



AUSTRALIAN MEDICAL ASSOCIATION
(SOUTH AUSTRALIA) INC.
ABN 91 028 693 268

3 September 2019

Hon Kyam Maher MLC
Chairperson
Joint Committee on End of Life Choices
Parliament House
North Terrace
Adelaide SA 5000

Email: jcendoflifechoices@parliament.sa.gov.au

Dear Mr Maher

**Submission from the Australian Medical Association of South Australia to the
Joint Committee on End of Life Choices**

On behalf of the Australian Medical Association of South Australia (AMA(SA)), I wish to thank you for the opportunity to provide a submission to your committee's inquiry into matters relating to end of life choices in this state.

The AMA(SA) believes that it is the wish of the South Australian community for individuals to be able to die in comfort and dignity at the end of their lives, and in a manner that aligns with their values and wishes.

In line with this, I ask that the Joint Committee refer to points 1.1 and 1.2 of the *AMA Position Statement on Euthanasia and Physician Assisted Suicide 2016*, which set out the obligations of doctors in providing end of life care to their patients:

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.*

On behalf of the AMA(SA) I would like to acknowledge the calm and considered approach that the Joint Committee has taken to this inquiry. In an area in which strongly divergent views and emotive arguments exist, it is important that the Committee remains undistracted and maintains a resolve to focus on the matter that the AMA(SA) believes should be at the centre of the Committee's deliberations: the availability of high-quality end of life care for all South Australians that allows individuals to:

- die in comfort and with dignity, and
- in line with their values and wishes.

In doing so, the AMA(SA) urges the Committee to balance the need to look at these matters through the lens of the rights and wishes of individuals with the need for a wider perspective in considering the requirements of the South Australian community as a whole. This includes considering how resources for end of life care should be allocated to have the

0723 AMA(SA) Submission-End of Life Choices Inquiry_030919

Postal: PO Box 134 North Adelaide SA 5006
Phone: (08) 8361 0100 Fax: (08) 8267 5349

Level 2 161 AMA House Ward Street North Adelaide SA 5006
Email: admin@amasa.org.au Web site: www.amasa.org.au

your AMA

your voice

your profession

greatest benefit for the greatest number of individuals, and considering legislation that supports individual rights but does not undermine the values and rights of the wider community, including potentially vulnerable groups such as those who are elderly or have disabilities.

I also wish to acknowledge that a calm but enlightened approach by the South Australian Parliament has stood the state well in the past. South Australia has had the most complete legislative framework in Australia to support the rights of an individual to die in comfort and in dignity, with the *Advance Care Directives Act 2013* succeeding and consolidating the *Consent to Medical Treatment and Palliative Care Act 1995* and the *Guardianship and Administration Act 1993*.

The AMA(SA) notes that the Joint Committee is examining legislation relating to voluntary assisted dying (VAD) as part of its terms of reference. VAD is an issue with complex social, medical, ethical and legal aspects, and this is reflected in the diversity of opinions in the community and among our members.

We also note that the *2019 Review of the Advance Care Directives Act 2013* was recently completed by Professor Wendy Lacey. The AMA(SA) supports most of the findings of this report, most particularly a renewed focus on resourcing for the promotion and uptake of Advance Care Directives across the community and for improved education and training of health practitioners.

Before completing this submission, the AMA(SA) contacted our members, seeking their opinions and comments regarding the matters included in your Terms of Reference. The AMA(SA) Council considered the feedback we received alongside relevant Federal AMA Position Statements, including the *AMA Position Statement on Euthanasia and Physician Assisted Suicide 2016*. This submission represents the overall view of AMA(SA) Council, and recognises and respects the significant diversity of opinions among our members about matters relating to end of life, in particular euthanasia and VAD.

I wish to refer you to the attached AMA Position Statements that relate directly to matters being considered by your inquiry:

- *AMA Position Statement on End of Life Care and Advance Care Planning 2014*
- *AMA Position Statement on Euthanasia and Physician Assisted Suicide 2016*
- *AMA Position Statement on Conscientious Objection 2019*.

In particular, I would like to refer you to point 1.6 of the *AMA Position Statement on Euthanasia and Physician Assisted Suicide 2016*, which sets out what the AMA believes should be the priorities in any endeavors by governments to improve end of life care for the greatest number in the community:

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.*

South Australian legislation supporting quality end of life care

The AMA(SA) believes South Australia has the most complete framework of legislation supporting good end of life care for patients in Australia, with the *Advance Care Directives Act 2013* succeeding and consolidating the *Consent to Medical Treatment and Palliative Care Act 1995* and the *Guardianship and Administration Act 1993*. Together, these laws promote individual self-determination while protecting the doctors who provide care for people at the end of their lives.

The *AMA Position Statement on Euthanasia and Physician Assisted Suicide 2016* sets out the following points:

1.4 All dying patients have the right to receive relief from pain and suffering, even where this may shorten their life.¹

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

- *the development of clear and nationally consistent legislation protecting doctors in providing good end of life care;¹*

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.*

¹ *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.

South Australia's *Advance Care Directives Act 2013* is among the most advanced in the world for promoting an Advance Care Directive as a means of providing a legally binding "voice" for individuals who have lost decision-making capacity, as is commonly the case when individuals reach the end of their lives. Individuals can document their wishes by appointing Substitute Decision-makers (SDMs) and/or by documenting their values and wishes – including binding refusals of treatment – to be put into effect when they can no longer express themselves.

However, more than this, the overriding principle enshrined in this legislation is that all those acting for or treating the individual – SDMs, carers and health practitioners – must apply the substituted decision-making standard in making decisions for the individual; that is, in making decisions, all parties should imagine that they are standing in the individual's shoes before they lost decision-making capacity, while possessing the current and relevant information at hand. This gives individuals the assurance of autonomy beyond the point at which they lose the capacity to express themselves, and the confidence that their choices

about how and where they are cared for as they approach the end of their lives are known and will be followed.

In addition, the *Consent to Medical Treatment and Palliative Care Act 1995* (and amendments instituted with the *Advance Care Directives Act 2013*) provide protections for doctors:

- making appropriate clinical decisions relating to patients near the end of life; specifically, protections regarding the non-requirement to provide, and the ability to withdraw, treatment that is of no medical benefit to a dying patient. Section 17(2) of the *Consent to Medical Treatment and Palliative Care Act 1995* supports doctors in making decisions about whether to provide or continue medical treatment for a dying patient based on good medical practice and protects individuals from treatment that is “intrusive, burdensome and futile”.
- who administer medical treatment with the intention of relieving pain or distress, even though an incidental effect of the treatment may be to hasten the death of the patient. Section 17(1) of the *Consent to Medical Treatment and Palliative Care Act 1995* sets out clear protections for the well-established principle in palliative care treatment of “double effect”, where doctors, in focusing their intention of care on relieving the distressing symptoms of a dying patient, are given legal protection if a side effect of the treatment may hasten the death of the patient. This is a fundamental principle that if instituted properly gives dying patients the assurance that palliative care treatment can provide relief from distressing symptoms which they might otherwise suffer from when they die.

Therefore, current legislation in South Australia provides an elegant balance in supporting good end of life care by:

- enshrining the need to focus on individual autonomy and an individual’s ability to express their values and wishes, particularly relevant refusals of treatment, even when they may have lost decision-making capacity
- at the same time, not requiring a doctor to offer or continue treatment of no medical benefit to a dying patient; and protecting the doctor in providing adequate treatment to ensure comfort and dignity.

This is in line with the professional standards set out in the *Medical Board of Australia’s Good Medical Practice: A Code of Conduct for Doctors in Australia (March 2014)* which state that, in caring for patients towards the end of their lives, good care involves:

3.12.3 Understanding the limits of medicine in prolonging life and recognising when efforts to prolong life may not benefit the patient.

3.12.4 Understanding that you do not have a duty to try to prolong life at all cost. However, you do have a duty to know when not to initiate and when to cease attempts at prolonging life, while ensuring that your patients receive appropriate relief from distress.

3.12.5 Accepting that patients have the right to refuse medical treatment or to request the withdrawal of treatment already started.

Resourcing of advance care planning and palliative care services in South Australia

While South Australia has excellent legislation supporting good end of life care for individuals, the AMA(SA) believes that major deficiencies and failures remain in:

- the promotion of advance care planning and Advance Care Directives (ACDs) to the community, and the education and training of clinicians and health practitioners about ACDs; and
- the provision and resourcing of palliative care for dying patients.

Despite having solid foundations in legislation, the care of dying patients in South Australia is undermined because individuals are unaware of, or fail to use, advance care planning and ACDs to express their wishes; doctors fail to understand their legal and ethical responsibilities in providing care at end of life; and care in line with patients' wishes is restricted by inadequate resources and poor coordination of services.

In her *2019 Review of the Advance Care Directives Act 2013*, Professor Wendy Lacey emphasised that the effectiveness of ACDs was greatly undermined by the failure to adequately resource promotion and education for both consumers and health practitioners. The AMA(SA) strongly supports more resourcing of:

- activities to increase the promotion of ACDs across the community; and
- a comprehensive education and training strategy for clinicians and health practitioners regarding the related matters of consent, end of life legal obligations, ACDs, and use of the Resuscitation Plan-7 Step Pathway. This Pathway is a standardised document used across the health system to interpret and document clinical instructions regarding resuscitation and end of life care for patients, in line with their wishes, including those expressed in their ACDs.

On the latter point, the AMA(SA) emphasises the stark misalignment of inadequate funding to educate and train health practitioners about their obligations to respect patient ACDs and their wishes when compared to the exponentially increasing cost of life-saving technologies for serious conditions approaching end of life – particularly in cancer and intensive care cases – which are sometimes used to treat patients, at odds with their wishes as well as good medical practice.

The effectiveness of a comprehensive education and training strategy for clinicians was demonstrated in a 2013 trial of a model of clinical leadership, education and mentorship of general medical staff at Lyell McEwin Hospital (LMH). In this model, palliative care specialist Dr Christine Drummond provided education and support for general medical staff regarding consent, their end of life legal obligations, ACDs, and use of the Resuscitation Plan-7 Step Pathway. Health Round Table data showed that after the model was implemented:

- there was a more than 75% reduction in medical emergency response (MER) calls to dying patients (20% of calls down to less than 5%; national average 20-30%)
- total and average days/hours for patients with chronic airways disease admitted to Intensive Care Unit (ICU) in the last month of life decreased by more than 50%
- the number of patients dying in ICU after a stroke decreased by 50%, and the number of hours stroke patients spent in ICU in the last month of life decreased by 75%
- the average hours for patients admitted to ICU and dying in hospital decreased by 1,640 hrs in the first 12 months of the initiative, resulting in savings of about \$307,000 (LMH ICU dropped to below the 25th percentile for this measurement when compared to other hospitals).

This example indicates what is possible when resources for funding treatments and new technologies are balanced with policy that ensures those resources are used only when they align with the patient's wishes and good medical practice. In addition, whereas the key interventions considered in hospitals are cardio-pulmonary resuscitation, ICU and oncology treatments, in community settings, the major intervention patients often wish to avoid is

transfer to hospital. This can be supported by documentation on a Resuscitation Plan-7 Step Pathway form.

With respect to the provision and resourcing of palliative care for dying patients, the 2013, 2018 and 2019 *Improving end-of-life care for South Australians* reports by the Health Performance Council identified major deficiencies across the health system, indicating that care often fails to align with patients' wishes (particularly their wishes to die at home) or is inadequate. This applies to both patients admitted to hospitals and those in the community; the provision of palliative care is further compromised in rural communities and for members of diverse populations such as Aboriginal and culturally and linguistically diverse populations.

The AMA(SA) believes that the identified deficiencies are due to inadequate resourcing and poor coordination of palliative and end of life care, particularly in the community where responsibility for care is fragmented across health siloes including general practice, specialist palliative care, private health services and numerous aged care services/NGOs.

In line with the initial recommendations of the 2013 Health Performance Council report, the AMA(SA) believes there is a need for a comprehensive plan to increase the resourcing to:

- enhance the capacity of the generalist workforce to provide end of life care in community, aged care and hospital settings
- support specialist palliative care services to deliver equitable, high-quality statewide services and provide support to generalist services
- improve coordination of care between primary care, aged care and specialist services, with a particular need to involve, resource and support general practitioners caring for dying patients in the community.

The AMA(SA) notes that SA Health has developed an "End of Life Care for South Australians Strategic Plan" (2018) that includes a vision for South Australians "to experience quality care at the end of their life". We also note that the Strategic Plan provided timeframes for some of the plan's deliverables and ask whether the Committee has been advised of progress in these areas and whether the plan has been adequately resourced.

2019 Review of the Advance Care Directives Act 2013

The AMA(SA) supports most of the recommendations of the *2019 Review of the Advance Care Directives Act 2013*.

The AMA(SA) notes Professor Lacey's comment that "barriers to the realisation of the Act's core goals have less to do with issues with the Act itself and more to do with the levels of understanding and awareness of ACDs and their operation" (2.1.17, page 30), and that medical professionals are among those who must be better educated about the Act and ACD implementation.

We support Professor Lacey's findings that there are insufficient resources, education, awareness and training to increase awareness and uptake of directives in the community. Among the recommendations that we support are:

- *Recommendation 1:* SA Health reinstate positions dedicated to promoting understanding and uptake of ACDs in the community.
- *Recommendation 2:* The Advance Care Directive Form and DIY Kit be reviewed and updated so they are more easily understood.

- *Recommendation 3:* Consideration that the Act be amended to ensure that directives that meet common law requirements are treated as legally valid.
- *Recommendation 4:* Each Local Health Network and hospital should be required to report on their practices and protocols for identifying, managing and implementing ACDs. Hospitals must adopt a “whole of hospital” approach to identifying, flagging and managing ACDs. Each institution must also develop a system for recording conversations and treatment plans (including the Resuscitation Plan-7 Step Pathway) which incorporate non-statutory directives in files related to ACDs. These files must be digitally retained by each hospital.
- *Recommendation 5:* The use of digital copies of certified ACDs should be both permissible and promoted within South Australia’s hospitals. The Act should be amended to facilitate this process and provision should be made in the Act to ensure that medical practitioners and hospital staff are entitled to rely on the purported validity of an ACD contained on a patient’s My Health Record.
- *Recommendation 23:* The government needs to fund a comprehensive education and awareness raising campaign throughout the State, but only following the establishment of local, community owned programs which support the completion and adoption of ACDs.
- *Recommendation 24:* A new Advance Care Directives Advisory Board be established, including expertise in palliative care, gerontology, general practice, succession law/estate planning, human rights law, nursing and aged care.
- *Recommendation 25:* The government should conduct a public consultation process and/or commission research for determining how persons with limited or impaired decision-making capacity can be facilitated to record and convey (including through supported decision making) their preferences for future medical care, accommodation and personal matters. The consultation must engage with the disability sector and be framed by a human rights-based approach.
- *Recommendation 27:* The Department should investigate how the use of digital signatures could be implemented under the Act and make appropriate amendments to the Act if required.

The AMA(SA) does have some concerns regarding Recommendations 9 and 10 relating to the appointment of SDMs:

- *Recommendation 9:* The wording in section 22 of the Act should be changed from “jointly and severally” to “separately and together”.
- *Recommendation 10:* The Act and the ACD form should be amended to enable people to have a hierarchy of SDMs, with one or more preferred SDMs, as well as alternate SDMs (i.e., appointing a spouse as the preferred SDM and children as alternate SDMs). All SDM appointments should be able to be exercised together and separately.

The AMA(SA) believes doctors should be able to rely on the decision of the first SDM they are able to contact, particularly in urgent and emergency situations, and it is important that doctors not be required to locate and contact all SDMs if a decision should be exercised together as this is impractical in most cases.

The AMA(SA) also has concerns regarding *Recommendation 11*, which suggests that Schedule 1 of the Regulations needs to be amended so that the list of suitable witnesses be reduced and limited to health practitioners, legal practitioners, judges and magistrates, social workers and Justices of the Peace. Reducing the number of potential witnesses available to sign an ACD may act as an impediment to wider completion of ACDs in the community, particularly in rural settings where the pool of potential witnesses is already restricted.

Finally, the AMA(SA) notes significant caution regarding *Recommendation 29*, which states:

“The Act must be amended to ensure that it is explicit, in the operative provisions of the Act, that an ACD cannot be used as the basis for refusing life-saving treatment following an attempt to suicide or cause self-harm. The remainder of an otherwise valid ACD must be preserved.”

The AMA(SA) is aware that the South Australian Government has already submitted the *Advance Care Directives Variation Regulations 2019* under the Act, which came into force on Thursday, 11 July 2019. These aim to clarify that health practitioners are not legally required to follow an ACD in the situation of attempted suicide. This means that if a patient who has attempted suicide has an ACD which states a refusal of treatment, health practitioners are still able to provide (lifesaving) treatment in this situation:

12A—Exemption from requirement to give effect to advance care directives

Pursuant to section 63(2)(a) of the Act, a health practitioner is exempt from complying with section 36(1) of the Act in respect of health care provided to a person where—

(a) the health practitioner believes on reasonable grounds that the person has attempted to commit suicide; and

(b) the health care is directly related to that attempt.

While the AMA(SA) does not support ACDs being used as tools to facilitate a clear attempt at suicide, such as a patient with depression completing an ACD and documenting a binding refusal of resuscitation just prior to taking a medication overdose, it does note the possibility that these new regulations may be interpreted so that the legitimate wishes of patients to refuse treatment are over-ridden. For example, if an elderly patient with serious chronic illnesses documented a refusal for resuscitation and treatment for pneumonia on her ACD, and presented with such a condition in a hospital, a doctor could interpret this as a “suicide” attempt and override the patient’s documented refusal. This is not the intention of the Act and the AMA(SA) is concerned that the new regulations run the risk of altering the fine balance between the need to protect individuals and the need to safeguard autonomy, to such a degree that the central principle of the Act to support self-determination will be significantly undermined.

Voluntary assisted dying

The AMA(SA) acknowledges the enacting of the Victorian *Voluntary Assisted Dying Act 2017* and inquiries being undertaken in Western Australia and Queensland regarding end of life matters and VAD.

Referring to the *AMA Position Statement on Euthanasia and Physician Assisted Suicide 2016*:

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.

However:

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.

Although the subject of euthanasia and VAD monopolises the discussion in the public domain regarding end of life, it is the important role of the AMA(SA), in representing doctors who are at the front line of care in these situations, to set out the wider perspectives that may not be so easily seen when viewed only through the lens of an individual.

In this regard, I would ask you to note point 1.3 of the *AMA Position Statement on Euthanasia and Physician Assisted Suicide 2016*:

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.

This acknowledges that while there are there are times where the symptoms suffered by dying patients are difficult to control, such symptoms can be alleviated for the vast majority of patients by providing quality end of life care. Even in countries and jurisdictions where VAD is available, 95-98% of all individuals will die under the framework of palliative care (where intention is of treatment is relief of symptoms) rather than by VAD (where the intention of treatment is the ending of the life of an individual).

If VAD is to be considered, the AMA position statement points to the potential impact that this may have on vulnerable individuals, doctors, the health system and society as a whole. The AMA(SA) suggests that if there is an appetite to legislate for VAD, now or in the future, the Joint Committee must understand that such a move will give doctors a power and responsibility that no other group currently has: the ability to end life. This is a significant change that must be balanced by commensurate protections to prevent abuse of this power, and to prevent the coercion of vulnerable patients, and their doctors, by family members or carers seeking to impose their values, or who may have malicious intent.

In addition, allowing the intentional ending of life may in itself lead to a change in the way individuals perceive the value of their own lives – or those of others. Some individuals, particularly among vulnerable groups such as the aged and those with disabilities, might then be at risk of considering the intentional ending of life as a valid option should they then feel their lives to be of less value. An individual with a disability might be subtly or overtly persuaded by others to perceive themselves as having less “value” than another member of society and begin contemplating action to end their life; over time, anyone reaching a certain degree of frailty or incapacity to provide physical labour could likewise consider they are a “burden” to their family or the economic progress of their community and, as a result, consider the same action.

In considering these matters, the AMA position statement is clear:

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.

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.

Assisted dying legislation and the “slippery slope”

The AMA(SA) points out that in the Victorian *Voluntary Assisted Dying Act 2017* was the result of a long and well-resourced consultation and development, followed by an 18-month period before it came into force. This gave individuals, health practitioners, politicians and lawyers an opportunity to understand what it meant for them before it came into effect. In addition, VAD in Victoria is supported by a very well-resourced framework of governance, monitoring, education and support for consumers and health practitioners.

Victoria has now become the first “test case” for VAD laws and their repercussions in an Australian legal, medical and cultural environment. The AMA(SA) recommends that South Australia monitor the Victorian experience before introducing similar legislation here.

In addition, should such legislation be contemplated, the AMA(SA) suggests that protections must be as strong as those provided in the Victorian legislation, and implementation must be supported by the same robust framework of governance, monitoring, education and support for consumers and health practitioners.

It has been noted that the inquiries into end of life in Western Australia and Queensland appear to be proposing legislation with fewer or less powerful protections, which is at odds with a principle of safety-first in new legislation, particularly when the experiences in Victoria are as yet extremely limited.

AMA(SA) members who have contributed to this submission point to international evidence that once a jurisdiction accepts the basic tenet that VAD is permissible, and acts to legalise it, then the jurisdiction over time widens its availability to more people. The premise is that once “suffering” is accepted as the reason to legally permit a medical procedure to end life, then extension by degrees to other degrees of suffering cannot be rationally opposed.

In the Netherlands, for example, after 30 years of voluntary assisted suicide legislation, one in five doctors could conceive killing an otherwise well patients who is tired of life, and one

in 50 has actually done so.¹ An Adelaide colleague who works in palliative care and has worked in Vancouver Island, Canada, which has the highest rate of assisted deaths in Canada, reports that less than 30 per cent of Canadians have access to appropriate palliative care.

Similarly, members have pointed out that if action to prevent suffering is perceived as “good”, it could be argued that anyone who might be suffering, such as people with advanced dementia, should be euthanised. This may be viewed as an impossible scenario now, but in a recent case a Dutch doctor appeared in court after performing euthanasia on a patient suffering with dementia without consent.² Government and personal financial pressures, fear of being a burden, and coercion from family members imposing their values on an individual are stressors that could erode autonomy and self-determination among the most vulnerable members of our society.

Conscientious objection

The *AMA Position Statement on Conscientious Objection 2019* states:

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.

Given the genuine and often strongly held opposition to euthanasia and VAD of many doctors, the AMA(SA) is firm in its recommendation that any legislative reform to permit VAD must allow medical practitioners to conscientiously object and refuse to participate.

In situations where a doctor conscientiously objects to providing VAD, services which are widely known and well established should be available for the individual to access so that their request is not impeded.

In summarising this submission, I would like to reinforce the central role of doctors in caring for their patients until the end of their lives, and the ethical duty doctors have to care for dying patients so that death can occur in comfort and with dignity.

The AMA(SA) asks the Joint Committee to focus on the things that will provide the greatest benefit for the greatest number of individuals at end of life: namely, markedly improved support for increasing the uptake of advance care planning and ACDs within the community, improved education and training of health practitioners regarding ACDs and end of life law, and significantly increased resources for palliative care services.

¹ Bolt EE, Snijdewind MC, Willems DL, van der Heide A, Onwuteaka-Philipsen BD. Can physicians conceive of performing euthanasia in case of psychiatric disease, dementia or being tired of living? *J Med Ethics*. 2015;41:592-598

² <https://www.bbc.com/news/world-europe-49478304>

If the committee does wish to consider the reform that the AMA(SA) regards as a lesser priority, the legalisation of VAD, I urge you to include the AMA(SA) in the development of any such legislation.

Most of all, however, I encourage your committee to continue its considered approach and remain undistracted in maintaining a fixed eye on the goal of improving end of life care for the majority of South Australians, now and in the future.

Yours sincerely

A handwritten signature in black ink, appearing to read 'Chris Moy', with a stylized flourish underneath.

Dr Chris Moy

President AMA(SA)

Chair, Federal AMA Ethics and Medico-legal Committee