will be reviewed accordingly.

PRINCIPLES

Conscience clause - It is a pre-requisite that a conscience clause is incorporated into any legislation. There must be no obligation for any pharmacist to participate in any aspect of an assisted suicide or similar procedure if he or she feels this is against their personal beliefs. The framework we are proposing allows pharmacists to 'opt in 'by completing the necessary training, rather than 'opting out'. It also avoids the need for anyone ethically opposed to assisted suicide to signpost to another pharmacist as this can also pose an ethical dilemma.

Pre-registration - We advocate that there be a legal requirement for patients to pre-register their wish with their own GP to have assisted suicide as an option at a later stage in their lives if they fit the legal criteria. Their wishes should be recorded in their health record. This concept is similar to carrying an organ donor card in that it is a request for a specific positive intervention. This differs from an advance directive which gives instructions for withholding a treatment which might prolong life and thus cannot be used for requesting specific treatments. This pre-registration process should be in a nationally agreed format.

Legal protection - There must be explicit protection in place in any legislation for pharmacists, pharmacy technicians and other health care professionals to be protected from prosecution when participating in the approved process for an assisted suicide procedure. We would not anticipate any non-regulated pharmacy support staff to be involved in any of these procedures.

Criteria - All safeguards initially agreed in any prospective legislation need to be effective and rigorously applied. The criteria for eligibility should be steadfast and unable to be altered without proceeding through the primary legislative process. Comparisons have been drawn to the parallel with the 1968 Abortion law where there has been criticism that the criteria for eligibility have not been upheld as was originally intended.

Commercial interests - One of the drivers for groups lobbying for a change to the existing legislation is that people currently travel to other countries to avail themselves of an assisted suicide procedure and this is felt to be an unnecessary burden on patients and their families. If assisted suicide procedures were to be available outside the NHS then there would be still be an issue of affordability and accessibility. This particular form of care is unique and must not conflict with the commercial considerations of a private sector organisation and therefore we feel strongly it should stay within the NHS.

Mental competence and eligibility - A person must be capable of making an informed decision i.e. have the mental capacity to do so. We recognise that this will exclude people with Dementia or Alzheimer's disease which are also terminal illnesses. However, this is a different situation from someone requesting assistance to change the timing of their inevitable death from a physical illness, probably shortening it by just a few days or weeks. Dementia as we understand it at the moment is frequently more distressing for friends and relatives than for the person themselves. An assisted suicide procedure necessitates someone being able to change their mind at any point in the proceedings and for the decision to go ahead to be theirs alone. The involvement of another person in the decision to end someone's life would mean the process was not assisted suicide, but euthanasia which is not currently being addressed. We therefore require people to have the mental capacity to make their own decision.

Alternative options - It must not be assumed that when a person presents with a request for assistance to end his/her life that this is indeed their actual first choice. People may present with a request for assisted suicide when they are not aware of all the alternative options available to them. It is imperative that the best possible standard of palliative care is provided and that all options have been fully explored in a multidisciplinary, holistic approach to care. It should be a pre-requisite that counselling and advice on all the alternative options be provided to anyone contemplating assisted suicide. Patients should be given the opportunity to discuss the alternative options available to them, to give a clearer understanding of the scope and range of the best practice available in palliative care, including pain management, as well as fully explaining the assisted suicide procedure, covering risks and expectations. A medication review to discuss polypharmacy issues including minimising the risk of side effects towards the end of life would be advantageous. We would expect all suitable alternatives to be pursued and exhausted before returning to the prospect of an assisted suicide. It is the experience at Dignitas in Switzerland that information and advice can encourage people to pursue alternatives to assisted suicide.[8] Pharmacists have a key role in this aspect of patient care.

Assistance - A person must be able to self-administer the lethal prescription and be able to change their mind and halt the procedure at any point in order to differentiate between assisted suicide and euthanasia. A person's physical state might deteriorate between making their decision to end their life and the date planned for the procedure. This should not be a barrier to carrying out their wishes and therefore a flexible approach to the practicalities of assisting someone is required. Mechanical devices might be required to overcome physical disability as some people by nature of their illness will not be able to swallow solids, or drink from a cup without a straw or without spilling. This aspect should be discussed in the care plan.

Facilitators - We support the concept of an independent facilitator of the person's choosing who would not necessarily be a health professional but would be present to witness the death and aid in all administrative tasks as required. They would complete the multidisciplinary training along with health professionals and be competent in the requirements around safe keeping, storage, security and disposal of the medication being used.

Assessment - Two doctors should carry out a full assessment of the patient, which carries the responsibility for ensuring that the patient fits the necessary eligibility criteria, before a lethal prescription can be issued. Whenever possible the patient and patient history should be known to one of the assessors.

National approach - National guidance and protocols would be expected to be in place to ensure that best practice for the procedure is consistently applied across GB with limited variation and based on a sound evidence base for the prescription. We would look to the experience of other countries in developing protocols. Similar protocols and procedures should be in place no matter in which setting the patient is being cared for. This would include hospital, hospice, care home, the patient's own home and any other domiciliary setting. The protocol should also cover the issue of prescriptions, supply, documented use and return and disposal of any unused medicines. A robust audit trail is required. Pharmacists from primary and secondary care must be included in any multidisciplinary working group to develop national guidance for all settings. The group membership should also include representation from the controlled drugs accountable officers' network, particularly, as controlled drugs are being considered for use. Registration with a GP in the country where the procedure is lawful and is to be carried out would also be required.

PATIENT CARE

Having pre-registered their wishes with their GP at some point in the past a person would make a formal request to their doctor at a later stage to indicate that they wish to use the legal process for assisted suicide now available to them. The procedure would require forward planning and the documentation should include a care plan drawn up with the patient to ensure all their wishes are accommodated. This should include planning of all aspects on how the procedure will be carried out, who will be present and any consent required.

Arrangements should be made for access to information and advice on the alternative options available. If the person still wishes to pursue the assisted suicide option after exploring and /or making use of the available options then a final request would be made which would trigger the issue of a lethal prescription and arrangements commenced as per the care plan with a pharmacist and facilitator being approached by the doctor. Close cooperation between pharmacy and medical colleagues would be required to facilitate all the necessary arrangements and ensure all documentation is in place before any final prescription is presented. The timing and administration details require careful consideration in order to avoid patients requesting a procedure ahead of their own particular need in order to satisfy protocol and administrative requirements.
A person-centred approach is crucial for all aspects of assisted suicide and people may change their mind from their initial decisions as life becomes more precious to them despite worsening health. It is vital that the person is able to indicate their wishes until the final moments of their life.
A person's wishes, around confidentiality and the number of people party to the process, needs to be accommodated. There should be flexibility in arrangements, to allow either primary or secondary care pharmacists to be involved depending on locality, with consideration given to remote and rural situations.

Families and carers should not be subjected to any unnecessary pressure and stress at such an emotional time. They may or may not want to be involved in the practicalities of arranging a procedure. The presence of an impartial facilitator would be useful for all practical aspects of the procedure including being an independent witness present at the death. The facilitator would not necessarily be a health professional and should not be a relative or anyone directly involved in the patient's healthcare. A confidential database, available to doctors when discussing assisted suicide procedures with patients, with a list of the pharmacists and facilitators who have opted in would allow patients a choice in whom they involve in this very personal experience. It would allow forward planning, including contingency planning in the event that any of the original personnel were to be unavailable for any reason.

PRESCRIBING AND DISPENSING

It must be remembered that in dispensing a prescription a pharmacist assumes a proportion of the responsibility for that prescription and therefore must be assured that all legal requirements are in place and that it is entirely appropriate for the patient. The same principles apply for prescriptions for an assisted suicide procedure but these do present as a unique situation. Although pharmacist independent prescribers could sign a prescription, we consider in this instance the link to the clinical assessment of eligibility criteria is essential and therefore the prescriber should always be one of the assessors. In addition to the usual practice of checking that the prescription fulfils the necessary legal requirement, pharmacists must have full access to the patient's diagnosis and assisted suicide care plan.

Consideration needs also to be given to the handling of all paperwork to ensure a full audit trail, and facilitators will be bound by the same confidentiality requirements as currently apply to healthcare professionals. All paperwork

would be seen and processed appropriately before the designated dispensing day. Close liaison between the doctor, pharmacist and any facilitator is required to ensure everyone involved is kept fully informed.

For arrangements relating to the dispensing, supply, pick up and potential return and safe disposal of medication, it is expected that the pharmacist and doctor would liaise to make all necessary arrangements between them and any appointed facilitator. Consent issues would be clearly documented in the care plan. Stock of the appropriate medicinal products may not be routinely held in stock but ordered as required for the individual patients. We anticipate that the forward planning required would allow adequate time for the pharmacist to ensure the prescription was available on the due date. The prescription would be written when the patient makes their formal request (having previously pre–registered) to their doctor and has fully considered all agreed alternative options. As the prescription would be for a controlled drug there would be a 28 day window of validity ensuring time to activate the patient's care plan and make the necessary arrangements.

Thought should be given in planning as to when the prescription will be picked up to allow the pharmacist adequate time for consultation with the facilitator to ensure all pharmaceutical care aspects are considered and that any remaining questions can be answered. The drugs used for this procedure will either not have a marketing authorisation (MA) in the UK for human use or will have an MA but will, by necessity, be being used off label rather than for the licensed indication. While this should not present any difficulties, the doctor, patient and pharmacist should be aware of this.

TRAINING AND EDUCATION

In order to balance the needs of confidentiality and access to services we advocate that pharmacists indicate their willingness to be involved by "opting in" to training and then be listed on a database with access restricted to doctors and those pharmacists and facilitators who have similarly opted in to participate in the scheme. Doctors would then be able to access the information and identify registered personnel in order to start proceedings at a patient's request. Pharmacists who do not wish to be involved would not be listed and therefore would not be approached. Pharmacists would require to be fully competent in the legal requirements of an assisted suicide procedure and have knowledge of the necessary paperwork, consent requirements and protocols. Joint training with other disciplines involved would be necessary to give a coordinated approach and common understanding of the process. It would be advantageous for any training to be holistic in nature and encompass some of the sensitivities pharmacists may encounter in practice. This might extend to the provision of peer support for colleagues or signposting to the Pharmacist Support resource of Listening Friends if required. This training would also be available to pharmacy technicians. Training would always be optional aligning with the conscience clause but successful completion of the training would be mandatory before any involvement in an assisted suicide procedure commences.

Organisations involved in the education and training of pharmacists and technicians namely, NHS Education Scotland (NES) Pharmacy, Centre for Pharmacy Postgraduate Education (CPPE) and the Welsh Centre for Pharmacy Professional Education (WCPPE) would be key participants in supporting the development and delivery of educational packages whilst ensuring a coordinated national approach is adopted across GB.

PALLIATIVE AND END OF LIFE CARE

Palliative care services have traditionally focused on cancer care but there are other therapeutic areas where illness can be terminal and end of life care can be distressing for patients and carers. These include heart failure, chronic obstructive pulmonary disease (COPD) and several neurological conditions. Hospice beds are not always available and patients die in hospital when their preference is often a hospice or supported home option.

In the other countries where assisted suicide has been established, distinct improvements in the quality of palliative care have been recognised we commend and support this approach. As a result of the information and advice which anyone requesting assisted suicide would have available to them, and in keeping with a patient-centred NHS, we would both support and expect improvements in palliative care to allow equitable access for all patients diagnosed with a terminal illness. It is however recognised that there are times when even the best palliative care provision fails to give patients an acceptable level of symptom control and the dignified death they would wish for. For these few patients assisted suicide, if it was available, may be their preferred choice.

Whilst palliative care specialists have specialist knowledge which will be useful in formulating the protocols and ensuring the use of evidence-based medicines, it must not be assumed that they would want to be involved in assisted suicide procedures, and indeed it could be a conflict of interests in some situations. Hospice pharmacists might not want to participate in case this raised anxieties among patients and their families or carers around hastening

a death. Anecdotally, hospice care is acknowledged as excellent and the pathways already used in palliative and end of life care will, for the majority of patients provide a route to a peaceful death with support available for both patients and their families to come to terms with this end stage of life. Established treatment pathways at the end of life should remain quite separate from a formal assisted suicide procedure.

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APPENDIX 1

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