

## **Trinity Hospice and Palliative Care Services**

### **Position statement on Assisted Dying**

Ethical dilemmas create tension within professional teams and misperceptions amongst the public. As an organisation, Trinity Hospice and Palliative Care Services has, therefore, decided to make clear position statements on a number of common, challenging ethical dilemmas including assisted dying. These are intended to work as a succinct guide on the issue for members of staff and users of our service.

This statement takes into account opinions expressed by staff, the current law as well as predictions of the impact of the statement on patient care across the family of services that make up Trinity Hospice and Palliative Care Services.

#### **Statement**

Trinity Hospice and Palliative Care Services will **not** seek to support the legalisation of the provision of assisted dying.

If the law in England is changed, Trinity Hospice and Palliative Care Services will not be involved in the provision of assisted dying for people under its care.

#### **Background**

Whilst palliative care strives to enhance patient dignity and choice towards the end of life, the perceived risk of providing assisted dying as a treatment option, within any part of the family of services that make up the organisation, is that vulnerable people who are dying may feel that they have a duty to die in order not to be a burden and to reduce the distress of loved ones.

Most requests to hasten death are expressions of distress and fear. As an organisation, we feel that, allowing any part of the family of services that makes up the organisation, to provide assisted dying will fundamentally undermine the trust between patients and staff which is a core part of the care provided by the organisation. This view applies whether assisted dying is brought about through the prescription of a lethal cocktail of drugs that the patient takes, or through the administration of such a lethal cocktail of drugs by a third party, (with the patient's consent).

This statement makes no value judgment about assisted dying or the people who make requests for assisted dying. The organisation recognises the right and validity of an individual's request for assisted dying.

Some individuals are strongly supportive of assisted dying and will wish to pursue this option for themselves in appropriate circumstances. Such views will not stop individuals who hold them from accessing the service Trinity Hospice and Palliative Care Service provides as long as they meet our eligibility criteria.

**Susan Salt Medical Director**

Written September 2009

Review September 2010

## **Trinity Hospice and Palliative Care Services**

### **Position statement on withholding and withdrawing potentially life prolonging treatments**

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#### **Statement**

Trinity Hospice and Palliative Care Services will not start any life-prolonging treatments and will stop any life-prolonging treatments which are deemed to be futile or excessively burdensome to the patient. Such decisions will be made after careful discussion with the patient and their representatives. Such decisions will be made on a patient by patient basis.

Decisions about life prolonging treatments will always be discussed with the patient, when they wish to be involved in such discussions, and have capacity to participate. Any patient shown to have the ability to make such decisions will be supported if they decide to decline life- prolonging treatment.

#### **Background**

As an organisation, Trinity Hospice and Palliative Care Services accept that life has a natural end and that there comes a point, for some people, when any medical treatments will either not prolong life or causes more suffering than benefit. Decision making in such situations requires sensitive and effective communication skills backed up with a sound knowledge of the options and likely consequences. The organisation will ensure that staff have the appropriate knowledge and skill to undertake such discussion.

Professional staff working for Trinity Hospice and Palliative Care Services are under no legal obligation to start or continue life-prolonging treatment when they, after careful consideration, believe the patient will suffer more harm than good from it.

Stopping or starting potentially life prolonging treatment is **not** a form of assisted dying because the intention is not to end life but purely to avoid additional, unnecessary suffering. Under such circumstances, when a patient dies, it is from overwhelming disease, not from being denied futile or excessively burdensome treatments.

**Susan Salt Medical Director**

Written September 2009

Review September 2010

**Trinity Hospice and Palliative Care Services**  
**Position statement on the use of sedating drugs at the end of life**

Ethical dilemmas create tension within professional teams and misperceptions amongst the public. As an organisation, Trinity Hospice and Palliative Care Services has, therefore, decided to make clear position statements on a number of common, challenging ethical dilemmas including assisted dying. These are intended to work as a succinct guide on the issue for members of staff and users of our service.

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**Statement**

Medication which is sedating in its effect will only be used within the family of services of Trinity Hospice and Palliative Care Services if symptoms cannot be relieved with more specific interventions such as pain relief.

If sedating medication is used, its effect and the dose used will be monitored in order to ensure that it is the minimum required to relieve the patient's distress. As an organisation, Trinity Hospice and Palliative Care Services believes that sedating medication used in this limited and controlled way does not shorten life.

**Background**

Rarely, patients may experience distress when symptoms cannot be controlled even after exhaustive attempts with specific interventions. In these circumstances, some patients may require sedating medication to diminish awareness of their suffering.

All medication used for symptom control across the organisation, including the use of sedative medication, is aimed at the relief of specific symptoms.

Sedation used across the family of services of Trinity Hospice and Palliative Care Services in this way is sedation while the patient dies and not sedating the patient to death.

Morphine and related pain killing drugs are wholly unsuitable for use as sedation and will not be used for this purpose within any part of the family of services that make up Trinity Hospice and Palliative Care Services.

**Susan Salt Medical Director**

Written September 2009

Review September 2010

## **Trinity Hospice and Palliative Care Services**

### **Position statement on the doctrine of double effect**

Ethical dilemmas create tension within professional teams and misperceptions amongst the public. As an organisation, Trinity Hospice and Palliative Care Services has, therefore, decided to make clear position statements on a number of common, challenging ethical dilemmas including assisted dying. These are intended to work as a succinct guide on the issue for members of staff and users of our service.

This statement takes into account opinions expressed by staff, the current law as well as predictions of the impact of the statement on patient care across the family of services that make up Trinity Hospice and Palliative Care Services.

#### **Statement**

Trinity Hospice and Palliative Care Services does **not** accept that morphine, related drugs and sedative drugs when used appropriately to manage symptoms associated with end of life care hastens death.

As an organisation, Trinity Hospice and Palliative Care Services believes that the doctrine of double effect is unnecessary to justify the use of the majority of drugs routinely used to manage pain or distress.

#### **Background**

The doctrine of double effect states that the risk of a potential known (foreseen), unintended consequence or side effect of treatment is justified only if all the following criteria are met:

- The intended effect is good in itself
- The clinician's intention is solely to produce the good effect
- The intervention is proportionate to the situation
- The good effect is not achieved through the bad effect

There is no credible research evidence to suggest that a patient's life is shortened either by opioids or sedatives when used in line with accepted palliative care practice.

**Susan Salt Medical Director**

Written September 2009

Review September 2010

## **Trinity Hospice and Palliative Care Services**

### **Position statement on advanced care planning**

Ethical dilemmas create tension within professional teams and misperceptions amongst the public. As an organisation, Trinity Hospice and Palliative Care Services has, therefore, decided to make clear position statements on a number of common, challenging ethical dilemmas including assisted dying. These are intended to work as a succinct guide on the issue for members of staff and users of our service.

The statement takes into account opinions expressed by staff, the current law as well as predictions of the impact of the statement on patient care within Trinity Hospice and palliative care services.

#### **Statement**

All the family of services that make up Trinity Hospice and Palliative Care Services supports the more widespread use of advanced care plans and advance decisions to refuse treatment.

All the family of services that make up Trinity Hospice and Palliative Care Services will support patients in advanced care planning.

Discussions about advanced care planning will be made in the context of the person, their understanding of their condition, their wishes as well as local resources. Advanced care planning will be undertaken in a sensitive, timely manner after honest discussion with the patient and those they choose to be part of such a discussion.

#### **Background**

Advanced care planning is helpful in clarifying decisions to withhold or withdraw treatments such as cardiopulmonary resuscitation, ventilation and artificial feeding. Advanced care planning allows the patient to express their preference about the kind of care they would like to receive and the location of that care.

Advance care planning requires sensitive, timely and honest discussion with the patients and those they choose to be involved in those decisions. The process should not be rushed but should recognise what may happen to the individual as part of their illness journey.

However, there are a number of issues that need to be highlighted:

- Any advanced care plan must be voluntary
- An advanced care plan will only come into operation when a patient loses capacity. Up until that point, the patients' contemporaneous views take precedence.
- Patients must be allowed to change their mind as their preferences are likely to evolve over a period time
- Under the terms of the Mental Capacity Act (in England and Wales), unless there is a properly constructed advance decision to refuse treatment or appointed lasting power of attorney, the doctor is bound to act in the best interest of the patients rather than only on the basis of a previously expressed preference.
- Issues of equity and limits on local resources have to be acknowledged in attempting to meet patient preferences.

**Susan Salt Medical Director**

Written September 2009

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