What will healthcare organisations and individuals need to consider if physician-assisted dying is legalised?

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If a society was to decide through its parliament to legalise physician-assisted dying as part of existing healthcare, teams and organisations will need to consider the consequences for the patients, families and staff in their care.

The term 'assisted dying' is used to refer to physician-assisted suicide and euthanasia. Some legislatures will legislate for both while others only the former, although case law can easily extend physician-assisted suicide to euthanasia.

Assisted dying laws that involve healthcare have common features on 'safeguards' and conscience, but these exclude institutions. In addition, their texts say little or nothing about the drugs used to cause death, their safety or what happens when an attempt at causing death encounters problems, or the person fails to die.

In this light, the following issues need to be part of discussions in all organisations.

1. Has your team or organisation discussed physician-assisted suicide and euthanasia?

Many teams and organisations have not openly and formally discussed how they would react if physician-assisted suicide or euthanasia were to be legalised. The challenge of the pandemic has taken up time and energy and, in many services, this has prevented healthcare professionals from understanding the practical issues that may arise. There may also be a reluctance to stir conflict or expose divisions and even a pressure, real or otherwise, to keep silent. The experience of teams and organisations who have openly discussed the issue has been positive and allowed open discussion to understand the spectrum of individual opinions and concerns, and to explore and consider what might be involved.

2. Should the organisation have a view on physician-assisted suicide and euthanasia?

It is not a healthcare organisation's role to state a view on society's choices, but it does have a duty to consider the clinical and practical implications for the patients, families, and staff in its care. If physician-assisted suicide or euthanasia become both legal *and* integrated into healthcare, organisations offering inpatient care will have to choose between providing lethal drugs on site or continuing to provide traditional end of life care without providing physician-assisted suicide or euthanasia. Community teams will have to consider whether they enable and accompany patients to the point of taking lethal drugs or whether they administer lethal drugs for euthanasia where this is legal.

3. If a team or organisation decides to provide physician-assisted suicide or euthanasia, what are the practical issues to consider?

3a. Preparation

Legislation will have criteria intended to establish 'safeguards', but these have implications:

- Who will have the responsibility to assess and confirm the individual has capacity for this decision and a fixed wish to die?
- How will larger organisations ensure such conversations are not taken by junior, inexperienced or untrained staff?
- Who will be responsible for speaking to relatives? Some patients will refuse permission for others to be told or may be in conflict with others over their decision.
- What support will be available for eligible young adults and their parents?
- Who will be responsible for verifying that no coercion or manipulation has taken place?
- Who will be responsible for excluding a reversible depression, anxiety state or other mental health problem?
- Who will be responsible for completing documentation, arranging for an independent doctor, and liaising with the High Court?
- How will this be documented?

Access to the means to end life

- Are there doctors willing to undertake the legally required assessments and prescribe the lethal drugs required (may be cocktails of up to 5 drugs)?
- Which pharmacy will dispense these drugs?
- Where will these drugs be securely stored to ensure they are separate from other patient's medications?
- Are there staff willing to prepare the drugs (may need to mix up to 100 capsules), prepare a mixture of drugs and administer an antiemetic injection beforehand.

3b. Process

- Will staff be allowed to exert their conscientious objection during the period from the request being processed until after the death, including handling of the body?
- Where will the death take place?
- Who is responsible for checking the patient has not changed their mind?
- Are there staff willing to hand the lethal drugs to the patient, or administer them if euthanasia is legal?
- Who will be present during the drug ingestion or the drug administration?
- If an IV pump is to be used, who sets up the cannula and pump?
- What happens if the patient does not die within 90mins of taking oral drugs?
- What happens if the patient vomits oral drugs?
- What happens if the patient becomes distressed or has a seizure? If only physician-assisted suicide is legal, administering seizure control drugs could be misinterpreted as euthanasia, in which case would the organisation's insurance and the doctor's indemnity view this as an unacceptable risk?
- Who is responsible for informing the authorities and completing the death certificate?
- What protocols exist should a death fail?
- How will questions from other patients be answered?
- Will additional staff be brought in to ensure the care of other patients is not jeopardised by staff needing time off after such a death?

4. If a physician-assisted suicide or euthanasia is to happen at home, what are the additional issues?

- All the issues in section 3 will apply.
- Has the GP agreed to be involved?
- Is there family or community support available in the event of a prolonged death lasting hours or days? For inpatients wanting to go home without a care package this may not be a problem for the two-thirds who die within 90mins with oral drugs, but will be an issue for the remaining third who take longer to die (see section 5).
- Who will provide backup if there are complications (see section 3b)?
- Is the team and organisation (community or outreach) prepared to allow their staff to attend a physician-assisted suicide or euthanasia at home? If so, would the organisational insurance indemnity cover this practice?

5. What if death at home is not an option?

This could be because home is unsuitable, a relative does not want the patient to die at home, a care package is not available even for a few hours (e.g. no family), or the patient requests to die on an inpatient unit. If the team and organisation have decided not to offer physician-assisted suicide or euthanasia, they would have to consider transfer to a facility that provides this.

6. What is the impact on the organisation?

- Teams and organisations need to consider whether providing physician-assisted suicide or euthanasia reinforces the negative belief that 'everyone dies there', or whether it would be viewed as somewhere providing a complete package of care.
- Teams and organisations refusing to offer physician-assisted suicide and euthanasia need to consider whether they will be viewed positively as a 'sanctuary' from repeated offers of such deaths, or viewed as providing restrictive care.
- For charities, will stating a position on involvement in physician-assisted suicide or euthanasia have any impact on funding?

- Will a personal view on physician-assisted suicide and euthanasia become a criterion in staff selection?
- How will conscientious objection be properly respected? Given that the legal provision of conscientious objection only applies to clinicians directly involved in an action, will other staff who have some involvement with the patient have their conscientious objection respected? If not, would they be required to leave the employment, and would this constitute constructive dismissal?
- How will the organisation's stance on physician-assisted suicide and euthanasia be made clear to ensure there is no misinformation?
- If physician-assisted suicide or euthanasia are to happen on site:
  -are there sufficient HR and counselling resources to support staff taking part and deal with complaints?
  - how will governance of deaths take place and who will be responsible?
  - who will ensure that all relevant policies are in place and being adhered to?
  -who will be responsible for monitoring and auditing the deaths?
  -will training on providing physician-assisted suicide or euthanasia be mandatory?
  -is the communications team ready to answer media questions?
  - how will the death be documented internally and on the death certificate?
- Will the organisation's insurance cover physician-assisted suicide and euthanasia, including what happens if a death has complications or fails?