

End-of-Life Care

CMAAO Meeting

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Euthanasia and Physician Assisted Suicide - the Australian Context

- Currently, neither Euthanasia nor physician assisted suicide is legal in Australia.
- Over the past few years, there have been numerous ‘assisted dying’ bills introduced in several Australian States, but all have been defeated.
- ‘Voluntary Assisted Dying’ Bills have recently been defeated in South Australia and Tasmania.
- In New South Wales, a Voluntary Assisted Dying Bill is expected to be debated this year.
- In Western Australia, it is expected that an Inquiry into End of Life Choices will be established next year.



Victorian Inquiry into End of Life Choices

- In 2016, as part of its response to an extensive Inquiry into End of Life Choices, the Victorian government recommended that a legislative framework for assisted dying be established.
- The Voluntary Assisted Dying Ministerial Advisory Panel (the Panel), chaired by former AMA President, Professor Brian Owler, was given the responsibility of developing a safe and compassionate voluntary assisted dying framework for Victoria.

Victoria – VAD Bill

- To access voluntary assisted dying, the Panel recommends a person must meet all of the following eligibility criteria:
 - be an adult, 18 years and over; and
 - be ordinarily resident in Victoria and an Australian citizen or permanent resident; and
 - have decision-making capacity in relation to voluntary assisted dying; and
 - be diagnosed with an incurable disease, illness or medical condition, that:
 - is advanced, progressive and will cause death; and
 - is expected to cause death within weeks or months, but not longer than 12 months; and
 - is causing suffering that cannot be relieved in a manner the person deems tolerable.
- We are currently awaiting the introduction of the draft Voluntary Assisted Dying Bill (Victoria) – release promised August/September



AMA policy on Euthanasia and Physician Assisted Suicide

- The AMA believes that doctors should not be involved in interventions that have as their primary intention the ending of a person's life. This does not include the discontinuation of treatments that are of no medical benefit to a dying patient.
- The AMA recognises there are divergent views within the medical profession and the broader community in relation to euthanasia and physician assisted suicide.
- The AMA acknowledges that laws in relation to euthanasia and physician assisted suicide are ultimately a matter for society and government.



AMA policy – Euthanasia/PAS

- If governments decide that laws should be changed to allow for the practice of euthanasia and/or physician assisted suicide, the medical profession must be involved in the development of relevant legislation, regulations and guidelines which protect:
 - all doctors acting within the law;
 - vulnerable patients – e.g. those who may be coerced or be susceptible to undue influence, or those who may consider themselves to be a burden to their families, carers or society;
 - patients and doctors who do not want to participate; and
 - the functioning of the health system as a whole.
- Any change to the laws in relation to euthanasia and/or physician assisted suicide must never compromise the provision and resourcing of end of life care and palliative care services.
- Doctors are advised to always act within the law to help their patients achieve a dignified and comfortable death.

Advance Care Planning

- Advance Care Directives (ACDs) are recognised in common law or authorised by legislation in some States and Territories.
- Legislation across States and Territories is quite variable and inconsistent.
- The AMA is a strong advocate of advance care planning (rather than just ACDs) which is a wider process of ongoing reflection, discussion and communication of health care preferences that may result in oral and/or written directives.
- The AMA strongly supports advance care planning and advocates for nationally consistent legislation and guidance in relation to ACDs.



Advance Care Planning

- The AMA advocates that advance care planning become part of routine clinical practice so that patients' wishes and preferences for health care, particularly end of life care, are known and met.
- Advance care planning can be part of a health care discussion with patients of all ages within the primary care environment or hospital setting.
- The planning process respects the patient's right to take an active role in their health care, in an environment of shared decision-making between the patient and doctor. It may involve family members, religious advisors, friends and other people the patient feels should be involved.

Withholding or withdrawing life-sustaining treatment



- In Australia, competent patients have the right to make their own decisions involving the withholding and/or withdrawal of life-sustaining treatment.
- Withholding or withdrawing life-sustaining treatment for an individual without decision-making capacity is often more complicated. Each State and Territory has guardianship legislation that may be relevant.

Withholding or withdrawing life-sustaining treatment



- The AMA believes the withholding and/or withdrawal of life-sustaining treatment is ethically and legally acceptable if undertaken in accordance with good medical practice.
- For many patients, the loss of decision-making capacity is progressive rather than immediate and may fluctuate over time. The AMA believes such patients should be encouraged and supported to participate in treatment decisions consistent with their level of capacity at the time a decision needs to be made.

Palliative Care

- Palliative care is not just care provided in the final stages of life but can be provided throughout the course of a person's life-limiting condition.
- Palliative care provides not only physical support to maximise quality of life but also psychological, social, emotional and spiritual support. This includes support for families and friends such as grief and bereavement support.
- All patients have a right to receive relief from pain and suffering, even where that may shorten their life.

Palliative Care

- Doctors should understand the limits of medicine in prolonging life and recognise when efforts to prolong life may not benefit the patient. In end of life care, medically futile treatment can be considered to be treatment that gives no, or an extremely small, chance of meaningful prolongation of survival and, at best, can only briefly delay the inevitable death of the patient.
- Doctors are generally not obliged to provide treatments that are considered medically futile.

Palliative Care

- There should be equity of access to appropriate care including respite care, palliative care, bereavement support, carers' support and other relevant services to patients undergoing end of life care and their families and carers.
- Limited health care resources should be used responsibly, fairly and effectively
- Doctors should receive education and support in cultural and religious awareness to enable them to care for all their patients and family members in a sensitive and culturally appropriate manner.
- This includes timely access to support personnel such as trained translators, indigenous community members and religious and spiritual advisers to ensure all patients receive appropriate end of life care.

Thank you

