10th December 2020

To: UTAS VAD Review Panel
VAD.Review@utas.edu.au

Re: Independent Review *End-of-Life Choices (Voluntary Assisted Dying) Bill 2020* (the *VAD Bill*)

Dear VAD Review Panel

I make this submission with focus on the Terms of Reference pertaining to the proposed VAD Bill's safeguards, protections and consequential implications for sustainable community trust in health service provision in Tasmania. The relevant sections of the Terms of Reference include but are not limited to:

2. Comparison of Tasmania's proposed VAD Bill to legislation (including Bills) relating to voluntary assisted dying, however described, in other Australian states and territories and overseas jurisdictions, including but not limited to the processes allowed by the legislation, safeguards and protections for vulnerable people.

3. An outline of the historical development of VAD legislation in other Australian jurisdictions in terms of scope and protections.

5.1 The safeguards put in place in other jurisdictions relating to the impact of VAD legislation on medical practice and practitioners, allied health and care professionals, family and social relationships, and provision for and practices in aged care.

Substance of this submission

A core role of the Medical Practitioner is to protect patients from harm. Irrespective of a decision to legalise voluntary euthanasia in Tasmania, comprehensive safeguards are required within any VAD Bill to protect the interests of vulnerable patients and maintain the integrity of the Medical Profession's primary role in caring for patients and not intentionally killing patients. This could be achieved in VAD legislation by:

(1) maintaining the existing legal embargo on the active involvement of registered medical practitioners in the promotion of euthanasia as well as prescription and administration of euthanasia pharmaceuticals,
(2) tight regulation and numeric specification of the number of approved euthanasia providers permissible in Tasmania and
(3) a requirement for the demonstrable and practical availability of holistic and adequate aged care, disability care and palliative care as an intrinsic counterpart to any VAD enabling legislation.

We must maintain public and professional confidence in relation to these matters.

Unfortunately, the proposed *End-of-Life Choices (Voluntary Assisted Dying) Bill 2020* is fundamentally flawed and inadequate in addressing issues (1), (2) and (3) outlined above. The proposed VAD Bill poses a completely unacceptable risk to the vulnerable.

The "open access" medical provider model fundamentally damages the medical profession's ability to both act and to be seen to act as an independent counterbalance to a legalised process for the active and intentionally extinguishing of human life by primary intent.

Rather than being considered an impediment to enacting voluntary euthanasia, continuing the protection afforded to the community by maintaining the existing legal embargo preventing registered medical practitioners either prescribing or administering pharmaceutical with a primary lethal intent, this should be viewed as a powerful safeguard for any new law enabling voluntary euthanasia. Therefore, this is not a matter of whether Tasmania legalises euthanasia, but a consequential matter. The physician (registered medical practitioner) must not be empowered as a means for euthanasia delivery.

Physician Assisted Suicide (PAS) involves the deliberate ending of a patient's life by a medical practitioner. PAS is not something that should be legalised in Tasmania. It is not an acceptable medical procedure, and it is not part of acceptable clinical medical practice according to the World Medical Association and the Australian Medical Association. Almost all medical societies worldwide (105/107) oppose the introduction of PAS – including our own AMA (Attachment 1).

Our focus as physicians must remain on the provision of optimal medical care for our patients while they are alive – not on the active and intentional delivery of their deaths. Physician Assisted Suicide is not accepted as standard or acceptable medical intervention, and it is certainly not a "clinical procedure" that doctors need to provide for medically managing their patients (Appendix 1)

If voluntary euthanasia is to be enabled in Tasmania, then let the registered doctor remain as an independent safeguard rather than an active participant. Moreover, if voluntary euthanasia is to be enabled in Tasmania, let the number of permissible euthanasia providers in the State be legislatively defined, carefully regulated and proportional to population need. Very importantly, let the resources needed to ensure access to high quality disability care, aged care and palliative care be clearly stipulated and required in any VAD legislation. Unfortunately, the currently proposed VAD Bill fails the test for each of these critical considerations.

Yours sincerely

John

Professor John Burgess

Past President, AMA Tasmania

Professor of Endocrinology
School of Medicine, University of Tasmania

Appendix 1
Reference: https://tas.ama.com.au/tas/common-questions-and-answers-regarding-euthanasia

Common Questions and Answers regarding Euthanasia

5 Feb 2020

Q. What is the AMA Position on Euthanasia?
A. The AMA does not support the introduction of Physician-Assisted Suicide. The AMA deeply respects the sincerity and good faith that underlies the diversity of the community and personal opinion regarding the topic of legalising euthanasia. The AMA seeks only to speak to the issue of Registered Medical Practitioners prescribing or administering pharmaceuticals with the deliberate intent of terminating a patient's life. The AMA position states, "doctors should not be involved in interventions that have as their primary intention the ending of a person's life". Similarly, the World Medical Association states that it is firmly opposed to Physician-Assisted Suicide.

Q. Do doctors need the law changed to allow them to provide palliative medicine?
A. No. There is occasionally a misbelief around potential legal risk to doctors delivering good palliative medicine or when doctors need to stop futile treatments. Established jurisprudence and medical ethics protect and uphold the appropriateness of medical practitioners in such circumstances. No gap exists in current laws that govern good medical practice and palliative medicine. The existing restriction on Registered Medical Practitioners that prevents them from providing Physician-Assisted Suicide in no way prevents a doctor from treating pain and distress with appropriate doses of medications to relieve suffering. It does not stop a doctor from ceasing or not providing futile treatments that offer no reasonable prospect of cure or which only serve to prolong suffering. Tasmanian doctors are already able to act professionally and with patient consent in these areas as part of providing good, ethical and contemporary palliative medical care.

Q. What happens when palliative measures are futile and are not helping the patient to live without pain and suffering?
A. This is an uncommon scenario when a patient has access to appropriate palliative medicine. However, it's for the legislature and the community to decide if Euthanasia is to be legalised. Any new legislation concerning Euthanasia must contain substantial safeguards and must continue to prohibit Physician-Assisted Suicide.

Q. If a Registered Medical Practitioners is not permitted to provide voluntary Euthanasia, then how will a patient in need be able to have a doctor to help them when they are at their most vulnerable?
A. The doctor can always be there for their patient - to understand their history, their family and belief context, their wishes and fears, their illness and treatment options, to advocate and care for them - but never by primary intent, to actively provide Physician-Assisted Suicide. It's akin to the separation of powers and process in the legal system. Any new Euthanasia legislative process must ensure a separation exists between the Registered Medical Practitioner and the process of delivering voluntary assisted euthanasia. Explicitly excluding all Registered Medical Practitioners from involvement in the provision of Euthanasia will ensure a patient's doctor can continue to care for and advocate for their patient without conscientious or ethical conflict forcing the doctor and patient apart. Consider the alternative, where through conscientious and professional ethical objection, the longstanding doctor-patient relationship is forced to be disrupted when a longstanding doctor must handover care to an unknown doctor who's prepared to provide Physician-Assisted Suicide.

Q. Why shouldn't patients have the choice to access euthanasia if they wish it as an ethical act of autonomy?
A. This may be an argument for legalising Euthanasia. However, it's not an argument for removing the legal or ethical embargo preventing Registered Medical Practitioners from providing Physician-Assisted Suicide.

Q. Why shouldn't Registered Medical Practitioners be allowed to provide Euthanasia if it's legal and they wish to?
A. There is a unique and trusted relationship between the doctor as a Registered Medical Practitioner, the vulnerable patient, and the community as a whole. This relationship is built on the ethical and legal foundation that the doctor is prevented from intentionally participating in interventions that seek to primarily and purposefully end a person's life. The trusted relationship between doctor and patient is upheld by the knowledge that this code binds all Registered Medical Practitioners. No doctor should be permitted to prescribe or administer pharmaceuticals to a person with primary lethal intent.

Q. If we accept that Physician-Assisted Suicide should not be legalised, then who else could prescribe the pharmaceutical and administer them if voluntary Euthanasia were to be legalised?
A. The pharmaceuticals involved in Euthanasia are neither complicated in nature or administration. The pharmaceuticals and their administration would be prescribed within the legislation itself, and delivered by a legally authorised service provider process, but not a Registered Medical Practitioner.

Q. Would a Doctor be needed to calculate a drug dose for Euthanasia?
A. There is no need for medical decision making about what drug to use or how much to administer. The law can stipulate this along with the other safeguards and processes related to the legalisation of voluntary Euthanasia.

Q. Are there alternatives to a Registered Medical Practitioner administering Euthanasia drugs?
A. Yes, there are practical alternatives to medical practitioner involvement in the delivery of Euthanasia - just as there are for the majority of currently available pharmaceuticals that are not administered by registered doctors. In the Victoria, for example, a person takes their own oral assisted dying medication that is provided by and delivered by Pharmacist from an authorised hospital pharmacy. The important thing is for a person to know that they can still have their doctor caring for them, the doctor just won't be prescribing or administering Euthanasia. Ultimately, voluntary Euthanasia should not be a doctor-led or delivered process. It can only be an autonomous personal decision made by an individual within a legislated process that defines the circumstances of terminal illness, the process and the safeguards by which euthanasia can be delivered.

Q. Who would ensure that the diagnosis and prognosis for a terminal illness are correct if Registered Medical Practitioners were not permitted to provide Physician-Assisted Suicide?
A. Registered Medical Practitioners currently issue medical certificates describing a patient's diagnosis, prognosis and capacity to make a decision. This would not change.

Q. Other jurisdictions have allowed Registered Medical Practitioners to be involved in Euthanasia; why shouldn't ours?
A. We have an opportunity in Tasmania to get it right. If the government chooses to legislate for voluntary Euthanasia, there is no need for this also to include Physician-Assisted Suicide.

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