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20 May 2019

Health, Communities, Disability Services and
Domestic and Family Violence Prevention Committee
via email: careinquiry@parliament.qld.gov.au

To the Chair of the Committee

Thank you for providing AMA Queensland with an extension (until today) to provide a submission on voluntary assisted dying to the Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee's (HCDSDFVPC) inquiry into aged care, end-of-life and palliative care and voluntary assisted dying.

AMA Queensland is the state's peak medical advocacy group, representing over 6000 medical practitioners across Queensland and throughout all levels of the health system.

This submission from AMA Queensland addresses the issue of Voluntary Assisted Dying (VAD), and consists of has two parts:

Part 1 - AMA Queensland position on Voluntary Assisted Dying (VAD), and
Part 2 - AMA Queensland responses to the Inquires questions on VAD (as an attachment).

Part 1- AMA Queensland position on Voluntary Assisted Dying (VAD)

AMA Queensland does not support the introduction of Voluntary Assisted Dying in Queensland.
AMA Queensland believes that doctors should not be involved in interventions that have as their primary intention the ending of a person's life[1]. AMA Queensland supports both the World Medical Association Resolution on Euthanasia[2] and British Medical Association Policy on Physician Assisted Dying[3] who oppose all forms of assisted dying as they are in conflict with basic ethical principles of medical practice.

AMA Queensland supports the *AMA Statement on Euthanasia and Physician Assisted Dying (2016)* which indicates:

1. **Good quality end of life care and the relief of pain and suffering**

1.1 Doctors (medical practitioners) have an ethical duty to care for dying patients so that death is allowed to occur in comfort and with dignity.

1.2 Doctors should understand that they have a responsibility to initiate and provide good quality end of life care which:
- strives to ensure that a dying patient is free from pain and suffering; and
- endeavours to uphold the patient's values, preferences and goals of care.

[1] AMA Position Statement on Euthanasia and Physician Assisted Suicide 2016
[2] World Medical Association Resolution on Euthanasia April 2013
[3] British Medical Association Policy on Physician Assisted Dying 2006

1.3 For most patients at the end of life, pain and other causes of suffering can be alleviated through the provision of good quality end of life care, including palliative care that focuses on symptom relief, the prevention of suffering and improvement of quality of life. There are some instances where it is difficult to achieve satisfactory relief of suffering.

1.4 All dying patients have the right to receive relief from pain and suffering, even where this may shorten their life.

1.5 Access to timely, good quality end of life and palliative care can vary throughout Australia. As a society, we must ensure that no individual requests euthanasia or physician assisted suicide simply because they are unable to access this care.2

1.6 As a matter of the highest priority, governments should strive to improve end of life care for all Australians through:

- the adequate resourcing of palliative care services and advance care planning;
- the development of clear and nationally consistent legislation protecting doctors in providing good end of life care; and
- increased development of, and adequate resourcing of, enhanced palliative care services, supporting general practitioners, other specialists, nursing staff and carers in providing end of life care to patients across Australia.

2. Patient requests for euthanasia and physician assisted suicide

2.1. A patient's request to deliberately hasten their death by providing either euthanasia or physician assisted suicide should be fully explored by their doctor. Such a request may be associated with conditions such as depression or other mental disorders, dementia, reduced decision-making capacity and/or poorly controlled clinical symptoms.

Understanding and addressing the reasons for such a The AMA supports nationally consistent legislation which holds that a doctor responsible for the treatment or care of a patient in the final phase of a terminal illness, or a person participating in the treatment or care of the patient under a medical practitioner's supervision, incurs no civil or criminal liability by administering or prescribing medical treatment with the intention of relieving pain or distress:

a) with the consent of the patient or the patient's representative; and
b) in good faith and without negligence; and
c) in accordance with the proper professional standards; even though an incidental effect of the treatment may be to hasten the death of the patient.

A doctor responsible for the treatment or care of a patient in the final phase of a terminal illness, or a person participating in the treatment or care of the patient under the doctor's supervision, is under no duty to use, or to continue to use, life sustaining measures which are of no medical benefit in treating the patient if the effect of doing so would be merely to prolong life.

Euthanasia is the act of deliberately ending the life of a patient for the purpose of ending intolerable pain and/or suffering. Physician assisted suicide is where the assistance of the doctor is intentionally directed at enabling an individual to end his or her own life. request will allow the doctor to adjust the patient's clinical management accordingly or seek specialist assistance.

2.2 If a doctor acts in accordance with good medical practice, the following forms of management at the end of life do not constitute euthanasia or physician assisted suicide:

- not initiating life-prolonging measures;
- not continuing life-prolonging measures; or
- the administration of treatment or other action intended to relieve symptoms which may have a secondary consequence of hastening death.

3. **AMA position on euthanasia and physician assisted suicide**

3.1 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.

3.2 The AMA recognises there are divergent views within the medical profession and the broader community in relation to euthanasia and physician assisted suicide.

3.3 The AMA acknowledges that laws in relation to euthanasia and physician assisted suicide are ultimately a matter for society and government.

3.4 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 – such as 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.

3.5 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.

3.6 Doctors are advised to always act within the law to help their patients achieve a dignified and comfortable death.

AMA Queensland also supports the *AMA Statement on Conscientious Objection (2019)*[4] which states that,

1. Preamble

1.1 Doctors (medical practitioners) are entitled to have their own personal beliefs and values as are all members of the community.

1.2 A conscientious objection occurs when a doctor, as a result of a conflict with his or her own personal beliefs or values, refuses to provide, or participate in, a legal, legitimate treatment or procedure which would be deemed medically appropriate in the circumstances under professional standards.

1.3 A conscientious objection is based on sincerely-held beliefs and moral concerns, not self-interest or discrimination.

1.4 It is acceptable for a doctor to refuse to provide or to participate in certain medical treatments or procedures based on a conscientious objection.

1.5 A doctor's refusal to provide, or participate in, a treatment or procedure based on a

[4] AMA Statement on Conscientious Objection 2019

conscientious objection directly affects patients. Doctors have an ethical obligation to minimise disruption to patient care and must never use a conscientious objection to intentionally impede patients' access to care.

1.6 Doctors should be aware of relevant legislation regarding their rights and obligations if refusing to provide or participate in treatments or procedures to which they conscientiously object. If unsure, doctors should consult with their medical defence organisation and/or State or Territory AMA office for appropriate legal advice.

1.7 Doctors with conscientious objections should not be treated unfairly or discriminated against.

1.8 A refusal by a doctor to provide, or participate in, a treatment or procedure for legitimate medical or legal reasons, does not constitute a conscientious objection. For example, where a patient requests a treatment or procedure that is of no medical benefit, outside the doctor's skills or scope of practice, illegal or where the doctor believes the patient has impaired decision-making capacity.

2. Patient care

2.1 A doctor should always provide medically appropriate treatment in an emergency situation, even if that treatment conflicts with their personal beliefs and values.

2.2 A doctor who invokes a conscientious objection to providing, or participating, in specific treatments or procedures should make every effort in a timely manner to minimise the disruption in the delivery of health care 47 and ensuing burden on colleagues and other health care professionals.

2.3 A doctor with a conscientious objection, should:

- inform the patient of their objection, preferably in advance or as soon as practicable;
- inform the patient that they have the right to see another doctor and ensure the patient has sufficient information to enable them to exercise that right;
- take whatever steps are necessary to ensure the patient's access to care is not impeded;
- continue to treat the patient with dignity and respect, even if the doctor objects to the treatment or procedure the patient is seeking;
- continue to provide other care to the patient, if they wish;
- refrain from expressing their own personal beliefs to the patient in a way that may cause them distress;
- inform their employer, or prospective employer, of their conscientious objection and discuss with their employer how they can practice in accordance with their beliefs without compromising patient care or placing a burden on their colleagues.

2.4 The impact of a delay in treatment, and whether it might constitute a significant impediment, should be considered by a doctor if they conscientiously object, and is determined by the clinical context, and the urgency of the specific treatment or procedure. For example, termination of pregnancy services is time critical whereas other services require less urgency (such as IVF services).

3. Institutional conscientious objection

3.1. Some health care facilities may not provide certain services due to institutional conscientious objection (for example, some institutions with religious affiliations will not provide termination of pregnancy, sterilisation or IVF services). In such cases, an institution should inform the public of their conscientious objection and what services

they will not provide so that potential patients seeking those services can obtain care elsewhere (for example, this information could be highlighted on the institution's website, patient brochures and on posters clearly visible at the front of the facility).

3.2 At times, a patient admitted to an institution may request a treatment or procedure that the institution does not provide due to conscientious objection. For example, a hospice patient may request access to a voluntary assisted dying service (in a jurisdiction where this is legal) but the facility does not provide such a service due to conscientious objection. In these cases, doctors should be allowed to refer patients seeking such a service to another doctor outside the facility.

AMA Queensland recommends that if the Queensland government decides to proceed with the development of legislation regarding Voluntary Assisted Dying, then 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 – such as 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.

Please find attached AMA Queensland responses to the Inquires questions on VAD (**attachment 1**).

In summary, AMA Queensland's Council supports the AMA position statement on Euthanasia and Physician Assisted Dying (2016) as well as the AMA position statement on Conscientious Objection (2019). However, it is imperative that AMA Queensland is fully consulted if the Government intends to proceed to legislation following the findings of the Parliamentary Committee.

Yours sincerely

Dr Dilip Dhupelia
President
Australian Medical Association Queensland

Q25. Should voluntary assisted dying (VAD) be allowed in Queensland? Why/why not?

The AMA believes that doctors should not be involved in interventions that have as their primary intention the ending of a person's life[5].

The AMA also recognises there are divergent views within the medical profession – and some of our members are supportive of voluntary assisted dying, and may choose to be involved in these processes. Should the Queensland Parliament approve legislation for voluntary assisted dying legislation in Queensland, then conscientious objections provisions must be included in the legislation to ensure that no doctor (or other health practitioner) will ever be forced to be involved in Voluntary Assisted Dying if they do not wish to be.

AMA Queensland recommends that should VAD become legal in Queensland, should never be at the expense of end of life care and palliative care. AMA Queensland strongly advocates that voluntary assisted dying cannot be discussed without drawing attention to the need for significant funding to be directed towards palliative care services and our chronically neglected mental health services. AMA Queensland calls on the Queensland Parliament to acknowledge, that palliative care and mental health services in this state are under-resourced particularly in regional and rural Queensland.

Should VAD become legal in Queensland, doctors should always be involved in developing legislation, regulations and guidelines. It will be essential to protect doctors and patients who do not want to participate as well as those who do wish to participate.

While endeavouring to prolong life, doctors also have a duty of care to ensure no patient endures avoidable suffering (acknowledging this is an entirely subjective matter). AMA Code of Ethics recognises the rights of severely and terminally ill patients to receive pain relief, even if it might hasten death (Doctrine of Double Effect).

Regardless of the legislative status of euthanasia and physician assisted suicide, doctors will never abandon their patients.

Q26. How should VAD be defined in Queensland? What should the definition include or exclude?

AMA Queensland believes the definition of VAD should be guided by legal and medical experts.

Q27 to Q36. – no response from AMA Queensland

Q37. Should medical practitioners be allowed to hold a conscientious objection against VAD? If so, why? If not, why not?
AMA Queensland supports the AMA Position Statement on Conscientious Objection 2019[6].

1. Preamble

1.1 Doctors (medical practitioners) are entitled to have their own personal beliefs and values as are all members of the community.
1.2 A conscientious objection occurs when a doctor, as a result of a conflict with his or her own personal beliefs or values, refuses to provide, or participate in, a legal, legitimate

[5] AMA Position Statement on Euthanasia and Physician Assisted Suicide 2016
[6] AMA Position Statement on Conscientious Objection 2019

treatment or procedure which would be deemed medically appropriate in the circumstances under professional standards.

1.3 A conscientious objection is based on sincerely-held beliefs and moral concerns, not self-interest or discrimination.

1.4 It is acceptable for a doctor to refuse to provide or to participate in certain medical treatments or procedures based on a conscientious objection.

1.5 A doctor's refusal to provide, or participate in, a treatment or procedure based on a conscientious objection directly affects patients. Doctors have an ethical obligation to minimise disruption to patient care and must never use a conscientious objection to intentionally impede patients' access to care.

1.6 Doctors should be aware of relevant legislation regarding their rights and obligations if refusing to provide or participate in treatments or procedures to which they conscientiously object. If unsure, doctors should consult with their medical defence organisation and/or State or Territory AMA office for appropriate legal advice.

1.7 Doctors with conscientious objections should not be treated unfairly or discriminated against.

1.8 A refusal by a doctor to provide, or participate in, a treatment or procedure for legitimate medical or legal reasons, does not constitute a conscientious objection. For example, where a patient requests a treatment or procedure that is of no medical benefit, outside the doctor's skills or scope of practice, illegal or where the doctor believes the patient has impaired decision-making capacity.

2. Patient care

2.1 A doctor should always provide medically appropriate treatment in an emergency situation, even if that treatment conflicts with their personal beliefs and values.

2.2 A doctor who invokes a conscientious objection to providing, or participating, in specific treatments or procedures should make every effort in a timely manner to minimise the disruption in the delivery of health care 47 and ensuing burden on colleagues and other health care professionals.

2.3 A doctor with a conscientious objection, should:

- inform the patient of their objection, preferably in advance or as soon as practicable;
- inform the patient that they have the right to see another doctor and ensure the patient has sufficient information to enable them to exercise that right;
- take whatever steps are necessary to ensure the patient's access to care is not impeded;
- continue to treat the patient with dignity and respect, even if the doctor objects to the treatment or procedure the patient is seeking;
- continue to provide other care to the patient, if they wish;
- refrain from expressing their own personal beliefs to the patient in a way that may cause them distress;
- inform their employer, or prospective employer, of their conscientious objection and discuss with their employer how they can practice in accordance with their beliefs without compromising patient care or placing a burden on their colleagues.

2.4 The impact of a delay in treatment, and whether it might constitute a significant impediment, should be considered by a doctor if they conscientiously object, and is determined by the clinical context, and the urgency of the specific treatment or procedure. For example, termination of pregnancy services is time critical whereas other services require less urgency (such as IVF services).

3. Institutional conscientious objection

3.1. Some health care facilities may not provide certain services due to institutional conscientious objection (for example, some institutions with religious affiliations will not

provide termination of pregnancy, sterilisation or IVF services). In such cases, an institution should inform the public of their conscientious objection and what services they will not provide so that potential patients seeking those services can obtain care elsewhere (for example, this information could be highlighted on the institution's website, patient brochures and on posters clearly visible at the front of the facility).

3.2 At times, a patient admitted to an institution may request a treatment or procedure that the institution does not provide due to conscientious objection. For example, a hospice patient may request access to a voluntary assisted dying service (in a jurisdiction where this is legal) but the facility does not provide such a service due to conscientious objection. In these cases, doctors should be allowed to refer patients seeking such a service to another doctor outside the facility.

Q38. If practitioners hold a conscientious objection to VAD, should they be legally required to refer a patient to a practitioner that they know does not hold a conscientious objection or to a service provider that offer such a service? If so, why? If not, why not?

A doctor who makes a conscientious objection to providing, or participating, in certain treatments or procedures should make every effort in a timely manner to minimise the disruption in the delivery of health care. If Doctors hold a conscientious objection they should:

1. inform the patient of their objection, preferably in advance or as soon as practicable;
2. inform the patient that they have the right to see another doctor. The doctor must be satisfied the patient has sufficient information to enable them to exercise that right. The Doctor needs to take whatever steps are necessary to ensure your patient's access to care is not impeded;
3. continue to treat the patient with dignity and respect, even if the doctor objects to the treatment or procedure they are seeking;
4. continue to provide other care to the patient, if they wish; and
5. refrain from expressing their own personal beliefs to their patient in a way that may cause them distress.