

POSITION STATEMENT

Position statement on voluntary assisted dying

2025

1. Preamble

1.1 Doctors have an ethical duty to provide their patients with quality end-of-life care that strives to alleviate pain and suffering, supports individuals' values and preferences for care and allows them to achieve the best quality of life possible.

1.2 In Australia, end-of-life care encompasses a variety of health services, including palliative care services and, where legal, voluntary assisted dying (VAD) services.

1.3 There is a wide range of opinions in relation to VAD within the Australian community as well as within the medical profession itself. This position statement serves to support doctors and patients who choose to participate, and those who choose not to participate, in VAD, where legally available in Australia.

1.4 This position statement serves as an overarching ethical framework for VAD rather than a prescriptive document addressing specific issues such as eligibility criteria or operational issues, which are generally undertaken at the state or territory level. It aligns with the AMA's 2023 position statement on issues arising at the end of life, which establishes policy on end-of-life care, including palliative care services and funding, advance care planning, decision-making capacity, groups with diverse needs, grief and bereavement, carers, and health workforce and system development.

2. Palliative care and VAD

2.1 Palliative care focuses on helping people with a life-limiting or terminal illness to live their lives as fully and comfortably as possible. It does not hasten or postpone death but aims to provide relief from pain and other distressing symptoms which may be physical, emotional, spiritual or social.^{i,ii,1}

¹ When undertaken in accordance with good medical practice, the following forms of patient management are considered an acceptable part of palliative care and should not be considered forms of VAD: not initiating life-prolonging measures; not continuing life-prolonging measures; the administration of treatment or other action intended to relieve symptoms which may have a secondary consequence of hastening death.

2.2 VAD refers to the assistance provided to a patient by a healthcare practitioner for the purpose of ending the patient's life at their request, in accordance with relevant legislation. VAD includes self-administration, where a person takes a VAD medication themselves, and practitioner administration, where a healthcare practitioner administers the VAD medication to a person.ⁱⁱⁱ

2.3 Doctors should continue to support patients as they explore their options and make end-of-life care decisions that are consistent with the patient's personal values, experiences, cultural beliefs and goals.

2.4 Patients should be informed they may receive palliative care while exploring, and throughout, the VAD process.

2.5 Patients, their family members and carers² should have access to high-quality culturally and linguistically appropriate resources that outline legally available end-of-life care options and how to access relevant services.

2.6 Sufficient supports that are culturally, spiritually and linguistically appropriate must be available. This is particularly important for Aboriginal and Torres Strait Islander peoples.

2.7 All patients should have access to appropriate support and counselling throughout their end-of-life journey, regardless of their end-of-life care choices. Patients' family members should also have access to appropriate counselling and bereavement support before and after the person's death.

2.8 Dedicated staff and VAD care navigators may help patients access information and relevant services.

2.9 Federal, state and territory governments must invest in affordable, quality end-of-life care services throughout Australia; however, investment in VAD must never compromise the appropriate provision and resourcing of palliative care.

2.10 There already exists a significant unmet need for palliative care services throughout Australia with demand likely to increase over the coming years.^{iv} It is imperative governments appropriately fund and resource palliative care throughout Australia. No patient should ever explore VAD because they are unable to access timely, quality palliative care.

2.11 Governments should resource and promote national public awareness and education that assist the community to better understand the role of end-of-life care, including palliative care and VAD.

²As outlined by Palliative Care Australia, the term 'family' includes people identified by the person as family. This may include people who are biologically related, however it may not. People who joined the family through marriage or other relationships such as kinship, chosen family, street family for those experiencing homelessness and friends (including pets) may be identified by the person as family. The term 'carers' may include family members and other members of the person's community (such as close friends or neighbours) who the person agrees to being involved in their care. A person may also choose not to have their family or carers involved in their care, or a person may not have any family or carers. Palliative Care Australia's *National Palliative Care Standards for All Health Professionals and Aged Care Services*. March 2022.

3. Conscientious objection and the medical profession

3.1 VAD can raise complex personal ethical issues for individual doctors, as it can with other members of the community. A doctor should be treated with respect and not be subject to discrimination or stigmatisation, including from employers, because of their position on VAD.

3.2 Doctors may have a conscientious objection to VAD and choose not to provide or participate in the VAD process.³ They must treat any patient who has requested VAD with respect and compassion. They must inform the patient of their objection in a timely manner. They must also inform the patient of their right to seek care from another doctor and ensure the patient has sufficient information to exercise that right.^v

3.3 Doctors should be familiar with their rights and obligations in relation to VAD legislation in their local jurisdiction. If unsure, doctors should consult with their medical defence organisation and/or state or territory AMA office for appropriate advice.

3.4 At times, a patient admitted to an institution may request VAD that the institution does not provide due to conscientious objection. In these cases, doctors should be allowed to refer patients seeking VAD to another doctor outside the facility without repercussions for the doctor.

4. VAD legislation

4.1 VAD legislation (including any associated regulations and guidelines) should be nationally consistent and ensure robust, accountable and transparent safeguards, protections, standards and oversight.

4.2 Doctors must be involved in the development, review and amendment of VAD legislation and associated regulations and guidelines.

4.3 VAD legislation, regulations and guidelines must:

- be evidence-based
- ensure protections and establish clear, rigorous safeguards for all patients
- ensure participation in VAD services remains voluntary for patients and doctors
- ensure doctors are not compelled or coerced into providing VAD services
- protect all doctors acting within the law
- ensure the availability of VAD services does not compromise the provision and resourcing of palliative care services
- be subject to regular monitoring, review and research
- be aligned to reduce barriers to VAD services for regional, rural, remote and cross-border areas.

³ As defined in the *AMA Position Statement on Conscientious Objection 2019*, conscientious objection occurs when a doctor, as a result of a conflict with his or her own personal beliefs or values, refuses to provide, or participate in, a legal, legitimate treatment or procedure which would be deemed medically appropriate in the circumstances under professional standards. A conscientious objection is based on sincerely held beliefs and moral concerns, not self-interest or discrimination.

4.4 State and territory governments must have independent oversight bodies such as VAD review boards which serve to oversee, monitor and report on the operation of and compliance with VAD legislation in their local jurisdictions. Doctors should be included in the membership of these review boards.

4.5 The development, review and updating of VAD legislation must be undertaken with appropriate community consultation that reflects the diversity of our community.

4.6 Information and support must be available for patients who wish to explore VAD even where their doctor or health service does not offer this service. Legislated VAD services must be available to provide this.

5. Telehealth and VAD

5.1 Legislation should not prohibit the use of telehealth to provide VAD services as this may severely disadvantage patients living in regional, rural and remote communities and those who are physically unable to travel for face-to-face consultations.

6. Workforce

6.1 Accessibility of VAD services require a workforce that is appropriately trained, resourced and distributed.

6.2 Funding for VAD services must include the provision of relevant education, training and professional development.

6.3 Doctors must be involved in the development of VAD-related education as well as training and professional guidelines.

6.4 VAD education encompassing ethical and legal issues should be included in the medical school curriculum.

6.5 Doctors-in-training who wish, and are legally able, to participate in VAD services must receive appropriate education, training and supervision. This should encompass undertaking VAD discussions with patients as well as clinical and/or professional supervision and support when providing VAD services.

6.6 All doctors should be required to complete mandatory approved training before they are able to provide VAD services which offer clear, comprehensive and consistent ethical, legal and clinical guidance.

6.7 National evidence-based clinical, safety and quality standards for VAD should be developed.

6.8 Doctors providing VAD services should be supported, resourced and remunerated appropriately. This includes access to appropriate counselling and debriefing services for all healthcare staff involved in the care of patients receiving VAD services.

6.9 Effective communication, collaboration and teamwork are required to ensure continuity and co-ordination between healthcare teams providing VAD and end-of-life services, within and in the transition between care settings, and across multiple episodes of care.

6.10 Engagement with the patient's usual general practitioner should be strongly encouraged whether they are directly involved in the VAD process or not.

6.11 There should be appropriate management of on-call cover and transfer of care between VAD practitioners. The doctor providing the VAD service should provide clinical handover to the doctor who examines and certifies the patient after death, if not the same practitioner.

7. Support for doctors

7.1 Doctors providing VAD services require appropriate support to address their own emotional and spiritual needs and to promote their health and well-being. They may require psychological support through counselling and debriefing services.

7.2 Doctors who provide VAD services should be indemnified as part of standard medical practice by medical defence organisations.

8. Data collection and research

8.1 Appropriate investment in VAD-related quality improvement activities and research is required to improve services. A co-ordinated, systematic, independent, ongoing process of research and evaluation enables the system to be refined and made safer, more efficient and more equitable.^{vi}

8.2 Doctors who provide VAD services are strongly encouraged to participate and collaborate in research and data collection, where able to do so. Transparent reporting of all such research is vital to improve patient safety and choice.

8.3 The introduction of VAD represents a major change in social policy in Australia. A formal, systematic, ongoing process of data collection that focuses on the experiences, attitudes and opinions of patients' family members and carers, healthcare professionals, community members, regulators and others should be established to help understand the impacts of VAD and to inform social policy and medical practice.

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ⁱ Australian Government. *Department of Health. National Palliative Care Strategy 2018*

ⁱⁱ Palliative Care Australia. *What is palliative care?* <https://palliativecare.org.au/resource/what-is-palliative-care/> (accessed 25 March 2025)

ⁱⁱⁱ Queensland University of Technology. *End of Life Law in Australia.* <https://end-of-life.qut.edu.au/assisteddying>

^{iv} Palliative Care Australia. *Voluntary Assisted Dying in Australia. Guiding principles for those providing care to people living with a life-limiting illness.* 2022

^v Australian Medical Association. *Position Statement on Conscientious Objection 2019*

^{vi} Palliative Care Australia. *Position Statement. Palliative Care and Voluntary Assisted Dying.* 2022