Written evidence submitted by The Royal College of Physicians (ADY0354)

The Royal College of Physicians (RCP) is the membership body for physicians. Our role is to support physicians to deliver the best healthcare possible for patients and improve standards of care. We represent 41,000 members and fellows in the UK and internationally from over 30 medical specialties.

The definition of assisted dying

1. The RCP notes the definition of assisted dying from the Parliamentary Office of Science and Technology briefing note on assisted dying. The RCP does not agree that “healthcare professionals administering lethal drugs (‘euthanasia’)” should be included in the definition of ‘assisted dying’ and nothing in this submission pertains to euthanasia. The RCP urges the committee to consider ‘assisted dying’ and ‘euthanasia’ as two distinct practices and issues with very different considerations.

The RCP position on assisted dying

2. In 2019 the RCP polled its members on whether or not the RCP should support a change in the law to permit assisted dying. We defined ‘assisted dying’ as, “The supply by a doctor of a lethal dose of drugs to a patient who is terminally ill, meets certain criteria that will be defined by law, and requests those drugs in order that they might be used by the person concerned to end their life.” We also asked whether they personally supported a change in the law and if they would be prepared to participate actively if the law was changed to permit assisted dying.

    a. 43.4% of respondents said that the RCP should be opposed to a change in the law to permit assisted dying, 31.6% said the RCP should support a change in the law, and 25% said the RCP should be neutral.
    b. 49.1% said they did not personally support a change in the law to permit assisted dying, 40.5% did support a change in the law and 10.4% were undecided.
    c. 55.1% said they would not be prepared to participate actively if the law was changed to permit assisted dying, 24.6% said they would be prepared to participate actively and 20.3% did not know.

3. Following that 2019 poll, the RCP adopted a neutral position on whether there should be a change in the law to permit assisted dying. This means the RCP neither supports nor opposes a change in the law to permit assisted dying. Regrettably, this position was interpreted by some as suggesting that the RCP was either indifferent to legal change or supportive of a change in the law. So that there could be no doubt, we clarified that the RCP does not support a change in the law to permit assisted dying at the present time. We also reiterated the following points relevant to the survey and its position:

    a. The RCP has an important role in informing the societal debate on this issue, and is keen to do so.
    b. While 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.
    c. 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.
    d. There is a plurality of views within the RCP membership on the issue of assisted dying.
    e. While a significant minority of its fellows and members support a change in the law, a greater number remain opposed.
    f. The majority of doctors said they would be unwilling to participate actively in assisted dying if the law were changed to permit it, with only 25% indicating willingness to do so.

To what extent do people in England and Wales have access to good palliative care? How can palliative care be improved, and would such improvements negate some of the arguments for assisted dying?

4. The current size of the physician workforce in general, and in palliative medicine specifically, is inadequate to provide palliative and other care, particularly given the increase in older people over the next 20 years. More dedicated funding for palliative care services would increase the number of people who had access to them. If the law were changed to permit assisted dying, the government would need to develop a dedicated assisted dying service. Any such service should not be funded from the healthcare budget – it would need additional and specific funding. It would be perverse if that funding was made available without additional funding for palliative care.

5. Specialist end of life care for all should be an NHS commitment. Not only does it have a positive impact on patients and the people to whom they are important, it can reduce costs by reducing the need for hospitalisation and aggressive intervention.[1]

6. The Office for National Statistics (ONS) expects the number of deaths in the UK to steadily increase between now and 2030, with deaths overtaking births by 2025. By mid-2045, the number of people aged 85 years and over will have nearly doubled from 1.7 million in 2020 to 3.1 million.

7. According to a 2021 independent report commissioned by Sue Ryder, 63% of palliative care costs in England are covered by fundraising. Just under half of all people dying in England receive palliative care and support. The report estimated that up to around 215,000 additional people could benefit from receiving palliative care.

8. NHS England data for September 2022 show that there were 377 full time equivalent (FTE) palliative medicine consultants employed by the NHS in England. Overall, NHS England employed 742 FTE healthcare staff working in palliative medicine, including associate specialists, specialty doctors, doctors in training, other doctor grades and clinical assistant/hospital practitioners.

9. Every year the RCP conducts a census on behalf of the RCP, the Royal College of Physicians of Edinburgh (RCPE) and the Royal College of Physicians and Surgeons of Glasgow (RCPSG). The 2021 census found that there were 630 FTE palliative medicine consultants in the UK. This equates to roughly one palliative medicine consultant for every 106,000 people, or one for every 16,700 people aged 65 years or over.

    a. 77% of palliative medicine consultants were women. 70% of women palliative medicine consultants worked less than full time. 18% of men palliative medicine consultants worked less than full time.
    b. 19% of palliative medicine consultants (18% of women and 20% of men) also had a commitment to provide acute medicine or general internal medicine (GIM).
    c. 50% of palliative medicine consultants were employed by the NHS. 28% were employed jointly by the NHS and another organisation, such as a hospice. 15% were employed by a non-NHS organisation, such as a hospice. 6% had an academic contract.

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[1] Evidence on the economic value of end-of-life and palliative care interventions: a narrative review of reviews | BMC Palliative Care | Full Text (biomedcentral.com)

d. Palliative medicine consultants are not spread evenly across the UK. The ratio of consultants to number of people ranges from 1 to 203,788 in north Scotland to 1 to 70,728 in Kent, Surrey and Sussex. Looking just at the population of people aged 70 years and over, the ratio ranges from 1 to 956 in Northern Ireland and 1 to 817 in South West England, to 1 to 300 in south London and 1 to 174 in central and north east London.
e. In the next decade, 40% of palliative medicine consultants expect to reach intended retirement age (average intended age = 61 years), 23% will reach 65 years of age and 37% will reach 67 years of age.
f. 29% of palliative medicine consultants reported daily (6%) or weekly (22%) gaps in the on-call trainee rota. 27% reported a substantive vacancy in their department.
g. 38% of palliative medicine consultants felt in control of their workload, 38% felt they had an excessive workload and 44% felt they worked excessive hours. 88% said they were always or often satisfied with their specialty, but only 4% were satisfied with GIM.

What are the professional and ethical considerations involved in allowing physicians to assist someone to end their life?

10. As the RCP 2019 poll showed, there is mixed professional opinion on whether or not there should be a change in the law to permit assisted dying. Only 24.6% said they would definitely be prepared to participate actively if the law was changed.

11. The RCP expects that any change in the law to permit assisted dying would include provision for conscientious objection. It must state that healthcare professionals would not be under any duty to participate in anything authorised by the legislation.

12. If the law were to be changed, physicians involved in assisted dying, even if they conscientiously objected, would be at risk of moral and psychological injury. This would have an impact on the need for occupational health services.

13. Involvement in assisted dying would have an impact on the relationship of a doctor with the person requesting the assisted death, with the people to whom that person was important, and with others who were aware of the doctor's involvement. The nature and extent of the impact would depend on the level and nature of involvement of the doctor, but even in situations where conscientious objection was exercised, there would be an impact.

14. The current size of the physician workforce in general, and in palliative medicine specifically, is inadequate. Any change in the delivery of healthcare would necessarily require a rethink of the roles and responsibilities required to deliver it and other care effectively.

What, if any, are the physical and mental health criteria which would make an individual eligible to access assisted dying services? What capabilities would a person need to be able to consent to assisted dying?

15. The RCP would expect that a request for an assisted death could only come from the person who wanted to die.

16. If the law were changed to permit assisted dying, as a minimum, the RCP would expect someone requesting an assisted death to

    a. have the capacity to make the decision to end their life
    b. have the ability to end their own life
    c. have been fully informed of their palliative care options
    d. have had their care and support needs fulfilled, including for uncontrolled symptoms, such as pain, and clinical depression
    e. have a clear and settled intention to end their own life, which had been reached voluntarily, on an informed basis and without coercion or duress.

17. It would be important that every case was taken on its own merits and a clinical assessment was made by doctors in consultation with the person requesting an assisted death. The RCP would expect, again as a minimum, that two doctors would be required to provide clinical evidence that the person met the criteria listed above at paragraphs 18 a-d.

18. Doctors can provide evidence about some clinical aspects of coercion. For example, a doctor could provide evidence on whether someone was vulnerable to coercion due to their mental health or capacity. But clinical evidence cannot extend to whether someone has made a decision with, or without, coercion or duress. It is neither within the power nor skillset of the medical profession to make that judgement.

What protections could be put in place to protect people from coercion and how effective would these be?

19. Protection from coercion is a matter for the police and legal system. Doctors do not have the powers or skills to adequately assess all aspect of coercion. Doctors would be able to act as witnesses of fact and expert witnesses to support any investigation by the authorities regarding aspects of a case which related to medicine.

What information, advice and guidance would people need in order to be able to make an informed decision about whether to access assisted dying services?

20. If the law were changed, a person requesting an assisted death should be fully informed of their palliative care options. They should have access to a palliative medicine consultant, along with other healthcare professionals, to discuss their options.

21. As we say above, if the law were changed, the government would need to develop a dedicated assisted dying service. All healthcare professionals involved in the process would need to receive appropriate training and support. Any such service would need to be audited and subject to ***external scrutiny.***

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