

**Submission
No 70**

**INQUIRY INTO PROVISIONS OF THE VOLUNTARY
ASSISTED DYING BILL 2021**

Organisation: The Australian and New Zealand Society of Palliative Medicine
(ANZSPM)

Date Received: 22 November 2021

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For the Attention Of:

The Director

Standing Committee on Law and Justice

Parliament House

Macquarie Street

SYDNEY NSW 2000

ANZSPM Submission re: Voluntary Assisted Dying Bill 2021

The Australian and New Zealand Society of Palliative Medicine (ANZSPM) notes the important work the Standing Committee on Law and Justice (the Committee) is doing to inform New South Wales Members of Parliament as they consider the Voluntary Assisted Dying Bill 2021 (the Bill).

ANZSPM is a specialty medical society that facilitates professional development and support for its members. ANZSPM promotes the discipline and practice of Palliative Medicine in order to improve the quality of care for patients with life-limiting illnesses and their families. Our focus is on palliative and end-of-life care (PEOLC), but our influence also affects the healthcare system via our advocacy for holistic care, improved communication skills, and education and resources to support professionals in shared decision-making discussions with patients. ANZSPM members are medical practitioners. Our members include Palliative Medicine specialists as well as other medical practitioners who either practice or have an interest in Palliative Medicine. As such, we have particular concerns and interest in the implementation of voluntary assisted dying (VAD) legislation across Australia and New Zealand.

We attach ANZSPM's Position Statement on Euthanasia and Physician-assisted Suicide (EPAS), so that it can inform the Panel's consideration of matters relating to the practice of Palliative Medicine, and the specialty's potential intersection with practices to be enabled by the new legislation. These points of intersection are profound and worthy of consideration by all legislators.

We also wish to make the following comments about aspects of this proposed law.

IMPORTANCE OF PALLIATIVE AND END OF LIFE CARE (PEOLC)

Prior to a substantive discussion about the Bill, we wish to make some preliminary points about the provision of end-of-life care in NSW. People who do not have access to quality PEOLC may opt for VAD to relieve their suffering. ANZSPM strongly advocates for the necessary changes to our healthcare systems that will ensure equitable access to quality PEOLC for all, before assisted dying becomes available. Specifically, ANZSPM calls on the NSW Government to urgently focus their attention on health reform and investment which would strengthen PEOLC including:

- Remedying shortages in the PEOLC workforce (including in specialist medical, nursing, and allied health fields)
- Ongoing training for the generalist health workforce, particularly for rural and remote generalists

- Policy directions which support and value advance care planning and patient preference
- Initiatives to support high-quality PEOLC regardless of setting (hospitals, community, residential aged care)
- Initiatives to ensure improved access to high-quality PEOLC, and
- Increased carer support, including the opportunity for quality respite care to address the sense of being a burden, which is a common concern held by many people at the end of life.

To ensure that funding committed to PEOLC leads to sustained improvement in patient outcomes, it is imperative that all State and Territory Governments, including the New South Wales Government, endorse PEOLC as a key priority for the National Cabinet. PEOLC services, both specialist and non-specialist, must be prioritised and funded to meet the needs of all people in our communities. Furthermore, to ascertain the quality of PEOLC provided by non-specialist PEOLC services, ANZSPM recommends that benchmarking via such bodies as the Australian Commission on Quality and Safety in Healthcare, the New Zealand Health Quality and Safety Commission and/or the Palliative Care Outcomes Collaboration (PCOC) should occur. It is important that paediatric PEOLC is in scope as a separate area of Palliative Medicine practice with its own considerations and desired outcomes, as part of this monitoring.

PEOLC needs span multiple sectors, including chronic illness, aged care, paediatrics, cancer, disability, and mental health. There is currently a severe lack of funding for PEOLC services to meet the growing needs of our populations. The evidence highlights that many people have reduced access to PEOLC: people with non-malignant life-limiting illnesses, geographically isolated populations, aged care residents, indigenous populations, and people from culturally and linguistically diverse backgrounds.

SEPARATING THE ASSISTED DYING PROCESS FROM PALLIATIVE CARE

Over many decades, palliative care services have been working to destigmatise the care that they provide, including the use of opioids. Unfortunately, however, both the public and healthcare professionals continue to conflate PEOLC with euthanasia. This leads to reduced access to PEOLC, and consequently suboptimal pain management, in people with life-limiting illnesses. The experiences of our members confirm that the conflation between PEOLC and VAD has not abated, despite the recommended separation between these two distinct end-of-life options by the Royal Australasian College of Physicians (RACP). VAD legislation in its current form, coupled with the assumption that palliative care services will support this end-of-life option, will continue the conflation between VAD and PEOLC whilst also undermining whatever work has been achieved by the palliative care sector thus far.

VAD involves a minimum of two doctors to complete the tasks required for the VAD process. These doctors are not involved with the holistic care of people requesting VAD, nor the support for their families. It is understandable that many of these patients will already be linked to a specialist palliative care service, and hence these services invariably provide the holistic care for those requesting VAD. These services also remain the providers of care for those people who are deemed ineligible for VAD – people who are angry and continue to have suicidal ideation. Furthermore, specialist palliative care services also provide bereavement support to families under their care whether they have chosen VAD or not. There is therefore no clear delineation currently, to outside observers, between VAD and the palliative care services involved in the care of these patients and their families.

EXPERTISE AND TRAINING REQUIRED OF PARTICIPATING PRACTITIONERS

The average PEOLC education in medical undergraduate curricula worldwide is one week. Consequently, the general ability of doctors to deliver high-quality PEOLC is not well-supported from an educational perspective. It is recognised

that the education of clinicians in healthcare regarding PEOLC is insufficient, even though most will need to care for a dying person and their family in their career. The training for VAD, approximately six hours of online training, is completely inadequate to support patients and families at the end of life. ANZSPM strongly recommends increasing the training requirements for VAD, as adequate training is an important safeguard to avoid reliance on potentially simplistic assessments/reviews.

The lack of medical education in palliative care, the taboo nature of the topic, and the limited support available for medical practitioner communications training and consult time, all hinder access to quality palliative care for many patients. New South Wales should be cautious not to make specialist palliative care services a component of the VAD patient pathway, as this could make them the 'gatekeepers' to VAD. Repeatedly, both nationally and internationally, the discipline of Palliative Care has drawn a clear distinction between it and VAD. The critical point of distinction is intention. The intention of VAD is to prematurely end the life of a patient; the intention of Palliative Care is to provide comfort, physically, emotionally and spiritually to a patient up to and including their natural death. As the WHO definition states Palliative Care should "neither obstruct nor hasten death".

Other misunderstandings would also be more likely, including accusations of 'delaying the VAD process' being made at palliative care services which have the specific intent of ensuring ongoing high-quality care at end-of-life.

If VAD is to be provided as an end-of-life choice, then ANZSPM believes that VAD clinicians should provide **all** the holistic care required for optimal healthcare outcomes for their patients and families at this significant time in their lives, including bereavement care. In so doing, there would be less conflation between VAD and PEOLC. The reliance on palliative care teams should not be permitted, on the grounds of the conflation mentioned earlier. VAD practitioners can be supported via direct or indirect consultations with specialist palliative care services, but there must be a clear delineation of roles during PEOLC and after death, so as to ensure clarity in transitions in care for all involved – patients, family and medical staff, general practitioners and specialists.

ANZSPM therefore proposes that those persons delivering VAD will require a high level of competency in communicating with patients that may extend beyond current training, to include a knowledge of:

- Health system pathways and the role of other professional groups in counselling for and delivering VAD, including when working with vulnerable populations
- Exploring the reasons for a VAD request with patients who may have depression and/or dealing with difficult family circumstances, live in isolation, or have multiple comorbidities
- Practicing clinical neutrality
- Detecting signs of coercion and reduced capacity.

In addition, there are many people within the health system who need to be made aware of the nature of palliative care and the potential positive outcomes for patients. This should be done as part of formal training and continuing education programs, including any training provided to those accredited to deliver VAD.

Educating the public will also be a priority. Within the Australian community, there is a generally poor understanding of the legislation and those alternatives to VAD that are available for dealing with their specific circumstances. Community education should also take account of the needs and circumstances of different cultural groups and vulnerable populations. We note that the Bill's principles recognise the importance of PEOLC, and that its provisions would prohibit health care workers initiating a discussion on VAD without also discussing PEOLC options. Any discussion about PEOLC should be undertaken by someone with the appropriate knowledge, due to the lack of education about PEOLC in the public and healthcare professionals.

ELIGIBILITY – AUTONOMY, CAPACITY, DUE DILIGENCE & PROGNOSTICATION

An autonomous decision to request VAD is part of the eligibility criteria. We raise our concerns regarding coercion below, but there are many other issues to consider before the actual request is made. It is important to recognise that decisions are not made in a vacuum – autonomy is relational. The health and death literacy of the population is poor, and people make decisions about their health in relation to their culture, religion, health beliefs, lived experiences, perceptions and fears, and they are influenced by their social networks and society.

Capacity assessments in people who have deteriorating cognitive function, depression, and demoralisation are difficult. Most doctors will be able to assess capacity in straightforward cases, but in more complex cases, many doctors have not been trained in the appropriate skills. Daily examples exist in clinical practice, when decisions need to be made about wills, ongoing treatment in elderly patients, or transition into aged care. The assessment of capacity needs to be contextualised in the psychosocial and existential concerns of the patient to fully evaluate their decision-making processes. This includes attention to the possibility of coercion. ANZSPM recognises that capacity must be maintained throughout the VAD process, however, our members raise concerns about the monitoring of capacity in accordance with the legislation.

When we meet people with suicidal ideation in clinical practice, we have a duty to explore their request and understand what has led to this decision. There is often much to uncover, as well as help to provide, as noted by the extensive work in suicide prevention and PEOLC. The medical profession often views a wish to hasten death (WTHD) statement, or an attempt to suicide, as a “cry for help”. Eligibility for VAD depends upon the “first request”, however this is very difficult to determine in clinical practice. Our members report patients requesting information about their prognosis, seeking support, and misunderstanding the extent of their illness. We have seen that the introduction of VAD legislation has led to clinicians bypassing their obligations of due diligence, as noted above, and impulsively referring for VAD. Many doctors have not had the educational support and guidance to appropriately deal with WTHD statements.

As with other medical practitioners, ANZSPM confirms the difficulty of prognostication in clinical practice. Our members are often caring for people who have been given a limited prognosis by their specialist doctors. The use of appropriate specialist doctors in the VAD process, in particular the lack of mandatory involvement of Psychiatrists, who can assist with accurate diagnosis, needs further review. ANZSPM is concerned about how VAD legislation risks ending lives prematurely - especially when diagnostic errors are made, and prognostication is based on incorrect information.

IMPORTANCE OF SAFEGUARDS

ANZSPM is concerned about the potential for VAD to be abused, jeopardise traditionally under-served populations, expose health practitioners to professional risk, harm patients and families, and erode trust in the medical profession and healthcare overall. ANZSPM acknowledges the safeguards proposed in this Bill to protect persons considering VAD from improper influence and coercion. We also add that implementation planning should include monitoring and evaluation of the patient and family experience. This will need to be expertly crafted and transparently reported to address these dangers and positively inform future practice.

We highlight that there are legitimate concerns being expressed by advocates for traditionally under-served individuals and groups around access to quality PEOLC. Healthcare depends upon relationships of trust within these communities, and between these communities and the broader health system. Hence, ANZSPM is keen to ensure that these relationships are not jeopardised by the introduction of VAD. Specific regard must be given to cultural and Indigenous experience. For example, cultural concerns have been raised in the translation and dissemination of VAD information in certain communities.

Coercion of patients will be difficult to safeguard against completely, however, we note that the Bill attempts to do this by providing multiple decision points and by enlisting a range of expert opinions in the VAD decision. A VAD service

provider will only be able to safeguard against coercion if they have appropriate training, the support of other health service professionals and a strong and continuing relationship with the patient, their families, and carers. In the aged care setting any introduction of VAD needs to be carefully monitored. Our members have reported that many patients have been requesting VAD to avoid aged care placements. ANZSPM highlights that elderly people requiring aged care are an extremely vulnerable population in our communities. Aside from issues with capacity, it is important to recognise the psychosocial and existential problems of elderly people and how this contributes to their sense of being a burden on others.

Whilst this sense of being a burden or wanting to avoid placement in a nursing home does not constitute undue influence or coercion (and nullify the voluntary nature of the decision), they do, nevertheless, influence the decision for VAD. Sadly, the experience in other jurisdictions, is that this is an unintended consequence of the legalisation of VAD. Given the findings of the recent Royal Commission into Aged Care Quality and Safety, ANZSPM raises the concern for any direct or indirect promotion of VAD in aged care facilities.

The COVID pandemic has allowed us to recognise the problems with our healthcare system. ANZSPM stresses the importance of high-quality PEOLC during any pandemic. During COVID, many people were disconnected from family, friends, communities, and healthcare services – but for some people this isolation led to depression and suicidal ideation. The provision of VAD during this time is of concern to ANZSPM, due to the ethical questions raised and the lack of safeguards to protect vulnerable people, especially those in aged care.

CONSCIENTIOUS OBJECTION

ANZSPM acknowledges that a health practitioner's decision to assist patients under the new legislation should and will be informed by their individual conscience. Similarly, the right for institutions to adopt a non-participatory stance (based on conscientious objection) to providing this service is important to uphold. ANZSPM considers that it is important to allow institutions and individuals to exercise their conscientious objection, but that this raises complex and unresolved issues.

Individual conscientious objection may be permitted, but the consequences on relationships with patients, their families, colleagues, and the institution have not been fully explored. The same issue arises from the willingness to participate in VAD. Indeed, proponents of VAD have commented on the division such legislation has caused within the healthcare setting. The position of the organisation can create a subtle form of coercion on its employees, as no organisation can truly represent the views of all its employees on the topic of EPAS.

The expression of individual views, as with an organisational stance, requires clarity for patients and families. Practical uncertainties expressed by an organization can emanate from unclear forms of conscientious objection. There are many levels of decision-making and governance involved in implementation of the legislation. An insistence in the legislation on clarity in communicating conscientious objection to VAD, or active participation in VAD, will ensure an individual patient's rights can be exercised with full vision of the patient pathway. Gaining this clarity should be a foundational principle in implementation planning.

Physicians and institutions will need to work closely together to review current governance around practice and ensure an appropriate governance framework is established. In instances where there is conscientious objection to VAD, or active participation in VAD, both communication and governance aspects should be continuously monitored and evaluated. Problems with documentation and communication are known to be a major source of complaints in healthcare. Our members report that these issues are more problematic with VAD, as they continue to try and deliver best practice PEOLC.

Healthcare professionals work in teams and in collective clinical groups, e.g., wards, departments, and specialties. The

legislation provides no protection for the conscientious objection of these groups. ANZSPM draws the Committee's attention to the fact that, in jurisdictions where VAD has been implemented, some staff on palliative care units have been unable to exercise their individual right to conscientious objection because of an opposing institutional position. In such cases, all the staff in the unit would need to collectively conscientiously object to prevent VAD occurring on the ward. When patients receive VAD on a palliative care unit, this further perpetuates the conflation VAD with PEOLC. Employee rights on transition to the new arrangements need to be carefully considered. Guidelines should be provided to services that either oblige or encourage VAD services to consult with their employees, with a view to conferring rights to conscientious objection and/or compensation if departure from the organisation is the only feasible option for them. ANZSPM recommends to the Committee the Declaratory Judgement of June 2020, issued to Hospice New Zealand, that allows hospices in Aotearoa New Zealand the ability to hold conscientious objection.

Conscientious objection may present issues in certain settings, for example, amongst objecting staff within a VAD-supportive hospital or hospice, and in cases where patients cannot be transferred to a VAD-supportive setting. We caution against the approach taken in the Bill, which attempts to address some of these issues through its provisions of access to VAD advice and delivery on site through external practitioners. Allowing medical practitioners to enter and perform a procedure on a patient in an institution without any oversight, credentialling or governance of that institution is not accepted medical practice nor accepted patient care. This is not done in any other part of medicine, nor is it accepted by any institution. In this situation, it is important to ask who would be ultimately responsible for an adverse outcome, and to firmly reject the possibility of procedures being performed outside of the governance and staffing arrangements of the patient's hospital or care facility.

Organisational participation, or non-participation, in VAD has major implications. We know that the number of doctors willing to be involved in VAD diminishes as the level of participation increases. New South Wales may wish to consider the percentage of physicians that have been actively participating in VAD in Victoria (which is anecdotally small) since its legislation came into effect. This may help establish the likelihood of professional willingness to engage with VAD, as well as help to assess the size and scale of any practical issues arising from conscientious objection. The high number of religious aged care facilities, who are likely to be non-participatory in VAD, presents further practical issues in this setting.

IMPLICATIONS FOR RURAL AND REMOTE HEALTHCARE SETTINGS

While access to quality PEOLC is an issue across New South Wales, current deficits in the provision of PEOLC are particularly evident in rural and remote areas. For people who are requesting assisted dying, particular attention is needed to ensure that access to high-quality PEOLC, including specialist palliative care, is available. ANZSPM supports the urgent need for equitable access to high-quality generalist and specialist PEOLC services across all States and Territories including New South Wales.

The effect of VAD legislation on the clinician-patient relationship has been documented in the EPAS literature. However, ANZSPM further highlights the implications for this relationship in rural and remote healthcare settings. The provision of PEOLC in these settings is often dependent upon a single Palliative Medicine specialist or a small number of general practitioners. There may be a public expectation in these communities that the local medical practitioner will provide access to EPAS if requested. While medical practitioners can exercise their right to conscientious objection under this proposed legislation, anonymity of the objecting professional will not be possible in these communities. Significant pressure could therefore be placed on medical practitioners by patients, families, and the wider community to be involved in the VAD process, particularly when no other medical practitioner is available. This also has the potential to undermine the credibility of the palliative care or other medical service. In settings where small rural hospitals are located, the local health departments should be responsible for sourcing out-of-area doctors who are willing to

participate in VAD. It should not be the responsibility of the local doctor to find an alternative medical practitioner willing to assess and provide life-ending medications.

CONFLICT AND BEREAVEMENT SUPPORT

ANZSPM acknowledges the emotional burden of healthcare on staff, and the importance of appropriate support for all healthcare workers, especially in the aftermath of the COVID pandemic. Subsequently, any introduction of VAD legislation needs to consider the support, counselling and mediation services available for individuals, families and the health professionals affected by VAD practices. This should include all persons who have been exposed to conversations, care and distress that are against their beliefs.

Support in the bereavement phase is not well-delivered within the current health system. The effects of VAD on the bereavement of families and carers will need to be monitored, especially in terms of prolonged grief disorder that can occur 6-12 months after death. There are long-term health and economic issues related to negative bereavement experiences. In relation to VAD deaths, the bereavement issues must be considered as a 'new need' separate from palliative care which by its nature does not involve the same considerations. This "new need" must be delivered by the new VAD providers including the proposed system navigator workforce.

We are very concerned that the participating doctors, nurses and VAD navigators are, under the Bill, purely involved in the VAD process. There is no mandatory follow-up for the surviving families.

MONITORING, EVALUATION AND EVIDENCE-BASED PRACTICE

ANZSPM recommends rigorous and independent data collection, practice monitoring and evaluation to ensure safe and robust evidence-based practice and data to inform prospective research. Monitoring and evaluation should be overseen by an independent Review Board from the first discussion (not the first request, because many misunderstandings and issues arise before the first request) and continue through the process to include the bereavement of caregivers and family. The membership of the Review Board should reflect an equally balanced representation of views for and against EPAS. We are concerned that a VAD Board made up purely of people in favour of VAD may not be robust in their critical appraisal and judgement of the process and results of VAD.

In summary, a rigorous monitoring and evaluation framework for New South Wales' VAD implementation would be established and maintained by an independent monitoring body and would include measures of:

- Effective communication of individual physicians' and institutional arrangements when conscientious objection is exercised
- Quality of governance including nature and extent of changes made to institutional governance, at the level of each institution, as a result of the legislation's implementation
- Patient and caregiver experience, including indicators of coercion and the levels of regard for the medical profession during decision-making and including death and bereavement.
- Reporting of VAD cases to national benchmarking reports, to evaluate the quality of care provided.

In the interests of patient and caregiver safety, an independent complaints body separate to the Review Board should also be established for the reporting and monitoring of poor practice. The complaints body should also have an equally balanced representation of views for and against EPAS. The information collected should be publicly available, and included for use in prospective research into VAD. Any process of complaint should also outline how potential whistle-blowers can be protected, given the many variables of concern in the system.

CONCLUDING COMMENTS

ANZSPM submits that the provision of VAD services is not part of medicine and that the New South Wales legislation and the implementation pathways developed for its implementation should acknowledge this. VAD is a major change in medical practice (contrary to the Hippocratic tradition) and at odds with any other drug intervention offered. Although the intention may be claimed to be the same (to relieve suffering), the lethal dose prescribed or administered is not within the bounds of medical practice. The service should therefore be provided as a non-medical treatment even in instances where clinicians are involved. That is, the clinician clearly distinguishes between their VAD activities and their medical practice.

Several of our members have had direct experience with the implementation of similar legislation in Victoria and New Zealand, and you may wish to speak with them to discuss any matters that relate to implementation. In particular, ANZSPM members could assist in developing a robust understanding of the inter-relationship between the VAD Bill and existing PEOLC services and advance care directives in New South Wales.

This response to the legislation has been formed with input from the Society's membership and with the leadership of Professor Leeroy William, who, as at 12 November 2021, became our Immediate Past President and who has overseen the Society's responses to the measures taken by the Victorian, Western Australian, New Zealand, South Australian and Queensland Governments' moves to legislate for voluntary assisted dying legislation in their jurisdiction. I encourage you to reach out to Leeroy in relation to any particular issues raised by our submission.

Yours sincerely

Dr Christine Mott

President Australian and New Zealand Society of Palliative Medicine

AUSTRALIAN AND NEW ZEALAND SOCIETY OF PALLIATIVE MEDICINE POSITION STATEMENT

The Practice of Euthanasia and Physician-Assisted Suicide¹

Last updated: November 2021

Preamble

As the peak body for Palliative Medicine in Australasia, the Australian and New Zealand Society of Palliative Medicine (ANZSPM) has prepared this position statement reflecting the majority view of its members. ANZSPM acknowledges that, as with the diversity of opinion in the general and medical communities across Australia and New Zealand, there are divergent views on euthanasia and physician-assisted suicide within its membership.²

At the date of revision of this document (November 2021), it is acknowledged that the issue of euthanasia and physician-assisted suicide is very high on the political and legislative agenda and in departments of health in jurisdictions across Australia and New Zealand. In the state of Victoria, the Voluntary Assisted Dying Act 2017 came into effect on 19 June 2019. In New Zealand, a referendum held in October 2020 resulted in the majority of the public voting in favour of voluntary assisted dying. The End of Life Choice Act 2019³ was subsequently passed in November 2020, and came into effect from 7 November 2021. In Western Australia, the Voluntary Assisted Dying Act 2019⁴ was passed in December 2019 and as from 1 July 2021 voluntary assisted dying became a choice available to eligible Western Australian citizens. In Tasmania, the End-of-Life Choices (Voluntary Assisted Dying) Act 2021⁵ was passed in May 2021 and will come into effect around 18 months after this date. In South Australia, the Voluntary Assisted Dying Act 2020⁶ was passed in June 2021 and will come into effect around 18 to 24 months after this date. Queensland passed its Voluntary Assisted Dying Bill on 16 September 2021 and voluntary assisted dying will be available in Queensland from January 2023.

As at this document's revision date, the Australian State of New South Wales is considering euthanasia and physician-assisted suicide legislation and an inquiry is underway.

¹ In its latest review of the statement, ANZSPM has chosen to continue to use the term 'Euthanasia and physician-assisted suicide' instead of 'Voluntary assisted dying' throughout this statement in alignment with the terminology used internationally by such bodies as the World Medical Association and the IAHP. Although voluntary assisted dying is more commonly used in Australia, this term is not used in New Zealand.

² As evidenced in the diverse feedback received from the ANZSPM membership at its 2016 Forum on physician-assisted suicide and euthanasia in Australia and New Zealand (18 March 2016, Sydney) and the associated membership survey.

³ End of Life Choice Act 2019, Available at <https://www.legislation.govt.nz/act/public/2019/0067/latest/DLM7285905.html>

⁴ WA Voluntary Assisted Dying Act 2019. Available at [https://www.legislation.wa.gov.au/legislation/prod/filestore.nsf/FileURL/mrdoc_42491.pdf/\\$FILE/Voluntary%20Assisted%20Dying%20Act%202019%20-%20%5B00-00-00%5D.pdf?OpenElement](https://www.legislation.wa.gov.au/legislation/prod/filestore.nsf/FileURL/mrdoc_42491.pdf/$FILE/Voluntary%20Assisted%20Dying%20Act%202019%20-%20%5B00-00-00%5D.pdf?OpenElement) (August 2020)

⁵ End-of-Life Choices (Voluntary Assisted Dying) Act 2021. Available at <https://www.legislation.tas.gov.au/view/whole/html/asmade/act-2021-001>

⁶ Voluntary Assisted Dying Act 2020, Available at https://www.legislation.sa.gov.au/LZ/B/CURRENT/VOLUNTARY%20ASSISTED%20DYING%20BILL%202020_HON%20KYAM%20MAHER%20MLC.aspx

About ANZSPM

ANZSPM is a specialty medical society that facilitates professional development and support for its members. ANZSPM promotes the discipline and practice of Palliative Medicine in order to improve the quality of care of patients with life-limiting illnesses and support their families. ANZSPM members are medical practitioners. Our members include Palliative Medicine Specialists as well as other medical practitioners who either practice or have an interest in Palliative Medicine.

In preparing this statement, ANZSPM acknowledges:

- (a) The World Medical Association *Declaration on Euthanasia and Physician-Assisted Suicide*,⁷ adopted by the 70th WMA General Assembly, Tbilisi, Georgia, October 2019
- (b) the International Association for Hospice and Palliative Care (IAHPC) Position Statement: Euthanasia and Physician-Assisted Suicide published in 2017⁸
- (c) the European Association of Palliative Care white paper 'Euthanasia and physician-assisted suicide: A white paper from the European Association for Palliative Care'⁹ published in November 2015
- (d) the American Medical Association's Code of Medical Ethics Opinion 5.7 on Physician-Assisted Suicide¹⁰ and Code of Medical Ethics Opinion 5.8 on Euthanasia¹¹ published in November 2016
- (e) the Australian Medical Association Position Statement *Euthanasia and Physician Assisted Suicide*¹² published in November 2016
- (f) the Royal Australasian College of Physicians' position statement on voluntary assisted dying published in November 2018¹³
- (g) the New Zealand Medical Association Position Statement *Euthanasia*¹⁴ approved 2005 and its 2017 *Report on Euthanasia for the NZMA*¹⁵
- (h) the *Euthanasia and Physician Assisted Suicide Position Statement*¹⁶ published by Palliative Care Australia and updated September 2019.

⁷ World Medical Association Declaration on Euthanasia and Physician-Assisted Suicide (November 2019). Available at <https://www.wma.net/policies-post/declaration-on-euthanasia-and-physician-assisted-suicide/> (August 2020)

⁸ De Lima et al (2017): International Association for Hospice and Palliative Care Position Statement: Euthanasia and Physician-Assisted Suicide. Available at <https://hospicecare.com/uploads/2016/12/IAHPC%20Position%20Statement%20Euthanasia%20and%20PAS.pdf> (August 2020)

⁹ Radbruch et al (2015): Euthanasia and physician-assisted suicide: A white paper from the European Association for Palliative Care. Available at https://www.eapcnet.eu/Portals/0/PDFs/PM2015_Euthanasia%281%29.pdf (August 2020)

¹⁰ American Medical Association (2016): Code of Medical Ethics on Physician assisted suicide E-5.7. Available at <https://www.ama-assn.org/delivering-care/ethics/physician-assisted-suicide> and Code of Medical Ethics on Euthanasia (August 2020)

¹¹ American Medical Association (2016): Code of Medical Ethics Opinion 5.8 on Euthanasia (August 2020)

¹² Australian Medical Association (2016): Euthanasia and Physician Assisted Suicide 2016. Available at: <https://ama.com.au/system/tdf/documents/AMA%20Position%20Statement%20on%20Euthanasia%20and%20Physician%20Assisted%20Suicide%202016.pdf?file=1&type=node&id=45402> (accessed August 2020)

¹³ RACP (2018): Statement on Voluntary assisted dying. Available at https://www.racp.edu.au/docs/default-source/advocacy-library/racp-voluntary-assisted-dying-statement-november-2018.pdf?sfvrsn=761d121a_4 (August 2020)

¹⁴ NZMA (2005): Position statement on Euthanasia. Available at: https://assets-global.website-files.com/5e332a62c703f653182faf47/5e332a62c703f631912fc5f2_Euthanasia-2005.pdf (August 2020)

¹⁵ Gillet, G (2017): A Report on Euthanasia for the NZMA. Available at: https://assets-global.website-files.com/5db268b46d028bbc0fc0b537/5de43f3e5f176241093d0b6c_NZMA-euthanasia-Gillett-report-Final.pdf (accessed August 2020)

¹⁶ Palliative Care Australia (PCA): Euthanasia and Physician Assisted Suicide Position Statement. Available at: https://palliativecare.org.au/wp-content/uploads/dlm_uploads/2015/08/20160823-Euthanasia-and-Physician-Assisted-Suicide-Final.pdf (August 2020)

STATEMENT

1. Palliative Care is an approach that improves the quality of life of patients and their families facing the problems associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual.¹⁷ In accordance with best practice guidelines internationally,¹⁸ the discipline of Palliative Medicine does not include the practices of euthanasia and physician-assisted suicide. ANZSPM activities are limited to the Palliative Medicine discipline.
2. ANZSPM does not support the legalisation of euthanasia and physician-assisted suicide, but recognises that ultimately these are matters for government to decide having regard to the will of the community and, critically, informed by appropriate research and consultation with the medical community, including Palliative Medicine practitioners.
3. With the legalisation of euthanasia and physician-assisted suicide practices in Victoria, Western Australia, Tasmania, South Australia, and New Zealand, and recognising that other jurisdictions in Australia are considering the introduction of similar legislation, ANZSPM endorses international guidelines reaffirming that these practices are not part of palliative care. ANZSPM will continue to advocate for and, through its members, deliver good quality care for the dying, and this does not include the practice of euthanasia or physician-assisted suicide.
4. Patients have the right to refuse life-sustaining treatments including the provision of medically assisted nutrition and/or hydration. Refusing such treatment does not constitute euthanasia or physician-assisted suicide.
5. Good medical practice mandates that the ethical principles of beneficence and non-maleficence should be followed at all times. The benefits and harms of any treatments (including the provision of medically assisted nutrition and/or hydration) should be considered before instituting such treatments. The benefits and harms of continuing treatments previously commenced should be regularly reviewed. Withholding or withdrawing treatments that are not benefitting the patient, is not euthanasia or physician-assisted suicide.
6. Treatment that is appropriately titrated to relieve symptoms and has a secondary and unintended consequence of hastening death, is not euthanasia or physician-assisted suicide.
7. Palliative sedation for the management of refractory symptoms is not euthanasia.¹⁹

¹⁷ WHO (2002) <http://www.who.int/cancer/palliative/definition/en/>. (August 2020)

¹⁸ Such as the European Association for Palliative Care's White Paper on standards and norms for hospice and palliative care in Europe: part 1, *European Journal of Palliative Care*, 2010, 17(1):http://www.eapcnet.eu/LinkClick.aspx?fileticket=uW_JGKKvpZl%3d&tabid=167

¹⁹ European Association for Palliative Care (EAPC) framework for palliative sedation: an ethical discussion. September 2010. Available at: <http://www.biomedcentral.com/1472-684X/9/20>. (August 2020).

8. Requests for euthanasia or physician-assisted suicide should be acknowledged with respect and be extensively explored in order to understand, appropriately address and if possible, remedy the underlying difficulties that gave rise to the request. Appropriate ongoing care consistent with the goals of Palliative Medicine should continue to be offered.
9. When requests for euthanasia or physician-assisted suicide arise, particular attention should be given to gaining good symptom control, especially of those symptoms that research has highlighted may commonly be associated with a serious and sustained "desire for death" (e.g. depressive disorders and poorly controlled pain). In such situations, early referral to an appropriate specialist should be considered.^{20, 21}
10. Despite the best that palliative care can offer to support patients in their suffering, appropriate specialist palliative care to remedy physical, psychological and spiritual difficulties may not relieve all suffering at all times.
11. ANZSPM acknowledges the significant deficits in the provision of palliative care in Australia and New Zealand, especially for patients with non-malignant life-limiting illnesses, those who live in rural and remote areas, residents of Residential Aged Care Facilities, the indigenous populations and those from culturally and linguistically diverse backgrounds.
12. ANZSPM advocates for health reform programs in Australia and New Zealand to strengthen end of life care by remedying shortages in the palliative care workforce (including in the specialist medical, nursing, and allied health fields), ensuring improved access to appropriate facilities and emphasising the role of advance care plans and directives.
13. ANZSPM advocates for increased carer support for respite care to decrease the sense of burden for many patients at the end of life.

Definitions

Palliative Medicine is the study and management of patients with active, progressive, far- advanced disease for whom the prognosis is limited, and the focus of care is the quality of life.²²

Palliative Care as defined by the World Health Organization²³ is an approach that improves the quality of life of patients and their families facing the problems associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable

²⁰ Breitbart W. Suicide risk and pain in cancer and AIDS patients. In: Chapman CR, Foley KM, eds. Current and Emerging Issues in Cancer Pain: Research and Practice. New York, NY: Raven Press; 1993:49-65.

²¹ Chochinov HM, Wilson KG. The euthanasia debate: attitudes, practices and psychiatric considerations. Can J Psychiatry. 1995;40:593-602.

²² Australian Medical Association: Online career pathways guide. Available at: <https://ama.com.au/careers/pathways/palliative-medicine>

²³ WHO (2002): WHO Definition of Palliative Care. Available at: <http://www.who.int/cancer/palliative/definition/en/>. (August 2020)

assessment and treatment of pain and other problems, physical, psychosocial and spiritual.

Palliative care provides relief from pain and other distressing symptoms. It:

- Affirms life and regards dying as a normal process
- Intends neither to hasten nor postpone death
- Integrates the psychological and spiritual aspects of patient care
- Offers a support system to help patients live as actively as possible until death
- Offers a support system to help the family cope during the patient's illness and in their own bereavement
- Uses a team approach to address the needs of patients and their families, including bereavement counselling, if indicated
- Enhances quality of life, and may also positively influence the course of illness
- Is applicable early in the course of illness, in conjunction with other therapies that are intended to prolong life, such as chemotherapy or radiation therapy, and includes those investigations needed to better understand and manage distressing clinical complications.

'Voluntary assisted dying'(VAD)²⁴ ANZSPM adopts the RACP's definition of voluntary assisted dying²⁵ which includes:

1. prescription or supply of a lethal drug which a competent patient self-administers without further assistance (sometimes called 'physician-assisted suicide'); or
2. administration of a lethal drug to a competent patient requesting assistance to die (sometimes called 'voluntary euthanasia').

Euthanasia is defined by the IAHPIC as the act of a physician (or other person) intentionally ending the life of a person by the administration of drugs, at that person's voluntary and competent request.²⁶

Assisted suicide is defined by the IAHPIC as the act of a person intentionally helping another person to terminate his or her life, at that person's voluntary and competent request.²⁷

²⁴ RACP (2018): Statement on voluntary assisted dying, page 4

²⁵ RACP (2018): Statement on voluntary assisted dying, page 4

²⁶ De Lima L, Woodruff R, Pettus K et al. *IAHPIC Position statement: Euthanasia and physician-assisted suicide*. Journal of Palliative Medicine Vol 20 No 1 2017.

²⁷ Ibid.