Physician Assisted Dying

Position Statement

6 December 2016

The Australian Medical Association (Victoria)

Introduction

AMA Victoria has prepared this position statement in response to the Victorian Parliament's Legal and Social Issues Committee's recommendation to legislate physician assisted dying in Victoria.

It is imperative that first and foremost the Victorian and Commonwealth Governments must adequately fund high-quality public and community based palliative care services. Palliative care must be freely available to all who have a terminal condition or who require management of the symptoms of chronic and incurable medical conditions.

AMA Victoria acknowledges that there are widely disparate views on physician assisted dying and euthanasia within its membership, the medical profession as a whole, and throughout the Victorian community. AMA Victoria understands that all such views reflect the authentically and long-held beliefs of the individuals expressing them.

This AMA Victoria position statement should be read in conjunction with the national AMA's position statements on Euthanasia and Physician Assisted Suicide (2016) and End of Life Care and Advance Care Planning (2014). The national AMA's position on physician assisted death is that: "doctors should not be involved in interventions that have as their primary intention the ending of a person's life".[1]

AMA Victoria's policy position on matters such as end-of-life care, physician assisted dying and euthanasia will continue to evolve. These changes are underpinned by the changing views of society (of which our members are a contributing part), further advances in medicine, new ethical perspectives and law reform as developed by our society.

Policy position

1. Medical practitioners must oversee the final stages of a patient's diagnosed and recognised terminal illness, as this is an essential part of clinical care.

   As with managing all medical conditions, end-of-life care must balance the patient's wishes with good medical practice, their medical practitioner's professional and ethical frameworks, and the law.

2. It is imperative that first and foremost the Victorian and Commonwealth Governments must adequately fund high-quality public and community based palliative care services. Palliative care must be freely available to all who have a terminal condition or who require palliative management of the symptoms of chronic and incurable medical conditions.

   Furthermore, the Victorian and Commonwealth Governments must increase funding for medical research and efforts to improve patients' clinical outcomes and experiences, especially in regard to any and all forms of suffering in the final stages of a terminal illness.

3. There are widely disparate views on the matters of physician assisted dying and euthanasia within AMA Victoria's membership, the medical profession as a whole, and across the Victorian community.

[1] AMA position statement 'Euthanasia and Physician Assisted Suicide', 2016, section 3.1.

4. For most patients at the end of life, pain and other causes of suffering can be alleviated through the provision of good quality end-of-life care, including palliative care that focuses on symptom relief, the prevention of suffering and improvement of quality of life.

5. All medical practitioners, whilst endeavouring to prolong life so that it can be enjoyed to its fullest, have a duty of care to ensure that no patient endures avoidable suffering, which is an entirely subjective matter.

6. The AMA's Code of Ethics clearly recognises the rights of severely and terminally ill patients to receive pain relief, even if it might hasten death (Doctrine of Double Effect).

   If a medical practitioner acts in accordance with good medical practice,[2] the following forms of management at the end of life do not constitute physician assisted dying or euthanasia:
   - not initiating life-prolonging measures;
   - not continuing life-prolonging measures which are of no benefit to the patient;
   - the administration of treatment or other action intended to relieve symptoms which may have a secondary consequence of hastening death.

7. Victorian legislation must provide legal certainty to medical practitioners in connection with the accepted clinical practices of:
   - acknowledging a competent patient's right to decline medical treatment;
   - double effect, where the administration of treatment or other action intended to relieve symptoms of suffering may have a secondary consequence of hastening death; and
   - non-provision of care from which a patient will not benefit, where medical practitioners are generally not obliged to provide such treatments.

8. Should the Victorian Government accept the Parliamentary Committee's recommendation and legislate assisted dying in Victoria, the medical profession must be involved in the development of relevant legislation.

   Should the Victorian Government accept the Parliamentary Committee's recommendation and legislate assisted dying in Victoria, it is essential that stringent safeguards and criteria are in place to protect and support patients, their family members, and their treating medical practitioner.

   These safeguards and criteria should include (but are not limited to) that:
   - the patient is in the terminal phase of a diagnosed terminal illness;
   - all feasible avenues to treat the underlying condition, to provide palliative care and to alleviate suffering have been exhausted;
   - the request for physician assisted dying is autonomously requested and consented by a competent patient who is fully informed and comprehends their request;
   - the patient's motivation to end their life is solely associated with a desire to end suffering that is associated with their diagnosed terminal illness;

[2] Refer to "Good Medical Practice: A Code of Conduct for Doctors in Australia", Medical Board of Australia.

- the patient's motivation to end their life is not directly associated with a mental illness;[3]
- the patient's motivation to end their life is not associated with a perceived view that they are a burden to others, are unfairly consuming resources, or cannot afford to receive health care;
- the patient's motivation to end their life is not associated with the perceived needs or wishes of another person (such as a family member or carer);
- the medical practitioner has developed an adequate (preferably long-term) professional relationship with the patient, and has a sufficient understanding of the patient's preferences and values in relation to end of life care;
- the medical practitioner has an informed understanding of the patient's medical condition;
- the process of consent must involve a minimum of two, independent medical practitioners;
- a period of time passes before any medical intervention commences (commonly understood as "cooling off" period);
- no medical practitioner, other health practitioner or health service is required to participate in physician assisted dying or euthanasia. This is known as conscientious objection;
- a medical practitioner who lawfully participates in physician assisted dying, and adheres to good medical practice, must be immune from any related prosecution, claims of negligence, or findings of professional misconduct or unprofessional conduct.

[3] Medical practitioners draw the distinction between physical and psychological suffering of the patient. If the patient's primary suffering is the direct result of a mental illness, then it is not suffering for which any intervention given or actions taken to assist the patient to end their life can ever be regarded as acceptable or ethical medical practice.