



RACP
Specialists. Together
EDUCATE ADVOCATE INNOVATE

**RACP Submission:
Draft Voluntary Assisted Dying Bill 2017
[NSW]**

July 2017

Introduction

The Royal Australasian College of Physicians (RACP) wishes to provide its feedback in response to the NSW Parliamentary Working Group on Assisted Dying's (PWGAD) Draft Voluntary Assisted Dying Bill 2017.

However, our submission should not be taken to mean the College supports the intention of this Bill.

There is diverse opinion within the RACP Fellowship regarding medical assistance in dying.

The RACP is currently developing a position on the issues in consultation with the membership. The purpose of our submission is to:

- 1) provide feedback on the concerning aspects of the Bill,
- 2) highlight the impact that the introduction of a scheme for medical assistance in dying would have on physician practice in NSW, particularly for palliative medicine specialists, and
- 3) highlight the impact on patients, bereaved families and carers and other health professionals.

Key issues observed in reading through the Bill are that:

- it conveys a legal process, with little understanding of the clinical care context. This is apparent in the sections covering assisting persons, prognosis, suffering and physician opinion,
- it is heavily based on individual autonomy and does not adequately address the context in which end of life decisions are made, and the significant role of family and carers,
- some clauses may be unworkable in practice, for example safeguards proposed in relation to financial and other gains,
- the process for preparation of a Bill of this nature has not been undertaken in a robust manner unlike the current Victorian process which has been far superior from a procedural perspective.

Separate to the Bill text, the RACP notes that the language of the 'Overview' document (particularly under the heading *'Difference between voluntary assisted dying and voluntary euthanasia'*) is unclear and potentially misleading. In describing the intent of this Bill, it seeks to separate the legalisation of 'physician assisted dying' from 'voluntary euthanasia', as if they were separate categories. Although not defined in the Bill, from descriptions used in the Overview document, it is clear that 'physician assisted dying' as described in this proposal is in fact one category of 'voluntary euthanasia', as that term is described in the Overview.

Terminology used in this submission

In this submission, the term *medical assistance in dying* refers to the following treatment provided at the request of a patient by a medical practitioner or those with appropriate prescribing rights, and includes:

- i. The prescription or supply of a lethal drug which a competent patient self-administers without further assistance; or
- ii. The administration of a lethal drug to a competent patient requesting assistance to die.

The following are not considered to be medical assistance in dying and are well established end of life practices:

- a. Refusing life-sustaining treatments: Patients with capacity have the right to refuse treatment including the provision of medically assisted nutrition and/or hydration
- b. Withholding or withdrawing treatments that are not benefiting the patient: physicians have a duty to consider the benefits and harms of any treatments including the provision of medically assisted nutrition and/or hydration before instituting them. The benefits and harms of ongoing treatment should also be regularly reviewed
- c. Providing appropriate palliative sedation to manage refractory symptoms
- d. Titrating medical treatment to relieve symptoms even if it may have the perceived potential to hasten death.

Whilst treatment intended to relieve symptoms could foreseeably hasten death (although this may not be an inevitable consequence as noted on page 12 of this submission re opiates), this is not the prescriber's intent but a secondary consequence. The primary intention is to relieve distress, not end life (principle of double effect).

Background

Legalisation of medical assistance in dying is a highly contentious and divisive issue, raising a number of ethical, social, legal and religious concerns. Arguments for and against legalisation are well-articulated in the medical literature and public discourse.

Individual patient situations at the end of life are often not straightforward. Assessment of quality of life, capacity and prognosis can be contested. If the law were changed to allow medical assistance in dying in certain circumstances, physicians would be required to assess many complex issues. Our experience tells us that there would be many patients who would not fit neatly into particular rules or situations and working through these issues would push any boundaries that are set.

RACP position on medical assistance in dying

The RACP is in the process of establishing a position paper on medical assistance in dying, in consultation with its membership.

While this policy work is underway, the RACP has drawn on consultations with key College bodies as well as our broader membership to inform this submission. These include the College's Euthanasia and Physician Assisted Death Working Party, Ethics Committee, the Australasian Chapter of Palliative Medicine Committee, and the RACP NSW State Committee.

Regardless of the many issues raised by legalising access to medical assistance in dying, the RACP holds that physicians and society have a duty to provide high quality end of life care to patients and their families and carers. This is set out in the RACP's position statement '[Improving Care at the End of Life: Our Roles and Responsibilities](#)' (May 2016), the RACP advocates for:

- High quality end of life care for patients and the duty of all physicians to provide this;
- Open and honest communication with patients about impending death;
- A doctor-patient relationship based on openness, trust and good communication;
- The positive contribution a physician can make to end of life care; and
- Acknowledging and respecting different cultural preferences and approaches to death and dying and providing culturally sensitive end of life care.

The RACP recognises that medical assistance in dying as defined above is distinct from the practice of palliative care. It should be noted that the Australian and New Zealand Society of Palliative Medicine has strongly stated that the practices of euthanasia or assisted suicide are not part of the Palliative Medicine discipline.¹

¹ Australian and New Zealand Society of Palliative Medicine (2013). Position Statement - [The Practice of Euthanasia and Assisted Suicide](#)

RACP comments on the Draft Voluntary Assisted Dying Bill 2017

Significant omissions and concerns with the Bill are detailed below.

Clause 3 - Definitions

- Definition of 'health care provider'
The dual definition of health care provider either as an institution, or an individual provider of care, is problematic and confuses the location of care with the individual providers of care. The two should be understood separately.
- Definition of 'terminal illness'
There is no objective definition of 'reasonable medical judgment' in relation to terminal illness as resulting in the death of the patient within 12 months; it simply appears to describe the judgment of two individual medical practitioners, without reference to any literature in relation to whatever disease(s) a requesting individual might be suffering with.

Being confident of a 12 month lifespan on an individual basis is very difficult. As expressed in a recent systematic review,² accurate forecasting is (nearly) impossible for a number of reasons explained below.

Prognostication is generally a variable skill not only affected by patient factors but also level of clinician experience, duration of relationship with the patient and whether it is done by an individual or a multidisciplinary team. It is based on statistical data which will only apply on average. Therefore if a certain group of patients have a 12 month expectation of life, a significant proportion will die before this time and a significant proportion afterwards. Studies are also heterogeneous. Most studies have been in the cancer population and there are studies in the non-cancer population where forecasting is even more inaccurate.

As described in the review, there are also varying types of estimates (continuous, categorical, and probabilistic) and of the three estimates, probabilistic "may be slightly more accurate than categorical or continuous".² The Bill is using the least accurate method to draw judgments which are uncertain in nature.

Studies show that clinicians are more likely to overestimate than underestimate survival.

Clause 4 - Request for assistance to voluntarily end life

The Bill provides no details about the 'primary medical practitioner', for example how long they have known the patient, qualifications, expertise, though this is stipulated for the 'secondary medical practitioner' as "a specialist in relation to the diagnosis or treatment of the relevant terminal illness". This is information physicians ordinarily have to provide when completing forms for patients to access superannuation, terminal illness benefit, critical illness insurance and the NSW Health Medicinal Cannabis Compassionate Use/Terminal Illness Cannabis Scheme.

Moreover, the Bill's explanatory notes could provide a rationale for why patients aged between 18 – 25 years are excluded from the provisions of this Bill. Noting that the eligibility age in many overseas jurisdictions is 18 years and above, the PWGAD may be asked to provide an explanation.

Clause 5 - Right to rescind request

This clause deals only with rescinding a written request and does not deal with rescinding an audio-visual request (e.g. with an interpreter, as envisaged in Clause 19 etc).

² White N, Reid F, Harris A, Harries P, Stone P A Systematic Review of Predictions of Survival in Palliative Care: How Accurate Are Clinicians and Who Are the Experts? PLOS ONE 2016;11(8): e0161407.

Clause 7 - Nomination of person to administer substance

Clause 7 is of significant concern for two reasons.

Firstly, there is inconsistency between the ages of the patient and nominee. The clause states the nominee must be at least 18 years old but the age limit for a patient is 25 years old. One would expect the same age restriction to apply to both nominee and patient. This also raises a potential risk of non-voluntariness/coercion of the assistor.

Secondly, the clause empowers the person nominated by the patient to administer or refuse to administer the substance “in due course” (as per the explanatory note). The evidence in terminally ill patients is that wishes and preferences change over time. As such, prospective “pre-approval” for lethal medication administration is highly fraught. It would be theoretically possible that a person has lost capacity for legal decision making but no longer wishes to end their life. Regardless, the lethal administration would have been pre-approved and may be legally administered regardless of the patient’s current wishes/preferences.

Other scenarios relating to administration of a lethal drug by the patient, which have not been considered fully considered include:

- The patient ingests the medication by self-administering it into a feeding tube;
- The patient is physically unable to take the medication but is able to independently direct a machine to administer the medicine.

Clause 8 - Cooling-off period

The RACP believes 48 hours is too short a cooling-off period in relation to making a decision to end life. People’s journeys as they approach death are intense periods of existential reflection and physical challenges. We note that a 10-14 day cooling off period with a second review and discussion would be in accordance with other jurisdictions which have legalised this model.

Clause 9 - Standards for provision of assistance

The reference to ‘appropriate medical standards’ in this clause is too unclear as a standard. For example, would this mean appropriate symptom control and prescribing of medications for relief of these, and involvement of specialist care providers in supportive and palliative care before any request for assistance under this Bill would be considered? The RACP would not recommend mandatory palliative care referral or consultation after a request has been made for the reasons detailed on page 5 of this submission.

If medical assistance in dying is legalised, the RACP would support the safeguards proposed by [AMA Victoria](#) that relate to participating medical practitioners having:

- developed an adequate (preferably long-term) professional relationship with the patient
- a sufficient understanding of the patient’s preferences and values in relation to end of life care;
- an informed understanding of the patient’s medical condition.³

Participating practitioners would also have to be properly skilled in a number of domains, and would have to be qualified in the diagnosis and prognosis of the specific medical condition. The PWGAD could consider setting out the domains of expertise required to provide medical assistance in dying, rather than circumscribing it to a particular profession or qualification level, which could create restrictions to access, or lead to an inexperienced medical practitioner confirming a request. For example, a neurologist who specialises in stroke care, and holding qualifications in neurology, may still not have sufficient experience of motor neurone disease management to be able to discuss prognosis in detail, or answer questions about the role of artificial ventilation. See comments above regarding prognosis in relation to Clause 3.

³ AMA Victoria (Dec 2016) [Physician Assisted Dying Position Statement](#)

This would need to be balanced against the equitable access issues that arise in the regional and remote areas of NSW when patients are too sick to travel. These situations would require more detailed consideration around how assessment could be done by someone suitably skilled.

Clause 11 - Financial and other advantages

This Clause does not address any financial advantage potentially gained by any relative or close associate of the patient, in particular, any advantage gained by a person nominated to assist, as in Clause 7.

Clause 12 - Conduct influencing provision of assistance

Clause 12(1), when read in the context of Clause 7(1), would seem to exclude the nomination of a family member to administer a substance, if the family member stands to benefit from execution of the person's Will. Moreover, any conversation with family as to their input — either for or against assisted dying — would become extremely delicate, as such conversations could be seen as "compelling or persuading the primary medical practitioner or other person to assist or refuse to assist". In effect the proposed law seems to make it illegal for family to have a role in decisions made between patient and medical practitioner.

It is also noted that Clause 25 grants nominated persons protection from legal liability, but subsection 25 (2) restricts such protection to "only if the assistance is provided in accordance with the requirements of this Act."

The legislation could be unworkable in practice as the conjunction of these clauses would appear to prevent a person nominated to assist in the process, by administering the substance, from being a Beneficiary (or Executor) of the patient's Will.

Clause 13 - Improper conduct relating to request certificate

The RACP would recommend a more rigorous deterrent than is set out in this Clause.

Clause 15 - Information to be provided by primary medical practitioner

This Clause is unlikely to enable patients to have real access to information and best practice end of life care.

Specialist physicians trained in palliative care are commonly part of the multidisciplinary team caring for and monitoring patients at the end of their lives. This involvement is often essential to ensure that patients are well managed. Every patient should receive timely, equitable, good quality end-of-life care, including access to specialist palliative care where appropriate.

Referral to specialist palliative care should be strongly recommended for patients considering medical assistance in dying. However, the RACP would not recommend mandatory palliative care referral or consultation after a request has been made, for a number of reasons:

- The provision of assisted dying must not be seen as part of palliative care - as already stated, these are distinct practices
- Referral or consultation is not mandated for any patients under existing arrangements
- Legalisation of medical assistance in dying in any form will create significant challenges for palliative medicine specialists and palliative care organisations
- The risk that involvement of palliative care referral and/or consultation is simply seen as, and becomes, a procedural step or 'tick the box' exercise.

At the very least, patients must be made aware of the benefits that palliative care can offer at the end of life.

To this end, information on palliative care should be available for patients and their carers through a neutral and centralised information service. Such a service could assist with informed consent and offer additional support by (amongst other methods):

- providing patients with consistent information

- providing information in accessible formats, and
- supporting practitioners and healthcare institutions in answering questions from patients, families, carers and other members of the health care team.

In regards to accessible formats, information should be provided in writing in the patient's preferred language (with oral provision of information only if the patient cannot read their primary language of communication). The form of the patient's response should correspond to that of the advice provided. If oral advice and response are provided, there should be a third person present to provide witness for the whole process.

Clause 16 - Examination by independent qualified psychiatrist or psychologist

Clause 16 is problematic because it is looking for a legal certification of capable decision making rather than a comprehensive review and understanding of the person's mental state. It requires a compulsory psychiatric review to assess capacity, "of sound mind, that the patient's decision making capacity has not been adversely affected by his or her state of mind, decision free, voluntary, and after "due consideration". This seems to misunderstand the role and function of psychiatric/psychology review in healthcare decision making. The Clause turns a psychological assessment into a procedural step on the road to medical assistance in dying and does not allow for or understand how nuanced the 'mind' may be. A person's state of mind will of course affect their decision making.

A psychologist is also unlikely to be able to provide the same opinion in relation to 16 (2)(b) as a psychiatrist, in that some medical conditions, which a psychologist is not trained to diagnose or assess, may affect the decision-making capacity of the patient.

Clause 17 - Opinion of medical practitioners

The RACP notes that "effecting a cure", as per 17(a)(iii) is not the primary aim and may be irrelevant in this context. The primary aim would be to relieve the "pain, suffering or physical incapacity" as per the previous wording.

Moreover, while pain, suffering or physical incapacity provide grounds in this legislation for the provision of medical assistance in dying, 17(a)(iv) only provides for medical treatment for relief of pain or suffering; it does not provide for other measures (e.g. rehabilitation, assistive devices or aids, community or other personal support care) that may relieve physical incapacity.

Clause 18 – Request certificate

Clause 18(b)(ii) is of significant concern as the meaning of the words "apparent agreement of the patient" are unclear and completely open to interpretation. In this case, there may need to be some provision for the patient to make a signature or physical mark of some kind on a document.

Clause 19 - Requirement for interpreter

If an interpreter is present and utilised at any stage in this process, they should both sign the interpreter's declaration, and counter-sign at all stages of the process. This is not sufficiently covered in this Clause and should apply for any assistance they give to any designated person in the process.

Further consideration would have to be given to the following issues:

- accessing interpreters, leading to questions of equitable access;
- privacy, where interpreters are part of the cultural community the patient is in; and,
- impact on interpreters.

Clause 21 - Close relatives may apply for order in respect of request certificate

The RACP notes the broad definition of 'close relative' but also questions the significance of limiting the capacity to apply for an order to a 'close relative'. It could be more appropriate to empower anyone involved

who feels that the delineated parameters of the Act are not being faithfully fulfilled to follow due process of appeal/review.

In regards to 21(1)(b)(ii) it should be noted that decision-making can be adversely affected by medical conditions, as well as state of mind.

Clause 24 - Participation in provision of assistance discretionary

Many physicians consider that providing medical assistance in dying is not within the professional boundaries, or authority of physicians.⁴

In general where objections of conscience have arisen in medical practice in Australia, clinicians have accepted they should refer patients to another practitioner. However, for some physicians the moral impact of referring a request for medical assistance in dying to a willing practitioner may be felt deeply. The RACP holds that physicians should not be forced to refer, but neither should they hinder patients from accessing such services.

It must also be acknowledged that this affects not only the medical practitioner but the multi-disciplinary team treating the patient. Conscientious objection may also occur for individuals within multidisciplinary teams or at an institutional level.

The matter of conscientious objection may present issues in certain settings, for example inpatients who may be within an objecting hospital or hospice, who are unable to go to another clinic; practitioners who would perform medical assistance in dying but are not accredited at that site; and patients living in rural areas serviced by an objecting practitioner(s).

The PWGAD should consider establishing in legislation a neutral intermediary body to maintain an opt-in confidential list of participating practitioners and to create links with providers where appropriate. As part of this arrangement consideration should be given to involving others such as patients themselves, family members and other health professionals in linking patients with an intermediary body.

Requirements for participating practitioners should still apply, in that they must have:

- developed an adequate (preferably long-term) professional relationship with the patient
- a sufficient understanding of the patient's preferences and values in relation to end of life care;
- an informed understanding of the patient's medical condition.⁵

Having a centralised body such as this managing conscientious objection may also go some way to alleviate very difficult conversations between patients and treating physicians. However, this must be on a voluntary basis.

Protections should be available for participating or objecting practitioners who do not wish to be identified. Some practitioners might encounter stigma, victimisation, harassment and other issues relating to the perception by patients, families, colleagues and the broader community, if a public register of practitioners is mandated. A practitioner may not want to be identified because they are concerned that patients will not come to see them if they are known to be participating in medical assistance in dying. Conversely, a patient may refuse to see a doctor if they choose not to participate which may compromise timely assessment and care in a geographical area where there are limited doctors to see.

⁴ The RACP notes the World Medical Association Declaration on Euthanasia which states that deliberately ending the life of a patient is unethical:

"Euthanasia, that is the act of deliberately ending the life of a patient, even at the patient's own request or at the request of close relatives, is unethical. This does not prevent the physician from respecting the desire of a patient to allow the natural process of death to follow its course in the terminal phase of sickness."

World Medical Association (1987) [WMA Declaration on Euthanasia](#) - Adopted by the 39th World Medical Assembly, Madrid, Spain.

⁵ AMA Victoria (Dec 2016) [Physician Assisted Dying Position Statement](#)

It should also be recognised that some practitioners may be potentially willing to participate in medical assistance in dying for eligible patients in limited ways e.g. in a limited range of cases, or in only providing a second opinion.

Clause 25 - Protection from liability

Please see above comments regarding the double definition of a health care provider as care institution and as individual healthcare professional.

Clause 26 - Effect on construction of wills and contracts

The RACP notes that contracts may include all manner of other matters to do with sale / purchase of assets, insurance of life, income or assets, and questions whether all of these are to be voided by a request for medical assistance in dying under this Bill.

Clause 27 - Medical records to be kept

It is imperative that robust and accurate records are kept both at the micro and macro levels and as part of the medical record. Reporting must be undertaken directly to a monitoring body to track trends, patient motivations etc. for example, there could be a specific reportable form filled out and sent to a monitoring body for review.

27(c) and (d) should appear in reverse order to how they are now listed, as that is the correct order of the process described.

Clause 28 - Application of Coroners Act 2009

The RACP believes the application of the Coroners Act 2009 in these circumstances would be appropriate. All deaths that are brought about by the provisions of the Bill should be reported to the Coroner (not just those of which he/she has been informed), who could then maintain the register, both for annual reporting, and for the 5-year review of the Act. This being different to recording a simple finding of suicide or homicide in the causes of death. Resourcing and expertise would be important considerations in having the Coroner's office administer this process.

Death brought about via medical assistance in dying must be reported in some form to enable audit of the scheme.

Clause 29 - Certification as to death

It is acknowledged there may be some stigma in listing medical assistance in dying as the cause of death on the death certificate; however there is significant public interest in having this information available in a de-identified manner. Cause of death data must remain accurate for future planning of medical care. The cause of death must not only include the terminal illness that made the patient eligible, but also that a substance was taken to provide active assistance to the patient in dying.

The PWGAD could consider enabling both the immediate and underlying causes of death to be listed.

Clause 33 - Review of Act

There is no provision in the Bill for setting up a register of all deaths in NSW that occur as a result of legalisation of medical assistance in dying. Without such a register the application of the Act, in respect of its policy objectives and terms, could not be properly reviewed,

All records in connection with a medically assisted death should be provided to a central body for transparent monitoring, and to enable important research on areas such as uptake, the reasons for requests, and requests amongst vulnerable groups. There should be a two stage process, which includes recording the request, requests which are declined, and patients who change their mind following a request.

At a minimum, a central database of all who have requested and been approved to access medical assistance in dying and a research programme that reports the outcomes of the new legislation over time will be necessary to track uptake and outcomes including adverse effects such as prolongation of the dying process, side-effects of medications. Accurate and explainable records of all deaths that occur due to medical assistance in dying should be maintained.

Safeguards are needed to prevent the diversion of the lethal drug by, for example, a bereaved family member. Patient level reporting processes for pharmacovigilance must also be built into any proposed scheme.

Evidence-based review period

It is recommended that a five-year review period be included in legislation. As a minimum a parliamentary committee should scrutinise the data collected and the operation of the legislation. This might lead to amendment or further public consultation. If the introduction of medical assistance in dying is found to have negative or unintended effects, there must be a mechanism to review or withdraw the legislation and to examine and manage problems arising in practice, unforeseen or otherwise.

Data collection

A system for the careful and thorough collection of data is essential for monitoring the effects of legalisation. This system must be part of any proposed legislation. Monitoring should cover a range of areas including reasons for requests, conscientious objection, disposal of unused lethal medication, and impact on suicide rates.

Schedule 1 - Form

The RACP notes the following:

- 'rehabilitation care' could be inserted into clause (c) of Schedule 1 ('Request Certificate').
- A space to be initialled by an interpreter, if used, should be present at each stage of this Certificate.

Schedule 2 - Amendments of other Acts

The RACP makes the following comments:

- As suggested, all deaths that occur as a result of the process described in this Bill must be reported to the Coroner.
- In reference to Section 3C of the Guardianship Act 1987, a guardianship order cannot have effect in making a request for medical assistance in dying, but provision should be retained for rescinding a request, if the guardian is of the view that the patient has not properly been through all steps in the process. Some continuity in the 'person responsible' hierarchy may be suitable if there is a proposal that external decision makers would have any power under these arrangements.
- In relation to potential changes to the Guardianship Act, we are concerned that anticipatory rather than contemporaneous requests or requests from a guardian in a person lacking decision making capacity might be incorporated.

Other significant issues not covered in the Bill:

1. Attendance by a healthcare worker or practitioner at the time the person self-administers the lethal dose of medication, including role and obligations

If medical assistance in dying is legalised, attendance may put treating physicians in a difficult situation – opening up the risk of a physician refusing care to a patient at a time of significant vulnerability and of major physical and existential need.

The RACP suggests that there be no statutory prohibition to attendance by a health practitioner, and that the patient and the health practitioner should both be freely able to request or decline the health practitioner being present.

However, the role and obligations of an attending practitioner are important considerations that require close examination. If a health practitioner is present, comprehensive guidance should be available covering what to do in a range of scenarios e.g. management of side effects, if the patient does not die in the expected time period, failure of self-administration or if the lethal dose of medication is not effective.

2. Lethal dose of medication not effective - the obligations of a health practitioner be to treat a person who has chosen to ingest a lethal dose of medication

This question raises different issues depending on the “health practitioner”. Documentation indicating that a person has chosen to take a lethal dose of medication would have to be readily available to ensure any treatment provided accords with the patient’s wishes. There are serious risks that outcomes may not always be certain and may be the opposite to what was intended. Possible scenarios include:

- A medical practitioner in attendance when the patient ingests and the lethal dose of medication has not been effective
- A medical practitioner in the Emergency Department receiving a patient who has ingested the medication but it has not resulted in the death of the patient – moreover, if there is uncertainty as to whether the patient intended to die, health professionals would be obliged to provide life saving interventions
- A medical practitioner in the Emergency Department receiving a patient who has ingested the medication and the family request treatment because they do not agree with their decision to end their life
- A paramedic called to a patient who has ingested the medication but it has not been effective
- A paramedic called by the family to a patient who has ingested the medication because the family do not agree with their decision to end their life.

Clear guidelines would have to be developed to assist and protect all individuals involved in the above scenarios before, during and afterwards. These must be developed in consultation with the medical profession and other relevant health professions.

3. Way to indicate that a person has chosen to take a lethal dose of medication?

It is important that individuals draw the right conclusions when faced with an unexpected death. A number of issues may arise here, for example, if the patient’s family is not aware of their decision. The Californian process, whereby a person must lodge a form when they plan to ingest the drug within the next 48 hours, could be a reasonable way of being able to identify a person who has chosen to take a lethal drug via medical assistance. However, it is unclear whether this would create unwanted administrative burdens, for example, for paramedics needing to check whether a form had been lodged for every unconscious person they attended.

4. Protection to vulnerable people

The RACP has the following concerns with regard to the many groups with poor access to good end of life care, and risks to individuals who do not fit the criteria or who do not want a medically assisted death. There is also the risk of coercion of vulnerable patients, which will be difficult to completely safeguard against.

Groups with poor access to good end of life care and palliative care

Individuals with poor access to good end of life care may choose medical assistance in dying even though symptom relief and a peaceful death could have been provided if they had had appropriate access to end of life care.

It is important to highlight the evidence that inequitable access to consistent, good quality end-of-life care persists for many groups of our citizens. This includes people from Culturally and Linguistically Diverse backgrounds, Aboriginal and Torres Strait Islander people, people with intellectual disability - acquired or congenital, patients dying from diseases other than cancers, and people living in residential aged care facilities, some of whom are under 65 years of age, living with a chronic disease. Inconsistent care is more prevalent in rural and remote communities in Australia.⁶

The quality of healthcare that patients receive towards and at the end of life also significantly affects the patient, and their family, friends and carers.

Individuals who do not fit the criteria or who do not want a medically assisted death

There is a risk that such legislation would compromise the treatment or palliation options available for people who do not fit the criteria or who do fit the criteria but do not want a medically assisted death. If medical assistance in dying is legalised, a contemporaneous legal provision clarifying double effect⁷ must be introduced to avoid any implicit assumption that those experiencing severe suffering who do not fit the criteria or who do not want a medically assisted death cannot receive treatments which might, as an unintended secondary consequence hasten their deaths.

Of particular note, the appropriate titration of opioid medication for pain control does not hasten death,^{8, 9, 10, 11, 12} and current evidence, although limited, suggests that use of sedation at the end of life does not have a significant impact on the timing of death.¹³

5. Support services for conflict, bereavement and distress

The RACP recommends that adequate family support should be provided, counselling and conflict mediation services as part of this process. The proposed model for medical assistance in dying is based on individual autonomy and does not acknowledge that end of life decisions are not made in a vacuum. It does not acknowledge the role, or the effect on family, carers and other loved ones. There is no mention in the proposal about what support systems will be provided for individuals, families and health professionals who may be involved, regardless of whether or not the patient ultimately proceeds with a medically assisted death.

⁶ [Queensland Health: Statewide strategy for end-of-life care 2015](#)

⁷ Where the administration of treatment or other action intended to relieve symptoms of suffering may have a secondary consequence of hastening death

⁸ Sykes N, Thorns A. Sedative use in the last week of life and the implications for end-of-life decision making. Arch Intern Med. 2003 Feb 10;163(3):341-4.

⁹ Sykes N, Thorns A. The use of opioids and sedatives at the end of life. The Lancet Oncology. 2003;4(5):312-8.

¹⁰ Good PD, Ravenscroft PJ, Cavenagh J. Effects of opioids and sedatives on survival in an Australian inpatient palliative care population. Internal Medicine Journal. 2005;35(9):512-7.

¹¹ George R, Regnard C. Lethal opioids or dangerous prescribers? Palliative Medicine. 2007;21(2):77-80.

¹² Philp MR, Poolman M, Martin NP, Makin MK. Opioid use in the last days of life: what is good practice? European Journal of Palliative Care. 2009;16(3):110-5.

¹³ Beller EM, van Driel ML, McGregor L, Truong S, Mitchell G. Palliative pharmacological sedation for terminally ill adults. Cochrane Database of Systematic Reviews 2015, Issue 1. Art. No.: CD010206.

This must be dealt with in any proposed framework, perhaps as an extended role of an Assisted Dying Review Board. The impact of conflict and bereavement can be considerable, as can the stress on individual doctors receiving requests on a regular basis, and at varying levels of involvement. Doctors may, for example, face pressure from patients who are deemed not to meet the criteria for access. Patients may also face pressure or coercion from family members or carers.

Medically assisted deaths may also lead to enduring conflict and complex grief for remaining family members, carers and health professionals. Physicians may be placed in very difficult situations when an individual wants medical assistance in dying but family members disagree with their decision, and the family may blame the physician if it goes ahead. Evidence shows that many doctors who have participated in medical assistance in dying experience emotional distress.^{14,15} If a proposal is legalised in NSW, there is a clear need for education, support and guidance for bereaved family members and health professionals.

About The Royal Australasian College of Physicians

The RACP trains, educates and advocates on behalf of more than 13,500 physicians – often referred to as medical specialists – and 5,000 trainees, across Australia and New Zealand. The College represents more than 32 medical specialties including palliative medicine, paediatrics & child health, cardiology, respiratory medicine, neurology, oncology and public health medicine, occupational & environmental medicine, sexual health medicine, rehabilitation medicine and addiction medicine. Beyond the drive for medical excellence, the RACP is committed to developing health and social policies which bring vital improvements to the wellbeing of patients. www.racp.edu.au

¹⁴ [Emanuel EJ, Onwuteaka-Philipsen BD, Urwin JW, Cohen J](#). Attitudes and Practices of Euthanasia and Physician-Assisted Suicide in the United States, Canada, and Europe. [JAMA](#). 2016 Jul 5;316(1):79-90. doi: 10.1001/jama.2016.8499.

¹⁵ Stevens KR Jr. Emotional and psychological effects of physician-assisted suicide and euthanasia on participating physicians. *Issues Law Med*. 2006 Spring;21(3):187-200.

