Australian Medical Association
Submission to the Inquiry into the *Exposure Draft of the Medical Services (Dying with Dignity) Bill 2014*

The Bill

The AMA does not support this Bill. While we recognise the diversity of views on 'assisted dying', we believe that doctors (medical practitioners) should not be involved in interventions that have as their primary intention the ending of a person's life. The World Medical Association (WMA), of which the AMA is one of over 110 National Medical Association members, declares that doctors' involvement in activities such as euthanasia and assisted suicide conflicts with the basic ethical principles of medical practice.[i,ii]

Definition of 'Dying with Dignity Medical Service'

We do wish to raise a specific issue with the Bill, however, in relation to the definition of 'dying with dignity medical service' as defined in Section 5 as follows:

(1) A dying with dignity medical service means a medical service provided by a medical practitioner to a person to enable the person to end his or her life in a humane manner.
(2) Without limiting subsection (1), such services include:
- *a. the giving of information to the person; and*
- *b. the prescribing of a substance to the person; and*
- *c. the preparation of a substance to the person for self-administration; and*
- *d. the administration of a substance to the person at the person's request.*

The services outlined in paragraph (2) a-d can reasonably be described as physician assisted suicide (lines a-c) and euthanasia (line d). Although the terms 'physician assisted suicide' and/or 'euthanasia' are absent from the Bill, they are defined by the AMA as follows[1]:

> *Physician-assisted suicide – Where the assistance of the medical practitioner is intentionally directed at enabling an individual to end his or her own life.*
>
> *Euthanasia – The act of deliberately ending the life of a patient for the purpose of ending intolerable pain and/or suffering.*

As written in the Bill, the use of the following words in (2):

without limiting section (1), such services include…..

implies that a 'dying with dignity medical service' could include services in addition to those listed in paragraph (2)a-d. It's not clear, however, what other services these may constitute; for example, are they additional services that may reasonably be considered forms of euthanasia and/or physician-assisted suicide? or are they medical practices that are already undertaken as part of good medical practice?

[1] From the AMA *Position Statement on the Role of the Medical Practitioner in End of Life Care 2007*.

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In its definition of 'dying with dignity medical service', it is essential that this Bill clearly identify, and separate, interventions that are currently accepted as good medical practice from those that are not accepted as such (eg., any practice defined as euthanasia and/or physician assisted suicide).

The AMA believes the following activities **do not** constitute euthanasia or physician assisted suicide (where taken in accordance with good medical practice):

- 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.

This view is supported by others. For example, in Section 3.12 End of Life Care in its Code of Conduct for doctors[iii], the Medical Board of Australia states that good medical practice involves:

> *3.12.4 Understanding that you do not have a duty to try to prolong life at all cost. However, you do have a duty to know when not to initiate and when to cease attempts at prolonging life, while ensuring that your patients receive appropriate relief from distress.*
>
> *3.12.5 Accepting that patients have the right to refuse medical treatment or to request the withdrawal of treatment already started.*

The Australia and New Zealand Society of Palliative Medicine (ANZSPM) recognises:

> *treatment that is appropriately titrated to relieve symptoms and has a secondary and unintended consequence of hastening death, is not euthanasia.*[iv]

Euthanasia and physician assisted suicide involve the *primary, deliberate intention* of causing the patient's death. These activities have not gained wide-ranging ethical acceptance by the medical profession globally; indeed, the World Medical Association deems a doctor's involvement in either activity to be unethical.[i,ii]

Withholding and/or withdrawing life-sustaining treatment (if undertaken in accordance with good medical practice) allows the course of the person's illness to progress naturally, which may result in death. In addition, the administration of treatment or other action to relieve symptoms which may have a secondary consequence of hastening death is undertaken with the primary intent to relieve the patient of distressing symptoms. It is important that these practices, which are ethically acceptable if done in accordance with good medical practice, are not confused with activities that constitute euthanasia and/or physician assisted suicide.

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Advance Care Planning and Palliative Care

While the AMA does not support the *Exposure Draft of the Medical Services (Dying with Dignity) Bill 2014*, we strongly encourage the wider community to engage in discourse on death and dying. In particular, we consider there needs to be greater public awareness and discussion of advance care planning as well as palliative care.

Many patients want to be able to control the care they receive if they lose decision-making capacity in the future. Advance care planning is a process for future health and personal care where the person's values, beliefs and preferences are made known so they can guide decision-making at a future time. Patients should be encouraged to discuss end of life care wishes with their family and doctor(s) and develop (and revisit) an advance care plan to assist in future decision-making.

Palliative care focuses on quality of life and reducing suffering through early identification, assessment, and treatment of pain, physical, psychological, social, cultural and spiritual needs.[v] Palliative care can alleviate many of the distressing symptoms associated with the dying process. Doctors and other health care professionals provide ongoing care throughout the course of the patient's condition, regardless of whether they are receiving care that is curative (focused on trying to cure a life-limiting illness or extend life) or palliative (care for which the primary treatment goal is comfort and quality of life).

Greater awareness, funding and access to advance care planning and palliative care services will ensure patients receive the treatment consistent with their values and goals of care at the end of life.

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[i] World Medical Association. *WMA Resolution on Euthanasia.* Adopted by the 53rd WMA General Assembly, Washington DC, USA 2002 and reaffirmed with minor revision by the 194th WMA Council Session, Bali, Indonesia, April 2013.
[ii] World Medical Association. *WMA Statement on Physician-Assisted Suicide.* Adopted by the 44th World Medical Assembly, Marbella, Spain, September 1992 and editorially revised by the 170th WMA Council Session, Divonne-les-Bains, France, May 2005.
[iii] Medical Board of Australia. *Good Medical Practice: A Code of Conduct for Doctors in Australia*. March 2014.
[iv] The Australian and New Zealand Society of Pain Medicine. *Position Statement. The Practice of Euthanasia and Assisted Suicide.* 31 October 2013.
[v] World Health Organization. *WHO Definition of Palliative Care*.