Voluntary Assisted Dying Policy

Background

The Australian Medical Students’ Association (AMSA) is the peak representative body for Australia’s medical students. AMSA believes that all communities have the right to the highest attainable standard of health and quality of life. Accordingly, AMSA advocates on issues that impact local, national and global health outcomes. Voluntary assisted dying (encompassing euthanasia and physician-assisted dying) is becoming increasingly important and relevant within the health sphere. While at the time of writing, both are illegal in all Australian jurisdictions, adopting a measured position on voluntary assisted dying is integral to progressing and improving how we care for people nearing the end of their lives.

Definitions

Euthanasia:
The word euthanasia comes from the Greek words eu and thanos, and translates roughly to English as ‘good death’. It describes the practice of intentionally ending a life in order to relieve suffering [1]. This policy concerns voluntary euthanasia, which is performed with a patient’s informed consent. Euthanasia may be active - a deliberate act undertaken to end a patient’s life - or passive - omission of an action which would reasonably be expected to keep the patient alive. [1] In the medical profession, passive euthanasia is commonly accepted as ethically permissible, in ‘futile’ circumstances [2]. Consequently, there is a perception of a strict moral delineation between passive and active euthanasia. Nonetheless, ethical questions can be asked regarding the difference between an action and an omission of an action. Such a discussion is outside the scope of this policy. In this policy, the term ‘euthanasia’ refers to active voluntary euthanasia.

Palliative Care:
The World Health Organization (WHO) defines palliative care as an ‘approach that improves the quality of life of patients and their families facing the problem associated with life-threatening illness’. Palliative care, amongst other things, ‘provides relief from pain’, ‘affirms life and regards dying as a natural process’, and ‘intends neither to hasten or postpone death’ [3].

Assisted Suicide:
Assisted suicide is any suicide committed by a person with aid from another person. Physician-assisted dying (PAD) is a subset of assisted suicide, whereby the patient’s death is enabled via means (a drug) or by information (how to use a
drug) by a physician [1]. This is distinct from active euthanasia as it is the patient taking the final action that will end their life, rather than the clinician.

Safeguards:
Safeguards in relation to voluntary assisted dying (VAD) legislation here refers to any restrictions or conditions designed to ensure that the principles and intention behind VAD legislation are properly implemented. While defining specific safeguards is beyond the scope of both this document and the expertise of AMSA, they must be designed with the express intention of protecting potentially vulnerable populations. These may include, but are not limited to, people with disabilities, elderly people, people with mental health problems and people of low socioeconomic status.

Throughout this policy, the term voluntary assisted dying (VAD) will be used to encompass both euthanasia and PAD.

Legality of Euthanasia and Physician-Assisted Suicide in Australia
VAD is currently illegal within all Australian states and territories [4]. However, prosecutions are rare. [5] PAD and euthanasia were briefly legalised in the Northern Territory in 1995-1996 (becoming the first jurisdiction in the world to do so), however the Bill was overruled by the Federal government soon after [2]. Generally, within Australia, any deliberate act which has the consequence of the death of another person is regarded as murder; or, where mitigating circumstances or no intent exist, manslaughter. It is also an offence within all Australian States and Territories to assist a person to commit suicide, however it is not an offence to commit suicide oneself [4].

Arguments for Euthanasia
There are two main arguments in support of VAD. One involves the ethical principle of autonomy, and the other involves the goal of medical care to relieve pain and suffering. Suffering is not limited to physical pain and discomfort for those with a terminal illness, and can extend to other forms of suffering such as the anxiety regarding when and how one is going to die [6]. Some elements of suffering cannot be alleviated completely from the dying process regardless of levels of analgesia [7]. Studies of terminal cancer patients [6,8] have demonstrated that patients perceive a good death as quick, with minimal suffering and on their own terms. VAD provides the opportunity to achieve all of these goals. In jurisdictions where PAD has been legalised it is not seen as a first-line option. [9] For example, In Oregon over the last 17 years the proportion of deaths from assisted death has remained less than 0.3% of all deaths [10].

Autonomy is commonly accepted as one of the pillars of healthcare ethics. [11] It is the right of competent individuals to make informed and voluntary decisions about their own care. [11] Currently, this principle is commonly brought up around the right of individuals to refuse life-sustaining treatment. VAD allows individuals with life-limiting illness to choose to die on their own terms, preserving their autonomy. Public support for terminally ill patients to be allowed to legally end
their own lives with medical assistance has been increasing over the past four
decades [12] and data from 2016 suggest that over 75% of Australians support
these individuals in their right to die [13]. By offering patients the opportunity to
choose death, their autonomy is respected, and fears and uncertainty about how
and when death will occur can be reduced. [14] Providing VAD as an option for
suitable patients can shorten the duration of physical and psychological hardship
for both patients and their families. This returns a measure of control to those
who may feel they no longer have control over their life, illness or death.

Physicians generally consider PAD more acceptable than euthanasia (perhaps as
the individual who has chosen to end their own life is the one taking actions to
end their life), although there is some evidence that the public takes the opposite
view [15]. PAD becomes more complicated when the individual is physically
unable to take the steps to end their own life. This is the case in conditions such
as locked-in syndrome and other neurological conditions (such as amyotrophic
lateral sclerosis) where the patient is still cognitively competent, yet cannot
control their own movements.

Arguments against euthanasia
Arguments against VAD can be broadly characterised into moral arguments
(relating to the permissibility of the act itself) and pragmatic arguments (relating
to the challenges of implementing comprehensive and safe VAD legislation).
Most arguments oppose both euthanasia and assisted dying (including PAD).

Moral arguments
An overarching and broad moral objection to VAD is the "sanctity of life" principle,
which affirms that the taking of human life is intrinsically wrong. Some
proponents view this principle as an axiom that requires no further justification
[16], holding primacy over other ethical principles that may support VAD (such as
respect for patient autonomy).

A variant of the sanctity of life principle is espoused by individuals from various
religious faiths: that life is a gift from God and interfering with death is
circumventing His authority over this natural process. [17] Some general
objections to this argument highlights inconsistencies with the approach of
modern medicine, whereby intervening to prevent death and preserve life via
‘unnatural’ means (such as by curing disease with medications/surgery, etc.) is
commonplace and largely uncontroversial [18]. It is important to acknowledge,
however, that religious beliefs are incredibly diverse and certain views will not be
held by all individuals that ascribe to a particular religion.

The ‘slippery slope’ argument against VAD relates to the perceived inevitability of
progression from voluntary euthanasia to other forms of euthanasia, particularly
non-voluntary euthanasia [19,20]. Proponents of this argument describe an
absence of moral barriers to prevent a downward spiral once voluntary
euthanasia is legalised.
A central argument against VAD is a concern for potentially vulnerable populations who might experience internal and external pressure to end their lives. This might include people with disabilities, elderly people, people with mental health problems, people of low socioeconomic status, and other individuals who may not be regarded as ‘useful’ contributors to society [21]. Indeed, the central idea supporting VAD that some lives are worth living and some are not, is deeply divisive and may be regarded as stigmatising to potentially vulnerable people. Fear of being a burden on family or society may drive individuals to end their lives prematurely [22], or conversely, the fear of being offered VAD prematurely may prevent potentially vulnerable people from seeking medical services that they require. It is plausible that the family or carers of a potentially vulnerable person may coerce the individual to seek VAD against their will [23].

There are widespread moral reservations about the role of the doctor in providing euthanasia and PAD. Opponents regard any involvement in actively ending a person’s life as a violation of the Hippocratic Oath which states “I will not give a drug that is deadly to anyone if asked [for it], nor will I suggest the way to such a counsel” [24]. Many modern physicians’ oaths do not make such specific reference to assisted dying, for example the World Medical Association Declaration of Geneva states more broadly “I will maintain the utmost respect for human life” [25]. Whether the act of assisting in, or actively ending, a person’s life when they are fully consenting and experiencing unbearable suffering is in fact a “harm” to the patient is a separate subject of debate.

Pragmatic arguments

Pragmatic arguments against VAD are not concerned with the moral permissibility of the act (of actively ending a life), but rather with the complex factors that may limit the practicality of legalising any form of euthanasia or assisted dying. Some salient arguments include:

- The difficulty in ensuring adequate safeguards for potentially vulnerable populations (such as the elderly and people with disabilities) such that they may not experience direct or indirect pressure to end their life [22,23];
- The difficulty in predicting the course of serious illness, despite best medical expertise [26,27], thus the possibility of prematurely ending a life;
- The challenges of defining competency/capacity and intolerable/untreatable suffering in the eyes of the law, such that objective decisions can be made regarding who is eligible for VAD;
- The need to invest more in palliative care services [28], such that fewer people experience intolerable suffering at the end of life and the need for VAD is reduced;
- The need to protect the values and beliefs of doctors and other health professionals who conscientiously object to any act of VAD;
- The difficulty in ensuring that any legal VAD services are accessible to all who seek them (for example, should services be provided as part of the public healthcare system);
• The inclusion or exclusion of psychiatric conditions, severe disabilities, and non-terminal (but untreatable) illnesses.

Positions of other organisations

Several health organisations, within Australia and abroad, have commented on VAD through a position statement or a policy paper. In 2016, the Australian Medical Association (AMA) published a position statement on Euthanasia and PAD. The statement concluded that doctors should not be involved in interventions that have as their primary intention the ending of a person’s life, but stressed that it 'does not include discontinuation of treatments that are of no medical benefit to a dying patient' [30]. Palliative Care Australia updated their position statement in 2016, stating that 'palliative care does not include euthanasia or physician assisted suicide' and that commented that there is not enough research surrounding the topic [31]. The World Medical Association, in 2015, reaffirmed their 1987 statement that ‘Euthanasia ... is unethical’ [32].

VAD in the context of palliative care and end-of-life care

It is important to consider the place of VAD within existing palliative care services. As per the definitions stated in this policy, VAD and palliative care have two distinct and opposing methods, fundamentally differing intentions, and therefore can be considered distinct separate treatment options of the end-of-life care continuum [33,34].

In this policy, and in many areas across the world, VAD is no substitute for, or replacement of, palliative care. Instead, VAD is to be a considered and well-thought-out option in the context of a patient’s end-of-life care and in conjunction with palliative care. Palliative care aims to affirm life and intends to neither accelerate or delay death [35], however supports dying as a natural life process. In most countries, including Australia, palliative care remains the standard of care for all patients nearing the end of their lives. However, VAD has the potential to be applied in cases of terminal illness that cause profound and unchangeable systemic, psychological and physical suffering. Non-pain related reasons for patients who are seeking a hastened death are typically the result of a loss of control, loss of hope, and loss of meaning in life or sense of burden to others [36,37]. Therefore, much of the justification for VAD lies in circumstances where the suffering described by patients can only be relieved by death, as all other options have been exhausted or the patient refuses treatment [33,37].

In countries that have accepted VAD, there seems to be no detriment or impact on the effect on palliative care services [38]. Moreover, most of the palliative care physicians who support VAD are in countries where it is legal, while those physicians oppose VAD are in countries where it is not legal [37]. Therefore, it is well regarded that palliative care services will be involved in all VAD cases and not discontinued until the moment of death.
Perspective from the medical profession

Doctors have an important voice in debates around any legislation on VAD, because if legalised in Australia, doctors are likely to be deeply involved in the process. Overall, there is a deficit of formal research surrounding the attitudes of medical professionals towards VAD.

The research that has been conducted in this area suggests that the medical profession is almost equally divided on their opinion on whether or not euthanasia or PAD has a place in medicine. Notably, support for VAD in the medical profession is low when compared with the general public [39]. Surveys of Australian general practitioners and specialists from South Australia and Victoria revealed that 44-53% of doctors believed VAD was appropriate in the right circumstances [40]. It was more common for GPs to hold this opinion than specialists, which was attributed to GPs’ increased exposure to requests for VAD [41]. Studies in New Zealand and the UK, where voluntary VAD is also illegal, report similar results [42]. Data from the UK revealed that palliative care physicians had the highest degree of opposition for VAD amongst any medical specialty (over 80%). [37]

Research demonstrates that in Australia and New Zealand medical professionals are sometimes asked for PAD or euthanasia services, the majority by the patient themselves, and some requests by the patient’s family (due to reduced capacity of patient) [42,40]. Despite the currently illegality of the actions, an Australian study from 2007 found that more than one-third (35%) of doctors who had received a request from patients to hasten death had taken active steps to end a patient’s life (via prescription or injection of lethal drugs), most commonly justified by persistent and untreatable pain, terminal illness, incurable conditions, or infirmities of old age [40].

In countries where euthanasia and/or PAD are currently practised legally, medical professionals are generally supportive of it [41,42,43]. However, medical professionals in these countries still vary on their willingness to be involved in VAD, some still personally objecting to the practice due to fear of their own incompetence or opposing personal attitudes towards VAD [42,37]. Moreover, the opinion surrounding VAD has the potential for change; in Belgium for example, support for PAD increased from 78% in 2002 around the time of the legislation recently passing to 90% in 2009 [44].

Global practices of voluntary assisted dying

As of 2017, few jurisdictions worldwide have legalised euthanasia or PAD. Both euthanasia and PAD can be legally practised in the Belgium, the Netherlands, Luxembourg, Colombia, and Canada. Further, PAD, but not euthanasia, is legal in five US states and in Switzerland [37] (a more extensive list can be found in Appendix 2). It is important to acknowledge that, due to both an absence and an underreporting of statistics, there is a lack of clarity in discerning just how widespread such practices currently are. In 2008, while PAD was not legal it was nevertheless occurring in other European nations, including England, Wales, France, Italy, Spain, Norway, Denmark, and Sweden [44].
An examination of euthanasia around the world presents several key messages:

Firstly, the extent, as well as the trends within that extent over time, of support for VAD are nuanced amongst and within populations. For example, Western European nations have erred towards supporting the legalisation of VAD while Eastern European nations have not followed that course [37].

Secondly, cultural differences and norms are crucial in guiding discussion and legislation with respect to VAD. The framing of discussions around VAD differ considerably between countries, as different cultures have markedly different attitudes towards death and dying. While some nations have implemented VAD legislation, it remains an unlikely prospect in many others, at least for the foreseeable future. [45].

Finally, trends occurring in some nations following the legalisation of euthanasia and/or PAD should be noted. The legalisation of PAD in Switzerland led to the creation of what has been viewed as ‘suicide tourism,’ where visitors travelled to that country for the sole purpose of suicide [46]. In the ten years following legalisation in Belgium, the number of reported euthanasia cases increased from 0.2% to 1.7% of all deaths; and palliative care teams were increasingly consulted about euthanasia requests [47].

Evidently, current practices of VAD differ in the states which they are legalised in. Some key recommendations for eligibility criteria, appropriate safeguards and other practical matters for legislating euthanasia and/or PAD in an Australian context have been provided in Appendix 1 (excerpts from the Victorian Government’s proposed Voluntary Assisted Dying Bill 2016).
Position Statement

AMSA supports voluntary assisted dying in principle. AMSA believes that:

1. Any legislation must be subject to stringent restrictions and appropriate safeguards to ensure its limited and appropriate use;
2. High quality accessible palliative care is an essential component of end of life care;
   a. VAD should not replace or be a substitute for high quality palliative care;
   b. VAD should be reserved for select patients; efforts should be made to ensure that any VAD legislation should not alienate people from palliative care service;
3. Medical professionals should be actively involved in the design and adoption of any VAD legislation;
4. Medical professionals have a right to conscientious objection in regards to VAD and should not be subject to judgement from within or outside of the health profession for any views they might hold;
   a. Any conscientious objection should not jeopardise patient autonomy, or limit patient access to legal and appropriate health care services that they are seeking.
Policy

AMSA calls upon:

1. Australian federal and state governments to:
   a. Ensure that before any legislation on VAD is put forward, that appropriate safeguards are able to be implemented;
   b. Ensure any VAD legislation is evidence-based, taking into account data and perspectives from overseas jurisdictions where this is legal;
   c. Protect potentially vulnerable people, through a series of rigorous safeguards, so that any access to VAD is strictly limited to the intended population only;
   d. Consult and engage potentially vulnerable people (including, but not limited to, people with disabilities, elderly people, people with mental health problems and disadvantaged populations), so that policy adequately addresses the needs and concerns of those it impacts;
   e. Measure and monitor any use of VAD programs, including providing statistics to the greater public while ensuring due process is adhered to;
   f. Ensure that the views of the general public remain central to the VAD debate and any relevant legislation;
   g. Continue to obtain up-to-date information on the views of both medical professionals and the wider public on this issue;
   h. Ensure medical professionals’ right to conscientiously object to provide VAD to patients is upheld, as long as access is not unjustly compromised;

2. Medical professionals to:
   a. First and foremost, abide completely and entirely by state or federal legislation, and the principles behind such legislation;
   b. Assist patients in their suffering or illness as part of appropriate palliative and/or end-of-life care;
   c. Ensure patients are fully informed about all treatment options - curative and palliative - before discussing VAD;
   d. In the event that VAD is legislated:
      i. Reserve VAD for only cases where all other viable and acceptable treatment options have been exhausted;
      ii. Ensure, to the best of their ability, that the true intention of patients seeking VAD are upheld in all circumstances;
      iii. Not discriminate against patients seeking VAD, or against doctors who choose to perform (or not to perform) related services within the boundaries of the law;
   e. Continue to engage in constructive debate both with individual patients and publicly on this topic, formally and informally;
3. Royal Australasian College of Physicians (RACP), Royal Australian College of General Practitioners (RACGP), and other bodies involved in the training of professionals involved in end-of-life care to:
   a. Continue to provide high quality training and support surrounding end of life care for training and member medical professionals;
   b. Provide appropriate information on VAD legislation to physicians involved in these services;
   c. Not discriminate against medical professionals who support VAD;
   d. Provide expert opinion where appropriate to the national debate surrounding VAD and end-of-life care.
Appendix 1

Excerpts from the Victorian Government 2016 [49]

In 2016, a Parliamentary Committee conducted a large inquiry into end of life choices, which concluded that palliative care in Victoria was not adequate to deal with the pain and suffering of a small percentage of individuals at the end of their life. It also found people want a choice about how they die, and want to plan for their death. It recommended that for the amount of people for whom palliative care is insufficient, assisted dying should be available. The following includes details of the Committee’s recommendations on how assisted dying should be practically implemented:

- Assisted dying would be available for an adult over 18 years old, with decision making capacity about their own medical treatment (as under the Medical Treatment Planning and Decisions Act 2016
  - If decision making capacity is in question due to mental illness, the person must be referred to psychiatrist for assessment
  - The person must be a Australian/Victorian citizen or permanent resident
- The person must be:
  - At the end of life (final weeks/months)
  - Suffering from a serious and incurable condition which is causing enduring and unbearable suffering that cannot be relieved in a manner which the patient deems tolerable
  - Suffering from a mental illness does not satisfy the eligibility criteria
  - properly informed. The primary and secondary doctor must each properly inform the person:
    - of the diagnosis and prognosis of their condition, as well as the treatment options available to them, including any therapeutic options and their likely results
    - of palliative care and its likely results
    - that they are under no obligation to continue with a request for assisted dying and may rescind their request at any time
    - of the probable result and potential risks of taking the lethal drug.
- The request for assisted dying must be:
  - Made by the person themselves
  - Voluntary and free from coercion
  - Not in an advanced care directive
  - Enduring
  - Withdrawal of the request is available at any time
- Two doctors (primary and secondary) must independently assess the patient and be satisfied that the patient’s request is enduring and that a reasonable amount of time has passed between the patient’s initial request and the provision of the lethal drug.
In making this judgement the primary and secondary doctors must have regard to the patient’s particular condition and its likely trajectory.

The primary and secondary doctors must also assess the reasonableness of the request. This is to ensure that the patient truly understands and appreciates the nature and consequences of the decision to request assisted dying, as well as the alternatives to assisted dying, and that the patient’s request is not ambivalent.

Each doctor must be properly qualified to make a professional diagnosis and prognosis regarding the patient’s specific condition. Each doctor must also assess the eligibility criteria.

- No doctor, or other health practitioner can be forced to participate in assisted dying
- A person should self-administer the lethal drug; the singular exception is where people are physically unable to take a lethal drug themselves. In this case, a doctor should be able to assist the person to die by administering the drug.
- An Assisted Dying Review Board be established to review each approved request for assisted dying. Membership of the Assisted Dying Review Board should include:
  - a representative of End of Life Care Victoria
  - a doctor
  - a nurse
  - a legal professional
  - a community member

The purpose of the Board is to ensure that doctors are complying with requirements of the assisted dying framework. If the Board finds a breach of the assisted dying framework, it should forward its report to the appropriate authority.
Appendix 2

Legislation permitting euthanasia and assisted suicide has existed in:

- **Netherlands since 2001** (Termination of Life on Request and Assisted Suicide Act);
- **Belgium since 2002** (Belgian Act on Euthanasia); and
- **Luxembourg since 2009** (Law on the Right to Die with Dignity).

The legislation in these jurisdictions permits competent individuals who make a voluntary and persistent request to have physician-administered euthanasia. In the Netherlands, assisted suicide is also permitted. In Belgium, although the law only explicitly provides for euthanasia, physician-assisted suicide is not prosecuted, provided the conditions and procedures for euthanasia have been complied with. Access to assistance is not restricted to those with terminal illnesses, but extends to individuals experiencing "constant and unbearable" physical or psychological suffering, which cannot be relieved in any other way.

- **Oregon in 1994** (The Death with Dignity Act, which permits assisted suicide)
- **Washington in 2008** (also known as the Death with Dignity Act) PAD
- **Vermont in 2013** (the Patient Choice and Control at the End of Life Act).

Under this law, competent adults who have been diagnosed with a terminal illness, and who are reasonably expected to die within six months, may request a prescription for a lethal substance from a physician.

- The law in Switzerland is unique in that whilst there is no specific legislation on assisted dying, assisted suicide is legal in the absence of selfish motives under s.115 of the Swiss Criminal Code. Anyone who incites or assists another to commit suicide for selfish motives will still be liable for conviction for murder.

The most recent piece of legislation on assisted dying is the End of Life Option Act, which was passed in **California in October 2015** in an extraordinary session called by the Governor. The law is very closely modelled on Oregon’s Death with Dignity Act, and would allow physician-assisted suicide for terminally ill California residents over the age of 18, who have the capacity to make medical decisions. The Act also creates a felony offence of pressuring someone to make a request, or forging a request. The Act is due to come into force on 1 January 2016, and will expire after ten years unless extended. It is subject, however, to potential legal challenge through an attempt to petition for a ballot referendum.

- **Canada 2015** - The Court’s ruling followed the passing of Bill 52 – the “Dignity with Dying Law” – by the Quebec National Assembly. This law was due to come into effect in 2015, and would permit competent adults to request medical aid in dying, provided certain criteria were met.
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Policy Details

Name: Voluntary Assisted Dying Policy (2017 Amended)

Category: F – Medicine in Australia

History: Adopted, Council 3 2017

Amended, October 24th 2017