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Transcript: AMA President, Dr Michael Gannon, with Gareth Parker, 6PR, Monday 27 November2017

Topics: Assisted Dying Legislation

GARETH PARKER: For some years there have been consistent published polls that show around 70 per cent - sometimes up to 80 per cent - of Australians support voluntary euthanasia laws. So is it a matter of politicians giving expression in legislation to the will of the people, or does all of this hinge on the model that the political system throws up?

Please do give me a call this morning. I'd be really interested to hear where you stand on this big social question. I'd like to hear your experiences as you've navigated these issues with friends, family, and loved ones. These questions, quite literally, are a matter of life and death.

The Federal President of the AMA is Michael Gannon. He joins me on the program.

Michael, good morning.

MICHAEL GANNON: Good morning Gareth.

GARETH PARKER: Why is the AMA leery about legislating for voluntary euthanasia?

MICHAEL GANNON: Well, it goes to the heart of our code of ethics. Doctors are there to, where possible, save lives; they're there to ease suffering; they're there to manage symptoms. Nowhere in the ancient codes of medical ethics, nor in their modern incarnation of the Declaration of Geneva is there anything which says that doctors should be involved with the ending of a patient's life. And very clearly, our ethical statements, our position statements say that doctors should never be involved in interventions that have as their primary intention the ending of a patient's life.

GARETH PARKER: And yet, as I said, if you ask the Australian people - as pollsters have done from time to time over many years - it does seem as though most Australians would like some sort of legalised regime for voluntary euthanasia.

MICHAEL GANNON: It depends on the question that you ask, Gareth. If you ask most reasonable humane people on the street: do you believe that if someone is suffering intolerably from unmanageable pain, should there be another option; then I'm surprised that 99 per cent don't say yes. The truth is the issue's a lot more complex than that. It is- we've heard sloganeering like dying with dignity; the idea that doctors, nurses, other staff aren't interested in the dignity of their patients at end of life is silly, if not offensive.

What we saw in the Victorian debate was a discussion that at many stages was devoid of intellectual vigour. You had people talking about very emotional individual stories. Every single one of those was an example of a failure of the health system to provide appropriate levels of palliative care or other services. That should be the focus of the West Australian Government; that should have been the focus of the Victorian Government.

GARETH PARKER: So, to your point, if people are asked about this question; you said that if you put the proposition to people that if someone is in unmanageable pain, should their suffering be eased as they - and I'm paraphrasing here - but as they move towards the end of

their life. Do you believe that such a provision can be made under the existing law of the land and under existing best medical practice?

MICHAEL GANNON: Well, certainly we do need legislative change, and certainly we do need better education of the community. So for example, many people in the community - and sadly, even at the end of this lengthy process, the Victorian Premier - don't seem to grasp the fundamental difference between active euthanasia or physician assisted suicide. And that's the appropriate terminology. If you're going to ask a doctor to give a lethal injection, that's physician assisted suicide. Euthanasia - in the Victorian context, the Oregon context, the Dutch context - is about patients self-administering themselves a lethal substance.

But we need to make it very clear that there is a very obvious ethical distinction between someone giving something that has its intention ending someone's life; and what we would call the doctrine of double effect. The idea that if you give someone the medication they need - the other symptom relief they need - and they're so ill that that has a secondary effect, a hastening of end of life, that is ethically very distinct.

There was an opportunity for the Victorian Parliament to codify that. They had an excellent many-month-long process in their Upper House and produced a report that had 49 recommendations. I'll leave you to judge whether or not they should have dived straight for recommendation 49 of 49, which was to legislate euthanasia assisted suicide. To codify double effect, to try and improve palliative care services, to recognise where the system fails people, that should have been their impetus.

I'll be doing my best - and so will my colleagues at the AMA in Western Australia - to make sure that improving palliative care services improving end-of-life care should be the impetus of any move in Western Australia.

GARETH PARKER: So, let's just run through a couple of the relevant provisions of the Victorian law so that we understand what we're actually talking about here. This is, sort of, some of the brief details of how the Victorian model is supposed to work. A person who seeks to access the regime must be over 18 and capable of making their own decisions. They must have an incurable illness which causes intolerable suffering, and have a diagnosis that sees them expected to live less than six months. Two doctors then have to sign off on any application, assessing whether a patient is eligible under the criteria. A doctor may not initiate or suggest voluntary euthanasia, I think that's important to note. And then a patient must make two formal requests, as well as a written statement. If it's then signed off by the doctors, then a doctor will prescribe a drug, the particular drug is not actually codified in the Victorian legislation, that drug is then dispensed by a pharmacist, and then, if a patient is able to self-administer a drug then they do so. If not, a doctor is able to assist with that administration of that drug. And doctors do have the right to be conscientious objectors.

That's probably about as brief a summary as I can give of the relevant provisions. Are there any there in particular, Michael, that you find a bridge too far?

MICHAEL GANNON: Well, I think that one important statement to make is that all of it is a bridge too far under medical ethics as they've existed through time. Secondly, it needs to be very clearly stated that a lot of doctors, a lot of AMA members, are very comfortable with the concept of euthanasia and assisted suicide. And in our survey they indicated that they would be willing to provide those services. Now, there's a majority of doctors that don't want a bar of this. But that's important to state.

The way you've laid it out, it does sound like reasonable legislation. And some of the things you've mentioned have come out of a process of amendment. The Bill hasn't passed the Lower

House, yet. For example, moving the life expectancy down from 12 months to six months is an Upper House amendment that I expect will be passed by the Lower House. I do expect that this will come into law.

The reality is that in the other parts of the world - the few other places in the world that have legislated euthanasia assisted suicide - the majority have changed their laws over time and they have extended it. Now, some of the higher profile euthanasia advocates have changed their language, they've played this game very smart. If Victorian parliamentarians are exhausted by what they've just been through, I've got news for them. They will be back in the Parliament in coming years because there is no question that people in society want to see this extended to patients with dementia, with other forms of degenerative disease, with mental illness. That's what we fear.

We fear that over time that this will change people's attitude to life and death, it will change the relationship between doctors and patients. And it's inevitable - not inevitable that it will be extended - but it's inevitable that people will seek to extend these laws to people with a broader range of disease processes.

GARETH PARKER: So, just briefly, Michael, is that you've already said that you do believe there needs to be legislative change here, is there a central feature of - perhaps what I'll term - maybe a minimalist model that you would seek to have as part of any bill that might emerge from the Parliamentary inquiry process that will be ongoing through the middle of next year?

MICHAEL GANNON: Well, there's unlikely to be a minimalist model that will enjoy the support or endorsement of the medical profession. One-hundred-and-seven of 109 national medical associations who are members of the World Medical Association oppose euthanasia. And of course, that includes like the American Medical Association, where this is legal in four States and the District of Columbia. That includes the Belgian Medical Association, where it's legal to euthanise children and legal to euthanise people with depression.

So, medical associations are unlikely to endorse it but doctors don't make laws, parliamentarians do. But one of the things that will be very clear is that doctors will point to the deficiencies in these laws and they will always speak up for the most vulnerable in our community. That's what we worry about. We worry about the voiceless. We worry about the fact that most people who get euthanised in the Netherlands are single women over the age of 50. This is a difficult issue, it's a contentious issue, and it's a lot more complex than a slogan like dying with dignity.

GARETH PARKER: Michael, I appreciate your time this morning.

MICHAEL GANNON: Pleasure, Gareth.

GARETH PARKER: Michael Gannon, the Federal President of the AMA.

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