ROYAL PHARMACEUTICAL SOCIETY

Assisted Dying and the Terminally Ill Adults (End of Life) Bill

The Royal Pharmaceutical Society (RPS) is the professional leadership body for pharmacists in Great Britain. Our members work across the health service, in primary and secondary care, as well as in care homes, prisons and other care settings.

While the Royal Pharmaceutical Society takes a neutral stance on assisted dying, we have maintained the position that any proposed legislation must include clauses on both **conscientious objection** and **criminal liability**.

> There must be no obligation for any pharmacist to participate in any aspect of assisted dying if they feel this is against their personal beliefs.
>
> Pharmacists and other healthcare professionals must be protected from prosecution should they choose to participate in the approved process for an assisted dying procedure.

While the Bill does not set out the operational details for how assisted dying procedures may be carried out, we would encourage policymakers to reflect on the potential implications for health professionals and the health service.

If legislation is passed, pharmacists will have a key role in developing protocols and guidance for prescribers. The role of pharmacists goes beyond the supply of the required medication.

Any legislation and subsequent regulations must give careful consideration to a number of key principles, set out below.

Key principles

Conscience clause and 'opt in' model

A conscience clause must be included in any legislation. [Section 23, No obligation to provide assistance etc] There must be no obligation for any pharmacist to participate in any aspect of an assisted dying or similar procedure if he or she feels this is against their personal beliefs.

Pharmacists and other health professionals should be able to 'opt in' to participating in aspects of assisted dying by completing the necessary training,

rather than having to 'opt out'. The British Medical Association[1] and Royal College of Nursing[2] have also proposed a similar approach. This would help avoid the need for anyone ethically opposed to assisted dying to signpost to another health professional, as this can also pose an ethical dilemma. This opt-in model would also help identify where it may be more difficult to access health professionals who are willing to support assisted dying, such as in a specific care setting or in remote regions.

Whilst palliative care specialists have specialist knowledge which will be useful in formulating the protocols and ensuring the use of evidence-based medicines, it must not be assumed that they would want to be involved in assisted dying procedures, and in some situations could be a conflict of interests.

Hospice pharmacists might not want to participate in case this raised anxieties among patients and their families or carers around hastening a death. Established treatment pathways at the end of life should remain quite separate from a formal assisted dying procedure.

Legal protection

There must be explicit protection in place in any legislation for pharmacists, pharmacy technicians and other health care professionals to be protected from prosecution when participating in the approved process for an assisted dying procedure. [Section 24, Criminal liability for providing assistance] This protection must encompass all steps of the process and include all potential outcomes following the administration of medicines or treatments involved in the assisted dying procedure.

Alternative options

It must not be assumed that when a person presents with a request for assistance to end their life that this is indeed their actual first choice. People may present with a request for assisted dying when they are not aware of all the alternative options available to them. It is imperative that the best possible standard of palliative care is provided and that all options have been fully explored in a multidisciplinary, holistic approach to care.

[1] https://www.bma.org.uk/advice-and-support/ethics/end-of-life/physician-assisted-dying
[2] https://www.rcn.org.uk/-/media/Royal-College-Of-Nursing/Documents/Countries-and-regions/Scotland/2024/Response-Assisted-Dying-for-Terminally-Ill-Adults-Scotland-Bill.pdf

It should be a pre-requisite that counselling and advice on all the alternative options be provided to anyone contemplating assisted dying. [Section 4.4, Initial discussions with registered medical practitioners]

Patients should be given the opportunity to discuss the alternative options available to them, to give a clearer understanding of the scope and range of the best practice available in palliative care, including pain management, as well as fully explaining the assisted dying procedure, covering risks and expectations. A medication review to discuss polypharmacy issues including minimising the risk of side effects towards the end of life would be advantageous.

We would expect all suitable alternatives to be pursued and exhausted before returning to the prospect of an assisted dying. It has been shown in other countries that information and advice can encourage people to pursue alternatives to assisted death.

Assistance

A person must be able to self-administer the "approved substance" (Section 20) and be able to change their mind and halt the procedure at any point, to differentiate between assisted dying and euthanasia. A person's physical state might deteriorate between making their decision to end their life and the date planned for the procedure. This should not be a barrier to carrying out their wishes and therefore a flexible approach to the practicalities of assisting someone is required.

Mechanical devices might be required to overcome physical disability as some people by nature of their illness will not be able to swallow solids, or drink from a cup without a straw or without spilling. This aspect should be discussed in the care plan and may include advice from a pharmacist on the form of medicine to enable it to be taken.

The Bill states that, "The coordinating doctor may be accompanied by such other health professionals as the coordinating doctor thinks necessary" (Section 18.5 Provision of assistance). The Bill does not stipulate what the role of an accompanying health professional might be.

Assessment:

Two doctors should carry out a full assessment of the patient, which carries the responsibility for ensuring that the patient fits the necessary eligibility criteria

before a prescription for the approved substance can be issued. Whenever possible the patient and patient history should be known to one of the assessors.

National approach

National guidance and protocols must ensure that best practice for the procedure is consistently applied, with limited variation and a sound evidence base for the approved substance. Similar protocols and procedures should be in place no matter in which setting the patient is being cared for. This would include hospital, hospice, care home, the patient 's own home and any other domiciliary setting. The protocol should also cover the issue of prescriptions, supply, documented use and return and disposal of any unused medicines. A robust audit trail is required.

National guidance should be developed in discussion with pharmacists from both primary and secondary care (Section 30, Codes of practice) (Section 31, Guidance from Chief Medical Officers), including pharmacist membership of any multidisciplinary working groups. This should also include appropriate representation from Controlled Drugs Accountable Officers and Medication Safety Officers.

Registration with a GP in the country where the procedure is lawful and is to be carried out would also be required.

While the Assisted Dying and the Terminally Ill Adults (End of Life) Bill applies to England and Wales only, if it passes and if assisted dying is legalised in other parts of the UK in future, best practice and procedures must be harmonised nationally to minimise variation and support a clear, consistent approach for both patients and health professionals.

Patient Care

While this legislation does not set out all aspects of a potential model for assisted dying procedures, key issues around patient care would include:

- Appropriate forward planning, with documentation including a care plan drawn up with the patient to ensure their wishes are accommodated. This should include planning of all aspects on how the procedure will be carried out, who will be present and any consent required.
- Access to information and advice on the alternative options available.
- A person-centred approach to all aspects of assisted dying. Since people may change their mind from their initial decisions, they must be able to indicate their wishes until the final moments of their life.

- A person's wishes around confidentiality and the number of people party to the process.
- Access to health professionals and appropriate safeguarding, including in rural and remote areas.
- Families and carers should not be subjected to any unnecessary pressure and stress. They may or may not want to be involved in the practicalities of arranging a procedure.
- The presence of an impartial facilitator would be useful for all practical aspects of the procedure, including being an independent witness present at the death. The facilitator would not necessarily be a health professional and should not be a relative or anyone directly involved in the patient's healthcare.
- A confidential database, available to doctors when discussing assisted dying procedures with patients, with a list of the pharmacists and facilitators who have opted in, would allow patients a choice in whom they involve. It would support forward planning, including contingency planning if any of the original personnel were to be unavailable for any reason.

Prescribing and Dispensing

Considerations around prescribing and dispensing would include:

- In dispensing a prescription, a pharmacist assumes a proportion of the responsibility for that prescription and therefore must be assured that all legal requirements are in place and that it is entirely appropriate for the patient. The link to the clinical assessment of eligibility criteria is essential and therefore the prescriber should always be one of the assessors. In addition to the usual practice of checking that the prescription fulfils the necessary legal requirement, pharmacists must have full access to the patient 's diagnosis and assisted dying care plan.
- Consideration needs also to be given to the handling of all documentation to ensure a full audit trail, and facilitators will be bound by the same confidentiality requirements as currently apply to healthcare professionals. Security of the supply chain, likely managed in the same way as for controlled drugs, including arrangements relating to record keeping, the dispensing, supply, pick up and potential return and safe disposal of medication.
- The appropriate medicinal products may not be routinely held in stock but ordered as required for the individual patients. Forward planning must allow adequate time to ensure the prescription was available on the due date and to allow time for consultation with the facilitator to ensure all pharmaceutical care aspects are considered.

- The drugs used for this procedure will likely either not have a marketing authorisation in the UK for human use or will be used 'off label' rather than for the licensed indication.

Training and Education

To balance the needs of confidentiality and access to services, we advocate that pharmacists indicate their willingness to be involved by "opting in" to training and then be listed on a database with access restricted to doctors and those pharmacists and facilitators who have similarly opted in to participate in the scheme.

Doctors would then be able to access the information and identify registered personnel in order to start proceedings at a patient's request. Pharmacists who do not wish to be involved would not be listed and therefore would not be approached.

Pharmacists would require to be fully competent in the legal requirements of an assisted dying procedure and have knowledge of the necessary documentation, consent requirements and protocols. Joint training with other disciplines involved would be necessary to give a coordinated approach and common understanding of the process and respective responsibilities.

Training would always be optional, in line with the conscience clause of any legislation, but successful completion of the training must be mandatory before any involvement in an assisted dying procedure commences.

Palliative and End of Life Care

As a result of the information and advice which anyone requesting assisted dying would have available to them, and in keeping with a patient-centred NHS, we would both support and expect improvements in palliative care to allow equitable access for all patients diagnosed with a terminal illness.

January 2025