A WARNING ABOUT YOUR FUTURE

ALERT

DEFENDING VULNERABLE PEOPLE'S RIGHT TO LIVE

::DID YOU KNOW THAT::

NEW GUIDANCE in July 2018 from the British Medical Association in conjunction with the Royal College of Physicians and the General Medical Council, will enable doctors to dehydrate and sedate to death large numbers of non-dying patients with dementia, stroke or brain damage.

This change is based on the current legal position in which food and water given by tube, (Artificial Nutrition and Hydration) is considered 'medical treatment.' This means that it can be withdrawn using the Mental Capacity Act if deemed in the patient's 'best interest.'

THE SUPREME COURT in July 2018 ruled that minimally conscious patients and patients in a so called permanent vegetative state can be dehydrated to death without the usual Court of Protection approval.

CONSIDER THIS: dehydration is a painful and long process. Many people who have been thought to be in this situation have made amazing full and for some partial recoveries. These patients are as human as the rest of us; none of us know when it might be our turn to be at risk.

ADVANCE DIRECTIVES are now being used and encouraged as normal practice; should you change your mind or be unable to communicate there is NO GOING BACK.

::HERE'S SOMETHING YOU CAN DO::

::READ THIS ARTICLE BY TANNI GREY-THOMPSON (The Times 23/01/2019)::

"Those of us who are disabled," (and able-bodied) "console ourselves with the thought that we can at least look to our doctors for support. But now we find the Royal College of Physicians (RCP) is consulting its members on whether seriously ill people should be given lethal drugs to end their lives.

"Consultations are to be welcomed, provided they are run fairly. In the past the RCP has done that. The majority of its members said in 2014 that they opposed an assisted dying law, and that became the college's declared position. Not any longer. This time the college has decided to change the rules: it will be "neutral" unless at least two-thirds of members vote otherwise. Yet in the last consultation the neutrals made up only 31 per cent of the votes.

"Why has this crazy change been made? The official reason is that by being neutral the college can reflect the differing views of its members. The real reason is activism by the assisted dying lobby. Only a small minority of members want to see an assisted suicide law.

"Neutrality is, for them, the next best thing because it suggests (misleadingly) that there is a shift in medical opinion. So the activists have been lobbying the college's management to go neutral.

"What is being done now is a travesty of a consultation and, unless it is halted and restarted, it risks bringing the college into disrepute as a professional body."

IT SEEMS TO US THAT THE SURVEY HAS EXCLUDED THE MOST IMPORTANT PEOPLE.....YOU, THE PATIENTS.

We invite you to send the information overleaf to your doctor, who we are sure will welcome your views.

Enclosed is the response by Amy Proffitt (Secretary Association for Palliative Medicine) to the Poll.

Assisted dying: Why the RCP should be opposed by Amy Proffitt

Date: 14 January 2019

Dr Amy Proffitt is executive secretary of the Association for Palliative Medicine (APM) Policy Team

Email: policy@rcplondon.ac.uk

With the RCP preparing to poll its members about its stance on assisted dying, Dr Amy Proffitt, executive secretary of the Association for Palliative Medicine (APM), argues the case for opposing medical involvement.

The RCP's questions go to the heart of medicine. Should the law change to permit doctors to assist in the suicide of their patients? If so, this is a fundamental and irreversible shift in medicine's philosophy and practice. The core issue in this survey is not whether assisting suicide is ever right or wrong, but whether this is a medical duty.

The profession's view is central to this political debate because it is about a doctor's involvement. It is not possible to be neutral about an activity that a clinician is involved in administering. Neutrality implies that we have nothing to say one way or the other as to where our professional duties lie in the care of society's potentially most vulnerable people.

Your vote and the RCP's position have social and political consequences. In other legislatures where medical organisations became neutral, doctors are the ones implementing assisted suicide and carry full responsibility, including when things go wrong.

What does 'assisted dying' really involve?

In law, 'assisted dying' is assisted suicide. It is not about use of high doses of analgesia and similar medication to relieve distress. It concerns doctors having legal responsibility for assessing eligibility, declining or approving a request and providing drugs to patients with the deliberate intent to cause their deaths. This is usually a massive dose of barbiturates (ie 9-10 grams) with or without other drugs.

[...] would I myself be willing to supply or administer a massive dose of sedative +/- a muscle relaxant to patients with the deliberate intent of bringing about their death?
Dr Amy Proffitt, executive secretary of the Association for Palliative Medicine (APM)

There is a core question. Walk a mile in the shoes of a physician whose patient requests assisted suicide or death and ask yourself:

'If the law were changed, would I myself be willing to supply or administer (Canada's law includes this) a massive dose of sedative +/- a muscle relaxant to patients with the deliberate intent of bringing about their death?'

As colleagues and physicians, I would ask you to consider the following before you respond:

The role of medicine in any proposed legislation. This is not about the rights or wrongs of assisting suicide. It is possible for one both to favour assisted suicide, as a citizen, and support society having a

provision outside clinical medicine (as in Switzerland) whilst, as a physician, to oppose doctors' direct involvement. The question is whether the RCP supports this as a medical duty. Opposition does not hinder informed debate. Other professional bodies whose members are affected by the issue - the BMA, the RCGP, the British Geriatric Association, the Association for Palliative Medicine and the World Medical Association - oppose assisted dying. But they still engage at every level with all aspects of the debate, including contributing to balanced publications.

Political Consequences. In moving from opposition to neutrality, the RCP signals a significant shift. This will be misinterpreted by society, the media and Parliament to mean that physicians as a whole support legal change. In legislatures where medical societies became 'neutral', a change in the law placing the responsibility with doctors, followed quickly and irreversibly.

This is not about being out of step with public opinion. Our responsibility here is our duties as doctors to avoid harm, to maintain the trust of all our patients when rendered vulnerable by their illnesses and to protect our relationship with them. The public would expect this of us.

Trust. How should doctors respond to patients requests for lethal drugs? Even though clinical pressures and understaffing can undermine continuity of care, the way we listen and respond to such requests carries substantial weight and steers decision-making. Behind requests, the vast majority are seeking and need confirmation that we are fully committed to helping them live as well as possible until they die, and ensure they die peacefully, not to have their lives ended prematurely.

Social and not medical pressures. Wanting assistance to suicide or die may be triggered by something clinical, but Oregon's data show that the majority of reasons people seek assisted suicide are social and not medical. They relate to concerns about the inability to enjoy previous activities, fears about the future, worry about being a burden in needing support with care and losing autonomy.

Is autonomy relational? Autonomy is not simply an isolated expression of control. The impact of one person's action to end his or her life affects friends, family and carers, as well as society's attitudes to the dying generally. Physician-assisted dying creates expectations that deliberately ending life early is one of a physician's responsibilities.

Clinical burden. Many young doctors are feeling increasing pressure and worry about their own and colleagues' mental health and burnout. The literature on the personal impact on them of being involved directly in assisting suicide and euthanasia reports significant psychological morbidity. Given existing challenges in our workforce this could well be a growing concern for the future.

Safety. Suggested safeguards from supporters of physician assisted suicide cannot be clearly defined in law. Should the RCP's outcome favour physician assisted suicide, safety will be a major concern. We all have our limits. Because of our caring and compassionate relationships with our patients, we are not always best placed to judge objectively the social factors affecting a 'settled' wish to die such as the coercive psychological, relational and cultural pressures that may be in play.

If legislation involving doctors is given a 'green light' those responsible for and concerned about some of the most vulnerable and sick in society will carry the responsibility for a fundamental change in clinical practice. Neutrality will be misread as support for a change in the law. If the College is to have a default position, it should be the existing - and safe one - opposing medical involvement in assisting peoples' suicides.

Dr Amy Proffitt is executive secretary of the Association for Palliative Medicine (APM), and a consultant in Palliative Medicine at Barts health. The APM is developing developing a web resource in which you can find further reading and links to both sides of the argument.

::Physician Assisted Suicide::

Name:.....D.O.B:.....

Address: .....

.....

.....

Post Code.....

1. As a patient in your practice I wish to register my strongly held belief that assisted suicide in any form is wrong in any situation.

2. As a patient in your practice I believe that we should offer and fund good palliative care at the end of life.

3. As a patient in your practice I will not be using an Advance Directive, other than to say I would assert my right to live and not to have a doctor decide when I die.

4. I would also like to also say the following about this issue:

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Signed.....Date.....

WHAT'S THE COST OF EUTHANASIA?

You are!

If you would like to contact the Distant Voices or Alert then please visit

thedistantvoices.org

or

alertuk.org

Should you prefer to telephone:

01588 660528 / 02077302800