

The impact on general practice of prescribing assisted dying drugs

Assisted dying is the topic of much debate by societies and governments today. The issue of the drugs used to assist patients in dying, and their safety and efficacy, is rarely discussed. This has important implications for UK general practice if assisted dying is legalised and incorporated into existing health care.

Until 2016, doctors in Oregon in the US prescribed one of two oral barbiturates to produce unconsciousness and death. Since the European Commission restricted the sale of these barbiturates to the US due to their use in judicial executions, the availability of these drugs has become increasingly scarce. This has compelled doctors to prescribe experimental drug combinations to bring about patient death.

For example, in 2020, 87% of assisted deaths in Oregon have used a drug combination called 'DDMA', a mixture of a benzodiazepine, a cardiac glycoside, an opioid, and an antidepressant, with some also receiving a barbiturate. In Canada, oral protocols vary from a barbiturate plus antiemetic, to combinations of a benzodiazepine, barbiturate, opioid, and a hypnotic. Oregon has used four different protocols in the last 7 years.

ADVERSE EVENTS

The safety and efficacy of previous and current oral assisted dying drug combinations is not known. There have been few well-conducted studies, some several decades old. Using multiple drugs multiplies the risk of adverse events, especially when they are used in high doses in patients with no previous exposure. Reported adverse effects include vomiting, myoclonus, and a prolonged dying process of up to 47 hours.

In 2020, the official Oregon report stated that, compared with single barbiturates, '*All drug combinations have shown longer median times until death.*' The physical



and psychological impact of a prolonged assisted death on the patient has not been investigated, and we do not know the impact of such deaths on the grieving process of friends and relatives.

Oregon states the complication rate for assisted deaths in 2020 was 6.9% (5 out of the 72 cases where this information was known), but this does not include prolonged deaths, and information on complications was unknown in 70.6% (173 out of 245) of deaths. Reports by the Canadian Association of MAID Assessors and Providers acknowledge that individuals may experience a range of complications with oral assisted dying drugs. Drugs are normally required to undergo a formal approval process that demands direct measurements of patient outcomes. Using death as the only endpoint takes no account of how quick this was or what complications occurred on the way. Medical history is littered with examples of treatments that were widely used and promoted but later found to be harmful. Thalidomide was approved by 17 countries including the UK, until its harmful effects were recognised. Assisted dying drugs have less published data on patient and carer outcomes than thalidomide.

UNWILLING DOCTORS

If assisted dying is legalised in the bills

currently before the Westminster and Holyrood parliaments, GPs will have to consider prescribing untested drugs or drug combinations. This could breach General Medical Council prescribing guidance that a doctor *'must be satisfied that the drugs serve your patient's needs.'* In addition, the British Medical Association's 2020 survey on assisted dying showed a majority of UK licensed doctors (47% versus 34%) were unwilling to prescribe oral drugs for assisted dying.

Unless assisted dying is practised separately from health care, this will pose challenges for working relationships in general practice. This assumes that conscientious objection is protected, and the UK does not follow Canada in requiring all doctors and organisations to take part in assisted deaths.

It is not clear which drug or drug combination is most effective for bringing about a quick and peaceful assisted death. Oregon and Canada's untested use of multiple drug mixtures should act as a warning to jurisdictions and clinicians considering the legalisation of assisted dying.

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This article (with references) was first posted on *BJGP Life* on 28 Sep 2021; <https://bjgplife.com/assisted>

DOI: <https://doi.org/10.3399/bjgp21X717605>

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