# Assisted Dying for the terminally ill: the debate continues

On 18 July, after a ten hour debate involving 130 members, the House of Lords allowed Lord Falconer’s Assisted Dying Bill to pass through Second Reading to Committee stage. This means that the Bill will now be scrutinised line by line and amendments proposed before moving to Report stage. This process is likely to happen over the Autumn.

[The Assisted Dying Bill 2014](http://www.publications.parliament.uk/pa/bills/lbill/2014-2015/0006/15006.pdf) is a Bill to enable terminally ill, mentally competent adults to end their own lives by self-administration of a lethal medication with physician assistance.

This is the fifth attempt to pass a Bill in England and Wales allowing physician assisted suicide for the terminally ill, and the second attempt to pass this particular Bill (which was first tabled last year but time did not permit debate). Previous Bills have not passed through second reading so this is the furthest an assisted dying Bill has progressed in England and Wales.

[The Assisted Suicide (Scotland) Bill](http://www.scottish.parliament.uk/S4_Bills/Assisted%20Suicide/b40s4-introd.pdf) is also currently in process though Scottish Parliament having been tabled in November 2013 by the late Margo MacDonald MSP.

The Assisted Dying Bill (England and Wales) proposes that a patient requesting assisted suicide would be assessed by two doctors to determine that they a) are terminally ill (have a progressive incurable condition who would not reasonably be expected to live beyond six months) b) have the capacity to make the decision to end their own life and c) have a ‘clear and settled intention to end their own life which has been reached voluntarily, on an informed basis and without coercion or duress’.

As with previous Bills in England and Wales, and in line with jurisdictions where assisted suicide is permitted, there is a clause whereby doctors would be able to conscientiously object to involvement in the practice were it not compatible with their own values or beliefs.

We are aware that [psychiatrists will hold a range of views](http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2673229/pdf/1472-6939-10-2.pdf) on the legalisation of assisted suicide for the terminally ill. Indeed, in the August RCPsych eNewsletter members were invited to take part in a vote, albeit a fairly crude one, on this matter - but we can anticipate a polarisation of views, just as was visible in the impressive House of Lords debate on the Bill.

Whilst our individual views and consciences will guide our own participation if assisted suicide were legalised, the role of the College is to consider only those issues that are specific to the profession of psychiatry.  So it is reasonable that the College should assist in the on-going debate on matters that are directly fall within our specific expertise.  Individual members are of course free to express their own views in which ever way they chose – be it lobbying their MP, writing to members of the House of Lords, or even for the privileged few, speaking in the Lords itself.  What we set out to do in this blog is make some observations relevant to the debate, from the perspective of psychiatry.

We start with some cautions. It seems likely the role of the psychiatrist will if anything be fairly limited. If the experience of jurisdictions where assisted suicide is legal is echoed in England and Wales, psychiatrists will be infrequently consulted for second opinions where mental capacity is in doubt and or there is concern that mental disorder is impacting negatively on the patient or their decision making. This Bill does not make psychiatric assessment mandatory or even recommended in cases where capacity is in doubt, in other words we are not following the Oregon example. But nevertheless, it is likely that there will be occasions when psychiatric assessment will be indicated.

The key issues of relevance as we see it relate to the determination of mental capacity, the psychological impact of advanced progressive disease and the phenomenon of response shift, the factors that impact upon on the desire for hastened death in the terminally ill and lastly the stability of desire for hastened death in patients with terminal illness.

### Mental Capacity

In clinical practice psychiatrists are frequently asked to support to colleagues in determination of capacity in physical health settings. The Bill construes mental capacity according to the [Mental Capacity Act 2005](http://www.legislation.gov.uk/ukpga/2005/9/pdfs/ukpga_20050009_en.pdf) and specifies that capacity is assessed at two points during the process, firstly at the time the person is making the request, and secondly at the time they intend to ingest the lethal medication. There is no guidance within the Bill beyond reference to the Mental Capacity Act as to how capacity should be determined, what standard of competence should be reached, or any specific considerations in assessment of capacity for this decision. Variation in concepts of capacity for assisted suicide have previously been identified in [experts presenting to the 2010 Commission on Assisted Dying](http://www.biomedcentral.com/content/pdf/1472-6939-15-32.pdf) and no further clarity has been given within the wording of the Bill. It only states that the Secretary of State may issue guidance in this area. The recent report of the [post-legislative scrutiny of the Mental Capacity Act 2005](http://www.publications.parliament.uk/pa/ld201314/ldselect/ldmentalcap/139/13902.htm) showed that the intended principles and provisions of the Act are not always followed in practice and a [survey of psychiatrists in Oregon](http://www.experts.scival.com/ohsu/pubDetail.asp?n=Linda+Ganzini&u_id=565&oe_id=1&o_id=&id=34080812) showed that individual values influence individuals’ ideas of how stringent standards of competence should be. In our opinion this suggests that without clear standards of competence and assessment and reporting processes there is a risk that this safeguard will not work as intended.

### The psychological impact of advanced disease

Diagnosis of potentially life limiting disease and the progression to non-cure focussed care in more advanced disease are often times of great distress which for some will be accompanied by the desire for death and suicidal thoughts.  Few maintain these high levels of distress and those familiar with patients with progressive disease will have witnessed the adaptive processes that can take place even in the face of great physical limitation. Situations that could not prospectively be countenanced can be still result in successful adaption when they do occur, a process known as “response shift”.  An acceptable or even good quality of life can still return even in these situations of severe adversity. [Desire for hastened death in terminally ill patients is uncommon and, for the majority transient, and strongly associated with depression](http://spcare.bmj.com/content/1/2/140.short) and the experience of distressing physical symptoms, and there is [evidence to show that antidepressants are effective in the treatment of depression for patients with life limiting disease](http://pmj.sagepub.com/content/25/1/36.full.pdf+html).

Experience with patients in other contexts also shows us that suicidal thoughts and intent are often fluctuating and rarely fixed. The determination of a ‘clear and settled intent’ is not straightforward and much may change with time, good symptom management and treatment of remediable depression, even if prognosis is short.  Thus a “one off” assessment over a relatively short period of time may not give a true picture.

### Conclusion

We believe that the above observations are relevant to the current debate, and hope that these concerns will be heard and reflected on. We will continue the debate at the October meeting of Council, and will continue to keep the membership informed, as well as welcoming comments and feedback.

But whether our professional views are listened to or not, the debate will continue. As individuals and citizens we also cannot fail to acknowledge that notwithstanding our appropriate cautions and caveats,  there will still be those who continue to believe that their current circumstances are unendurable and unacceptable.  Each of us will have our views on how we should respond to these situations.  We do not think that the College should take a specific position on this.  Finally, the decision on whether to legalise physician assisted suicide is a matter for Parliament and the Courts. The only position the College takes on this matter at present is that we will always act within the law.

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