



# Medical Assistance in Dying

RACP Consultation and Engagement

September 2018



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## 1. Introduction

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The Royal Australasian College of Physicians established a Working Party to develop and articulate a position on the complex topic of medical assistance in dying. The RACP did not previously have a position on the issues.

Supported by Woolcott Research and Engagement, the College undertook followed a significant programme of consultation and engagement with members throughout 2017 in order to discuss, and debate the various issues and boundaries that should be considered as part of the College's position.

To inform consultation, the Working Party prepared a Discussion Paper canvassing ideas and issues to prompt feedback.

Opportunities for feedback included a consultation session open to all members at RACP Congress 2017 in May. Throughout the year, members of the Working Party attended various College committee and specialty society meetings. In addition to the verbal feedback received at these meetings, the Working Party put a call out to all members for written submissions, receiving 94 written submissions in response from Fellows, trainees, College bodies and specialty societies.

In November 2017, a series of face to face deliberative forums were held in Sydney, Melbourne and Auckland led by members of the Working Party and an independent engagement expert from Woolcott Research and Engagement. These forums were open to Fellows and Trainees and enabled attendees to engage on the topic of medical assistance in dying with colleagues from varying specialties through small-group discussion of impacts at the personal and practice level.

To enable all members to engage in this important discussion, an online forum was opened to all members until late December 2017.

The anonymous feedback and views expressed through the above activities are included in this consultation report and have been considered by the College's Working Party in preparing the RACP's position statement on medical assistance in dying.

## 2. Consultation events

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The RACP comprises over 25,000 Fellows and Trainees across Australia and New Zealand and as such, broad efforts were made to encourage participation.

The consultation and engagement programme consisted of three key elements:

- A series of face to face forums amongst College members;
- An online forum with anonymous participation;
- A call for written feedback from members.

Each element of the programme was advertised to all members via the RACP e-bulletins, the RACP website and via College bodies, Specialty Societies and the Policy Reference Group.

### Stimulus material

The Working Party developed a Discussion Paper to support the consultation and facilitate feedback from Fellows and trainees,.

The paper engaged with ethical issues and the evidence and covers terminology, historic framing of the issues, data from legalised jurisdictions, the socio-cultural context, issues raised from clinical experience, common ground principles for physicians, and practical impacts. The paper was not intended as a statement either for, or against, medical assistance in dying, rather its purpose was to help Fellows and trainees provide feedback as the RACP develops its approach.

The paper set out for consideration the following range of options for a College position:

1. In opposition to any form of medical assistance in dying
2. Of 'studied neutrality' to any form of medical assistance in dying acknowledging that it is the prerogative of society to decide whether laws should be changed and that there are diverse views both within the College and society
3. Supporting medical assistance in dying; such support might be restricted to defined cases and circumstances.

Separate from the above options, the paper also set out two possibilities as to how the RACP might engage on the issue:

1. Decline to take part in further public discussions around proposed legislation
2. Continue to take part in discussions around proposed legislation, in order to exert its influence on issues such as safeguards, conscientious objection and protection for our members.

## 2.1 Face to Face Forums

The forums were conducted in Auckland, Sydney and Melbourne at the following locations and dates.

- Auckland - 13 November 6.15-8.45pm at The Cordis Hotel -
- Sydney - 16 November 6.00-8.30pm at The Intercontinental Hotel
- Melbourne –22 November 6.00-8.30pm at the Melbourne Convention and Exhibition Centre

Each forum involved 33-44 participants covering RACP members, both Fellows and trainees. The demographics for each forum are set out below.

All RACP members were given the opportunity to register their interest for the forums, and the specially developed consultation microsite was promoted via ebulletins, a news tile on the RACP website, the Policy Reference Group email list, and other College bodies and Specialty Societies. While some members self-selected, participants for the forum were also recruited through Woolcott Research’s internal call centre.

The direct phone calls utilised lists provided by RACP and quotas were used to ensure that attendees reflected a cross section of the College membership. Given the issues and likely patient profiles, input from oncologists, neurologists, and geriatricians was felt to be important and these groups were therefore overrepresented. Beyond seeking over-representation from the above groups, no further direction was provided to Woolcott Research on how participants would be invited.

To optimise attendance, Woolcott Research over-recruited by 20-35% and confirmation calls were made in the week leading up to the events.

	Auckland	Sydney	Melbourne
<b>Total</b>	<b>37</b>	<b>33</b>	<b>44</b>
<b>Age:</b>			
Under 50	23	26	32
50 plus	14	7	12
<b>Gender:</b>			
Male	21	16	25
Female	16	17	19
<b>Position:</b>			
Fellow	23	20	18
Trainee	14	13	26
<b>Division/Faculty/Chapter:</b>			
Adult Medicine	27	23	34
- Oncologists	0	4	1
- Neurologists	2	4	1

- Geriatricians	2	11	5
Paediatrics & Child Health Division	5	3	3
Australasian Faculty of Occupational and Environmental Medicine (AFOEM)	0	1	1
Australasian Faculty of Occupational and Environmental Medicine (AFPHM)	2	3	2
Australasian Faculty of Rehabilitation Medicine (AFRM)	1	1	1
Australasian Chapter of Addiction Medicine (AChAM)	0	0	0
Australasian Chapter of Palliative Medicine (AChPM)	2	2	3
Australasian Chapter of Sexual Health Medicine (ACHSHM)	0	0	0

Forum participants were sent the RACP's discussion paper and were encouraged to read it prior to attending.

Forums ran for two and a half hours each, including a provided dinner. Participants were seated at tables of 8-10, with a table facilitator from Woolcott Research seated on each table to facilitate the discussion and capture the discussion content. Speakers were members of the College's Working Party and a lead facilitator from Woolcott Research provided overall event management.

As per the agendas at **Appendix 1**, discussion during the event was enabled by a series of case studies presented by working party members. Participants spent most of the time working in small groups and feedback to the room took place in the form of table presentations.

Findings from participant discussion at the forums are detailed in **Section 3**.

Participants completed an evaluation survey (**Appendix 2**) after each event and these results are presented at **Appendix 3**.

### 3.2.2. Online Forum

The online forum was open to all members for two and a half weeks from 6 - 23 December 2017.

In addition to being advertised to all members, extra efforts were made to recruit and promote the online forum to members who would not be expected to be available for the face to face forums i.e. those outside of Sydney, Auckland and Melbourne and those located in regional, rural and remote areas.

The online forum took a similar approach to the face to face forums. It included an introductory video featuring working party members and the RACP President to set the scene for the discussion, the full discussion paper, and excerpts from the discussion paper with questions to stimulate an online discussion. In order to maximise involvement, participants were able to engage anonymously in their own time by watching the video and registering their comments or responding to the comments of other members which were visible to all.

The online forum attracted a total of nineteen participants, who made a total of 77 different contributions. All participants remained anonymous. Two participants were particularly engaged, and between them accounted for 37 of the contributions, or almost half.

Findings from the online forum are detailed in **Section 4**.

### 2.3. Call for Written submissions

A call for written submissions in response to the discussion paper was advertised to all members and open from 9 May to 7 July 2017 and several late submissions were also accepted.

The College received 94 written submissions from Fellows, Trainees, College bodies and Specialty Societies.

Submissions were in response to a series of eight questions put to members:

1. In light of the options listed above, what would you like the College to say about legalisation of medical assistance in dying?
2. If you believe there are cases and circumstances in which the College should support medical assistance in dying, what should they be?
3. Are there points in this discussion paper that you strongly agree or disagree with and why?
4. Are there issues we have not covered that the RACP should consider?
5. Do you perceive particular issues about the applicability of medical assistance in dying to particular people or groups? Can you outline those issues?
6. What do you envisage being the impact on your practice?
7. What supports and guidance do you think you, and other health practitioners you work with, will need?
8. Recognising that there are major implications for palliative medicine and a number of other medical specialties, would legalisation of medical assistance in dying likely have special implications for your medical specialty?

Findings from these responses are detailed in **Section 5**.

### 3. Findings from the Face to Face Forums

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#### Comment regarding location differences

It is difficult to extrapolate differences across locations for a number of reasons. Recruitment is often 'self-selecting' in that sometimes only those with a strong point of view respond. More generally, despite the Discussion Paper setting a proposed definition of medical assistance in dying, it is also not always clear from discussion on this complex issue what precise patient circumstances and scenarios individuals might be referring to.

A further variable was the stage at which legislative proposals were being discussed in each jurisdiction, with proposals in Victoria and NSW further advanced at the time than in New Zealand. Differences could also have been due to the mix of participants at the event – noting that different specialties, age groups, and genders may have (dis)similar perspectives.

As such, the findings expressed are not intended to be fully representative of the feelings of College members as a whole and what is presented in this report is a sample of views.

Differences could have been due to the mix of participants at the event. For example, younger participants tended to be more in favour and participants from palliative medicine were more vocally against involvement in medical assistance in dying.

What did emerge at a very high level was a tendency for Auckland participants to be against medical assistance in dying, and also to be more against the College taking a neutral position. Conversely in Sydney, participants were more in favour of critical neutrality, but then were more likely to discuss aversion to the medical assistance in dying terminology. Sydney participants also tended to raise concerns regarding patient cultural issues more often than the other locations.

A further variable was the stage at which legislative proposals were being discussed in each jurisdiction. Melbourne participants were more advanced in their discussions on the issue and tended to be more concerned about the erosion of trust in the doctor-patient relationship and trust in palliative care.

It is important to note that, by coincidence, the Melbourne forum took place hours after Victoria's Voluntary Assisted Dying Bill 2017 (a Government sponsored bill) passed the upper house and appeared very likely to become law (this was confirmed subsequently when the amended bill was ratified by the lower house), and this was discussed at the forum. Also by coincidence, the NSW Voluntary Assisted Dying Bill 2017 (a cross-Party private members' bill) was being debated in the NSW Legislative Council on the night of the Sydney forum, with the bill being voted down by one vote hours after the forum finished.

## Initial Thoughts

Medical assistance in dying was a subject participants were willing to engage in regardless of their views:

*“Society is going to develop its framework and we have to decide how we are going to act in that.” (Auckland)*

*“Members should have input now. We can’t complain if we’re not part of the process. There is a role for the College in this.” (Auckland)*

Members stated that medical assistance in dying was against the principles that underpin medicine:

*“Doctors are life savers – if we assist in either type 1 (prescribing drug) or type 2 (administering drug) we have that burden on our conscience.” (Auckland)*

*“I think medicine is about kindness and once we have an option to end life we are not doctors anymore” (Sydney)*

However, others suggested that it is not up to doctors to go against patient wishes in this context:

*“If a person wants to end life there are a number of reasons for doing so, it is difficult to know what reasons we would accept and not accept. Psychological issues – may outweigh physical symptoms. Fear of loss of autonomy is the biggest issue or reason – is that a good reason? What are the critical factors?” (Auckland)*

*“It’s really up to them, as a society we should have the freedom of choice and not take the big brother role that we think is best for them” (Sydney)*

*“We need to balance the ground swell and say we are respectful of their wishes” (Melbourne)*

Another area that was discussed upfront was in regard to whose role or what specialty should handle medical assistance in dying. There were questions regarding whether or not it would become a specialty in its own right and where and how the service would be provided. There was some concern that medical assistance in dying could become a commercialised business:

*“I fear that medical assistance in dying would become a bogus type specialty like hair loss clinics” (Melbourne)*

*“Will it become a specialty in its own right? Or will it be integrated?” (Melbourne)*

*“It should be given to all specialities. Not left to a few.” (Sydney)*

*“Big specialty that will deal with this is General Medicine” (Auckland)*

## Reactions to the Discussion Paper

There was strong agreement across all the face to face forums that the Discussion Paper was well written, put a balanced view across and was a demonstration of the College supporting its members by providing a common language.

The document was considered to have an appropriate tone and was seen to put the issues forward in a clear, concise, expressive way:

*“The current document is well written and non-polarising. Tries to diffuse the emotion and be objective but informative.” (Auckland)*

*“I thought the discussion paper was well written – everyone should feel supported by the College” (Melbourne)*

*“I agree with the tone of the discussion paper but I don’t support medical assistance in dying” (Melbourne)*

*“Many things in this document should be articulated in the College position, even if they are a given” (Auckland)*

Members had mixed feelings towards the term ‘medical assistance in dying’ and commented on the word ‘suicide’:

*“The use of the term medical assistance in dying implies that there is acceptance of medical responsibility. I’d like to question whether this is a critical role.” (Auckland)*

*“I would feel uncomfortable if the medical profession was not involved” (Auckland)*

*“Why make up a new word? What do you mean, I’ve been assisting people to die for years.” (Sydney)*

*“I’d use euthanasia” (Sydney)*

*I think it’s a better term, I changed my opinions of this – medically assisted dying is a more accurate term” (Sydney)*

*“It’s taboo in other cultures – suicide. Families complain about this term. So not a good term to use” (Sydney)*

The common ground principles and section on vulnerable people were felt to be sound and to be a useful component of the discussion paper:

*“The section that is entitled common ground is very useful in the discussion paper.”  
(Melbourne)*

*“I like that the College has taken a position to support vulnerable people – having this as a separate section is important” (Melbourne)*

*“Common ground principles are really important to ensure that the doctor-patient relationship is not compromised or jeopardised” (Sydney)*

*“The common ground section is good, no-one would disagree; this probably what we could all agree on.” (Auckland)*

Areas that members mentioned were lacking related to advance care planning, mental health and terminal sedation:

*“The common ground principles in the DP indicate terminal sedation cannot hasten the longevity of life but this is not correct; counter argument is that intent is the key thing i.e. pain management vs sooner death” (Auckland)*

*“Advance care planning seems to be absent. Not much mention of mental health either”  
(Melbourne)*

### **Development of a College Position**

It was felt by some participants that public support for medical assistance in dying in some form meant that a change in law was inevitable. In that regard it was felt that a College position was important to demonstrate leadership and support for physicians. However, many appreciated that this position was difficult to articulate or decide upon with a diversity of views across the membership. Many recognised the difficulty for the College in formulating a view either in favour or against:

*“The College should have a position, obviously there are going to be polarised views; it would be wrong for us to stick our heads in the sand; whatever the law change is we need to look after our membership in order to look after our patients” (Auckland)*

*“The RACP needs to have a position and a committee to help make this decision, but there is a common recognition in the difficulty the RACP is facing in deciding this position when doctors all have such divergent views – can the RACP please everyone?” (Sydney)*

*“It is hard to disentangle your own beliefs from the position you think the College should take”  
(Melbourne)*

Mixed feelings were expressed about how the College position should be developed:

*“It is suggested that the RACP do a more quantitative survey to find out what the ‘majority’ of RACP members think – that would be the most diplomatic solution. Although many also understand that “it is not a yes or no question” (Sydney)*

*“RACP is doing the right thing by not just taking a ‘majority’ position and is deliberating with their members in order to incorporate the broad spectrum of opinions. This is believed to be respectful.” (Melbourne)*

*“Hope the College strongly opposes medical assistance in dying as it’s not the doctor’s role”  
(Auckland)*

There was support for the acceptance of diverse opinion from within the College and for members to be respectful of all opinions:

*“Selecting one view will alienate some parts of the public, we should not do this” (Auckland)*

*“The College will need to reflect the variety of physician views” (Auckland)*

*“If legislation is passed and a doctor can prescribe medicine, then I need to know that the College supports me in my decision to prescribe that medicine” (Auckland)*

*“We need to question if a doctor is competent and willing to prescribe the lethal medicine. As a College we need to adopt a position that doesn’t criminalise doctors for what society wants them to do” (Auckland)*

*“The College needs to tolerate support and protect a divergence of views” (Sydney)*

*“We do not want to risk criminalising doctors if the legislation is passed” (Sydney)*

*“There will never be consensus, it’s best to discuss the varying issues but not come to a common end discussion” (Melbourne)*

*“The College can still stand for and say something in supporting the peripheral elements of a Bill, such as strong emphasis on support for families/access to palliative care, strong advocacy for vulnerable groups – this would be a strong stance without weighing into good/bad debate” (Melbourne)*

It was also felt in supporting physicians there needed to be an educational component incorporated to inform the public about palliative care, about the implications of medical assistance in dying and what to expect from their physician:

*“RACP should have a role in the public debate to ensure that it is an informed debate”  
(Auckland)*

*“There is an opportunity for the College to help the public understand the issues.”  
(Melbourne)*

*“Instead of adopting a ‘for or against’ policy, we should be asking what we can do to improve dying for patients at the end of life.” (Auckland)*

### **What the College should say**

Many participants supported the notion of ‘critical neutrality’, this being one of the options raised in the opening presentation. Whether they were personally in favour or against medical assistance in dying, a number of physicians understood the difficulty of finding common ground amongst the membership base:

*“There is no way you will find common ground across the college on this issue.” (Auckland)*

*“I support neutrality – but I am against medical assistance in dying. Promote palliative care rather than jump into a decision.” (Sydney)*

*“I am in favour of it, but I support the neutral position” (Melbourne)*

*“I am against, but like the idea [of neutrality].” (Melbourne)*

*“The College position should be focussed on keeping it safe for the patient and physician”  
(Melbourne)*

*“Agree with the concept of critical neutrality – with reservations.” (Melbourne)*

There was some criticism however, that the word ‘neutral’ would be seen as weak and be misinterpreted as the College being unable to make a decision. Some also raised concerns that a ‘neutral’ stance could leave doctors in a difficult position, especially in their dealings with patients and would further impact the development and structure of support materials for both objecting and participating physicians.

*“Neutral could come across wishy-washy, the College is a group of people who can’t make a decision.” (Melbourne)*

*“Don’t like the word neutral, we aren’t neutral if we are advocating for great care, it’s a considered opinion” (Melbourne)*

*“Concerned if college was to be neutral as that leaves doctors in difficult position as they will be the agent of assisted dying and will be administering the medicine.” (Auckland)*

*“They can’t be neutral, it affects our practice, and a stance will be helpful and will help the College to support the members with a structure and support system.” (Auckland)*

### **The physician-patient relationship**

There was a fear expressed by some participants that the availability of medical assistance in dying could lead to the potential for the erosion of trust in doctors:

*“My biggest fear is it impacts trust in doctors” (Melbourne)*

*“The erosion of trust; the people I’m going to be trying to come to terms with in this dilemma are people I know” (Melbourne)*

*“Relationships between patients and doctors will need to be strengthened and much more communicative” (Melbourne)*

*“Need long term relationship with patients” (Melbourne)*

*“The impact on physicians and the impact on physician and patient relationships generally - there can be negative outcomes on some doctors while others may find it to be empowering” (Melbourne)*

*“There may be a form of erosion of trust involved – if there is conflict between patient and family views” (Sydney)*

*“Impact on how doctors are perceived by the community – perceived by the wider community” (Sydney)*

However, it was also stated that ongoing care and support must be a key focus for physicians:

*“Ensuring ongoing care, if you stop caring, what is the objective of the physician? No abandonment of the patient.” (Sydney)*

*“Going from pro-choice in life (mid-life) then going to the end of life where the patient loses autonomy can be difficult. The patient may feel they don’t have a choice and lack support from close family and friends. That point can be unfair to load onto the patient at that point as a decision to come to alone. We should do it together with them.” (Auckland)*

## Assessing mental state at the end of life

A key practical issue was the perceived difficulty of understanding the patient's real wishes and the subsequent need to allocate a significant amount of additional time to ensure that the doctor - patient relationship was sufficient to realistically interpret an individual patient's preferences. This issue also extended into judging competence.

*"Relationships between patients and doctors will need to be strengthened and much more communicative" (Melbourne)*

*"Clinicians will be confused. Won't always know what the patient wants" (Auckland)*

*"Lengthen the consult time because it is an option – it may be that we need to get to know the patient better" (Melbourne)*

*Competence, how is it judged, who judges it? What levels do we judge as competent for this, is it a different level to making other decisions in terms of financial and other medical procedures..... Always going to be somewhat controversial.....can only do it if working in your area of expertise, what the choices are for that patient and discuss with them". (Melbourne)*

Some participants expressed doubt over their ability to make an effective judgement of capacity, and believed that perhaps more specialised experts would need to become involved.

*"There is a problem with capacity assessment. Capacity is a legal construct." (Sydney)*

*"Mental competence is hard to judge – physicians often don't have the skills to judge competence" (Sydney)*

*"Understanding competency and vulnerability - it is really a specialty system. Needs people who are specialist in that." (Auckland).*

*"Competence is something we already have recognised expertise with." (Auckland)*

It was recognised that patient mood and intention could vary significantly from time to time; that patients may be subject to a range of pressures (some more relevant than others); and that consultation with other medical experts may be needed:

*"But which decision is the right one? It's a very difficult dilemma" (Sydney)*

*“The whole thing will put the patient in a difficult position more than anything else, it’s a very difficult choice and are they capable of making that decision especially under family stresses, medications, suffering of sickness, it is virtually impossible” (Sydney)*

*“Fluctuating moods that patients have towards end of life should be factored in but could be really difficult to factor in” (Sydney)*

*“There will need to be palliative and psychiatric assessments in the decision making process”. (Auckland)*

*“Would want a strong framework around how to establish competence” (Melbourne)*

In the case of neurological diseases in particular, the issue arose of balancing an estimate of life expectancy against the possibility that the patient may lose capacity further down the track.

*“I think it is important for all our patients to help them understand that all patients are different and there is not a universal answer. Some will find it a blessing – maybe I will be the one who succeeds. Except where capacity becomes an issue. They might lose that capacity. That is a complicated one.” (Melbourne)*

*“Someone facing a neurological death who won’t have the capacity to make the decision when they need to, don’t know what we do with that, some patients will find this quite limiting, discriminating.” (Sydney)*

*“Dementia patients – it’s very hard to prognose life expectancy, for these people they wouldn’t be able to exercise the right to dying.” (Sydney)*

### **Family involvement and the possibility of conflict**

The possibility of family conflict was also raised as a significant challenge to a physician whose primary responsibility was to their patient:

*“Different views from the patient’s family in terms of what care they think is appropriate, doctor is usually in the middle of this conflict with different expectations from different parties, the patient’s wishes are what you want to achieve but then you have to deal with the family and that is probably more difficult” (Sydney)*

*“Need to bring family members along to have the conversations” (Melbourne)*

*“Victorian legislation allows patients to go solo” (Melbourne)*

*“Hard to see in current situation how we have time to support family.” (Auckland)*

*“If it comes in it will open a hornet’s nest of issues – inequities, houses, inheritance, and dementia” (Sydney)*

*“Mother dying, one of the daughters was around and two others weren’t, decision had to be made to withdraw care, decision made, died very peacefully quickly, when the others came back, you killed mother; we deal with this all the time, only exacerbated by medical assistance in dying”.(Melbourne)*

### **Access issues**

Some participants expressed concern that many physicians may not have the required level of training, leading to variation in practice. Potential issues were also raised in relation to regional areas, due to a lack of palliative care options and lack of access to other medical specialties.

*“In some country towns, GPs refer to the city for abortions, don’t want it done in their town; could happen with this too; in terms of best care for the patient, it is not the best for them to be shipped off away from their home and family.” (Melbourne)*

*“Need for second opinion consultations – could cause problems in rural/remote communities where doctors are already scarce enough.” (Melbourne)*

*“If a patient is ensconced in that institution, even if the patient were able to travel, very difficult to transfer to another hospital; then there is the problem of a regional centre like Bendigo, no meaningful access for these patients; huge discrepancies for patients to access.” (Melbourne)*

*“There are a number of diseases that patients will need to the perspective of other specialists, should this preclude access?” (Auckland)*

*“Competency assessment would be even harder to undertake in rural/remote areas where they don’t have access to specialists” (Melbourne)*

***“The gaps in palliative care will be the same gaps in medical assistance in dying – spotty and inadequate” (Sydney)*** **Vulnerable Groups and the Risk of Coercion**

Participant views on vulnerability varied considerably. Certainly there was a belief that low socioeconomic, culturally and linguistically diverse, Indigenous, and rurally based individuals represented potentially vulnerable groups, but some participants suggested that anyone in the final stages of life could be thought of as vulnerable.

There was a great deal of concern over the possibility of coercion, either overt or more subtly expressed. Such coercion was thought to emanate from a range of factors, including people feeling

the pressure while waiting for a nursing home placement; the cost of nursing homes; general family financial pressures; inheritance related considerations; and a sense of the patient not wanting to be a burden to their family or to 'the system':

*"Not enough social support. The answer to loneliness is not this." (Auckland)*

*"Medical assistance in dying could cement negativity towards modern medicine in rural and Indigenous communities. This could adversely affect general medical care in these vulnerable communities. They already believe that the hospital is the place they go to die" (Sydney)*

*"A lot of covert coercion is seen in practices already – we see a lot more subtle coercion than people might be aware of... does being made to feel a burden count as coercion, a lot of people don't see what we see in public hospitals – life is full of coercion" (Melbourne)*

*"Non-verbal coercion (e.g. body language when talking about medical assistance in dying with a patient) – need for more training around communication"*

*"Patients waiting for nursing home placements – coercion becomes critical here. People will feel the pressure." (Melbourne)*

*"It's important to really know the patient and where they were in terms of life journey." (Auckland)*

*"What about the vulnerable? How do we know the difference between coercion and free will?" (Auckland)*

*"In a NZ setting financial constraints may play a part in funding cancer medications and the point at which end of life is acceptable" (Auckland)*

*"The patient might think – Is this the means that I could help set up my family for the future?" (Auckland)*

*"There could be an adverse effect on patients, who (having access to medical assistance in dying) might see this as pressure upon them to appease the 'economic burden' on the system and their families". (Sydney)*

### **Specialty Specific Implications**

Some comments were made by individual specialists with regard to specific implications for their area of practice. *"Some specialties will encounter this more than others. A lot of people go through physical suffering and some more existential suffering." (Sydney)*

Some participants highlighted Two key implications for oncology - firstly the difficulty of estimating how long a patient was likely to live; and secondly the importance of having end of life discussions with patients early to understand their values and preferences, before they had developed a sense of becoming a burden on their family and friends.

*“Not clear that someone is going to die, not always able to predict for cancer patients”  
(Auckland)*

*“Need to talk about it early with cancer patients and ask how they think they want to cope with it/ what their options will be and what they are thinking they want”. (Melbourne)*

One issue referred to by neurologists was a concern that their patients often progressively lose capacity to make the decision, leading to a sense that these people may be denied the opportunity to access medical assistance in dying:

*“Someone facing a neurological death who won’t have the capacity to make the decision when they need to, don’t know what we do with that, some patients will find this quite limiting, discriminating”. (Sydney)*

Geriatricians expressed concern that competency would be hard to judge amongst the elderly; and some noting that they may also lose access to medical assistance in dying.

*“For Geriatricians - we have to represent the incompetent. ... How do you gauge someone’s competency? Are you taking away the rights of the incompetent?” (Auckland)*

A respiratory physician made the observation that their patients often failed to gain access to palliative care, leading them to be more open to medical assistance in dying than they may otherwise have been:

*“Respiratory physicians have many breathless patients – but they can’t get community palliative care. A lot of these patients are keen on medical assistance in dying”. (Melbourne)*

## **Prognostication**

It was accepted that giving a precise prognosis in terms of remaining life expectancy was often quite difficult and may be more so in this context:

*“How informed the patients are – how do we assess that? Ensure that patients have all the information available. So hard to say you have three months to live. Hard to give a prognosis. How incapacitated do they have to be.” (Melbourne)*

*“There will be huge conflict in haematology speciality. Goal posts keep moving all the time in terms of prognosis. Many of them die. Some respond to new innovative therapies. Cancer medicine – not always easy to define who is going to pass away in the given timeframe.”  
(Melbourne)*

*“Medical oncology perspective, prognostication is only getting more difficult, often people reach a point where the trajectory is such that you can, but now all of us will have someone who we thought was at deaths door and a year later they are walking into the clinic and doing quite well, so this could be problematic for people - not sure what the answer is.”  
(Sydney)*

### **Paediatric perspectives**

While the scope of medical assistance in dying discussed throughout the forums was limited to competent adults, various perspectives were shared by paediatricians:

*“From a paediatric point of view – patients don’t have a voice” (Auckland)*

*“Difficulty from the perspective of paediatrics. Can the views of the young be considered? Recognition that this is not part of legislation at the moment. However it is relevant for 18 year olds. But can an 18 year old be trusted with this decision?” (Sydney)*

### **Importance of Palliative Care**

Good palliative care was thought to be highly desirable, and to have the potential to reduce the need for medical assistance in dying. Many participants emphasised that the resourcing of palliative care was inadequate; that access for non-cancer patients was patchy; and that regional and rural areas suffered from a greater lack of proper resourcing relative to major cities:

*“Good palliative care may diminish the need for assisted dying, we do not want to risk eroding palliative care” (Auckland)*

*“We know there is a big gap in terms of resources/ support for palliative care patients”  
(Auckland)*

*“The government will never fund palliative care properly and that’s the real issue here”  
(Sydney)*

*“Regional people don’t have good access to palliative care”. (Melbourne)*

*“If patient is motivated by particular symptoms – need to have a better idea of the implications – [does the person need] better access to specialists e.g. palliative care (Sydney)*

It was felt that many patients may not understand what is possible in palliative care and that some may have incorrect perceptions. Similarly, there was some suggestion that doctors themselves may not always recognise that expert palliative physicians were available to assist:

*“Need to be educating patients, especially around palliative care” (Melbourne)*

*“There is a lot of misperception about what palliative care can offer. Presume the majority of the public do not understand” (Melbourne)*

*“Biggest challenge is not palliative care provision. It is getting physicians to realise that there are palliative care physicians to help them” (Melbourne)*

*“There has to be something around this about physicians engaging other physicians. I see a lot of people saying they do advanced care/palliative care with little engagement of other people. Bring them into the process” (Melbourne)*

## **Obligations on Physicians**

Some participants offered views on the obligations of doctors in the context of medical assistance in dying such as the provision of information to patients and their families, the possible obligation on doctors to give patients the choice, and the obligation to fully understand the patient and accurately interpret their real desires, including the potential for them to change their mind.

*“When we discuss any options, we always have knowledge, pros/ cons, risk and benefit, provide information for the patient to make a decision, now there is the option of how capable you are of providing this information to the patient, how long do they request before we consider it a genuine request, complications, how much information can you provide for the patient at the outset? They have the option but very limited information, very difficult situation, they will seek information from others who may have had similar experiences, who may not be professional enough, and patients expect you as a caring doctor to provide relevant information, how much are we able to provide this information?” (Sydney)*

*“Is it ethical to not give the person choice? If it is her wish. Is it all about the person or is there a wider social context” (Melbourne)*

*“Shouldn’t be encouraging doctors to promote for or against medical assistance in dying – it should be left to the individual patient to initiate rather than to promote a particular stance. The patient should initiate the discussion” (Melbourne)*

*“Becoming something else more than a doctor, you are trying to kill someone, no limitations; this is something we have to consider..... do we make an assumption that they don’t want prolonging measures? What happens if they’ve changed their minds?” (Sydney)*

### **Perceived Generalised Need for Support**

The initial comments of participants within the area of support and guidance strongly suggested that doctors believed that medical assistance in dying would potentially produce quite powerful emotional responses amongst those involved, leading to the need for more generalised emotional support:

*“It’s not in any doctors medical values, it’s going against our principles and values – huge psychological impact/distressing” (Sydney)*

*“We need time to reflect on our personal view and, if involved in assisted dying, time to reflect on this... as trainees, when will we find time to reflect on this huge issue... we are burned out already” (Auckland)*

*“Guidance for navigation through communication issues/our own beliefs” (Auckland)*

*“Guilt is a major issue” (Auckland)*

*“Need support to cope with guilt of assisting dying and also guilt where things go wrong. Have not helped at all but made things worse.” (Auckland)*

*“There can be negative outcomes on doctors while others may find it to be empowering – offering new support and resources” (Melbourne)*

The kind of generalised support that was suggested included the provision of clarity about the physician’s role, a level of mutual support within the profession, and clear guidelines from the College about how doctors should navigate the expected myriad of practical issues involved.

*“Look to the College for guidance and support. How to navigate the minefield” (Auckland)*

*“What you look towards RACP for is the boundaries. Clarity about the physician’s role within that. How are you going to navigate through that? You are going to be busy and have to think quickly on your feet. How much time do you have to talk about that?” (Auckland)*

*“We want to be there for each other from the beginning – to have this support we need a culture change among the profession.” (Auckland)*

The introduction of medical assistance in dying was felt to represent a totally new and unfamiliar area of operation for the profession and needing a very basic level for clear and detailed guidance. It was suggested that the College should provide a detailed framework for its members to work within - a statement of what the College regards as good practice:

*“Supporting physicians in how to implement it. Nitty gritty of how it is going to work day to day” (Auckland)*

*“College needs a framework for physicians to work within.” (Auckland)*

*“A working framework with commonly asked questions and potential responses – standardised answers for less ambiguity.” (Melbourne)*

*“If it does go ahead, we need clear guidelines on how to do this. Not just from legislation, but clear guidelines and parameters as doctors around how we do this” (Auckland)*

*“Guidelines, you can’t just put this question to the individual doctors or medical carers, people may have different views and you have to have some sort of standardised guidelines to follow, if you want to open the option to the patient.” (Sydney)*

*“Different approaches by specialty – need to take into consideration the individual physicians; there are clear pathways in some specialties more than others; support for the individual and tailored by specialty” (Auckland)*

*“Screening tools and assessment tools for decision making” (Auckland)*

*“If you tell people they are not going to get what they want you get a lot of aggression. [Need] support for the negativity that will come from them to the physician. If they haven’t got a short prognosis or competence. Not going to fit into box neatly” (Melbourne)*

It was cited that in Canada, many doctors struggled with patient requests for medical assistance in dying. There was a feeling that initially doctors may experience a lot of emotional stress and strain including those who felt they could not refer or participate in any way:

*“I feel it is a great burden to be part of someone’s death” (Auckland)*

*“There will be stress on physicians emotionally, the process is not something that we are familiar with and could put a lot of strain on professionals” (Auckland)*

*“If you were to refer this patient to someone else who is willing to do it, are you helping?” (Sydney)*

*“There is implication in writing a referral” (Sydney)*

*“Using the analogy of abortion, we have an obligation to refer on and that is accepted by society broadly, and we have an obligation to listen to the law” (Melbourne)*

*“Needs something where you don’t need to make a referral but there is access independently and go through that process that is independent from you, as soon as it requires a referral from the physician it’s a lose-lose, you’re either the person who keeps them happy by offering it but alienates family, or you are the Trojan who doesn’t offer it, not our role as doctors to block that option for people if they feel very strongly, it has to be somehow independent” (Sydney)*

*“When abortion clinics were first brought in, doctors were being attacked; should there be protection for doctors? Difficulties for smaller communities for the practitioners to be anonymous” (Auckland)*

The need for support extended for some physicians into a desire for the College to provide ‘someone to talk to’. This personal element was thought necessary to help cope with psychological issues amongst practitioners, to assist with interpretation of the guidelines, and to provide generalised support to doctors who either did, or did not, implement medical assistance in dying.

*“If law changes then anyone could be asked to partake in that. Some will feel comfortable and some won’t. There will be a strong divide. Most will fall one end or the other.” (Auckland)*

*“Peer support for anyone involved in this, need someone who you can talk to and debrief about these things regardless of your decision to do or not do it; we need more support structures than already exist” (Melbourne)*

*“Psychological problems are a key issue and it may be that the RACP could provide a trained psychologist with a 24hr helpline” (Melbourne)*

*“Is the profession able to handle this – impact on trainees and vulnerable doctors?” (Sydney)*

*“Trainees may need to be kept out of the process due to lack of training” (Sydney)*

*“It would be nice to speak to someone who deals with it all the time. We know that not everyone will have great expertise. An expert to help you translate whatever guidance is there. It may not be something that you do very often.” (Auckland)*

*“You need to be able to feel that when you ask for advice you won’t be judged” (Melbourne)*

*“Should there be a committee approach to the decision or should it be left to the one physician?” (Auckland)*

It was anticipated the diversity of views between practitioners could lead to difficulties in the workplace. Whilst differences of opinion occurred already on a range of practice issues, those relating to medical assistance in dying were seen as potentially more emotional and divisive. It was imagined that some kind of external support may be necessary to assist in resolving the problems.

*“Diverse views in teams will affect working relationships/ teams; potentially quite divisive, white heads (old) and black heads (young); divisive between teams; could there be financial pressure to take on a role? What about small practices?” (Auckland)*

*“There will need to be someone you can ask for advice on how to deal with other doctors and their opinions.” (Melbourne)*

*“Support in regards to any type of ‘power play’ that might occur in a team setting.” (Melbourne)*

*“I work for an organisation that has publically said that it won’t support [medical assistance in dying]” (Melbourne)*

*“There will be institutional positions therefore this may override the position of the physician or the College – the legislation doesn’t seem to take account of this. So what happens to these patients if they have a disconnect in care?”*

A further workplace concern related to the situation where a patient was being looked after by more than one doctor, and where a difference of opinion concerning medical assistance in dying arose within the team.

*“What about when someone is being looked after by several different teams and one person on one team has a conversation with the patient but someone else is against (this happens all the time) – primary physician looking after the patient across teams. Need to protect the continuity of teams (important reason the college needs to act)” (Auckland)*

*“Handover (e.g. if one doctor is sick or away on holiday and they have opposing views from initial doctor – It’s going to become “who is on call for medical assistance in dying this week?” (Sydney)*

*“How to deal with people having different positions” (Melbourne)*

*“Ethically, the issue was raised about differences of opinion, especially between a doctor and trainee” (Sydney)*

*“Acknowledging that everyone has a different perspective, every patient has a lot of physicians looking after them particularly in a hospital setting” (Auckland)*

*“A physician who is an objector may be subjected to criticism, even threats if made public, puts physicians in a vulnerable position as well”. (Sydney)*

Allied to the provision of a framework for good practice was the clear perceived need for the College to provide formal training. There was a recognition that physicians had in the past received virtually no formal training in this area and that it represented an aspect of practice that embodied a range of very difficult issues. It was generally expected that the College would need to play a significant role in enabling training and support in the provision of medical assistance in dying and areas such as:

- Being respectful of patient wishes
- Dealing with conflicting views amongst staff, colleagues, and family members
- Maintaining trust and protect physician reputation
- Working in a facility that is against medical assistance in dying

*Handling vulnerable patients “College standpoint [is needed] on professional qualities and behaviours” (Auckland)*

*“RACP can encourage acceptance of diverse opinions” (Melbourne)*

*“College should take an active role – dedicated training on this” (Melbourne)*

*“Learning modules on the RACP have been very useful/ they could have a module on this to help us gather information/ how to deal with it” (Melbourne)*

*“Colleges should do the training. They are in the best place to do this. Online module not sufficient. Physicians need to be able to trust the training.” (Melbourne)*

*“The patient needs special support – medical, emotional, practical, legal etc. We are here to support the community and play one role in the overall process. We can’t be expected to take it all on. (Auckland)*

*“Further training on ethics and the law will be required” (Melbourne)*

*“A worry is that there is going to be different laws across the states and NZ” (Auckland)*

*“Issues around legal advice for the physician, you essentially open yourself up to malpractice from family members” (Sydney)*

*“The college must be careful not to advocate anything that is against the law. e.g. if a member was against medical assistance in dying and attempted to persuade a patient and this was illegal the RACP should not stand by them.” (Melbourne)*

## Conscientious objection

Protection and support for practitioners who had a conscientious objection to medical assistance in dying was believed to be essential. The views of doctors were imagined as likely to be extremely varied in the workplace and there was a call for tolerance and support for this diverse array of positions. This extended into the provision of clarity and support around the question of referral - would refusal to refer be legal and would the College support those who adopted that particular stance?

*“Are we going to stand up and support those who refuse to refer?” (Sydney)*

*“The issue is complex and our views are diverse – we need to be able to embrace each other’s stances without judgement” (Auckland)*

*“Management of difference is going to be a challenge for RACP. Could we look at the abortion issue and how that is handled? Could this be handled the same?” (Auckland)*

*“College should support doctors ability to withdraw if conscientious objectors, regardless of the College’s overall position. The College needs to support physicians in both situations – College needs to recognise the diversity of beliefs and respect and value them, not ignore them” (Auckland)*

*“Conscientious objection – needs to be clear guidance about what the obligations are of a practitioner who has a request from a patient for a referral; right to refuse; what to do in the situation when a referral is requested?” (Melbourne)*

*“Perhaps there could be guidance for doctors who conscientiously object to refer on, ensuring an appropriate pathway for patients and physicians; moral dilemma, if I refer the patient to someone who does do it, that makes me complicit; is that a bit paternalistic to an extent, or do I have to act in the best interests of the patients?” (Melbourne)*

With respect to referrals, some participants wondered whether the College would play a role in facilitating the process:

*“The problem is that no one will know who to go to get a referral/ referral pathway training” (Melbourne)*

*“Are we going to have a list of competent people to whom we can refer?” (Sydney)*

## Community education

At a more general level, the issue of media and community relations was mentioned. This issue revolved around community perceptions, the retention of trust in the profession, and the role of the media. It was suggested that the College could have a role in helping to understand and manage community views on medical assistance in dying, and to help the public understand the physician point of view and be respectful of differing views.

*“The nitty gritty has a lot of difficulties that the public doesn’t see” (Sydney)*

*“Education and engagement. Helping the public understand the physician’s position – I don’t know if the population knows the consequences, they want the easy way out; they want control; psychosocial issues make it very difficult for the physician” (Sydney)*

*“If society forms a stance there are 2 things the College can do; 1 - lead an open discussion on the issue and 2 - where there is an opportunity, the College can explore the potential difference between doctors view and the society view – so it can take the role of educating society in an honest open way” (Auckland)*

*“Media will be asking us questions and we have to know how to respond.” (Auckland)*

## Data collection and evidence based practice

With regard to the generalised need for support, there was a feeling that the compilation of relevant data would be important:

*“College should keep data on physicians who do it – need meaningful statistics” (Sydney)*

*“Have to collect data on this. Rigorous review process on this. How many people are actually doing this – patients and physicians?” (Melbourne)*

*“Need a data repository for requests and outcomes” (Sydney)*

## Communication

There was a clear recognition that conversations about medical assistance in dying could possibly become very difficult. There was a perceived need for assistance in developing the communication skills required to handle this well.

*“Multicultural area (hospital), all about educating the public as well as the doctors themselves ... coming from a different religious or cultural understanding, could be*

*unacceptable to a group of people; educating not just the patients but acknowledging the cultural diversity” (Sydney)*

*“Need support in communication skills so can clearly and objectively communicate with all people – the patient, other medical specialists, the family, legal, outside carers...” (Melbourne)*

*“Assistance in having the conversation around being a conscientious objector.” (Melbourne)*

*“Need a framework on how to have a conversation with each patient.” (Melbourne)*

### **Supports for junior doctors**

There was a specific need for support expressed by junior doctors. In this case it was assumed that at some point in the conversation a more senior physician would need to become involved. Junior doctors asked for support in managing the conversation and the need for a senior colleague to contribute and how and when this should occur.

*“As a trainee, I would question the communication skills needed and don’t think that I would be involved as a trainee...wonder if it’s just to be done by consultants” (Auckland)*

*“Conversations around end of life and pall care happen at the interface of patients and junior doctors, first point of call, level of experience can determine how confronting this is, communications skills training at the beginning of medical career is essential; for junior doctors, having a clear protocol for who has this conversation, we need to know at what point to escalate, I need to bring in my senior doctor to discuss this with you; important to have protocols to lean on” (Melbourne)*

*“Mid-way through a consultation, can’t tell someone to just wait to speak with senior doctor.” (Melbourne)*

## 4. Findings from the Online Forum

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The online forum attracted a total of nineteen participants, who made a total of 77 different contributions. All participants remained anonymous. Two participants were particularly engaged, and between them accounted for 37 of the contributions, or almost half.

The nature of online forums should be taken into account in the interpretation of the contributions received. Firstly, participants can read what has been recorded in the forum up to the time of their contribution and there is a tendency for people to avoid saying things that have already been reported. This tends to result in a lot of individual comments, rather than responses that fall within collective themes.

Another consideration is that being self-selecting, participation in an online forum of this kind is usually limited to those with a very strongly held position. This did in fact seem to apply in the current instance, with the single most frequent participant expressing very strong opposition to medical assistance in dying and making a large number of contributions repeating and elaborating on that point of view.

### Comments relating to the College approach

Some participants expressed appreciation of the College's approach, and particularly the acknowledgement of diverse views and the search for common ground. Others suggested that a comprehensive survey of members needed to be conducted to determine the precise degree of support and opposition, with the College position then becoming a reflection of the majority of its members.

*"Thank you to those in the college who have put their time into making this a less combative process and have opened the door to opinions that are often kept private for fear of retribution. There is support for [medical assistance in dying] in the RACP."*

*"Finding common ground is an excellent approach"*

*"I suggest that the college does a short online survey to seek members' views on this. The majority view then wins. This is the only way forward to any sensible position"*

### Opposition to medical assistance in dying and the idea of neutrality

Some participants held a position opposed to what may be seen as the common ground, recommending that the College should not be neutral for a number of reasons:

*"It is medically unethical to purposely end the life of a human being."*

*“A college that represents a profession that takes an oath not to harm patients cannot be seen to participate in helping people to commit suicide’*

*“The RACP would be out of step with most international medical associations if it had a position of anything other than opposition.”*

*“Over 100 medical societies worldwide do not support VAD - only 2 or 3 do. The RACP would be about the third medical society in the world to support it if they chose to”*

*“I highly recommend that the RACP adopts the American College of Physicians (ACP) published position statement which concludes that the ACP does not support the legalisation of physician assisted suicide.”*

*“Neutrality in this context is the same as support.”*

*“The relationship between a doctor and her patient should be one of trust. I do not believe that trust can exist when a doctor has permission to kill as well as heal.”*

*“As soon as we set a standard that it is possible to take a life under certain conditions, it then opens a trend to allow people to take their lives under other conditions.”*

## **Terminology**

One participant stated the following in regards to terminology:

*“The terminology is an issue - euphemisms make everyone feel better but this is assisted suicide using medical practitioners.”*

## **Palliative Care**

A number of participants recorded comments stating that medical assistance in dying would exacerbate challenges within the palliative care specialty:

*“Many patients are already nervous of engaging with palliative medicine with a completely misplaced fear that engaging with us will shorten their lives in some way. Vulnerable patients will be even more fearful of engaging with us if assisted dying were legalised.”*

*“Those who work in palliative care will have a challenge philosophically to work in this area of medicine”*

*“Supporting people through a dying process is vital and great palliative care is essential.”*

*“Euthanasia and assisted suicide will cut through the heart of Palliative Medicine. Palliative Medicine doctors will consider resigning from practice”*

*“I know that many of my colleagues would retire or leave palliative medicine should it be legalised”*

*“The impact will be unmeasurable yet enormous. The bond between patient and doctor will change, as has happened in other jurisdictions, palliative care will be eyed with mistrust”*

*“As a medical oncologist my patients will be more fearful of being referred to and accepting palliative care in case their deaths are deliberately hastened against their wishes”*

## **Autonomy**

Participants raised the potential implications of patient autonomy in this context:

*“Autonomy is all well and good until it impinges on another person’s autonomy.”*

*“Euthanasia is essentially a selfish concept that puts the value of individual autonomy above the needs of family, community and society.”*

## **The need for support**

Many participants agreed, that if legalised, patients and physicians would need a great deal of support and training around the ethical responsibilities, processes and practicalities:

*“Support for patients should be provided.”*

*“Support for physicians who either wish to assist patients, or who do not wish to do so should be provided.”*

*“Training should be provided.”*

*“Clear and explicit guidance around their ethical responsibilities is very important, the College should set the standard”*

*“How can we be certain that the request is not made under some form of duress, explicit or implicit, given that such patients may never acknowledge such a motive.”*

*“For those who choose to provide VAD, specific training around the process assessment and practicalities would be very valuable”*

*“Counselling in the mismatch in their profession in both the saving and taking of life”*

*“Clear guidelines are required not just to spell out the process of VAD to avoid becoming mired in legal battles”*

*“If the College decides to oppose VAD but it is still legalised, then the physicians who decide to participate in VAD are likely to need more support with guidance, education, medico-legal and pastoral care support”*

Some participants stated that the provision of medical assistance in dying, if legalised, should be implemented by a different profession:

*“If society insists on euthanasia and assisted suicide, create a group of trained technicians to act as agents.”*

*“If legalised, I believe it should be managed by a different profession”*

## 5. Analysis of Written Submissions

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A call for written submissions in response to the discussion paper was advertised to all members and open for 2 months from 9 May to 7 July 2017. Several late submissions were also accepted.

The College received 94 written submissions from Fellows, Trainees, College bodies and Specialty Societies.

It is important to note that the process of voluntary submission of opinions is 'self-selecting' in that often only those with a strong point of view may respond. In that sense, the views expressed are a sample of the feelings of College members.

### 5.1 Overview of Themes

The major themes to emerge from written submissions are set out below, including a summary of the various views expressed under each theme.

#### **'Position I want the College to take'**

- Opposed to legalisation
- Opposed to legalisation for now
- Engage and direct the policy
- Studied neutrality acknowledging the membership holds diverse views
- No position acknowledging the membership holds diverse views
- RACP should not presume medical assistance in dying will become legal
- Supportive of legalisation
- Supportive of the Victorian Bill's eligibility criteria
- Supportive of both sides by acting as a resource
- 77% of 21,435 responses sought in NZ oppose medical assistance in dying

## Risks and dangers of legalisation

- Pressure and coercion on patients that can be difficult to detect
- Medical assistance in dying expanding beyond original boundaries
- Undiagnosed depression
- Ensuring laws are equitable/feasible/appropriate
- Evidence from overseas is worrying - “Slippery slope” is valid and the European data supports this
- Assessment of capacity – which is already difficult in palliative and geriatric medicine
- Medicine would be undermined and it would undo medical tradition
- Support for medical assistance in dying will become a cost saving measure
- Support for medical assistance in dying will become a requirement for employment in hospitals
- Polls and surveys are flawed and statistics are manipulated/missing
- Mixed message about suicide causing an increase in suicide rates
- Oversight bodies not having medical expertise
- Lethal dose doesn’t work
- Diversion of lethal drugs

## Resources Needed

- Opposition or support of medical assistance in dying should not be predicated on the availability of good palliative care
- Research and public education on end of life care and how it can be improved
- Support for everyone – families, nurses, doctors, admin staff, even cleaners
- A clear guidelines statement/especially around 'double effect'
- Time for record keeping and to obtain reliable data
- Time to discuss situations with patients, families and to peer review with colleagues

## Concerns about particular groups

- Those with cognitive impairment especially dementia
- Indigenous communities
- Children and minors
- Culturally and linguistically diverse groups – different cultural approaches to death
- People experiencing mental illness
- People in rural/remote areas
- The aged
- People in institutions or areas where medical assistance in dying is not offered

- The competent, but unable to communicate e.g. stroke victims
- The young impoverished
- The homeless
- Patients tired of chronic disability
- Patients tired of trying to stay alive

### **Clinical concerns**

- Aspects of suffering we can't relieve e.g. psychological/existential/fear
- The impact on doctors' mental/spiritual health
- Doubtful we can define unbearable suffering
- Ambivalent requests/ people often changing their minds /compounded by medical advances
- Prognostication is very difficult
- We are good at treating pain, but that isn't necessarily the reason for wanting death
- A large percentage of Australians believe in life after death/religious edict not to kill and these can't be dismissed

### **Education**

- For the community - education about palliative care
- For health personnel - training in communication
- For the community - currently understanding of death and dying is poor
- For health personnel - medical education e.g. about palliative care and making it more effective
- For health personnel – ongoing training in support to patients and families
- For health personnel -education about the relevant law/record keeping
- For the community / and medical personnel - education about advance care planning
- For health personnel - specialised medical education for practitioners willing to take part in Medical assistance in dying

### **Doctor- Patient Relationships**

- Trust/especially in palliative care
- Resolving different opinions
- If we support Medical assistance in dying, the relationship will be forever changed/are we ready for this?
- The medical assistance in dying doctor is not the one with the long term relationship with the patient

- Understanding the complexity of the factors that constitute the 'person' e.g. their relationships, how they live

## Legal

- Legal support/protection will be needed for conscientious objection
- This is the prerogative of society, the community changes the law
- There are so many legal hoops/and complexities to jump through, autonomy is not improved for patient
- If assisted suicide becomes legal, anyone should/will have access/without doctors

## Terminology

- I don't like the term Medical assistance in dying/it is a confusing term/not in line with global discussion
- I don't like the term Medical assistance in dying/it is euphemistic
- Just continue with the terms euthanasia or assisted suicide/ they are widely understood
- Palliative sedation/difference between appropriate palliative care and terminal sedation
- I am/we are pleased the term euthanasia is not being used/it is too polarising
- "Final months of life" - e.g. 6 months or 60 months?
- Terms used need to be consistent/e.g. drug/medication/medicine
- Don't characterise "slippery slope" with the dismissive "so called slippery slope"

## Doctor-Doctor Relationships

- Palliative care must be kept separate from medical assistance in dying / medical assistance in dying is not part of palliative care
- Working with doctors / at hospitals with different attitudes
- It's not just a matter of conscience, but of professional boundaries
- How would my boundaries work?/we would need to co-exist
- VCAT and some other authorities consider medical assistance in dying to be part of palliative care
- How do I interface with the medical assistance in dying doctor?

## Comments on the discussion paper

- Thanks/discussion paper is important
- Section on historic framing helps to put the issues in context
- Section on historic framing has some incorrect statements

- Discussion paper does not give adequate coverage of the human misery under the current regime
- Discussion paper is subliminally anti legalisation of medical assistance in dying
- There should be a clearer sentence regarding the lack of data
- It's too hard and we need guidance from ethicists on this
- The Discussion Paper should state voluntary refusal of food and fluids has many advantages and should be offered as an alternative
- The Discussion Paper should state that terminal sedation as accepted in palliative care is a slow and distressing form of euthanasia

### Reassurance I want

- Stringent clinical supervision and process/data collection/better than elsewhere
- All aspects be tightened/tight
- That medical assistance in dying is evaluated after 12 months
- Governments must remain vigilant

### Doctor-Family Relationships

- We may be damned (or even sued) if we do and damned if we don't
- Grief and anger towards doctor

## 5.2 Extracts from Submissions

A range of verbatim quotes are presented below to provide additional insight into some of the more detailed comments received.

### 5.2.1 'What would you like the College to say about legalisation of medical assistance in dying?'

#### College Position

*"As physicians within the hospital system, most of us see patients with terrible suffering, particularly at the end of their lives. For patients who retain their cognition till the very end, the last few days of their lives can be devastating - both for themselves and their families. I have often stood helpless at their bedsides, wrestling with the knowledge that death is inevitable and that the suffering will continue. I, for one, can clearly see how a policy around assisted dying will be useful. The issues around assisted dying, however, are so vast that I do not think it is the mandate for doctors or the health profession to make a call on legalising this process. Society and its elected representatives have always come first in deciding what conventions become law - it is my opinion that the same should apply in this case too. I*

*support the college adopting an attitude of "studied neutrality" as outlined towards the middle of this paper."*

*"The fundamental issue here is continued debate about an issue which is of great importance to many people. A wide range of views exists both for and against medically assisted dying. People will have reached their views on this issue after much personal reflection. This range of views would no doubt be reflected in the membership of the RACP. However, for the College to express a view either strongly in favour or against medically assisted dying is unlikely to be supported by individuals holding a contrarian view. The information in this excellent review reflects this neutrality and encourages reflection on the part of the individual who is reading it. It is also important for the debate to continue in a fashion that respects differing views. One is mindful of a tendency for opposing views to degenerate into mindless, low level and often vituperative comments. We do not want to contribute to anything that might conceivably contribute to plumbing these depths!!"*

*"I think that the College needs to acknowledge that its membership holds diverse views such that it cannot give a definitive statement on 'where it stands' but can only state some of the concerns and complexities. We are obliged to remain members of the College for professional reasons; we cannot 'resign' to demonstrate objection to the stated position (as one could if, for example, you disagreed as a member of ANZSPM), so the College needs to adopt a 'considered opinion stance'."*

*"Say NO to doctors being part of the euthanasia and assisted suicide regime. Society if it wishes can do it without doctors. Say No as euthanasia and assisted suicide is unnecessary and unsafe. Say NO on behalf of the vulnerable people whom we serve night and day as doctors. Follow the great lead provided by the WHO in upholding the principle that Palliative care neither hastens nor prolongs dying. Follow the lead provided by the WMA in pronouncing that euthanasia is unethical for the medical profession and even when legal in a country remains unethical for medical practice. Once the state says that euthanasia or assisted suicide is legal, you cannot logically deny others outside the legislative limits from access. If euthanasia is to be available because you have unbearable suffering then it cannot be limited to adults and it cannot be limited to physical pain. It must be made available to young and old. It must be available to anyone at any time who deems that their suffering is unbearable. The idea of legislative safeguards is ridiculous."*

*"RACP support of euthanasia will mean the RACP turns its back on the highest principles of medicine. The RACP will lose all credibility as a professional body. It will in my view be a technical body of workers who follow the rules, having failed to lead the way for the profession. Leadership does not require that all members of the organization agree."*

*Leadership is about having the wisdom and vision to perceive what is best overall for the profession and the vulnerable people its members serve.”*

*“I will have lost respect for the profession of medicine. I may resign from my role as a practicing doctor. If I continue to practice, I will struggle to provide the holistic palliative medicine for which I have trained in four countries over 10 years with 17 years further of experience. It is not easy to provide the intensive holistic care to people who are facing their death. I have dedicated my life to being an excellent physician-believing and knowing from experience that I with the multidisciplinary team can care for people in their suffering. I have given my professional life to not abandoning people as they face death. I know that excellent palliative care works. For the RACP to support euthanasia is a slap in the face to me and to the profession of palliative medicine. It is as if the RACP announced publically “Hey you there, don’t bother trying so hard to be good doctors, willing to stay with people in their suffering, take it easy, euthanasia is available, hey presto, and your professional burden is lightened.”*

## Terminology

*“I do not want the College to use the confusing term of “medical assistance in dying”. As a palliative medicine physician of 26 years standing, I object to the use of euphemistic language in the term “medical assistance in dying”. I provide medical assistance to the patient and their family while the patient is dying. That is a description of the medical role in providing palliative medicine. What the proponents of euthanasia/assisted suicide wish is for the medical profession to change the language because of the gradual social unacceptability of the phrases euthanasia and assisted suicide. I practice palliative medicine. I provide medical assistance to the patient in their dying. I do not intentionally end the life of a patient. Be aware and mindful of the seduction of language. “Medical assistance in dying” will confuse the public and do palliative medicine harm as a result.”*

*“I definitely agree with the terminology used and the definitions. I am pleased that the term “euthanasia” is not used as it is too polarising.”*

*“It is both disturbing and confusing that the working party has chosen to muddy the waters about definitions. The previously well accepted and understood terms of Euthanasia and Physician Assisted Suicide (PAS) were replaced by the working party with the term “Medical Assistance in Dying”. The terms Euthanasia and Assisted Suicide (or Physician Assisted Suicide) are the terms almost universally referred to in the published literature, whereas the novel term Medical Assistance in Dying is rarely known in the scientific community, poorly understood and ambiguous. Many physicians currently believe they provide their patients with “medical assistance” in their “dying” phase. In fact, not to assist the person in some way while they are dying is a dereliction of duty of care. We physicians assist (or should assist)*

*patients to die well all the time – by providing analgesia, sedation, anti-emetics, laxatives, pressure area care as well as comprehensive team-based palliative care. The term that describes what many of us already do (i.e. provide medical assistance to patients in the dying phase) has been taken and redefined by the Working Group to be the new (euphemistic) name for Euthanasia and/or PAS. The Working Group should look at the problem with their use of terminology, specifically whether they are confusing the issue by moving away from readily-understood and historically-used terms in the scientific literature.”*

### **5.2.2 ‘If you believe there are cases and circumstances in which the College should support medical assistance in dying, what should they be?’**

*“If the principles inherent in the comments referable to Question 1 are accepted, access to high quality palliative care should be sufficient to manage the great majority of cases. There may be a few circumstances in which quite high doses of drugs are necessary to control pain and suffering and to ensure comfort and peace for the patient. Doses may be such as to cause significant sedation and even hasten death (Principle of Double Effect) but this is not the same as using very high doses of drugs with the primary purpose of deliberately ending patients’ lives.”*

*“There are undoubtedly some cases where it is justified eg. Inevitable progression of a truly horrible situation eg. Eroding local cancer with nasty symptoms eg. Hole in face or valval wound or similar, where there is no systemic disease (eg. liver mets) that will kill the person very soon. I also believe that patients with certain progressive neurological disorders should be able to have the opportunity to ask for assisted death at some time in the future whilst they are competent- most notably here: Huntingdon’s & probably MND. Patients with the former diagnosis will generally know only too well from having seen a family member go through years of dementia/psychosis what is ahead and I do believe that they should have the opportunity to access VAD”*

*“I think the main issue is about suffering even if this is hard to define and individual. I think suffering is more of an issue than the cause of the suffering and suffering does not necessarily relate to the diagnosis, underlying pathophysiology, stage of the disease or prognosis. A lot of attention has been paid to metastatic cancer and some of the chronic neurological conditions but I have seen persistent and uncontrolled suffering in a range of other conditions such as "stable" function post stroke, end stage organ failure and dementia. I feel the emphasis should be on the beliefs and impact on the patient not the disease diagnosis.”*

### 5.2.3 'Are there points in this discussion paper that you strongly agree or disagree with and why?'

*"I definitely agree with the terminology used and the definitions. I am pleased that the term "euthanasia" is not used as it is too polarising. I like the acknowledgement that some things are hard to define/measure (such as suffering) but that does not negate their validity and therefore they have to be considered. I like the presentation of the arguments for and against medical assistance in dying and more importantly the inclusion of the associated literature review."*

*"There should also be some clarification of the use of the doctrine of double effect. Would a practice be deemed consistent with best practice, as assessed by a body of peers? IF NOT, then such practice should be deemed illegal. The considered dosing of drugs in palliative care should be used as a standard for best practice in straightforward end-of-life scenarios. In more complex cases, the question would be why specialist palliative care advice was not sought?"*

*"It appears a well-considered and nuanced paper. Thank you."*

*"I think that this paper has done a good and respectful job of presenting a range of positions. While I personally agree and disagree with various positions contained in the document, I don't wish to strongly support or disagree with what has been presented. There are several comments I would make in specific response to points in this paper.*

- Section 7, dealing with common ground for physicians, suggests that introduction of medically-assisted death is essentially inevitable, and so guidance for physicians is required. While it may be correct to believe that such legislation will be introduced in future, it is also a concern that preparing detailed guidelines for physician practice in relation to medically-assisted death communicates to the public and political actors that the RACP endorses the practice, at least under certain conditions. This is problematic for the many RACP members who feel that the practice of medically-assisted dying is in itself unethical, and harmful to our professional practice. If the College were to prepare such guidelines, it would be important that they clearly detail an ethical position, and unequivocal support for conscientious objection in the event that legislation was introduced.*
- Section 8 highlights an important point of tension in relation to proposed legislation for medically-assisted dying, which is how to reconcile the desire for practitioners with long-term professional relationships to participate versus the creation of a voluntary, centralised register. It would be very likely that only a small number of physicians would opt in to such a register, and there would be limited instances for practitioners*

*with long-term therapeutic relationships to be engaged. Referrals to a separate medically-assisted dying practitioner would be problematic with regards to the appropriate provision of holistic end-of-life care, and in my view should be discouraged. “*

#### **5.2.4 ‘Are there issues we have not covered that the RACP should consider?’**

*“I think more attention needs to be given to the issue of prognosis given the proposed Victorian legislation which tries to frame this unframable concept. I think there are circumstances where chronic non-life threatening suffering would qualify for medical assisted dying. I think that any protocolled requirement for “experts” to make judgements likely will interfere with the trusted relationship with the main physician (including GP) and the patient in what is often a private matter. Further if such requirements were introduced, there would be substantial inequality of access especially in rural areas.”*

*“Overall, I agree with the contents of the paper. One area that is not covered well is the impact of medical assistance in dying on the family of affected patients. My view is that the ability of patients to talk openly about their desire for medical assistance in dying could have a positive impact on understanding by the family and on their grieving. At present, such discussions are not possible. Similarly, the ability of family to be present towards the end, if they and the patient wish, would be enhanced. The paper tends to cover the negative aspects of medical assistance in dying on the family, but not the positive ones. I also believe that there needs to be a requirement that practitioners refer to another doctor if they have an objection to providing this care – this could be via a statutory body, rather than direct. As physicians we have a duty to respond to the patient’s wishes, and to ensure that there is equitable access to all appropriate and legal forms of care, if desired by the patient.”*

*“I think there needs to be a strong emphasis on the availability of palliative care services as noted in the paper. I am concerned by the lack of societal discussion of the provision of palliative care in this debate. I believe education regarding the practice and provision of palliative sedation could address many of the current community concerns.”*

#### **5.2.5 ‘Do you perceive particular issues about the applicability of medical assistance in dying to particular people or groups? Can you outline those issues?’**

*“Cultural aspects of care are a very complex area for patients ... and are very sensitive. My feedback personally would be that euthanasia is really not in the cultural vernacular of patients.... There is a lot of stigma and cultural misunderstanding, misconception and need for expectation management for both Indigenous patients and the clinicians providing end-of-life care. Something that is becoming apparent to me is that for many remote Aboriginal*

*patients, often regardless of age or reversibility of disease, the value is often on remaining in community over travelling to a centre capable of providing life-saving health interventions or palliation, but it is not one size fits all.”*

*“I believe all people who are sick are vulnerable. On top of that, I see how on a daily basis we strongly encourage older people to eventually agree to rest home care even though they wish to go home. We work with the multidisciplinary team to explain all the risks of being at home, how our support of them is limited and we eventually convince them to say yes. Is this not coercion? How more vulnerable are these same elderly people going to be to muster the emotional, cognitive and physical strength to justify their continued existence in the face of freely available euthanasia and assisted suicide. A common reason for requesting euthanasia/assisted suicide in the Netherlands and Belgium is fear of disability and being a burden. Legislating for euthanasia in this context suggests that such are legitimate reasons for euthanasia. So how do those with disability feel about this? They already struggle on a daily basis to proclaim their human dignity, their worthiness of life and a dignified life with their disability and they are already made to feel a burden on society.”*

*“My concern is for the ‘young’ impoverished patient. The over 65s can access residential care subsidies if unable to live alone unsupported. Younger patients are often a genuine burden on family and friends as the services aren’t set up to care for them when home-care is no longer possible. These patients risk choosing an earlier death to remove this burden from their families.”*

### **5.2.6 ‘What do you envisage being the impact on your practice?’**

*“As a medical oncologist, I already have conversations with patients who wish to explore the concept of medical assisted dying. Many are confused, terrified and depressed. Often an understanding of what dying is likely to be like including support/services available makes this a temporary concern. As non-funded treatments become more expensive, I think many patients will be conflicted as to whether to spend money for themselves or leave it behind. These conversations will take time and are becoming increasingly complex without space in our caseloads to have them. Any patient contemplating medically assisted dying in the context of a cancer diagnosis, MUST meet an oncologist to discuss options, prognosis etc. as cancer and therapies are moving so quickly that it is not possible for non-oncologists to keep up with which diseases genuinely are ‘no-hopers’ and for which simple therapies are now available that make them into ‘chronic illnesses.’*

*“I think at the very least more time will be needed in all of our consultations with patients. All of the general practice, medical and psychiatric professionals could expect to have consultations about this, The complexity of these consultations and that they may have to*

*happen many times, has the potential to make us demoralised and less effective in our usual work. The moral distress, complexity, ambiguity, pressure from either patients or family and lack of referral pathways will lead to more burnout amongst medical professionals.”*

*“The practical implications of legislation allowing medical assistance in dying are considerable for Palliative Care. A high percentage of specialist Palliative Care is practiced in institutions with a religious foundation, particularly those associated with the Catholic Church. Both patients and health workers must expect that a request for medical assistance in dying will not be allowed to proceed within those institutions. When a patient seeking medical assistance in dying is based in such a setting, how that person’s expressed needs will be met, cannot be anticipated. At this time the constraint exercised by the Catholic religion and its place in medical services, together with the difficulties that may result for requesting persons and for Catholic staff, can only be openly acknowledged.”*

### **5.2.7 ‘What supports and guidance do you think you, and other health practitioners you work with, will need?’**

*“Protection for patients and doctors when there are issues of conscientious objection. Doctors should maintain the right to be ‘anti-assisted dying’ and should remain able to practice in their chosen field without restriction. However, if this is a legal avenue, patients shouldn’t have access restricted. This is where I see a non-medical model as being useful. A ‘someone/something’ else that assists with the actual dying to keep doctors doing the caring.”*

*“As identified in the discussion paper, I believe that there will be a need for readily accessible mechanisms of support for families, friends and all health professionals who have involvement in the process of medical assistance in dying. The availability of such mechanisms should be significant in decreasing the prevalence of mental health and other problems consequent on the implementation of such legislation.”*

*“I think we will need better access to mental health review/support to assess for undiagnosed depression. We will need training in how [enduring power of attorney] etc. work legally and morally. We will need TIME to discuss situations with patients, families and to peer review with colleagues. Those practitioners who choose to be prescribers/providers will need professional supervision and support. Those practitioners who refer or who choose not to refer will similarly need support. This has the potential to be very divisive within the profession and very stressful for the entire medical team assisting patients with their decision making.”*

### 5.2.8 'Recognising that there are major implications for palliative medicine and a number of other medical specialties, would legalisation of medical assistance in dying likely have special implications for your medical specialty?'

*"Unless there is a clear distinction between the new specialty of medical assistance in dying providers and palliative care medicine, this has the potential to irreparably damage palliative medicine as a specialty. Palliative medicine seeks to provide patients a good death and has been built on the foundation of neither hastening nor slowing death, rather dealing with providing good medical care and a team approach to relief of suffering. Most patients when unwell or in the terminal phase of life want to live well and have as much quality time as possible, without the spectre of medical assistance in dying hanging over them, and that is where our duty of care is. Having medical assistance in dying as a legal option increases the complexity for patients at a time when they are vulnerable."*

*"I am a Geriatrician and patients and families not infrequently raise the issue of medical assistance in dying. If it is legal then I expect these discussions are likely to be more frequent but also more open. There hopefully, will be a more honest discussion about illness trajectories, treatment options and symptom control. Hopefully, there will be more discussion about goals of care, advance care directives and understanding of what does or does not constitute suffering and burden for the individual."*

*"Renal Medicine - there are 20,000 people on renal dialysis in Australia. All are technically "terminally ill". Renal Physicians will be under pressure from patients who want to end their lives with a lethal injection rather than ceasing dialysis and waiting 3-14 days to die. If the patient is awaiting transplantation and requests euthanasia, the Renal Physician will be under increased pressure."*

*"There is a need for the development of psycho-oncology or liaison psychiatry in oncology and palliative care, however one may style it."*

*"If palliative medicine is perceived to be the specialty with carriage of medical assistance in dying then it will not survive as a specialty as it has evolved. Patients will either not want to be referred due to fear (patients currently have to consent to a palliative care referral and cannot be forced) or the specialty will be seeing the referred patients/family wishing to discuss this thus taking palliative care physicians away from the core business of palliative medicine, which is not to be involved in medical assistance in dying as described in this bill."*

*"Neurology - patients with early dementia will be demanding to be euthanased even though they may have many years to live. Furthermore, there may be treatments for this condition in years to come."*

## Appendix 1: Forum Agendas

### A. Forum Agenda – Auckland



#### RACP Deliberative Forum on Medical Assistance in Dying

**6:15-8:45pm**  
**The Cordis Auckland**  
**Crystal Ballroom**

#### Agenda

Time	Session details
6.15-6.25 (10 min)	<b>Dinner</b> <ul style="list-style-type: none"> <li>Participants arrive and take dinner from buffet to tables</li> <li>Introductions around tables – name, specialty, type of practice</li> </ul>
6.25-6.30 (5 min)	<b>Welcome from the College</b> <ul style="list-style-type: none"> <li>A/Prof Mark Lane, RACP President-elect, to welcome and thank participants for coming and introduce Woolcott Research</li> </ul>
6.30-6.35 (5 min)	<b>Housekeeping</b> <ul style="list-style-type: none"> <li>Woolcott Research Lead Facilitator to give overview of Forum agenda and approach, the key sessions, guidelines and housekeeping.</li> <li>Explain that there will be time after each presentation to ask questions.</li> </ul>
6:35-6:45 (10 min)	<b>Introduction - Dr George Laking (Working Party Chair)</b> <ul style="list-style-type: none"> <li>Overview of RACP activity to date</li> <li>Open up discussion on what should be the elements of a College position</li> </ul>
6:45-7:00 (15 min)	<b>Table discussion: Elements of a College position?</b> <ul style="list-style-type: none"> <li>Initial thoughts on the issues and developing a College position on this?</li> <li>What needs to be considered when developing a position?</li> <li>Thoughts on the discussion paper in general (explain that we will be going into more detail in subsequent sessions)?</li> </ul>
7:00-7:15 (15 min)	<b>Table feedback: Elements of a College position</b> <ul style="list-style-type: none"> <li>Feedback invited from <b>all tables</b> on their key points</li> </ul>
7:15-7:20 (5 min)	<b>Perspective - Dr Simon Allan, AChPM President</b> <ul style="list-style-type: none"> <li>Perspective from palliative medicine</li> <li>Case study: 64 yo male with motor neurone disease</li> </ul>
7:20-7:25 (5 min)	<b>Practical Implications - Dr George Laking, Working Party Chair</b>

	<ul style="list-style-type: none"> <li>• High-level overview of some areas likely to be impacted e.g. vulnerable populations, if legalised, impact on families, specialty specific implications</li> <li>• Case study: 94 yo female with multiple chronic diseases</li> </ul>
7:25-7:40 (15 min)	<p><b>Table Discussion: Practical Implications</b></p> <ul style="list-style-type: none"> <li>• What do you envisage being the impact on your patients and practice?</li> <li>• Are there common themes across these issues?</li> </ul>
7:40-7:55 (15 min)	<p><b>Table Feedback</b></p> <ul style="list-style-type: none"> <li>• Feedback invited from <b>all tables</b> on their key points</li> </ul>
7:55-8:10 (15 min)	<p><b>Refreshment break – participants to bring dessert, tea or coffee back to tables</b></p>
8:10-8:15 (5 min)	<p><b>Support and guidance – Dr Chris McKinlay, Working Party Member</b></p> <ul style="list-style-type: none"> <li>• High level overview of the challenges for physicians and types of supports and guidance that could be required, if legalised</li> <li>• Case study: oncology patient</li> </ul>
8:15-8:30 (15 min)	<p><b>Table Discussion: Support and guidance</b></p> <p>What support and guidance do you think you, and other health practitioners you work with, will need should legislation regarding medical assistance in dying to be brought in?</p>
8:30-8:40 (15 min)	<p><b>Table Feedback</b></p> <ul style="list-style-type: none"> <li>• Feedback invited from <b>all tables</b> on their key points</li> </ul>
8.40-8.45pm (5 min)	<p><b>Closing remarks and next steps – Dr George Laking, Working Party Chair</b></p> <ul style="list-style-type: none"> <li>• Summing up and thank you</li> <li>• RACP closing remarks – what RACP will take from today and confirmation of next steps.</li> </ul>
8.45pm	<ul style="list-style-type: none"> <li>• Woolcott Research Lead Facilitator – thank and close, and reminder to fill in end of session questionnaire on tables</li> </ul>

## B. Forum Agenda – Sydney



### RACP Deliberative Forum on Medical Assistance in Dying

6:00-8.30pm

Hotel Intercontinental, Sydney  
The Fort Macquarie Room

#### Agenda

Time	Session details
6.00-6.10 (10 min)	<b>Dinner</b> <ul style="list-style-type: none"> <li>Participants arrive and take dinner from buffet to tables</li> <li>Introductions around tables – name, specialty, type of practice</li> </ul>
6.10-6.15 (5 min)	<b>Welcome from the College</b> <ul style="list-style-type: none"> <li>Dr Catherine Yelland PSM, RACP President, to welcome and thank participants for coming and introduce Woolcott Research</li> </ul>
6.15-6.20 (5 min)	<b>Housekeeping</b> <ul style="list-style-type: none"> <li>Woolcott Research Lead Facilitator to give overview of Forum agenda and approach, the key sessions, guidelines and housekeeping.</li> <li>Explain that there will be time after each presentation to ask questions.</li> </ul>
6:20-6:30 (10 min)	<b>Introduction – A/Prof Andrew Cole (Working Party Deputy Chair)</b> <ul style="list-style-type: none"> <li>Overview of RACP activity to date</li> <li>Open up discussion on what should be the elements of a College position</li> </ul>
6:30-6:45 (15 min)	<b>Table discussion: Elements of a College position?</b> <ul style="list-style-type: none"> <li>Initial thoughts on the issues and developing a College position on this?</li> <li>What needs to be considered when developing a position?</li> <li>Thoughts on the discussion paper in general (explain that we will be going into more detail in subsequent sessions)?</li> </ul>
6:45-7:00 (15 min)	<b>Table feedback: Elements of a College position</b> <ul style="list-style-type: none"> <li>Feedback invited from <b>all tables</b> on their key points</li> </ul>
7:00-7:05 (5 min)	<b>Perspective - Dr Linda Sheahan, Working Party Member</b> <ul style="list-style-type: none"> <li>At the interface: palliative care and VAD</li> <li>Case study: 64 yo male with motor neurone disease</li> </ul>
7:05-7:10 (5 min)	<b>Practical Implications – A/Prof Andrew Cole, Working Party Deputy Chair</b> <ul style="list-style-type: none"> <li>High-level overview of some areas likely to be impacted e.g. vulnerable populations, if legalised, impact on families, specialty specific implications</li> <li>Case study: 94 yo female with multiple chronic diseases</li> </ul>

7:10-7:25 (15 min)	<p><b>Table Discussion: Practical Implications</b></p> <ul style="list-style-type: none"> <li>• What do you envisage being the impact on your patients and practice? Are there common themes across these issues?</li> </ul>
7:25-7:40 (15 min)	<p><b>Table Feedback</b></p> <ul style="list-style-type: none"> <li>• Feedback invited from <b>all tables</b> on their key points</li> </ul>
7:40-7:55 (15 min)	<p><b>Refreshment break – participants to bring dessert, tea or coffee back to tables</b></p>
7:55-8.00 (5 min)	<p><b>Support and guidance – Dr Anthonilla Mohamudally, Working Party Member</b></p> <ul style="list-style-type: none"> <li>• High level overview of the challenges for physicians and types of supports and guidance that could be required, if legalised</li> <li>• Case study: oncology patient</li> </ul>
8:00-8:15 (15 min)	<p><b>Table Discussion: Support and guidance</b></p> <p>What support and guidance do you think you, and other health practitioners you work with, will need should legislation regarding medical assistance in dying to be brought in?</p>
8:15-8:25 (10 min)	<p><b>Table Feedback</b></p> <ul style="list-style-type: none"> <li>• Feedback invited from <b>all tables</b> on their key points</li> </ul>
8.25- 8.30pm (5 min)	<p><b>Closing remarks and next steps – A/Prof Andrew Cole, Working Party Deputy Chair</b></p> <ul style="list-style-type: none"> <li>• Summing up and thank you</li> <li>• RACP closing remarks – what RACP will take from today and confirmation of next steps.</li> </ul>
8.30pm	<ul style="list-style-type: none"> <li>• Woolcott Research Lead Facilitator – thank and close, and reminder to fill in end of session questionnaire on tables</li> </ul>

## C. Forum Agenda – Melbourne



### RACP Deliberative Forum on Medical Assistance in Dying

6:00-8.30pm

Melbourne Convention & Exhibition Centre  
Meeting Room 212

#### Agenda

Time	Session details
6.00-6.10 (10 min)	<b>Dinner</b> <ul style="list-style-type: none"> <li>Participants arrive and take dinner from buffet to tables</li> <li>Introductions around tables – name, specialty, type of practice</li> </ul>
6.10-6.15 (5 min)	<b>Welcome from the College</b> <ul style="list-style-type: none"> <li>Prof Paul Komesaroff, to welcome and thank participants for coming and introduce Woolcott Research</li> </ul>
6.15-6.20 (5 min)	<b>Housekeeping</b> <ul style="list-style-type: none"> <li>Woolcott Research Lead Facilitator to give overview of Forum agenda and approach, the key sessions, guidelines and housekeeping.</li> <li>Explain that there will be time after each presentation to ask questions.</li> </ul>
6:20-6:30 (10 min)	<b>Introduction – Prof Paul Komesaroff (Working Party Member)</b> <ul style="list-style-type: none"> <li>Overview of RACP activity to date</li> <li>Open up discussion on what should be the elements of a College position</li> </ul>
6:30-6:45 (15 min)	<b>Table discussion: Elements of a College position?</b> <ul style="list-style-type: none"> <li>Initial thoughts on the issues and developing a College position on this?</li> <li>What needs to be considered when developing a position?</li> <li>Thoughts on the discussion paper in general (explain that we will be going into more detail in subsequent sessions)?</li> </ul>
6:45-7:00 (15 min)	<b>Table feedback: Elements of a College position</b> <ul style="list-style-type: none"> <li>Feedback invited from <b>all tables</b> on their key points</li> </ul>
7:00-7:05 (5 min)	<b>Perspective - Dr Danielle Ko, Working Party Member</b> <ul style="list-style-type: none"> <li>At the interface: palliative care and VAD</li> <li>Case study: 64 yo male with motor neurone disease</li> </ul>
7:05-7:10 (5 min)	<b>Practical Implications – Dr Clare White, Working Party Member</b> <ul style="list-style-type: none"> <li>High-level overview of some areas likely to be impacted e.g. vulnerable populations, if legalised, impact on families, specialty specific implications</li> <li>Case study: 94 yo female with multiple chronic diseases</li> </ul>

7:10-7:25 (15 min)	<p><b>Table Discussion: Practical Implications</b></p> <ul style="list-style-type: none"> <li>• What do you envisage being the impact on your patients and practice?</li> <li>• Are there common themes across these issues?</li> </ul>
7:25-7:40 (15 min)	<p><b>Table Feedback</b></p> <ul style="list-style-type: none"> <li>• Feedback invited from <b>all tables</b> on their key points</li> </ul>
7:40-7:55 (15 min)	<p><b>Refreshment break – participants to bring dessert, tea or coffee back to tables</b></p>
7:55-8.00 (5 min)	<p><b>Support and guidance – Dr Jim Howe, Working Party Member</b></p> <ul style="list-style-type: none"> <li>• High level overview of the challenges for physicians and types of supports and guidance that could be required, if legalised</li> <li>• Case study: oncology patient</li> </ul>
8:00-8:15 (15 min)	<p><b>Table Discussion: Support and guidance</b></p> <p>What support and guidance do you think you, and other health practitioners you work with, will need should legislation regarding medical assistance in dying to be brought in? (</p>
8:15-8:25 (10 min)	<p><b>Table Feedback</b></p> <ul style="list-style-type: none"> <li>• Feedback invited from <b>all tables</b> on their key points</li> </ul>
8.25- 8.30pm (5 min)	<p><b>Closing remarks and next steps – Prof Paul Komesaroff, Working Party Member</b></p> <ul style="list-style-type: none"> <li>• Summing up and thank you</li> <li>• RACP closing remarks – what RACP will take from today and confirmation of next steps.</li> </ul>
8.30pm	<ul style="list-style-type: none"> <li>• Woolcott Research Lead Facilitator – thank and close, and reminder to fill in end of session questionnaire on tables</li> </ul>

## Appendix 2: End of Session Questionnaire

### End of Session Survey

We would like your help to evaluate today's session so would be grateful if you could complete this questionnaire.

- Based on your experience today, please indicate whether your level of agreement with each of the following statements

*PLEASE TICK ONE BOX ONLY ON EACH LINE*

	Strongly Agree	Agree	Neither agree or Disagree	Disagree	Strongly Disagree	Don't know
a. I enjoyed taking part in the session	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. It was informative and I feel I have learned a lot	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. The session was well organised and structured	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. I was able to provide my views and contribute during the session	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. I think the RACP will act on the information from this session	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. I think events like this are a good way of consulting with members about issues	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

- What were the strengths of the session today?

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- What do you think could have improved the session today?

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**Thank you for your time and participation.**

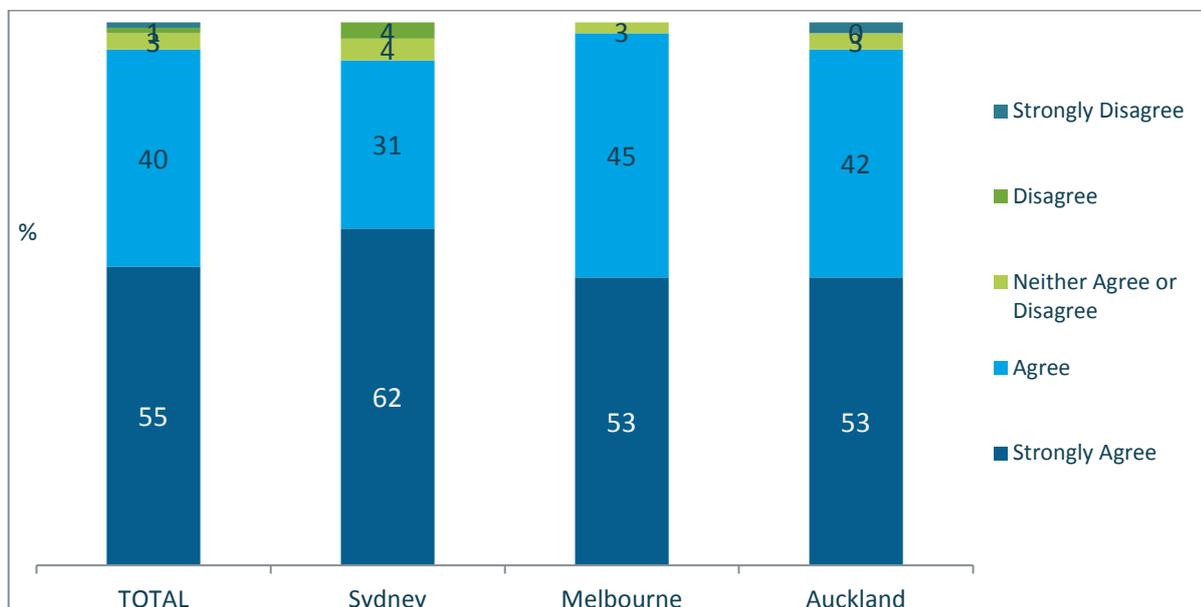
## Appendix 3. Evaluation of Face to Face forums

At the end of the deliberative forums, participants were asked to fill out a short survey (questionnaire appended) about their overall enjoyment of the forums and the degree to which they found it useful.

### 5.1 Extent to which participants ‘enjoyed taking part’

The vast majority of participants (95%) claimed to enjoy taking part in the forum.

Figure 1: Extent to which participants ‘enjoyed taking part’



Q1. Based on your experience today, please indicate whether your level of agreement with each of the following statements  
 Base: All participants (n=102)  
 Total n=102; Auckland n=36; Sydney n=26; Melbourne n=40

Enjoyment levels were similar across the three forums.

## 5.2 Extent to which participants felt it was ‘informative and that they learnt a lot’

Nine out of ten participants (90%) felt that the forums were informative, with the Sydney specialists being more likely to agree with this statement than those from the other forums.

Figure 2: Extent to which participants felt it was ‘informative and that they learnt a lot’



Q1. Based on your experience today, please indicate whether your level of agreement with each of the following statements

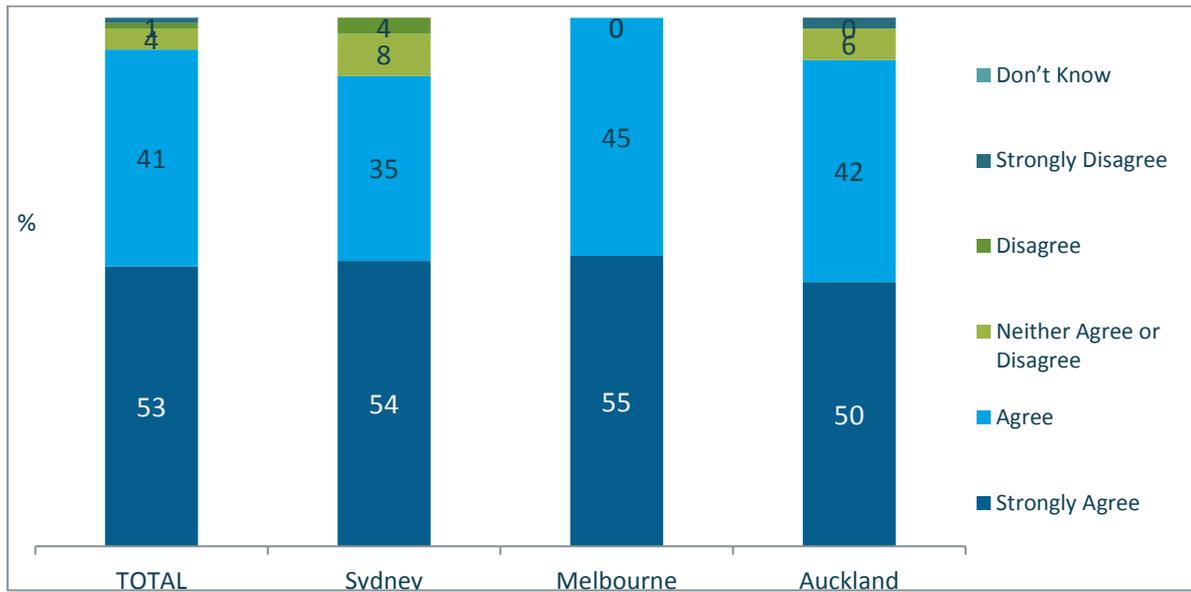
Base: All participants (n=102)

Total n=102; Auckland n=36; Sydney n=26; Melbourne n=40

### 5.3 Extent to which participants felt ‘the session was well organised and structured’

Attendees of the events, were also very positive about the organisation and structure of the forums, with 95% in total agreeing with the statement. Again this was consistent across the locations.

Figure 3: Extent to which participants felt ‘the session was well organised and structured’

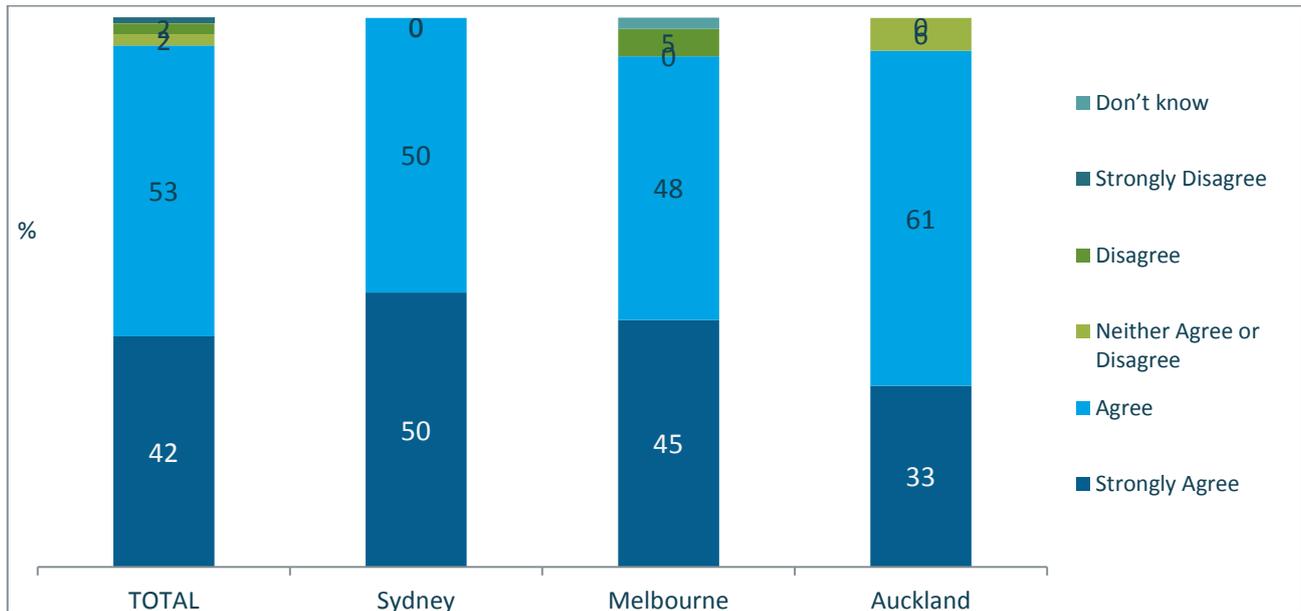


Q1. Based on your experience today, please indicate whether your level of agreement with each of the following statements  
 Base: All participants (n=102)  
 Total n=102; Auckland n=36; Sydney n=26; Melbourne n=40

### 5.4 Extent to which participants they were ‘able to provide their views and contribute during the session’

Participants (95%) felt they were about to contribute to the conversation and express their views during the sessions. In fact, there were only one or two within each location who didn’t feel that they were able to contribute.

Figure 4: Extent to which participants they were ‘able to provide their views and contribute during the session’

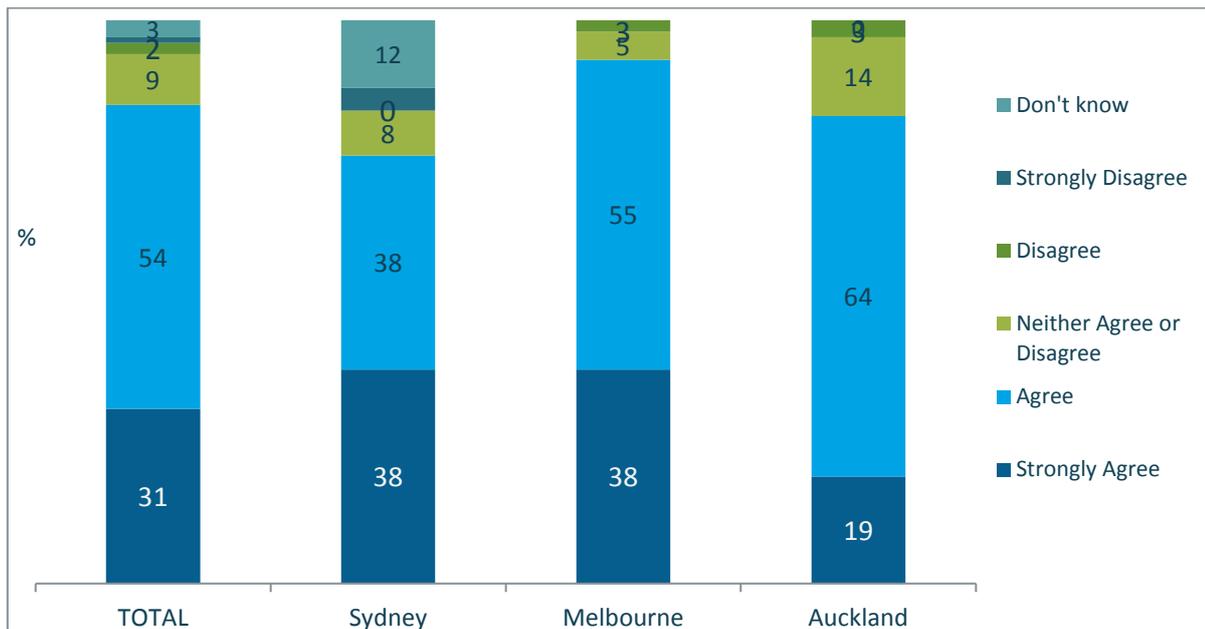


Q1. Based on your experience today, please indicate whether your level of agreement with each of the following statements  
 Base: All participants (n=102)  
 Total n=102; Auckland n=36; Sydney n=26; Melbourne n=40

### 5.5 Extent to which participants believe 'RACP will act on the information in this session'

When asked, 85% of specialists agreed that RACP would act on the information provided. Conversely, over 10% of participants were uncertain (or did not agree) as to whether RACP would act on the information in the sessions.

Figure 5: Extent to which participants believe 'RACP will act on the information in this session'



Q1. Based on your experience today, please indicate whether your level of agreement with each of the following statements  
 Base: All participants (n=102)  
 Total n=102; Auckland n=36; Sydney n=26; Melbourne n=40

Those in Sydney were slightly more sceptical than participants from the other locations. With almost a quarter indicating that they 'disagreed' or were unsure that RACP would act on the information.

## 5.6 Extent to which participants ‘think events like this are a good way of consulting about issues’

Overall attendees of the forums were very positive about the process as a way of consulting about issues. Over 90% of specialists agreed that events like these are a good way to consult, with almost no one disagreeing.

Figure 6: Extent to which participants ‘think events like this are a good way of consulting about issues’



Q1. Based on your experience today, please indicate whether your level of agreement with each of the following statements  
Base: All participants (n=102)  
Total n=102; Auckland n=36; Sydney n=26; Melbourne n=40

## 5.7 Perceived Strengths of the Session

At the end of the session, participants were asked to comment as to what they regarded as the key strengths of the event. The table below lists all the comments provided.

Verbatim Comments
Mix of different fellows/RMOs. Case based discussions
Clear presentations, good discussion, concise views
Good way to generate a 'seed' for opinions to be formed and matured both for the members present and the RACP
Dinner, table format
Good time management - good length of each section, not too long or brief. Well-arranged between talks and discussions. Flowed well.
Good discussion on topics. good idea with round table discussions
Gave chance to provide input
Good discussion, variety of ideas

Mixing up seating for a wide range of views
Excellent way of addressing a complex issue and attempting to capturing a position
Small group. Chairing of small groups so content couldn't deviate too much
Open and easy to share views
Discussion with colleagues
Short feedback sessions meant people didn't start fist fights. Bringing diverse people together. Good food. Having facilitators
Everyone had a chance to express their views
Enough time. Covering the main issues.
Good group table discussions on a difficult topic with a lot of discussion. Well moderated
Well planned and organised with pre-reading to stimulate thought and a structured process
Respectful dialogue. Diversity of opinions.
Well organised, plenty of time to discuss scenarios. excellent discussion paper
Great discussion about complex topic
Well moderated, small groups
Good co-ordination of timing, discussion points, group of varied members
Adequate time, good facilitation and discussion regarding a very complex subject
Small group sessions
Views from diverse medical specialists from both adult and paediatric medicine
Good format, well lead, very important issue
Open discussion of opinions/views
People from multiple specialists involved. Open discussion
The fact that RACP are actively involved in seeking member opinions. Variety of experiences on table. Relevant topics allowed different view points
Wide representation of views. Chance to hear others.
Good opportunity for discussion, wide range of members present
Not enough time to deal with any of the questions
Opportunity to contribute in a relaxed setting. balanced of presentations and discussions
Discussion of specific topics and a wide variety of situations of Medical assistance in dying
Kept well to time. Nice venue and good. Well organised
Table discussions
Exposure to broad range of views, evidence
Diversity of fellows and trainees and specialties
Group discussion
Good outline, like pre-reading
Appreciation of variety of opinions and kind and generous discussion. Excellent discussions. Good and felt heard.
Consultative process. Small groups facilitated respectful and frank discussion. Non-judgemental and informative
Involved more variety of doctors from different specialties and experience to give a good representation of the college as a whole
Frank discussions
Open discussion, good and interactive

Interesting to learn how little so many people understand about the issue
Explaining and discussing viewpoints/issues related
Focus - group atmosphere with structured canvassing of all points of view
Informative
Well run succinct. great discussion paper which helped us prepare well
Pre reading was essential. good range of views and additional points raised by diverse audience
Range of views, the deliberation process
Good range of specialties, with diverse opinions
Respectful discussion
Small group discussions. Information. Food. CPD
Open discussion, education
Frank discussion
The session was well structured with good introductions to set the scene for discussion. it started very robust discussion
Well organised, areas for discussion were chosen. Good cross section of fellows and trainees.
Ability to discuss issues
Independent mediators
I think it was run really well

### 5.8 Suggested Improvements

Similarly, participants were asked to suggest ways in which the event could have been improved.

Verbatim Comments
More diverse representation from specialists. More presentations from specialists
An overview of thinking across the board. More information from centres in Europe and north America
Discussions needed to be longer and more focussed
Not a lot of chance to interact with others informally
It was getting exhausting into the night so maybe a weekend session would be better. Discussion paper circulated earlier.
Limited number of participants
Longer discussion time
Pre-circulation of discussion paper
Wider invitations as only a few people from my unit were invited
Smaller groups, longer discussions
Depth of information, depth of discussion
Anonymous surveys might also help to encourage freedom of speech and thoughts in a topic which is polarised and sensitive
Use different ways of getting opinions. Instead of just round-the-table discussions
More time
Need lots of time
More time for discussions

Not enough time!
Nothing in particular.
More stats. An idea would be to vote to see what people actually think
Not enough time to explore details
Time. Such a complex issue, difficult to discuss in short time
Other issues could have been raised. Do physicians have to be the ones involved in assisted dying?
During daytime for next session please
Longer time discuss. ongoing follow up, pre-questionnaire
I only found out because a friend told me
More registrars
Surprisingly un-diverse views about medical assistance in dying at my table. Overwhelming against.
That we need a firm stance
More direction for facilitators
No, really good
Perhaps greater time for discussions. difficult topic to talk about in 15 mins
Could involve more people
Maybe not on working days
More discussion
Participants had not done their homework and read the relevant documents. RACP has a real problem if they only consult palliative care
Perhaps inviting other colleges
Longer time for discussions, maybe over 1 day
Don't know
More pre presentation from different specialties. I would have appreciated an email about such an important event - but happy to have been involved at the last minute never the less
All good, great food
Longer session rather than a mere 2 hours on this key topic
More info, discussion on what is actually contained in Act
People having read the NSW Bill. Most of the points covered are in the bill
More information about the acts in more detail that are under discussion
Somewhere with less traffic
Having a member of the working party on each table
There was not enough time for feedback/discussion
Possibly opportunity to raise matters not addressed during the forum
Very little
More time
It was good and kept to time. No suggestions
I think some form of interaction with other disciplines would be good - e.g. APC, nurses
More time
Slightly longer discussion time per topic
Clear indication of what the expected outcome will be
Improved direction in topics and questions
Provide a longer/multiple sessions

It would have been hard to do it better. Thanks

Some groups would have benefited from 'stronger' chairing to ensure opinions from quieter participants were heard

Woolcott leader could have summarised the discussion better

Introduction on the legislation i.e. key issues of the legislation such as an understanding that a doctor cannot institute the medically assisted dying act on their own. That it needs to be initiated by the patient.

Longer discussion sessions

Have it in Tasmania!

Clearer explanation of what was required for questions

Difficult topic, difficult to do better than this session

No major concerns

More time for discussion

More time for discussion/more moderation to get views from all

Great - thanks