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Research Report

Royal College of Anaesthetists

Assisted Dying / Suicide Research

November 2024

Please note, this report was updated in February 2025 following additional analysis of the free text responses to the survey. Section 4 has been expanded to include more detail but there are no substantive changes to the key findings.

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1. Key Findings

Over half of respondents (54%) think that the RCoA should change from its current position of "no stance".

- 34% believe that the RCoA should maintain the "no stance" position.
- Just over 1 in 10 (12%) meanwhile select 'don't know'.

Those who believe the RCoA should change from its current "no stance" position hold different views in terms of why they believe the RCoA should change its position, however a common thread amongst them is the belief that the RCoA should be involved in the discussions where its knowledge and expertise is relevant.

When asked about the RCoA's position regarding a change in the law **allowing doctors to prescribe drugs for eligible patients to self-administer to end their own life**, just under half of respondents (49%) say they are supportive, believing that the RCoA should actively support attempts to change the law.

- 17% are opposed (the RCoA should actively oppose attempts to change the law).
- 3 in 10 (29%) are neutral, believing that the RCoA should neither actively support nor actively oppose attempts to change the law.
- 5% of respondents say they were undecided on the matter.

Furthermore, two-fifths (40%) express the view that the RCoA should actively support attempts to change the law **allowing doctors to administer drugs with the intention of ending an eligible patient's life**.

- 23% are opposed (the RCoA should actively oppose attempts to change the law).
- 29% believe the RCoA should be neutral on this matter.
- The remaining 8% are undecided.

Respondents who believe that the RCoA should change from its no stance position, and who think that the RCoA should actively support attempts to change the law, typically express the view that they want to see patients who are terminally ill suffer less, and they feel that it is a positive move to give autonomy to terminally ill patients to decide how they want to die.

Respondents who oppose attempts to change the law believe that assisted dying / assisted suicide goes against the core role of an anaesthetist whilst also increasing the risk that vulnerable people may be negatively affected by the change in law which allows for assisted dying / assisted suicide.

The overall results, including free-text responses, highlight the deep emotional impact of assisted dying / assisted suicide among RCoA members, revealing a significant division in opinions. These differences in opinion are illustrated in the subsequent findings.

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2. Background & Methodology

2.1 Background

The Royal College of Anaesthetists (RCoA) is the professional body responsible for the specialty representing c.26,000 members and anaesthetists across the UK. It is a charity, acts as a voice for the profession, oversees standards for training, sets exams, sets clinical standards, conducts research, and develops evidence-based policy.

In 2024, the College commissioned independent research agency Research by Design (RbD) to conduct research on understanding the views of the entire RCoA membership on assisted dying/assisted suicide.

Currently, the RCoA has a 'no stance' position on assisted dying, which means it does not actively contribute to public debate on the subject. The purpose of this research was therefore to understand what the RCoA membership think about the College's position regarding assisted dying/assisted suicide so that Council can consider your views in discussions about the current 'no stance' position

2.2 Methodology

The survey questions used in this research were designed by the RCoA's Ethics Committee and then agreed by Council. In total, the survey consisted of 8 questions (7 closed questions and 1 free text question).

The survey sought the opinions of RCoA members on whether the RCoA should maintain its current position of 'no stance' regarding assisted dying/assisted suicide. After this question, all respondents were then asked an additional two questions about two key scenarios:

- Situations where a **doctor would prescribe** drugs so that an eligible patient can self-administer them to end their own life; and
- Situations where a **doctor would administer** drugs to end an eligible patient's life.

The questions were designed to capture the opinions of members on what they think the College's position should be for each scenario if the College were to change from its current position of no stance.

RbD scripted and hosted the survey, ensuring that individual responses remained strictly anonymous, adhering to the Market Research Society Code of Conduct. Members of the RCoA were each supplied with a unique link, meaning participants could only complete the survey once. All members of the RCoA were invited to take part. Throughout fieldwork, those who had not completed the survey received up to 4 reminders encouraging them to take part.

The survey launched on the 8th of July 2024 and was live until 5th of August 2024. The survey received a total of 4,902 complete responses, comprising a 23% response rate.

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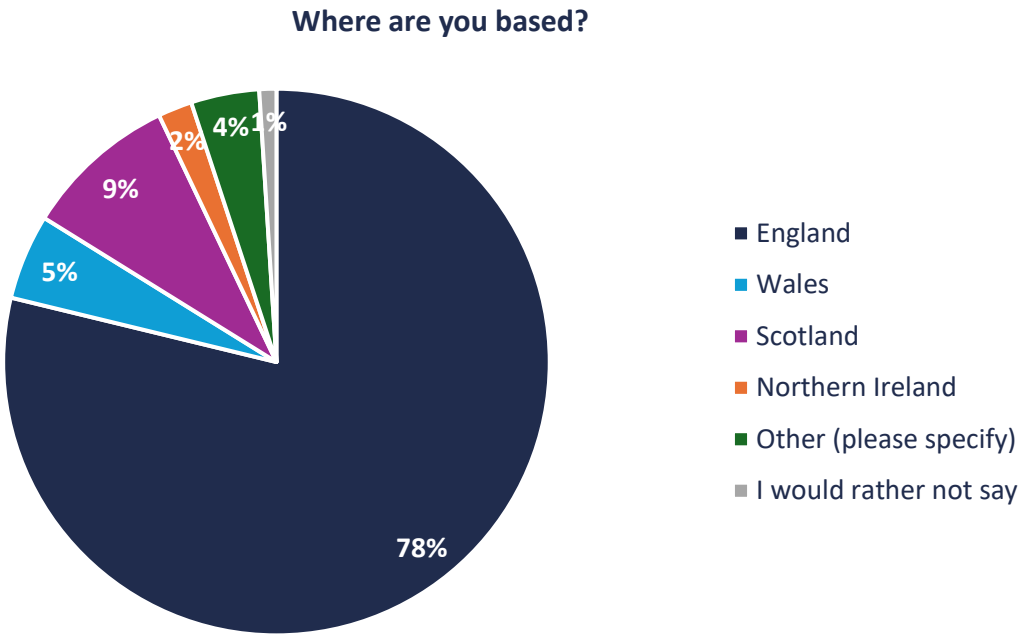
For the free text question, we have chosen a representative selection of quotations that broadly reflect the balance of supportive, opposed and neutral sentiment shown in the quantitative data. The chosen quotations are spread across a range of member grades and locations to illustrate the views across a broad demographic range.

2.3 Overview of responses

The survey achieved a total of 4,902 responses, and allowed respondents to self-declare the following details:

- Their location (where they are based)
- Their grade
- Whether they are a member of the Faculty of Pain Medicine
- Whether they are currently registered or provisionally registered with a licence to practise in the UK.



Where are you based? Base: Asked to all (4,902 respondents).

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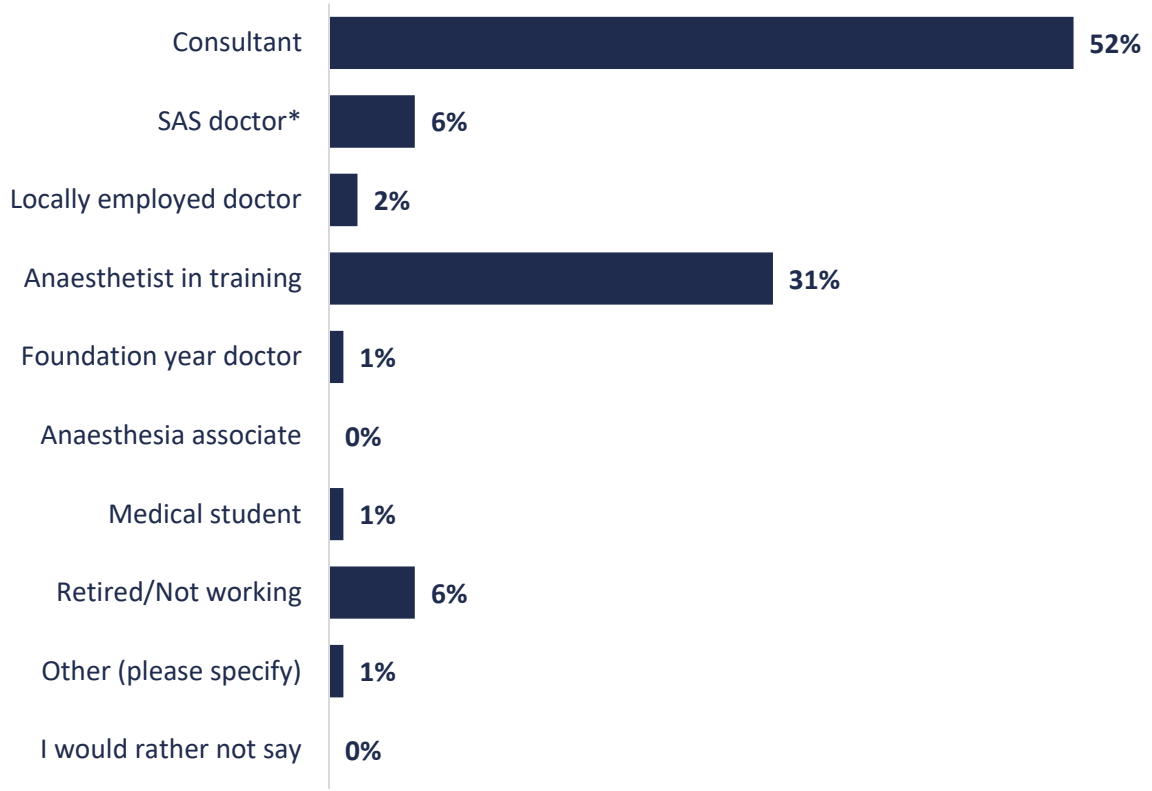
What is your current grade?



What is your current grade? Base: Asked to all (4,902 respondents).

**Specialty Doctors, SAS Specialists, Associate Specialists, Staff Grades and other closed SAS grades*

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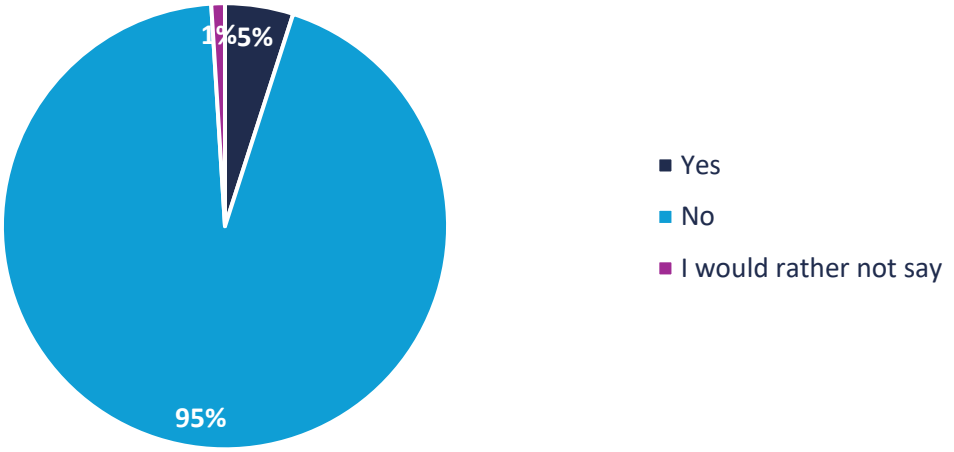
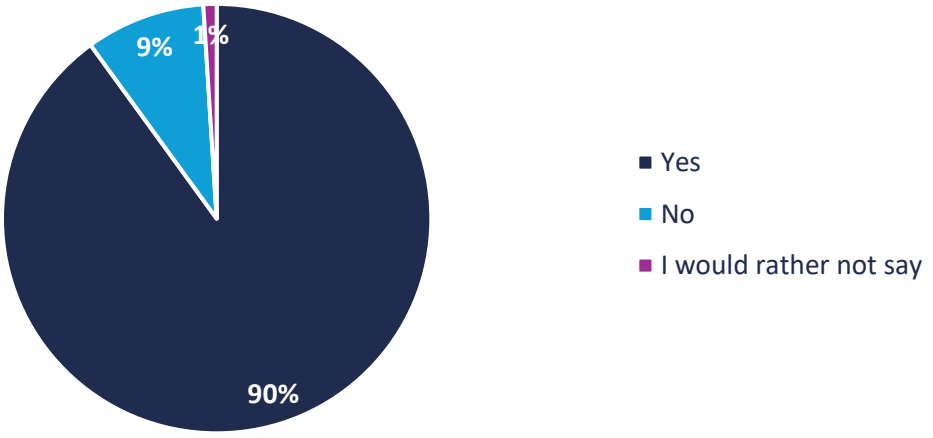
Are you a member of the Faculty of Pain Medicine?



Are you a member of the Faculty of Pain Medicine? Base: Asked to all (4,902 respondents).

Are you currently registered or provisionally registered with a licence to practise in the UK?



Are you currently registered or provisionally registered with a licence to practise in the UK? Base: Asked to all (4,902 respondents).

2.4. Interpretation of the data

2.4.1 Tables and charts

Within the main body of the report, where figures are not shown in the charts, these are 3% or less, and where percentages do not sum to 100% this is due to rounding or more than one answer being given.

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The 'base' figure referred to in each chart and table is the total number of respondents answering the question. The population group (e.g., all or a particular member category) is defined alongside the base.

Whilst all RCoA members were invited to participate in the survey, the report focuses on respondents who selected one of the following answers when asked 'Where are you based?':

- England
- Wales
- Scotland
- Northern Ireland

The total number of respondents based in the UK is 4,670, which makes up 95% of the total sample.

All those who selected 'I would rather not say' or 'Other (please specify)' and who have left free text comments revealing they are based in another country (outside of the UK) are not included in the overall analysis of the results. However, Appendix 1 provides a table showcasing how respondents from outside of the UK (identified through selecting 'Other') compare to those based in the UK.

When results are analysed by current grade, the charts only show those grades whereby the sample size is equal to or greater than 50. Any grades where the base is lower than 50 (Anaesthesia associates, Medical Students, those who selected 'Other' or 'I would rather not say') are not shown in the charts, although they are still included in the total.

2.4.2. Weighting

Research by Design compared the RCoA database (the total population) with the total sample achieved in the survey to check whether the survey sample required weighting. After running the comparisons, the sample was not weighted as the natural fallout of the survey sample closely aligned with profile of the full RCoA membership database.

2.4.3. Sampling confidence and margin of error

By the nature of surveys typically representing the views of a sample of the population, sampling error must be considered when evaluating the findings. This is measured by the confidence level and confidence interval of the data. Most commonly, market research studies require a 95% confidence level, indicating that we can be 95% confident that the estimate has not been arrived at by chance.

The confidence interval shows the variation that may exist in the findings drawn from a sample. When interpreting a result from this survey based on a question which all respondents answered, with a response of 50%, a margin of error of ±1.3% is created when analysing results at the 95% confidence level. If the survey was repeated, then 95 times out of 100, the result to that same question would fall somewhere between 48.7% and 51.3%. This is shown in the table below:

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Confidence intervals			
	Split on question (%s responding)		
Size of sample	10% or 90% ±	30% or 70% ±	50% ±
4,902 (total sample size)	0.8	1.2	1.3

2.4.4. Statistical significance

The differences in results between sub-groups, for example role, are tested for statistical significance. This way we know whether the differences are "real" or whether they could have occurred by chance. The test reflects the size of the samples, the percentage giving a certain answer and the degree of confidence chosen. Where statistically significant differences between sub-groups exist, details have been included within this report. Throughout this report we have used capital letters (e.g., A, B, C, …) to reference, in order, each column of data. For example, A refers to the first column, B to the second column, and so on. These letters are then used in the main body of the table to highlight statistically significant differences; letters are boldened to show whether a percentage is significantly higher when compared with another in the same row. This is demonstrated in the key below.

Significantly higher

Here is an example of significance testing used in the report. This table shows the proportion of participants (by UK Nation) who are supportive, opposed, neutral, or undecided on what the position of the RCoA should be on a change in the law allowing doctors to prescribe drugs for eligible patients to self-administer to end their own life.

Looking at column E – those in Northern Ireland – we see that 38% are opposed. The significance testing indicates that the proportion of this group who oppose is significantly higher than the proportion of those who oppose from England (B), Wales (C), and Scotland (D).

	UK Nation			
	England (B)	Wales (C)	Scotland (D)	Northern Ireland (E)
Sample size	*3,832*	*245*	*457*	*121*
Supportive	50%	47%	46%	29%
	E	E	E	
Opposed	16%	19%	18%	38%
				BCD
Neutral	29%	29%	30%	26%
I am undecided	5%	5%	6%	7%

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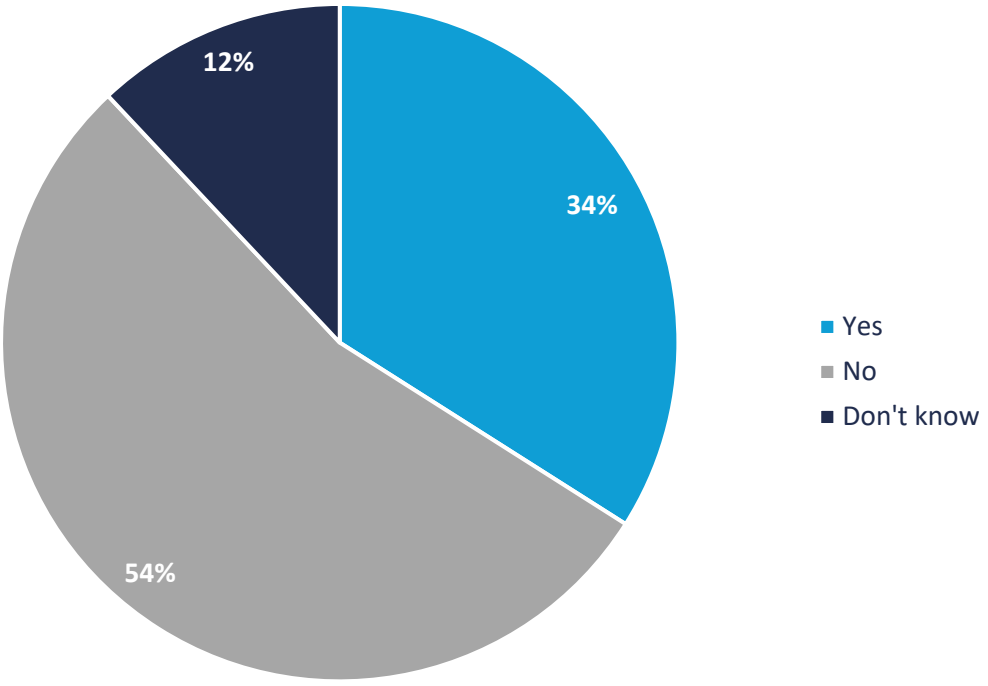
3. Research Findings

3.1. Views on the current position of the RCoA

All respondents were asked their view on whether the RCoA should maintain its current position of "no stance" on Assisted Dying/Assisted Suicide. Just over half (54%) express the view that the RCoA should change from its current position of "no stance".

Meanwhile, one third (34%) do not feel that the RCoA should change its current position, with the remaining 12% selecting 'don't know'.

Should the Royal College of Anaesthetists maintain its current position of "no stance" on Assisted Dying/Assisted Suicide? [UK only]



Should the Royal College of Anaesthetists maintain its current position of "no stance" on Assisted Dying/Assisted Suicide? Base: Asked to all (4,670 respondents).

Those who are in favour of the RCoA moving away from its current position of "no stance" believe that it is best that the RCoA has a stance which means that it is able to be involved in the discussions that are being had.

"I think we [the RCoA] should have a stance, rather than no stance. We should have an opinion and be able to engage in discussion, rather than not having an opinion."

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"This is perhaps a once in a generation opportunity to move the discussion forward with assisted dying. Too many patients we see are suffering and I have met my fair share of patients (when consenting for high-risk anaesthesia for emergency operations & mortality risks are discussed) who, out of desperation, have asked if I can make sure they don't wake up. It is an immensely difficult subject to be involved with, but we should not shy away from difficult subjects. How will society move beyond its current impossible situation unless we are prepared to take a stance?"

Section 4 provides additional analysis as to why respondents believe that the RCoA should change its current position, exploring the reasons for this view held by those who believe the RCoA should actively support attempts to change the law, as well as though who believe the RCoA should actively oppose such attempts.

As highlighted in the above chart, around a third of respondents do believe that the RCoA should maintain its current "no stance" position. Firstly, they believe that the very nature of the topic (assisted dying/assisted suicide) is so sensitive and divisive that having a stance would result in alienating and aggravating a considerable proportion of members. As such, they feel that in order to **respect the varying personal views of all members**, the College should maintain its position of 'no stance' until there is a clear majority one way or the other. However, it is worth noting that the free text below evidences that some members use the term 'no stance' and 'neutral' interchangeably. Taking this into consideration, it will be important to clearly communicate the nuances of these positions.

"This is a highly controversial topic with a wide range of views within the medical community. Taking a stance one way or the other will inevitably alienate some members, and the decision is ultimately a legal one. Unless it becomes clear that an overwhelming majority of members support or oppose assisted dying, it seems appropriate for the college to take a neutral stance."

"This is a divisive topic. The College should stay neutral to support members on both sides of the discussion and also those whose views are undecided or wish to stay neutral."

"I think the College is, at most, a minor stakeholder and so we should not be seeking to shape or influence the debate. Views of patients who are terminally ill, those with disabilities, those in palliative care, those with legislative experience are more valid for informing public debate. Most anaesthetists will make a personal decision when/if the law changes about their degree of involvement. Attempting to shape/influence will concurrently run a risk of losing trust of at least some of our patients, or by allowing us to make them unconscious place themselves a very vulnerable position."

"I expect that members have a diverse range of views on this topic, of varying strengths either in favour, opposition or neutrality. I do not think it is fair on members for the College to take a side in this debate without a significant majority of members holding the same view."

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Meanwhile other respondents believe that it is **not for the RCoA to influence societal and political debates** such as assisted dying/assisted suicide. As such, they believe that being involved in the discussion would be **beyond the remit of the College**.

"I don't think the policy on assisted dying should be decided by clinicians. We should react to any chance in societal desires but be guided by wider society. It is not our place to push our views as a specific cohort onto the entire population of the country. If legislation were to change, then asking how we respond in terms of anaesthetists partaking would be appropriate."

"I think it would be very unwise to get involved in the public debate on this and that we should maintain a distance until the legal position is established."

"This is a societal issue not a medical one per se. The colleges should avoid trying to influence opinion one way or another. If the law changes, then the colleges should absolutely exert influence on how any changes are implemented, appropriate checks and balances."

"The Royal College of Anaesthetists is responsible for setting standards and training in our profession. I can see no role for the college in influencing debate, or lobbying to influence legislation on what is at its core a societal question."

"This is an ethical and moral question. I regard this as falling outside the core role and responsibilities of the College. I am personally supportive of a change in the law, but it is not the role of the College to support / oppose it."

"I feel this is not the scope of anaesthetic practice and if the law were to change, doctors in the specialisms of palliative care, psychiatry, medicine for the elderly and intensive care would be better placed to be involved in these discussions."

Another key theme emerging from the free text responses of those who believe the RCoA should keep its "no stance" position is that they believe that **anaesthetists should not be playing a role** in the decision-making process of a patient who is considering ending their life.

"We are primarily tasked with providing safe perioperative care, I do not think we should be dealing with end-of-life issues outside of the ICU and even then, with input/guidance from our colleagues in Palliative Care."

"I think the college should remain neutral on this topic as I don't feel this is an area where anaesthetists should be involved. if it is legalised which I am generally in support of, I think this area should be managed by palliative care

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consultants with special training who are experienced in the management of patients with terminal disease as they are best placed to make ethical decisions on end-of-life care."

"Although pain management is part of anaesthetic expertise, we do not have the longer-term relationships with patient which would allow us to support patients in these decisions."

Finally, respondents within this category also express **anxiety** around how patients (and potentially society in general) will feel towards anaesthetists if assisted dying/assisted suicide is supported by the College – **how can patients trust anaesthetists** to preserve their life if their role in ending lives becomes more prominent?

"I think anaesthetists should not participate in assisted dying as it might severely undermine the trust of patients towards us."

"This is a very slippery slope. It is not something that I want my college to be supportive of as once you have opened the door you will not be trusted by the public to offer care in places like ICU or in theatre if the public think that we are pro death."

"Attempting to shape/influence will concurrently run a risk of losing trust of at least some of our patients, or by allowing us to make them unconscious place themselves a very vulnerable position."

3.1.1 Analysis by grade

Consultants (38%), SAS Doctors (36%), Locally Employed Doctors (37%) as well as those who are retired / no longer working (41%) are the more likely groups to say that the RCoA should maintain its current position of "no stance". However, over half of all these groups still express the view that the RCoA should change its position.

Compared to other membership grades, Anaesthetists in Training (AiTs) are most likely to think that the RCoA should change its current position (59% think this). When looking at statistically significant results, AiTs are significantly more likely than Consultants and those who are retired / not working to believe that the RCoA should change from its position of "no stance".

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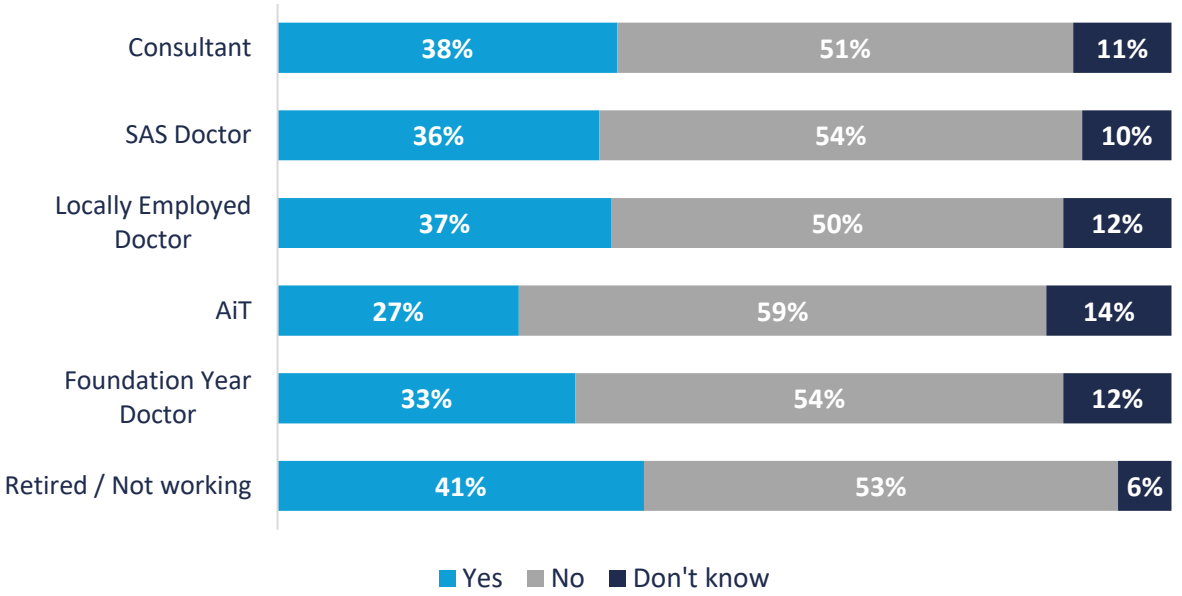
Should the Royal College of Anaesthetists maintain its current position of "no stance" on Assisted Dying/Assisted Suicide?

[By grade - UK only]



Should the Royal College of Anaesthetists maintain its current position of "no stance" on Assisted Dying/Assisted Suicide? Base: Consultant (2,374 respondents); SAS Doctor (282 respondents); Locally Employed Doctor (107 respondents); AiT (1,488 respondents); Foundation year doctor (57 respondents); Retired/Not working (291 respondents).

3.1.2 Analysis by UK nation

When breaking responses down by where respondents are based in the UK, the results show that there is little variance by location.

37% of respondents from Wales, Scotland and Northern Ireland express the view that the RCoA should maintain its current position of "no stance".

49% of respondents from Scotland and Northern Ireland and 52% of respondents from Wales believe that the RCoA should change its position. Meanwhile a slightly higher proportion of respondents from England (55%) feel the RCoA should change its position.

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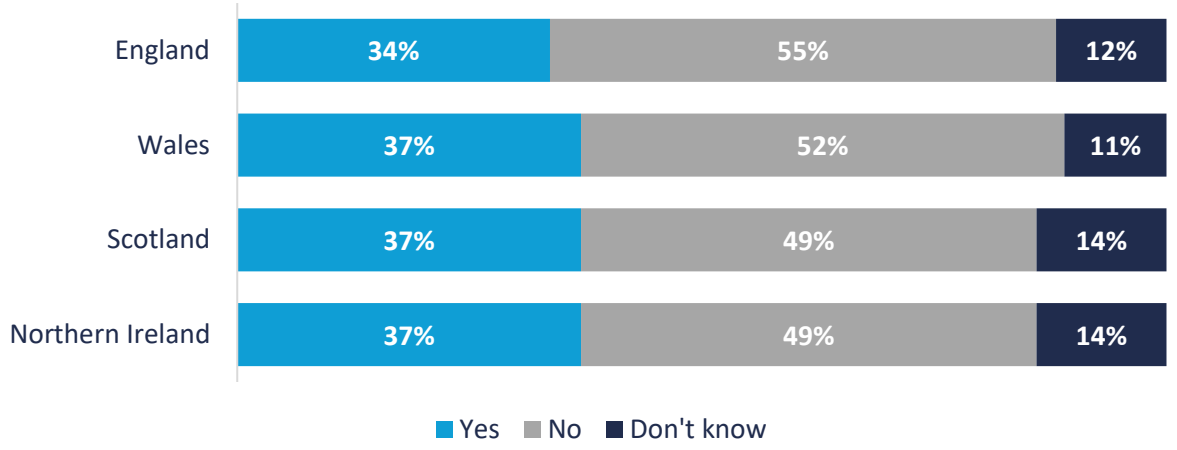
Should the Royal College of Anaesthetists maintain its current position of "no stance" on Assisted Dying/Assisted Suicide?
[By Devolved Nation]



Should the Royal College of Anaesthetists maintain its current position of "no stance" on Assisted Dying/Assisted Suicide? Base: England (3,845 respondents); Wales (245 respondents); Scotland (459 respondents); Northern Ireland (121 respondents).

3.1.3 Analysis by whether respondents are a member of the Faculty of Pain Medicine

There is little variation (and no significant difference in the survey results) by whether respondents are a member of the Faculty of Pain Medicine at the RCoA or not. 55% of respondents who are a member of the Faculty of Pain Medicine think that the RCoA should change from its current position of no stance, but this proportion is in line with the 54% who are not a member of the Faculty of Pain Medicine.

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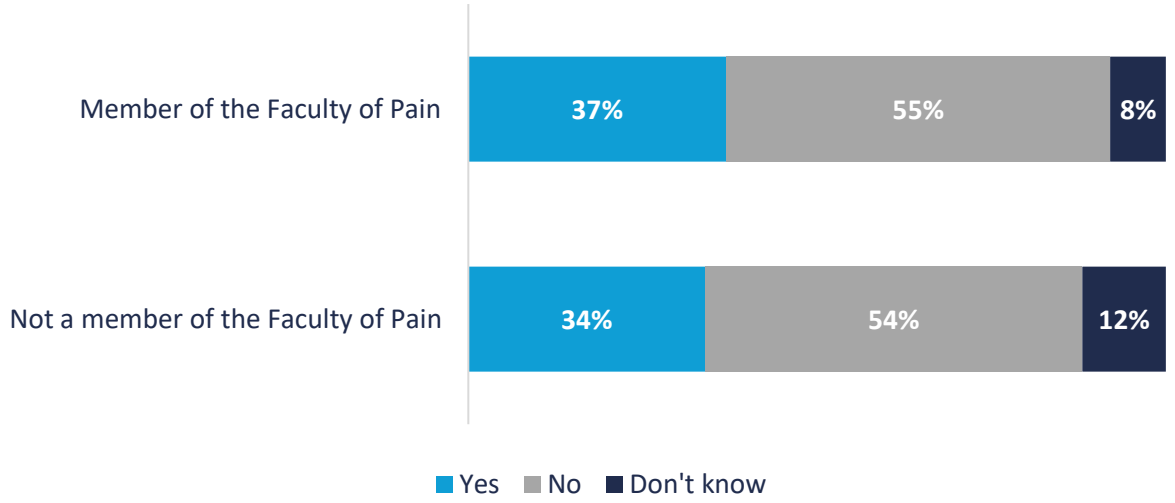
Should the Royal College of Anaesthetists maintain its current position of "no stance" on Assisted Dying/Assisted Suicide?
[By Faculty of Pain Medicine membership - UK only]



Should the Royal College of Anaesthetists maintain its current position of "no stance" on Assisted Dying/Assisted Suicide? Base: Member of the Faculty of Pain Medicine (219 respondents); not a member of the Faculty of Pain Medicine (4,429 respondents). Those who selected 'I would rather not say' to whether they are a member of the Faculty of Pain Medicine (22 respondents) have not been included in the chart.

3.2. Views on what the RCoA's position should be regarding a change in the law allowing doctors to prescribe drugs for eligible patients to self-administer to end their own life

All respondents[1] were asked for their view on what RCoA's position should be on a change in the law **allowing doctors to prescribe drugs** for eligible patients to self-administer to end their own life.

Just under half (49%) say they are supportive, believing that the RCoA should actively support attempts to change the law. Meanwhile 17% are opposed (the RCoA should actively oppose attempts to change the law) and 3 in 10 (29%) are neutral, believing that the RCoA should neither actively support nor actively oppose attempts to change the law. 5% of respondents say they were undecided on the matter.

[1] Whilst this question was shown to everybody, it was not mandatory meaning those respondents who did not want to answer this question could skip and move on to the next question.

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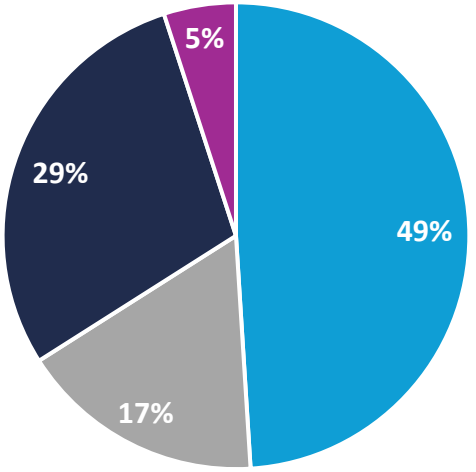
What should the position of the Royal College of Anaesthetists be on a change in the law allowing doctors to prescribe drugs for eligible patients to self-administer to end their own life? [UK only]



- Supportive – the RCoA should actively support attempts to change the law
- Opposed – the RCoA should actively oppose attempts to change the law
- Neutral – the RCoA should neither actively support nor actively oppose attempts to change the law
- I am undecided

What should the position of the Royal College of Anaesthetists be on a change in the law allowing doctors to prescribe drugs for eligible patients to self-administer to end their own life? Base: Asked to all (4,655 respondents).

3.2.1 Analysis by grade

Whilst opinion does vary a little by grade, every grade has the highest proportion of respondents being supportive of the RCoA actively attempting to change the law:

- Foundation year doctor – 60% supportive
- AiTs – 55% supportive
- Locally Employed Doctors – 48% supportive
- Consultants – 46% supportive
- SAS doctors – 46% supportive
- Retired / not working – 45% supportive

When comparing grades and identifying statistically significant differences, Foundation year doctors (60% supportive) and AiTs (55% supportive) are significantly more likely to express the view that the RCoA should

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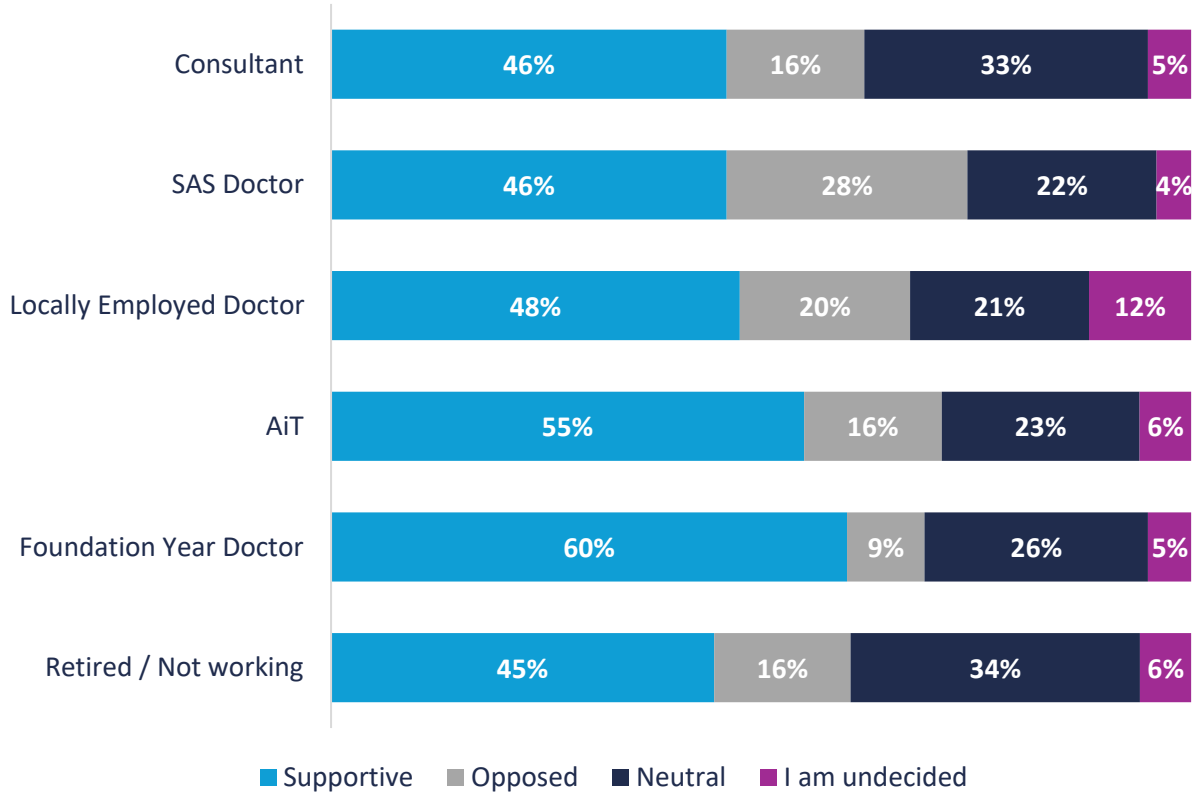
actively support attempts to change the law compared to Consultants (46%) and those who are retired or not currently working (45%).

A third of both Consultants and those retired / not working believe the position of the RCoA should be neutral (the RCoA should neither actively support nor actively oppose attempts to change the law) and they are significantly more likely to hold this view compared to SAS doctors (22%), AiTs (23%) and Locally Employed Doctors (21%).

SAS doctors have the largest proportion of respondents who say they are opposed (28%), believing the RCoA should actively oppose attempts to change the law.

What should the position of the Royal College of Anaesthetists be on a change in the law allowing doctors to prescribe drugs for eligible patients to self-administer to end their own life?
[By grade - UK only]



What should the position of the Royal College of Anaesthetists be on a change in the law allowing doctors to prescribe drugs for eligible patients to self-administer to end their own life? Base: Consultant (2,370 respondents); SAS Doctor (280

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respondents); Locally Employed Doctor (107 respondents); AiT (1,485 respondents); Foundation year doctor (57 respondents); Retired/Not working (286 respondents).

3.2.2 Analysis by UK nation

Amongst respondents from England, Wales and Scotland, there is consistency regarding their views on the position of the RCoA regarding a change in law allowing doctors to prescribe drugs for eligible patients to self-administer to end their own life. For each of those three nations, around half express the view that the RCoA should actively support attempts to change the law.

Respondents from England, Wales and Scotland are also significantly more likely than respondents from Northern Ireland to say they are supportive.

	UK Nation			
	England (B)	Wales (C)	Scotland (D)	Northern Ireland (E)
Sample size	*3,832*	*245*	*457*	*121*
Supportive	50%	47%	46%	29%
	E	E	E	
Opposed	16%	19%	18%	38%
				BCD
Neutral	29%	29%	30%	26%
I am undecided	5%	5%	6%	7%

Respondents from Northern Ireland are significantly more likely than those in England, Wales and Scotland to say they are opposed (38% express this view, with 29% being supportive), believing that the RCoA should actively oppose attempts to change the law.

3.2.3 Analysis by whether respondents are a member of the Faculty of Pain Medicine

Overall, there is little variation in terms of level of support for the RCoA actively attempting to change the law by whether respondents are a member of the Faculty of Pain Medicine at the RCoA or not. Of those who are a member of the Faculty of Pain Medicine, 50% cite being supportive, whilst those who are not a member, 49% are supportive.

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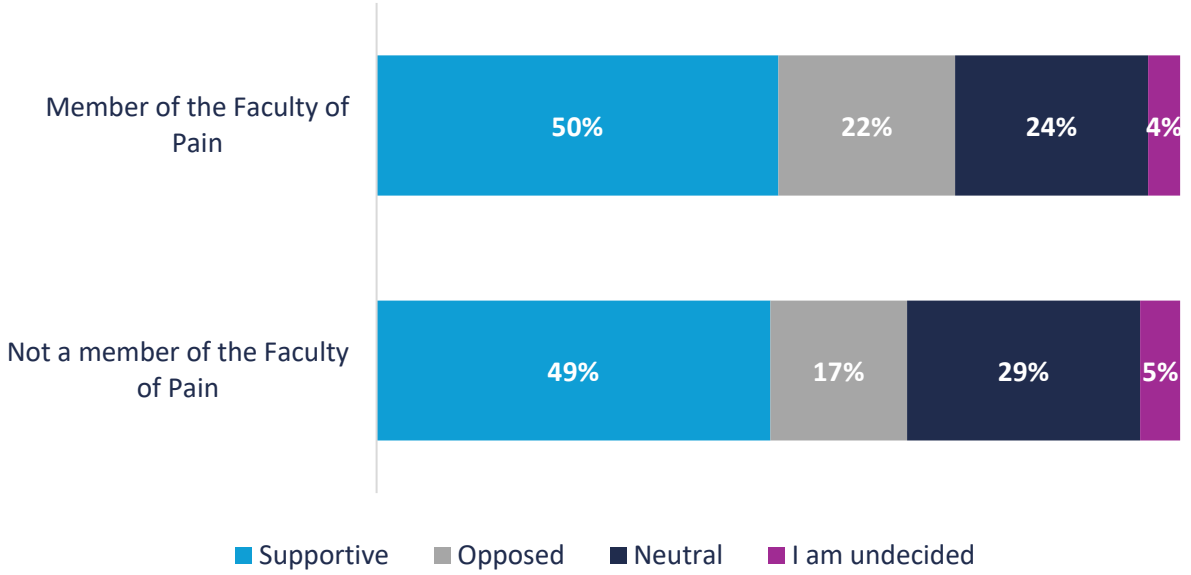
However, 22% of respondents who are a member of the Faculty of Pain Medicine believe that the RCoA should actively oppose attempts to change the law, in comparison to 17% who are not a member of this Faculty, with this difference being statistically significant.

What should the position of the Royal College of Anaesthetists be on a change in the law allowing doctors to prescribe drugs for eligible patients to self-administer to end their own life?
[By Faculty of Pain Medicine membership - UK only]



What should the position of the Royal College of Anaesthetists be on a change in the law allowing doctors to prescribe drugs for eligible patients to self-administer to end their own life? Base: Member of the Faculty of Pain Medicine (218 respondents); not a member of the Faculty of Pain Medicine (4,415 respondents). Those who selected 'I would rather not say' to whether they are a member of the Faculty of Pain Medicine (22 respondents) have not been included in the chart.

3.3. Views on what the RCoA's position should be regarding a change in the law allowing doctors to administer drugs with the intention of ending an eligible patient's life

The final closed question asked respondents their view on what the position of the RCoA should be on a change in the law **allowing doctors to administer drugs** with the intention of ending an eligible patient's life.

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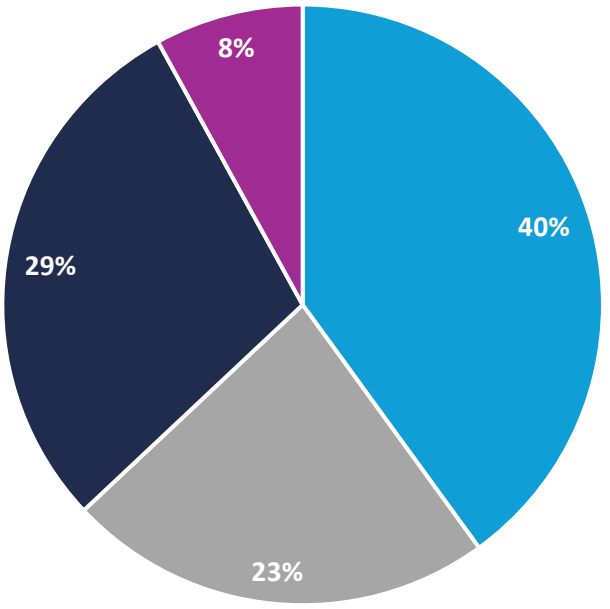
Two-fifths (40%) express the view that the RCoA should actively support attempts to change the law with 23% being opposed (the RCoA should actively oppose attempts to change the law). 29% cite that the RCoA should be neutral with the remaining 8% being undecided.

What should the position of the Royal College of Anaesthetists be on a change in the law allowing doctors to administer drugs with the intention of ending an eligible patient's life? [UK only]



- Supportive – the RCoA should actively support attempts to change the law
- Opposed – the RCoA should actively oppose attempts to change the law
- Neutral – the RCoA should neither actively support nor actively oppose attempts to change the law
- I am undecided

What should the position of the Royal College of Anaesthetists be on a change in the law allowing doctors to administer drugs with the intention of ending an eligible patient's life? Base: Asked to all (4,627 respondents).

3.3.1 Analysis by grade

Compared to other member grades, Anaesthetists in Training are most likely to express the view that the RCoA should actively support attempts to change the law allowing doctors to administer drugs with the intention of ending an eligible patient's life (44% of this grade express this view). Locally Employed Doctors are the 2nd most likely group to express support (43%) followed by SAS Doctors (41%).

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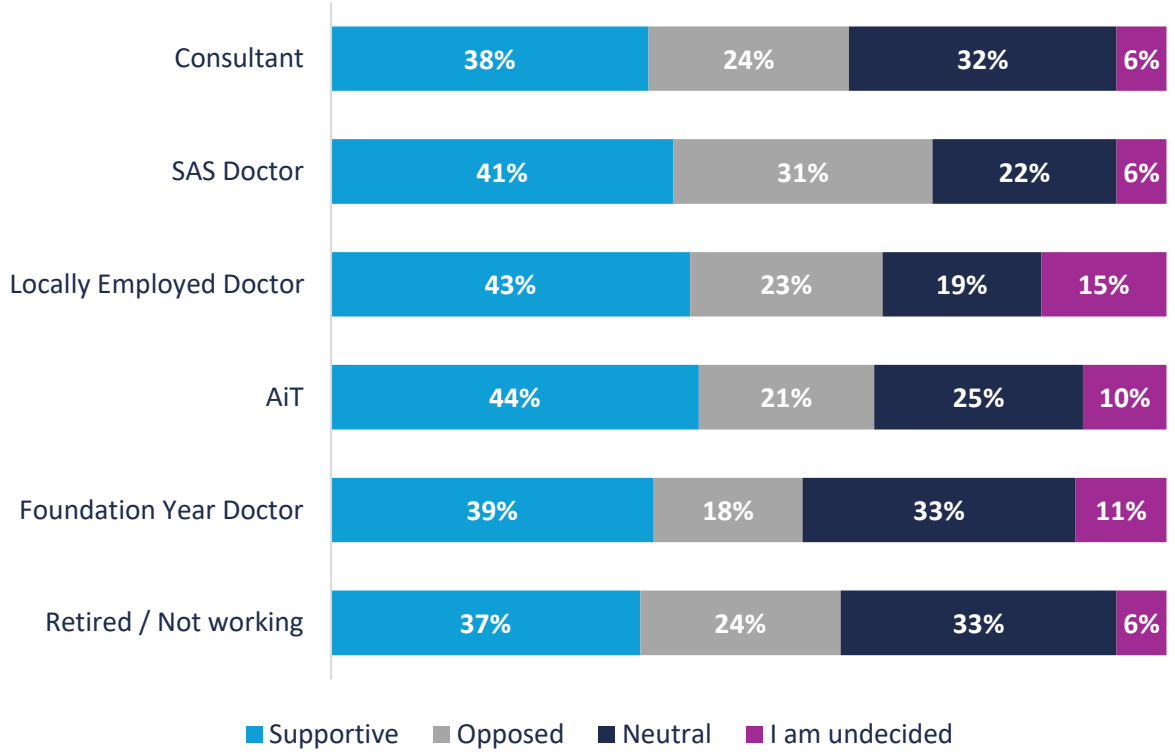
Meanwhile, 39% of Foundation year doctors, 38% of Consultants and 37% of those who are retired / not working say they are supportive.

What should the position of the Royal College of Anaesthetists be on a change in the law allowing doctors to administer drugs with the intention of ending an eligible patient's life?

[By grade - UK only]



What should the position of the Royal College of Anaesthetists be on a change in the law allowing doctors to administer drugs with the intention of ending an eligible patient's life? Base: Consultant (2,353 respondents); SAS Doctor (279 respondents); Locally Employed Doctor (103 respondents); AiT (1,482 respondents); Foundation year doctor (57 respondents); Retired/Not working (282 respondents).

Looking at those who oppose attempts to change the law, SAS doctors are most likely to say that they believe that the RCoA should actively oppose attempts, with 31% selecting this. Meanwhile a quarter (24%) of Consultants and those who are retired / not working say they are opposed.

A third of Foundation year doctors express neutrality, and this makes them the most likely of all the grades to hold this view along with those who are retired / not working. These groups are followed by 32% of Consultants who also express this view.

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3.3.2 Analysis by UK nation

Respondents from England are most likely to say they are supportive (41%), believing that the RCoA should actively support attempts to change the law allowing doctors to administer drugs with the intention of ending an eligible patient's life. Respondents from England are significantly more likely to be supportive compared to respondents from Scotland (36%) and Northern Ireland (25%).

Respondents from Northern Ireland are significantly more likely than those from England, Wales and Scotland to express the view that the RCoA should actively oppose attempts to change the law (43% express this view).

	UK Nation			
	England (B)	Wales (C)	Scotland (D)	Northern Ireland (E)
Sample size	*3,807*	*242*	*458*	*120*
Supportive	41%	40%	36%	25%
	DE	E	E	
Opposed	22%	25%	27%	43%
			B	BCD
Neutral	29%	27%	29%	26%
I am undecided	8%	8%	8%	6%

3.3.3 Analysis by whether respondents are a member of the Faculty of Pain Medicine

Finally, 46% of respondents who are members of the Faculty of Pain Medicine feel that the RCoA should actively support attempts to change the law, compared to 40% of those who are not members (this difference is not statistically significant).

27% of respondents who are members of the Faculty of Pain Medicine feel that the RCoA should actively oppose attempts to change the law, compared to 23% of those who are not members of the Faculty of Pain Medicine (this difference is not statistically significant).

However, those who are not members of the Faculty of Pain Medicine are significantly more likely than those who are members to express being neutral on the matter (29% vs 22%).

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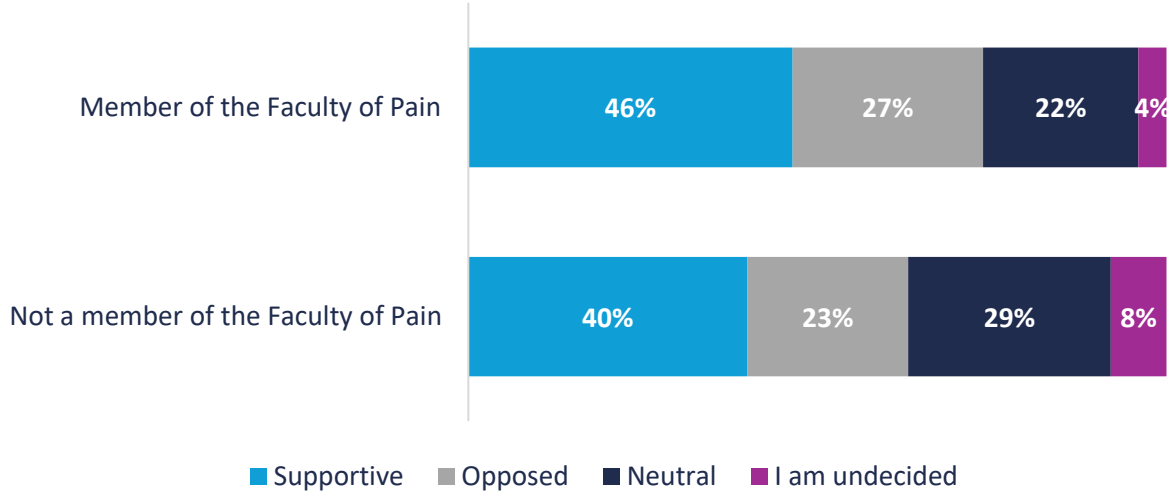
What should the position of the Royal College of Anaesthetists be on a change in the law allowing doctors to administer drugs with the intention of ending an eligible patient's life?

[By Faculty of Pain Medicine membership - UK only]



What should the position of the Royal College of Anaesthetists be on a change in the law allowing doctors to administer drugs with the intention of ending an eligible patient's life? Base: Member of the Faculty of Pain Medicine (216 respondents); not a member of the Faculty of Pain Medicine (4,390 respondents). Those who selected 'I would rather not say' to whether they are a member of the Faculty of Pain Medicine (21 respondents) have not been included in the chart.

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4. Free Text Analysis

The final question in the survey asked respondents 'to expand on your views with regard to the position of the Royal College of Anaesthetists on assisted dying/assisted suicide'.

To understand the key themes emerging from all of the free text comments left by respondents[2], full quantified coding was conducted; each verbatim response was analysed and assigned a numerical code (one response can yield multiple codes) which were then quantified.

The table below shows what respondents are focusing on when discussing assisted dying / assisted suicide.

Free Text Theme	Mentioned by[3]:
People should have the right to choose how and/or when they die	14%
The RCoA adopt a neutral stance	11%
Support* with appropriate safeguards	10%
People should be able to die with dignity/humanely	9%
Support (no further comment)**	8%
Should be improvements to palliative care rather than support assisted dying	7%
Anaesthetists should not be involved	7%
Doctors/our role is to preserve life/do no harm	7%
The RCoA should be involved/Support it*	6%
Moral/ethical issue	6%
RCoA needs to be involved in the debate regardless of its stance	6%
Anaesthetists are best placed to help with assisted dying	6%
Vulnerable people will be put at risk	5%
Concerned about 'slippery slope'/expanding criteria/mission creep	5%
Doctors should not be involved	4%
Oppose (no further comment)**	4%
This is a wider issue for politics / general public / government / legislative body / society	4%
Oppose the idea of doctors administering the drugs	3%
The RCoA should not be involved in the discussion	3%
Support in cases of terminal illness	3%
Doctors/anaesthetists should have the autonomy to decide whether to end life or refuse	3%
Patients are able to get this abroad, so we should provide it	3%
Doctors should administer/prescribe medications or drugs	3%
Undecided/Unsure/conflicted	3%

[2] A total of 2,420 individual free text comments were left by respondents, equating to 49.3% of the total sample.
[3] % shown as a proportion of those who left a free text comment.

May/Will affect the trust the public has in the profession	3%
Concerned about legal loopholes/misuse of the system/eligibility criteria	3%
We don't let animals to suffer in the same way we do humans	2%
Opposed based on religion	1%
Palliative Care teams are best placed to deal with this / administer drugs	<1%
Other	14%

**Comments which mention 'support' or 'be involved' are where respondents are supportive of the RCoA actively supporting attempts to change the law in reference to 'allowing doctors to prescribe drugs for eligible patients to self-administer to end their own life' and/or 'allowing doctors to administer drugs with the intention of ending an eligible patient's life'.*

***Where a respondent has written their view on what stance the RCoA should take (e.g. supportive, opposed, neutral) but left no comment as to their reasoning for their viewpoint.*

The extent to which respondents cite one of the above themes can differ depending on their level of agreement with question 6 (What should the position of the Royal College of Anaesthetists be on a change in the law allowing doctors to prescribe drugs for eligible patients to self-administer to end their own life?) and question 7 (What should the position of the Royal College of Anaesthetists be on a change in the law allowing doctors to administer drugs with the intention of ending an eligible patient's life?) included in the survey. This additional breakdown of the data can be found in the accompanying data tables.

The below represents the key themes that emerge from the free text comments, and they are shown in order in terms of the frequency that each is mentioned, providing quotation which illustrate the emerging themes.

4.1. Those who believe the RCoA should change from its current position of "no stance" and actively support attempts to change the law

Focusing on those who believe the College should change from its current position of "no stance", a number of key themes emerge from the free text responses from those who believe the RCoA should actively support attempts to change the law. These themes are outlined below:

- The belief that people should have the right to choose how and/or when they die.
- That they support attempts to change the law as long as there are appropriate safeguards in place.
- That people should be able to die with dignity/humanely.
- That the RCoA should be involved.
- That Anaesthetists are best placed to help with assisted dying/assisted suicide.

Looking at each theme in more depth:

Firstly, there are those who believe it is right that terminally ill patients are given the autonomy to decide when it is time to choose to end their own life, and that they are able to end their life in – what is perceived to be by some – a more dignified manner.

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"Patient autonomy is promoted as a key component of ethical medical practice. A patient who is terminally ill and capacious should be able to make the most important health choice. The medical and legal complexity of facilitating choice should be supportively overcome to enable patients to decide how and when they die."

"I believe that people should have the autonomy to decide when the right time is to end their life in a dignified way. I think people should be able to choose the right time for them, safe in the knowledge that the medication they take will be successful, painless & calm."

"The emphasis is increasingly on patient autonomy, which applies in the context of assisted dying for a terminal condition. You could also argue that allowing a patient to end suffering they are experiencing is a beneficent act."

Furthermore, linked to the above is generally being supportive of **ending the suffering** of terminally ill patients.

"I personally believe that being able to facilitate a patient with a chronic debilitation disease to have a dignified death, after all feasible treatment has been exhausted, would be a serious step forward in UK medicine."

"All patients should have individualised and holistic care with dignity and the principles of beneficence, non-maleficence and autonomy at the heart of decision making. Death is not a failure in all patient situations, prolongation of suffering is."

"I think a gentle death should be a basic human right where it is possible, this right should not be removed by a patient's inability to self-administer."

They are generally supportive if there are **appropriate safeguards** in place since there are concerns about prospective patients being coerced into making decisions that aren't right for them.

"Assisted dying could be seen as a personal choice. However, it is important to ensure that certain criteria are met because, although the patient might have capacity, they would still be in an emotionally fragile [state] which might affect their ability to make the right decision. Hence, Royal Colleges should work collaboratively to ensure that strict eligibility criteria are met."

"I believe that patients should have the right to decide when they die within a protective set of legislation to prevent them being taken advantage of by third parties."

"I have no moral objection to assisted dying and the current legislation denies people the opportunity to end their suffering in a dignified and a humane way. I have grave concerns about the potential for misuse of assisted dying and people being coerced into it. If we were to support assisted dying, I would want there to be very robust protections against individuals being pressured or coerced into it or allowed to undergo it for the wrong reasons. No system is perfect and there will be mistakes made. The safety system's error should be engineered to deny assisted dying if there is concern it is inappropriate, rather than to allow it. This would deny it to some for whom it is appropriate but would be less bad than allowing it for someone who should not be dying."

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They believe that anaesthetists are best placed to deliver the required care, having the **most appropriate skills and experience** to allow for assisted dying/assisted suicide. For this reason, there is the desire for the RCoA to be involved.

"As a group of professionals, anaesthetists are very well placed to facilitate assisted dying. We have the knowledge and skills to do this safely and compassionately. The risk if we oppose the legislation or do not engage, is that the procedure would be undertaken by an individual who lacked the skills, resulting in things going wrong."

"Anaesthetists/intensivists have particular expertise in end-of-life care and should be involved in decision-making around this issue rather than simply executing wishes of other stakeholders."

"Anaesthetists are in a unique position to administer drugs for euthanasia. I think we are the best qualified doctors to relieve pain and end suffering in terminally ill patients. Also, we have experience in discontinuing life support in intensive care type environments so are familiar with ending of life when this is the best course of action for the patient."

"Should the law change on assisted dying anaesthetists are likely to be called upon given our experience of medications and end of life care. I believe the RCoA should have a stance for this reason. I would be supportive of a law change in favour of assisted dying given my own clinical experience of protracted dying and subsequent suffering. This would of course need to be highly regulated."

4.2. Those who believe the RCoA should change from its current position of "no stance" and actively oppose attempts to change the law

Those who believe the RCoA should change from its current position, but who believe the RCoA should actively oppose attempts to change the law often focus on issues relating to:

- It not being the role of doctors take life (their role is to do no harm).
- The belief that there should be improvements to palliative care (rather than supporting assisted dying).
- The concern that vulnerable people will be put at risk.
- The belief that assisted dying/assisted suicide could be the beginning of a 'slippery slope' with criteria expanding as time goes on.
- Moral/ethical concerns.

They believe assisted dying/assisted suicide **goes against the core role of an anaesthetist**, which is to preserve life and do no harm. This is a firm belief amongst a large proportion of those respondents who are opposed to the RCoA actively attempting to change the law (39% of those who left a free text comment and who are opposed).

"I strongly believe that doctors should do no harm. Assisted suicide is a very complex and painful subject, especially for those patients with chronic conditions who may seek to end their life. However, once we cross the red line and assist patients to die there is no going back from this and it becomes very open to abuse. We should keep our core moral standards very crystal clear to maintain our role in helping make people better and not instigating death."

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"Whilst many end-of-life journeys are hugely distressing for the patient and their family I don't feel it is ever our role to take life. I accept the double effect principle but don't agree with deliberate killing however well-intentioned."

"We have trained so hard and long as doctors to save lives, not to end it! The RCoA must not, under any circumstance, support a law allowing the practice of euthanasia in the UK."

"This is outside our professional remit of, first, do no harm. We are trained to offer care we believe is in the interest of our patients. We are not trained to evaluate whether we should be offering treatment to end a patient's life. Currently, patient care entitles them to refuse treatment but not demand treatment. These are all concepts that will become blurred if we move towards supporting assisted dying as a professional body."

"I believe as a doctor we should not aid or cause death of a patient as it's against the principle that we cause no harm. Every second in life is valuable and we need to help them live. We can assist to treat pain and discomfort."

They believe the focus should be on **improving palliative care services**, rather than supporting assisted dying/assisted suicide.

"I totally oppose any movement towards assisted dying in any way at all. The RCoA should campaign for world class Palliative Care services. If the College moved to support assisted dying in any way, I would definitely leave the College. Canada has shown how the homeless and depressed are offered death, rather than societal support. The UK would inevitably and very quickly follow that path."

"We need to manage end of life care better and ensure we are controlling people's symptoms, so they aren't suffering. If we do this, then assisted dying shouldn't be necessary."

"Assisted dying in any form goes against all the principles of medicine. We need better quality palliative care and a more realistic approach to medicine in the frail and elderly."

"I would much prefer the RCoA to push for much improved palliative care services. If that were more readily available e.g. more hospice beds, more consultants and nurses, then the public might have more confidence in it and it might reduce the requests for assisted dying."

They feel a change in law to allow assisted dying/assisted suicide will potentially put **vulnerable people at risk**.

"Assisted suicide legalisation in countries such as Canada, Belgium and the Netherlands illustrates how quickly this can become a slippery slope to providing euthanasia to children and the mentally vulnerable. The College, like its members, has a duty to act for the preservation of human life."

"A change in law to allow assisted suicide will inevitably expose potentially vulnerable people who have begun to feel that their continued existence is burden on others to the pressure to request suicide when they would not have truly freely chosen this had the option not been made readily available and socially normalised. Such a person could easily be assessed as meeting the kind of criteria usually given for physician assisted suicide, such as those given at the start of this survey, as it would be impossible to reliably distinguish between people making a truly

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free choice, some of whom will be for their own reasons taking into account the impact of their illness on their loved ones, from those who have been unfairly made to feel that they have become an excessive burden upon those who should be reasonably expected to provide such care."

Linked to the above, is the belief that assisted dying/assisted suicide could be the beginning of a **'slippery slope'** with criteria expanding as time goes on, meaning that more people will potentially be put at risk as the aim of assisted dying/assisted suicide creeps.

"I think the system of assisted dying is too open to abuse and requirements, e.g. confirmed degenerative condition leading to death, are likely to be gradually expanded. We risk being in the situation of other countries where people can request assisted dying for mental health problems or just because they feel they don't want to be here anymore. Both patients and medics are also at risk of pressure from others to agree to cases of assisted dying."

"It's very much a slippery slope. Look at other countries, where the criteria ends up expanding. The estimated numbers of people choosing this option is invariably too conservative (too low) compared to what happens after laws are changed, with increasing incidence thereafter."

"I am concerned about the safeguards for those who are vulnerable, in financial difficulties, have mental health issues or have chronic illness and have listened to the concerns raised by those living with disabilities, palliative care professionals and those who have experience of the system of assisted dying in other counties. I am concerned about the slippery slope of where this could end, about patients and families requesting that we end the lives of critically ill patients and the legal ramifications for doctors and also for patients."

Additionally, they are generally opposed to assisted dying/suicide on **ethical** grounds, or grounds relating to their religion.

"As an extension of my beliefs and to " first do no harm", I cannot deliberately and intentionally end or help to end a patient's life. If faced with unbearable suffering, palliative care should be the norm."

"Assisted dying in all its forms and proposed iterations of law, fundamentally goes against the sanctity of life and undervalues human dignity and the preciousness of our designed existence. Assisted dying puts additional unreasonable and dangerous pressure on vulnerable, poor, disabled or chronically ill patients who feel guilt or shame about needing loved ones to care for them, giving them an option of a cheaper or easier way out of their family's hardship. Wherever legalisation has happened around the world, mission creep has set in and those previously not eligible for AD, have managed to qualify for it- for example a homeless man in Canada was able to be approved on the basis that being homeless was unbearable suffering, and chronic depression has qualified in other states. If the money and political pressure invested in trying to change the law was invested in care services and palliative care availability, we would see such an increase in dignity for those patients and a reduction in the demand for a change in the law by those that fear an undignified or neglected end. Finally, as a doctor, my charge and mandate is to protect and uphold life. My belief as a Christian is that life is precious and not mine to take or decide the fate of. Assisted dying goes against all of my principles and I will contest any change in the law, or any change in stance as a Royal College."

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4.3. Those who believe the RCoA should change from its current position of "no stance" and be 'neutral', that is neither actively support nor oppose attempts to change the law.

Finally, those who believe the College should move to a neutral stance say feel that, currently, the College should not have a say in whether to pass laws allowing for assisted dying/assisted suicide. They express the view that **the College should be more involved if any laws do pass**.

"I think the RCoA is about good standards- if the law changes to allow assisted dying, the RCoA should help to ensure that if/when anaesthetists are involved in this, they participate in an appropriate way (i.e., respecting patients, maintaining trust, etc)."

"I don't think the Royal College of Anaesthetists is best placed to contribute to decisions on whether assisted dying should be legal. They may be able to assist in advising government / public policy advisors regarding how to implement a proposed assisted dying protocol but the decision on legalisation should be for government primarily and other medical organisations e.g. BMA / GMC may have a role."

"I do not think that this is a subject where the skills and experience of anaesthetists adds a lot to public debate on whether it is right or wrong. It is for the public to decide with expert advice [on whether we as a country are for or against assisted dying/assisted suicide. Therefore, having our own stance seems unnecessary and likely highly divisive. We could perhaps offer some thoughts on how feasible it would be to do humanely and reliably but with no stance on whether we support or not."

"I think we need as a profession to be very careful here. We are clearly the most experienced and suitable people to administer drugs that ablate consciousness and eventually cause death. I think it would be very unwise to get involved in the public debate on this and that we should maintain a distance until the legal position is established."

Another reason why respondents believe the College should take a 'neutral' stance is because they feel that this debate sits outside of the remit of the College. This is in part because they feel such a decision (whether to play a role in ending someone's life) is extremely **emotive** and should be **very much down to individuals**.

"I am in favour of assisted dying but think that the College should maintain a neutral stance, as the decision is very much a personal one. I am also uncertain about doctors actually administering the drugs, as opposed to providing them to patients for self-administration, although I understand that situations would arise in which this may be necessary. What is the practice in those countries that currently permit assisted suicide?"

"This is an emotive subject and the RCoA should remain neutral."

"The decision for assisted suicide is a public debate and not part of the Royal College's Role. Individuals will have an opinion but that is personal and can be reflected as an individual. The college should remain neutral (i.e. have no position) at this time. If the law changes, then there will be other issues to discuss, and the Faculty of Pain

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Medicine may be more in the fore regarding requests to actively participate in the process. I remain of the opinion that no change in position is required although it may need to be stated publicly that it has not changed."[4]

"As a college, it should hold neutral ground and leave it to individual doctor to act based on their consciousness and current law."

"This is not a medical matter. It is an ethical and political matter and the rightful place for it to be discussed, debated, and decided is Parliament. Individuals from within the RCoA can of course contribute to that debate and would no doubt bring experience and knowledge which may be helpful. But the College itself should not align itself with either side on an ethical debate like this."

Other respondents who believe the College should take a 'neutral' stance cite that there should still be a focus on **improving palliative care** whilst others cite being **undecided and needing more information**.

"I feel the topic currently gets more attention than needed. Excellent palliative care and importantly (but I feel usually neglected) more emphasis on advanced care planning. I would support both propositions but currently feel the system does not achieve the basics and time and resources should currently be spent elsewhere. Also, [there needs to be] more public discussion should happen before the College takes an opinion."

"I would be more supportive of Assisted Dying if I was convinced that we could not improve hospice and palliative therapy. We are nowhere near this objective."

"[I] need more information on the details of what is being proposed before any active stance is taken."

"I would like more information to make a decision."

[4] Please note that this free text response has confused the current 'no stance' of the RCoA as being a 'neutral stance'.

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Appendix 1: Comparing respondents from the UK to those based outside of the UK

		Respondents from the UK (F)	Respondents based outside of the UK* (G)
Base:		4,670	189
Should the Royal College of Anaesthetists maintain its current position of "no stance" on Assisted Dying/Assisted Suicide?	Yes	34%	35%
	No	54%	55%
	Don't know	12%	10%
Base:		4,655	189
What should the position of the Royal College of Anaesthetists be on a change in the law allowing doctors to prescribe drugs for eligible patients to self-administer to end their own life?	Supportive – the RCoA should actively support attempts to change the law	49%	56%
	Opposed – the RCoA should actively oppose attempts to change the law	17%	16%
	Neutral – the RCoA should neither actively support nor actively oppose attempts to change the law	29%	26%
	I am undecided	5% G	2%
Base:		4,627	185
What should the position of the Royal College of Anaesthetists be on a change in the law allowing doctors to administer drugs with the intention of ending an eligible patient's life?	Supportive – the RCoA should actively support attempts to change the law	40%	50% F
	Opposed – the RCoA should actively oppose attempts to change the law	23%	19%
	Neutral – the RCoA should neither actively support nor actively oppose attempts to change the law	29%	28%
	I am undecided	8%	3%

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		G	

**Respondents who selected 'I would rather not say' have not been included in the above results.*

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Appendix 2: Survey questions

Q1. Where are you based:

- England
- Wales
- Scotland
- Norther Ireland
- Other (please specify)
- I would rather not say

Q2. What is your current grade?

- Consultant
- SAS doctor (Specialty Doctors, SAS Specialists, Associate Specialists, Staff Grades and other closed SAS grades)
- Anaesthetist in training
- Locally employed doctor
- Foundation year doctor
- Anaesthesia associate
- Medical student
- Retired/not working
- Other (please specify)
- I would rather not say

Q3. Are you a member of the Faculty of Pain Medicine?

- Yes
- No
- I would rather not say

Q4. Are you currently registered or provisionally registered with a licence to practise in the UK?

- Yes
- No
- I would rather not say

Q5. Should the Royal College of Anaesthetists maintain its current position of “no stance” on Assisted Dying/Assisted Suicide?

- Yes
- No
- Don’t know

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Q6. If the Royal College of Anaesthetists was to move away from its current position of "no stance", could you please tell us what you think the position of the College should be on the following:

What should the position of the Royal College of Anaesthetists be on a change in the law allowing doctors to prescribe drugs for eligible patients to self-administer to end their own life?

- Supportive – the RCoA should actively support attempts to change the law
- Opposed – the RCoA should actively oppose attempts to change the law
- Neutral – the RCoA should neither actively support nor actively oppose attempts to change the law
- I am undecided

Please note that this question was not mandatory.

Q7. If the Royal College of Anaesthetists was to move away from its current position of "no stance", could you please tell us what you think the position of the College should be on the following:

What should the position of the Royal College of Anaesthetists be on a change in the law allowing doctors to administer drugs with the intention of ending an eligible patient's life?

- Supportive – the RCoA should actively support attempts to change the law
- Opposed – the RCoA should actively oppose attempts to change the law
- Neutral – the RCoA should neither actively support nor actively oppose attempts to change the law
- I am undecided

Please note that this question was not mandatory.

Q8. Please use the box below to expand on your views with regard to the position of the Royal College of Anaesthetists.

[Free Text Question]