Voluntary assisted dying legislation

Position Statement – June 2019

Position

The RACGP recognises that changes to the law are a matter for society and government and all health professionals must operate within the boundaries of State and Federal Law.

The RACGP supports patient centred decisions in end-of-life care and respect that this may include palliative care and requests for voluntary assisted dying. Any legislation must:

- protect both patients and doctors from coercion
- ensure doctors are not compelled in any way to participate
- have clear eligibility criteria
- support the optimisation of end of life and palliative care services..

Background

States across Australia are either considering or have passed voluntary assisted dying legislation.

The RACGP is acutely aware there are a range of views on voluntary assisted dying, both within the general practice profession and, the broader community. Arguments for and against legalisation for voluntary assisted dying are highly complex and raise significant practical and ethical issues. Both proponents and opponents of voluntary assisted dying wish to alleviate suffering of dying patients, and recognise that doctors as medical professionals have ethical responsibilities, not merely providers of services.

This position statement has been written to ensure that both patients and general practitioners (GPs) are supported when legislation for voluntary assisted dying is being considered and implemented.

Respecting patient choices

As with all good medical practice, end-of-life care should be patient-centred. Compassion, dignity, respect and participation in decision-making are important to the delivery of high quality palliative and end-of-life care.

Whilst not taking a formal position on whether voluntary assisted dying should or should not be legalised, the RACGP recognises that if assisted dying becomes a legal option, some patients will request it, and that such a request requires a respectful and compassionate response.

To facilitate a patient-centred approach, there should be open and informed communication between GPs and patients, their families, carers and those people nominated to make treatment decisions where applicable. This should be an ongoing conversation, covering topics including goals of care, advance care planning, prognosis, and symptom control measures.

The suffering experienced by dying patients may be great. In addition to pain and disability from the terminal illness, nausea, asthenia and medication side effects are common.

Existential suffering as a product of hopelessness, indignity or loss of independence can result in a patient belief that meaningful life has ended in all but a biological sense. For some patients a sense of control over the manner and timing of death can bring comfort.

Requests for voluntary assisted dying must be patient initiated, voluntary and should be free of coercion from family members, health practitioners and others. While requests for voluntary assisted dying are few in number[1], people who express these wishes must be supported in a way that allows time for full exploration of their concerns and options.

Lack of palliative care services should not compel patients into voluntary assisted dying. Regular audit of services and Government responsibilities should occur to prevent this.

Eligibility criteria for access to voluntary assisted dying should be clear to provide certainty and clarity to the community and health practitioners, and patient centred to allow patients themselves to judge whether the suffering/experience cannot be relieved in a manner they deem tolerable.[2]

A Legislative framework

Any legislation should be consistent across Australia and must ensure robust standards, protections and transparent safeguards. A complex and robust oversight mechanism should be implemented to ensure the integrity of the system and to provide protections to keep the community safe. Regulations that are introduced must also be properly monitored by Government.[3]

There should be protection from improper coercion for both patients and doctors.

There should be provision to ensure the law does not compel a medical doctor to take positive steps to end a patient's life, whether this is by recommending, administering, or providing approval for administration of a medical intervention. Voluntary assisted dying law should have adequate provisions to allow doctors with a conscientious objection to refrain from involvement in accordance with their personal beliefs and values.

Law should not confuse voluntary assisted dying with other acts

It is important to differentiate that certain activities when aligned with patient wishes, do not constitute voluntary assisted dying.

It must be emphasised that as we understand, the following acts do not constitute voluntary assisted dying or, assisted suicide:

1. Withholding or withdrawing medical treatment in accordance with that person's previously expressed wishes (in the form of an advance care directive and/or person with substitute decision-maker as per the law of the relevant State or Territory).

2. Withholding or withdrawing treatment in a situation where a person retains capacity to make decisions and has refused life-sustaining interventions.
3. Withholding or withdrawing futile treatment. At common law, there is no legal duty upon a doctor to provide treatment that is not in the patient's best interests.
4. Administering palliative medication with the intention of relieving a person's pain and suffering, with the understanding that this may have a secondary consequence of hastening death. This has some legal protection under the common law doctrine of double effect.[4]
5. Terminal or palliative sedation to induce decreased or absent awareness in order to relieve otherwise intractable suffering at the end of life.[5]

Legal status of these acts is noted as a general guide only (for a detailed review, see the Australian Human Rights Commission's issue paper on this topic).[6]

The role of general practitioners in end-of-life care

Recognising and supporting the role of general practice is central to meeting society's growing need for high quality end-of-life care.

The rapport GPs build with their patients over years creates an ideal setting for end-of-life planning and care. GPs often have contextual knowledge of the patient and their family. Trusting, long-term GP-patient relationships can help facilitate timely discussions about needs and preferences in the context of various end-of-life scenarios.

Optimal end-of-life care is often delivered by a multidisciplinary team in a shared-care arrangement. In many cases, this will be coordinated through a general practice and may be augmented by specialist palliative care services where needed. Continuity of care is maintained across settings and between services when GPs work closely with palliative care and other service providers, including other health practitioners, Aboriginal and Torres Strait Islander health workers/health practitioners, pastoral care workers and residential aged care facility (RACF) staff where relevant.

Patients are up to four times more likely to die in their preferred setting when GPs are informed of their preference in the end-of-life phase.[7]

Following a patient's death, their GP is usually involved in providing bereavement care to family and carers.

A GP's involvement in voluntary assisted dying will be determined by personal, cultural and religious beliefs, and our profession's guiding ethical principles. GPs should always be guided by the principles laid out in the Medical Board's *Good medical practice: a code of conduct for doctors in Australia* but they should not be obliged to participate and be placed in the difficult position of responding to pressure from patients and their families to engage in voluntary assisted dying. Doctors that are willing to participate should opt into the process and receive the necessary training. Doctors who choose to opt-in should have unambiguous legal protection for all associated services, including the administration of the substance in circumstances where the patient has specifically requested assistance in accordance with relevant state legislation.

Summary

The RACGP recognises and advocates the importance and centrality of the role of the GP in high quality end-of-life care. This position statement has been written to provide frameworks and commentary to ensure that both patients and GPs are supported when legislation for voluntary assisted dying comes into the clinical setting.

Relevant RACGP resources

- RACGP Position statement on advance care planning
- RACGP Curriculum for Australian General Practice
- Medical care of older persons in residential aged care facilities (Silver book).

References

1. Hudson P, Hudson R, Philip J, Boughey M, Kelly B, Hertogh C. Legalizing physician-assisted suicide and/or euthanasia: Pragmatic implications. Palliative Support Care. 2015 Oct;13(5):1399-409

2. Victorian Government, Ministerial Advisory Panel on Voluntary Assisted Dying: final report, Melbourne, 2017

3. Pereira J. Legalizing euthanasia or assisted suicide: the illusion of safeguards and controls. Current Oncology 2011;18:e38-45.

4. State Government of Victoria. Voluntary Assisted Dying Bill: Discussion Paper. Melbourne: DHHS; 2017

5. Caresearch: Palliative sedation, available at www.caresearch.com.au/caresearch/tabid/1548/Default.aspx [accessed 13 Oct 2017].

6. Australian Human Rights Commission. Euthanasia, human rights and the law: Issues paper. Sydney: AHRC; 2016

7. Abarshi E, Echteld M, Donker G, Van den Block L, Onwuteaka-Philipsen B, Deliens L. Discussing end-of-life issues in the last months of life: a nationwide study among general practitioners. J Pall Med 2011;14(3):323-30