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Clinical Paper

The Regional Palliative Medicine (RPMG) Assisted Dying Survey 2024

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ABSTRACT

Assisted Dying (AD), the ending of a person's life pre-emptively under a legal criterion is widely debated, both in the United Kingdom (UK) and Ireland. The expectation is often those doctors closest to dying would be both the proponents and facilitators of this action. A survey of Palliative Medicine in Northern Ireland (NI) on this topic has never been previously undertaken.

The Regional Palliative Medicine Group (RPMG) a representative body of all the Palliative Medicine Consultants in NI organised an anonymous 'Google Forms' survey on AD from 3/6/24 to 17/6/24 of all doctors of all grades working within Specialist Palliative Medicine at the time.

The survey had a 69% response rate (56/81) demonstrating 80% of all responding doctors working within Palliative Medicine and 100% of responding Palliative Medicine Consultants and Registrars in Northern Ireland do not favour a change in legislation allowing for AD.

91% (n=51) have concerns that AD will be influenced by a lack of availability of personal care at home. 93% (n=52) are concerned that AD will be influenced by cost-saving for the patient and their family and 82% (n=46) are concerned that AD will be influenced by cost savings for health and social care.

98% (n=55) stated if AD is legalised it should not be 'part of mainstream healthcare' with 45% (n=25) saying it should be 'via the legal system' and 46% (n=26) saying 'via a separate independent facility'. 53% (n=28) 'would not' and 40% (n=21) 'don't know', if they could remain working for an organisation that undertakes AD.

These results clearly show that Palliative Medicine in Northern Ireland will not be part of an AD service model. The question is who will be? Healthcare leaders now need to support their Palliative Medicine workforce by stating there will be AD-free healthcare facilities if AD is legalised.

Introduction

'Assisted dying' (AD) is used in this paper as an umbrella term encompassing both euthanasia (active administration of lethal medications) and physician-assisted suicide (providing the means for the patient to take lethal medications).

There are current debates about the introduction of AD legislation in both the Republic of Ireland and the United Kingdom (UK). If either of these jurisdictions legalise AD there are direct and indirect consequences for the Northern Ireland (NI) population. In particular, the new Irish 'Voluntary Assisted Dying Bill 2024'[1] proposes an eligibility criterion of being a "resident on the island of Ireland and has maintained such residency for not less than one year." Thus, this Bill will legislate for NI adults to access AD across the border.

Background

The views of Palliative Medicine doctors regarding AD are well documented in multiple surveys. The Association for Palliative Medicine of Great Britain and Ireland (APM) members survey in 2015 demonstrated 82% were opposed to changing the law [2]. The Royal College of Physicians (RCP), stratified for Palliative Medicine outlined in 2019, 84.3% opposed a change in the law, and 84.4% were not prepared to actively participate in physician-assisted suicide [3]. The British Medical Association (BMA), stratified for Palliative Medicine in 2020 demonstrated 84% would not be willing to actively participate in the process of administrating life-ending drugs [4]. The APM Scotland survey demonstrated in 2022, 75% would not be willing to participate in any part of the AD process and 98% stated that AD should not be part of mainstream healthcare. However, there has never been a specific survey on the views of Palliative Medicine in Northern Ireland.

The Regional Palliative Medicine Group (RPMG), the representative body of all the Palliative Medicine consultants in Northern Ireland, sought to close this gap by conducting a comprehensive survey of all the doctors working in Palliative Medicine in Northern Ireland. This survey has been conducted by the RPMG.

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This survey was undertaken by the RPMG.

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Ethics

Using the UK Medical Research Council website, it is determined this paper does not need reviewed by a NHS Research Ethics Committee. [5]

Methodology

The Palliative Medicine clinical lead in each trust and charitable hospice, community and hospital service throughout Northern Ireland was contacted to provide the name and email address of each doctor (of any grade) who was working in Palliative Medicine between the 2 weeks - 3/6/24 to 17/6/24. This equated to 81 individual doctors.

A 'Google Forms' was set up so that each email was anonymously logged against a response, and although the individual link did not expire once completed, there were no duplicate uses of any individualised link.

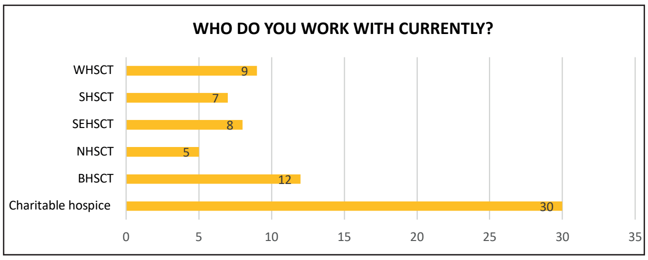
All data was stored anonymously, and password protected on the 'Google Forms', transferred to Excel and analysed. All emails were removed before analysis, thus maintaining anonymity.

Response rate

The survey had an overall 69% response rate (n=56/81) from all medical staff, at all grades, in Palliative Medicine. This represents an 85% (n=23/27) response rate from Palliative Medicine Consultants and an 86% (n=6/7) response rate from Palliative Medicine Specialty Registrars.

Demographics

Out of all the responses (56), 42% (n=23) were Palliative Medicine consultants, 34% (n=19) were SAS doctors / speciality doctors / hospice physicians (non-training), 11% (n=6) Specialty Registrars (in training), 11% (n=6) GP's or GP trainees working in Specialist Palliative Medicine and 2% (n=1) as another junior trainee.



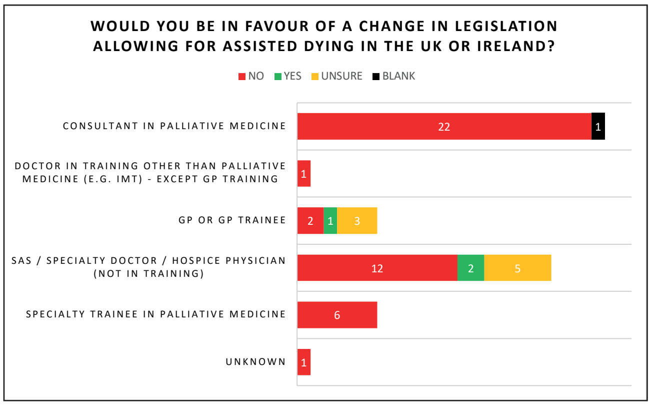
The Palliative Medicine workforce is complex with 27% of respondents (n=15/55) having multiple employers across various trusts and charitable hospices.

77% (n=43/56) of the Palliative Medicine workforce, who responded, provide either a trust or charitable hospice/ inpatient specialist palliative care (SPC) service. The charitable sector hospices are the Foyle Hospice, Marie Curie Hospice Belfast, Northern Ireland Hospice and Southern Area Hospice. The Trust inpatient SPC services include the Macmillan Unit Antrim and the Palliative Care Unit Omagh Hospital and Primary Care Complex.

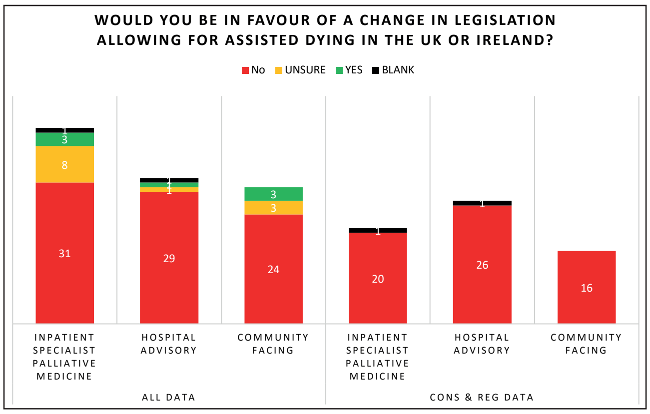
Also, within the responding workforce, 54% (n=30/56) had a community aspect to their jobs. 46% (n=26/56) had a hospital liaison role / cancer centre liaison.

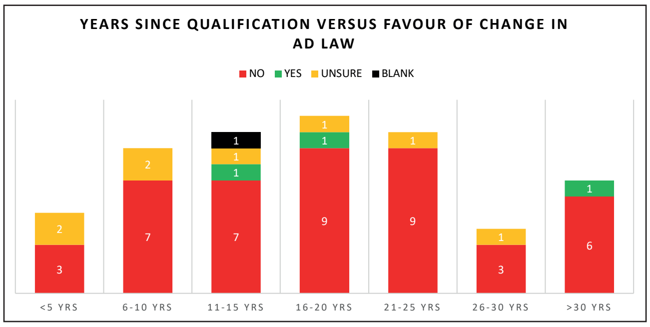
Results

Out of the 69% of respondents, 80% (n=44/55) of doctors working within Palliative Medicine and 100% of Palliative Medicine consultants and Palliative Medicine registrars do not favour a change in legislation allowing for AD in the UK or Ireland. Out of all doctors surveyed, 14.5% (n=8) were unsure and 5.5% (n=3) were for a change in the law to legalise AD.



Breaking the results down by role shows; that 93% (n=37/40) in-patient specialist Palliative Medicine, 96% (n=25/26) hospital advisory / cancer centre , 89% (n=24/27) Community Palliative Medicine would not be in favour of a change in legislation for AD.





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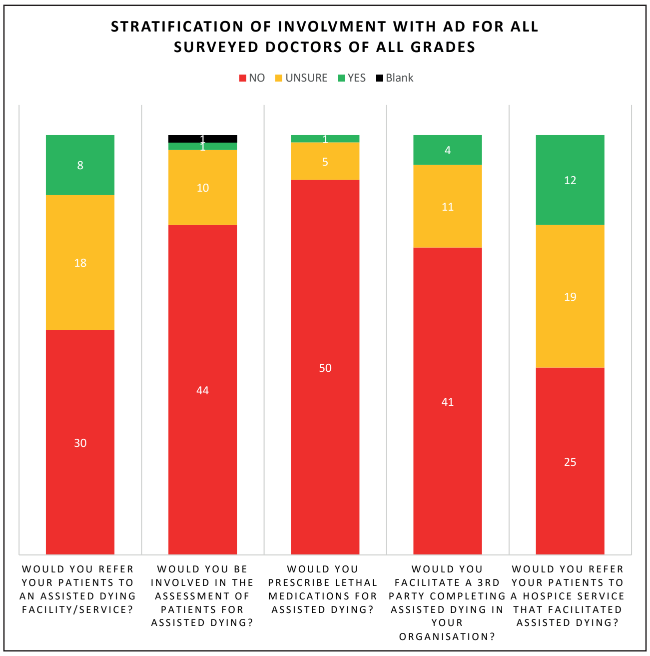
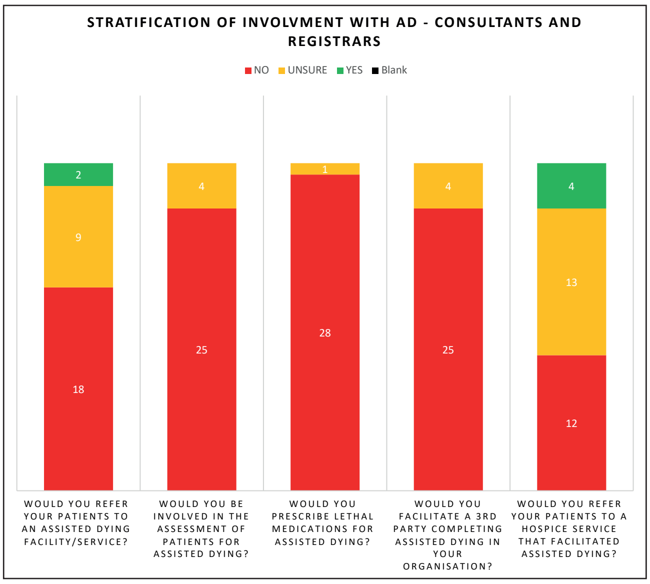
The SAS doctors and GPs were the only 2 groups of doctors to vote unsure or yes to a change in the law. The Hospital advisory (incorporating the Cancer Centres) was the least likely place of work to vote for a change in law.

Years since qualification did not seem to have any correlation with views on changing the AD law.

When asked to consider the legalisation of AD, respondents considered their potential to be involved. 0% of responding Palliative Medicine consultants and registrars would agree to be involved in prescribing lethal medications, facilitate a 3rd party completing AD, or be involved in the assessment of patients for AD (n=29).



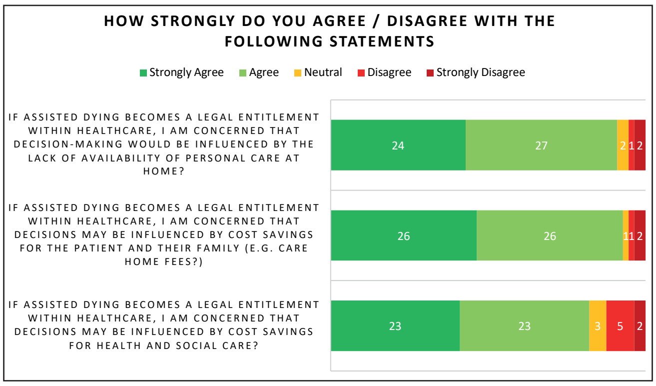


14% (n=8/56) of all the surveyed palliative doctors of all grades would refer a patient to AD services, but only 1 person would prescribe lethal medications. 7% (n= 2/29) of consultants and StRs would refer to an AD service, but 100% (n=29/29) not would be involved in the process. 86% (n=25/29) of consultants and registrars are not convinced they would refer their patients to a hospice/in-patient service that facilitated AD (even if it was not for AD).

To What Extent Do You Agree With The Statement 'Legal Safeguards Will Be Sufficient To Prevent Harm To Vulnerable Patients If AD Were Legalised'

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
Consultant in Palliative Medicine	15	8	0	0	0
Specialty trainee in Palliative Medicine	3	3	0	0	0
SAS / specialty doctor / hospice physician (not in training)	10	4	4	1	0
GP or GP trainee	1	2	1	2	0
Doctor in training other than palliative medicine (e.g. IMT) - except GP training	0	1	0	0	0
Unknown	1	0	0	0	0

100% of Palliative Medicine Consultants (n=23) and Registrars (n=6) 'Strongly Disagree' or 'Disagree' with the statement "legal safeguards will be sufficient to prevent harm to vulnerable patients if assisted dying were legalised" A total of 3 doctors comprising of 1 SAS doctor and 2 GPs / GP trainees, in the survey agree safeguards will be sufficient. No one strongly agrees.



91% (n=51/56) 'Agree' or 'Strongly Agree' in concern that AD will be influenced by the lack of availability of personal care at home. 92% (n=52/56) 'Agree' or 'Strongly Agree' in concern that AD will be influenced by cost saving for the patient and their family and 82% (n=46/56) 'Agree' or 'Strongly Agree' in concern that AD will be influenced by cost savings for health and social care.

The consequences 'If' AD becomes legalised questions when averaged out demonstrate 40% 'Very Negative' (mean 22), 35% 'Negative' (mean 19.8), 22% 'Neutral' (mean 12), 3% 'Positive' (mean 1.8) and 0% 'Very Positive'.

When asked if AD becomes a legal entitlement and what

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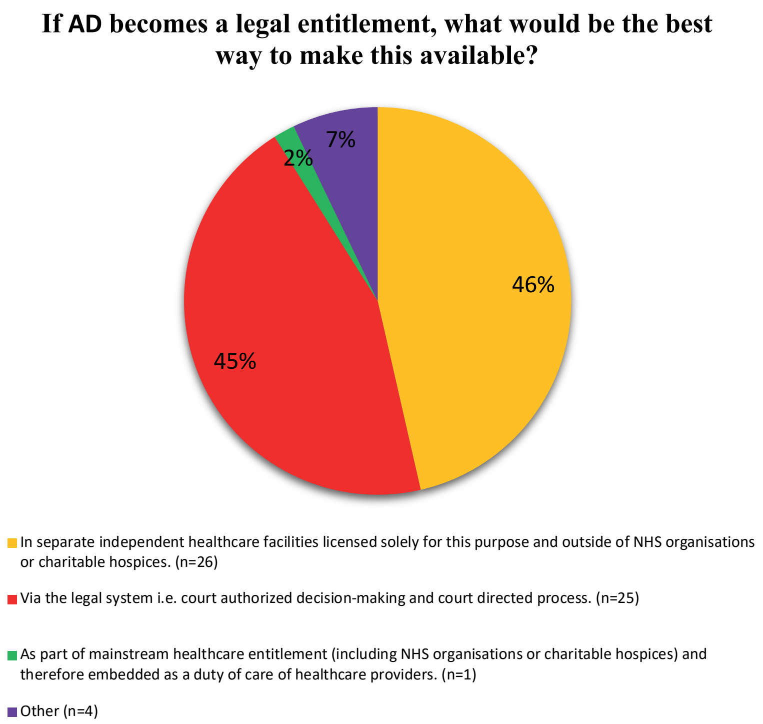
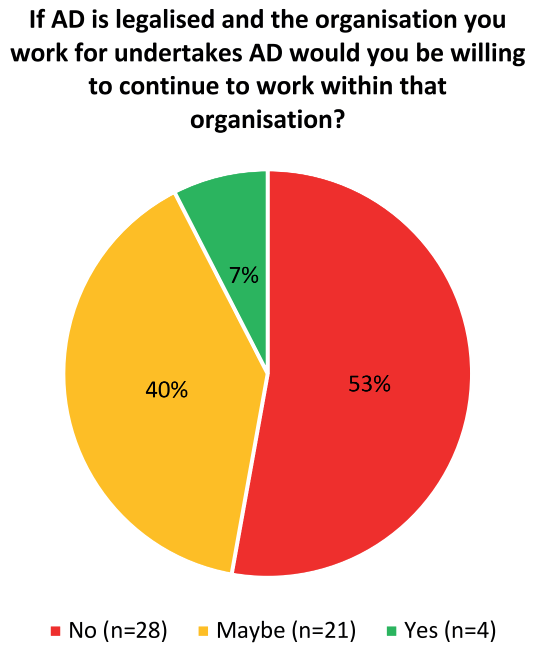


‘Other’ includes: (quoted)

- as a private option
- given the potential for backlash i wonder if a combo of the above eg. independent org plus court assisted decision making although at the same time i see this would be very clunky and potentially expensive for patients. so not ideal
- Ideally to not be within our society, if it is within our society completely out side healthcare. This is not healthcare
- Performed by the specialist with expert knowledge of the condition in question. If cancer causing the suffering - the oncologist should do the assisted suicide, if MND - the neurologist should do the assisted suicide etc etc



All the reasons given: (quoted)

- I just don't know - I would have to fully appraise how it impacts on my day to day ability to care for the in-patients.
- As long as I can remain apart from it
- If there wasn’t a true way to conscientiously object I would have to consider leaving
- Only if I was able to opt out of any involvement in assisted dying
- Depends on what involvement we were expected to have
- Not within a hospice setting. Perhaps if it was performed in the NHS.
- I love working in Palliative Medicine and essentially don't know what other aspect of medicine I would be useful in! But I would be watching very closely to the expectations of organisation and patients in regards to my personal involvement in this. And bottom line, I can and would retrain in something less involved in Assisted Suicide if needed to.
- I do not feel an organisation should be offering both palliative care and assisted dying. Assisted dying should be a separate specialty where people are referred to.

would be the best way to make this available, the answer ‘as part of mainstream healthcare’ was 2% (n=1). The majority was within an equal split between ‘through the legal system’ or a ‘separate independent licenced facility’.

This last question may help employers understand what their Palliative Medicine staff views are regarding working for an organisation which facilitates AD and thus helps form organisational positions. Indeed, ‘Assisted Dying free zones’ are now appearing in legalised jurisdictions around the world. Employers will need to seriously consider this approach.

Limitations

The survey was open for 2 weeks and although the response rate was overall 69% this could have possibly been higher if we had the survey open for longer. The survey also selects those who are interested in this topic and debate and therefore there is a non-random selection bias in those who completed this survey. The survey also did not seek the views on this topic from both the wider multidisciplinary team working in palliative care and other professionals in other specialities. We also did not pilot the survey to ensure understanding of the questions, this has resulted in uncertainty regarding one

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specific question with four parts which could be interpreted in very different ways and therefore has been omitted from the analysis. This question did not state if the situation was about patients before palliative medicine was involved or after and therefore is impossible to interpret.

Conclusion

This is the first survey of the views of Palliative Medicine physicians in NI about AD. The results are consistent with the wider picture from similar polls in other parts of the UK over the last 9 years. From those surveyed, the majority of NI Palliative Medicine doctors of all grades (80%) are against the introduction of this legislation, and this is unanimous when looking specifically at the consultant and registrar palliative medicine doctors, who are 100% against legalising AD. The survey also demonstrates the view does not change with 'years since qualification' thus it is unlikely to change in the future.

The survey demonstrates serious concern regarding the many consequences legislation of AD would have; on the various groups of patients (the disabled, prisons, vulnerable, learning difficulties), our society (lack of social care, cost-saving for healthcare), the funding (both statutory funding and charity fundraising), the doctors themselves (mental health, family life) and Palliative Care as a whole (reduced access to good Palliative Care).

The current body of legislation (particularly the most recent Voluntary Assisted Dying Bill in Ireland 2024, for the Island of Ireland) being proposed has an expectation of integration into the current healthcare model, with Palliative Medicine integral to its implementation, assessment and safeguarding[1]. However, this will not be a sustainable service model in NI as only 2% (n=1) of Palliative Medicine doctors (0% Palliative Medicine consultants and registrars) are in support of this model.

It is imperative, before any legislation is potentially enacted, that the leadership in both the charitable hospices and Health and Social Care Trust services see the strength of opinion within these results. Indeed, it is clear by some margin that the results of this survey demonstrate the view that AD is not within the remit of Specialist Palliative Medicine. Imposing such controversial and divisive legislation will create risk and division in the already under-resourced Palliative Care services across NI.

Often individual conscientious objection is cited as an answer to varying opinions. However, for AD, this isn't an adequate answer as Palliative Medicine clinicians will invariably face impossible moral and legal situations if legislation is imposed. Indeed, there remains no 'true' conscientious objection as a requirement to refer onwards remains in legislation[1]. There now needs to be a clearly stated and published organisational position from each institution supporting their Palliative Medicine staff. It is stark that 53% (n=28) would 'not' and 40% (n=21) 'don't know' if they could remain working for an organisation that undertakes AD.

These results highlight the large contribution of the charity sector to Palliative Medicine as 55% (n=30/55) have a role in a hospice. Surely the ambition of the government would be to continue the development of Palliative Care services across NI and not abandon such a responsibility to the charitable sector.

If society wishes to pursue AD, this is for society to decide. The consensus from this survey of Palliative Medicine is that although AD legislation is not wanted; if it were to be implemented, the suggested models of implementation strongly favour a model out with healthcare and certainly Palliative Medicine. Individual patient 'Choice' includes not being recurrently asked 'Have you considered AD?' and thus there should be AD free-zones. With the strength of staff opinion outlined, at the very least it should be the specialist palliative care services which provide these AD free-zones. The vast majority of Palliative care physicians in NI believe that when a palliative care specialist comes to see you or your loved one, it should be reassuringly clear their role is to treat you and your suffering and not offer or refer for AD.

We would encourage other medical specialities and the wider multidisciplinary teams to replicate this survey to clearly inform any future decisions.

Acknowledgements

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