AMA Victoria's submission to the Victorian Government's Voluntary Assisted Dying Bill discussion paper

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The Australian Medical Association (Victoria)

Introduction

In December 2016, AMA Victoria released its position statement on physician assisted dying,[1] which reaffirmed the AMA's stance that "doctors should not be involved in interventions that have as their primary intention the ending of a person's life". AMA Victoria's position statement also outlined that "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…[and] it is essential that stringent safeguards and criteria are in place to protect and support patients, their family members, and their treating medical practitioner".[2]

This submission responds to the Victorian Government's discussion paper on the Voluntary Assisted Dying Bill.

Q. Is the existing decision-making capacity test in legislation such as the Medical Treatment Planning and Decisions Act 2016 sufficient?

The *Medical Treatment Planning and Decisions Act 2016* is sufficient to determine decision-making capacity.

Q. In what circumstances should a psychiatric assessment be required? Are there any other specialist referrals that would be appropriate for assessing decision making capacity?

Psychiatric referrals for those seeking (and who meet the legally determined criteria) voluntary assisted dying should only be required if clinically necessary. A patient should be referred to a psychiatrist if the patient's treating medical practitioner believes that the patient may be depressed, suffering from another mental illness or may have impaired decision-making capacity. The role of the psychiatric referral would be to determine the patient's decision-making capacity.

Q. Is greater specificity required to identify what constitutes a person being at the end of life and, if so, how should that specificity be worded? How should a 'serious and incurable condition' be defined?

The patient should be in the terminal phase of a diagnosed terminal illness. All feasible avenues to treat the underlying condition and to alleviate suffering have been exhausted. The patient has been informed of their options, including palliative care.

Specific timeframes should not be included in legislation.

Q. What safeguards are necessary to ensure that a request is voluntary? How should this be assessed?

The Parliamentary Committee's recommendations regarding three requests by the patient, two independent doctors, two independent witnesses, a cooling off period and the ability to withdraw the request at any time are all necessary steps to ensuring that a request is voluntary.

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[1] AMA Victoria's position statement on Physician Assisted Dying, 2016.
[2] Ibid.

Q. Should there be a prescribed time period that must pass between the first and final request and, if so, what period?

As outlined in AMA Victoria's position statement on assisted dying, a "cooling off" period is essential. AMA Victoria recommends that two weeks pass between the first and final request.

Q. Should the legislation include prescribed information that a medical practitioner must provide to a person requesting voluntary assisted dying and, if so, is the list recommended by the Parliamentary Committee sufficient?

AMA Victoria supports good medical practice, which includes informing the patient of all their options, and the likely outcome of their condition and their decisions. This is covered in the Parliamentary Committee's recommended list.

Q. Should the legislation prescribe specialist expertise required for medical practitioners to participate in voluntary assisted dying?

AMA Victoria recommends that medical practitioners choosing to be involved in assisted dying should have a minimum of 5 years post-fellowship level experience (or equivalent) in Australia.

Medical practitioners choosing to be involved should also be required to undertake a fully-funded training course on the laws and regulations associated with assisted dying in Victoria.

Q. Should there be a requirement for a palliative care specialist referral or consultation?

Palliative care should be discussed and all options made available to the patient, but a referral and/or consultation should not be compulsory.

Q. How should conscientious objection to voluntary assisted dying operate?

Please refer to the AMA's position statement on conscientious objection[3], extracts of this statement include:

- Doctors (medical practitioners) are entitled to have their own personal beliefs and values, as are all members of society.
- When a doctor refuses to provide, or participate in, a legally-recognised treatment or procedure because it conflicts with his or her own personal beliefs and values, this constitutes a 'conscientious objection.'
- A doctor who makes a conscientious objection to providing, or participating, in certain treatments or procedures should make every effort in a timely manner to minimise the disruption in the delivery of health care… If you hold a conscientious objection you should:
    - inform your patient of your objection, preferably in advance or as soon as practicable;
    - inform your patient that they have the right to see another doctor. You must be satisfied the patient has sufficient information to enable them to

[3] The AMA's position statement on Conscientious Objection, 2013.

exercise that right. You need to take whatever steps are necessary to ensure your patient's access to care is not impeded;
  - continue to treat your patient with dignity and respect, even if you object to the treatment or procedure they are seeking;
  - continue to provide other care to your patient, if they wish;
  - refrain from expressing your own personal beliefs to your patient in a way that may cause them distress.

Q. Are additional safeguards required when a medical practitioner administers the lethal dose of medication and, if so, what safeguards would be appropriate?

The 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".

AMA Victoria recommends that if a person is unable to administer the medication themselves, then they should be able to nominate someone else (e.g. next of kin or Medical Power of Attorney) to administer the medication. It is important that the nominated person is not forced to act against their conscience, and they should have the right to reject or accept the request to administer the lethal dose of medication.

If the person is provided with the properly calculated lethal dose and it does not work, the prescribing medical practitioner should not be held responsible.

Q. What should be recorded as the cause of death for a person who has ingested the lethal dose of medication?

The terminal condition which was the antecedent for the request for voluntary assisted dying.

Q. Should death as a result of voluntary assisted dying be a reportable death?

No.

Q. What information should a medical practitioner be required to report to an oversight body such as the Assisted Dying Review Board?

Reporting requirements should not be onerous. Requests, the prescribing and the dispensing of the medication should be reported to an oversight body.

Q. At what stage should medical practitioners or pharmacists be required to report to the Assisted Dying Review Board?

All requests should be reported to the Assisted Dying Review Board.

Q. When should an oversight body be required to refer a matter to another agency?

When there has been a breach of the Act.

Q. Should an oversight body have any investigatory powers, or should this be conducted by other agencies?

Complaints and concerns should be investigated by relevant authorities already in existence, such as the Medical Board, the Pharmacy Board, AHPRA and the Health Complaints Commissioner.

Q. What protections would be necessary for health practitioners who act in accordance with the new legislation in good faith and without negligence?

As detailed in AMA Victoria's position statement on assisted dying, a medical practitioner who lawfully participates in voluntary 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.

Q. How should insurance and other annuities of people who access voluntary assisted dying be protected?

The Parliamentary Committee's recommendations state that the person must be at the end of life (final weeks or months of life) and suffering from a serious and incurable condition which is causing enduring and unbearable suffering that cannot be relieved in a manner the patient deems tolerable.

Insurance and annuities should apply to the person's medical state, not final manner in which they die. Similarly, insurance should not be impacted if a person refuses treatment or alternatively accepts all treatment and healthcare services that are available.