VOLUNTARY ASSISTED DYING BILL EXAMINED

MORE THAN 1500 DOCTORS SPEAK THEIR MIND

THE ONLY DEFINITIVE SURVEY

A DETAILED LOOK AT THE VAD BILL 2019 BY THE AUSTRALIAN MEDICAL ASSOCIATION (WA)

A question of trust... in an imperfect world

Does AMA scepticism on the proposed VAD Bill processes betray a lack of faith in doctors and others who are caring for patients at the end of life, asks AMA (WA) President Dr Andrew Miller

As President, I have fostered discussion and supported disparate views on VAD being presented in *Medicus*, and I have acknowledged that the profession is in many minds on this issue.

The AMA has a carefully crafted policy on euthanasia. The policy is rightly subservient rather than instructive, and while it starts from the status quo – as does the law of the land – it respects Parliamentary process and suggests that doctors must be involved in the crafting of any euthanasia legislation. That is where we are now.

In the presence of apparently strong public support, the celebrity campaign and all-night sittings have seemed over the top. There is nothing to fear from long-term consultation to improve such an important Bill; a matter of conscience should be carefully conducted.

Doctors each have their own threshold issues, informed by their background and practice. More than 1,500 of you have generously responded in detail to form a powerful resource for the Parliament, the public and the profession. I am proud of what we can achieve by mining the experience of the doctors who will be central to this.

Just one example of the generosity of contribution was from Dr Peter Hannay who for many years has been involved in palliation in the regions. He offered important insights on problems with assessment of capacity, and the interaction between city Oncology services and rural GPs. This type of thoughtful colour and shade in addition to the big data is invaluable to the AMA.

We need to take the next step – from expressing our views to actually listening to others – to come up with the best result and propose meaningful amendments that contribute to safety and workability if this VAD Bill is to become law. The AMA (WA) has focused on potential problems with the Bill and differences to the Victorian legislation, as these are the issues that need to be understood as the Bill proceeds through the Legislature.

Since the last edition of *Medicus*, one sentence from former AMA (WA) President Dr Simon Towler has stayed with me:

We need to take the next step... to come up with the best result and propose meaningful amendments that contribute to safety and workability if this VAD Bill is to become law

"If the only argument against supporting the Bill being enacted is a lack of faith in medical practitioners to behave ethically and legally in providing coordinating and consulting support to persons seeking VAD, then our belief in our professional colleagues has reached an all-time low."

As Dr Towler was a member of the Ministerial Expert Panel and an insider on the VAD Bill formation, I took particular notice of his view and was troubled by my respectful disagreement with his conclusion. His comment, in fact, reveals a lot about the design of the process, in that it does rely centrally on faith in doctors.

Around the world, in the relatively few jurisdictions where VAD is legal, the main safeguards proposed have either been referral to an expert tribunal or relying on individual independent doctors to make good decisions, with threats of close monitoring, subsequent investigation and penalties.

The main touted disadvantage of a tribunal is the time it would take for it to assess each patient, and its remoteness from the consultations. This has led, for example, the Netherlands and Victoria to propose reliance on two or more doctors, not just as facilitators but as the main safeguard.[1,2]

While the Victorian Act requires a VAD Board permit to proceed, this has been described as essentially a bureaucratic step that does not involve an independent set of eyes on the facts. Victorian law, like the WA Bill, instead places heavy reliance on the integrity, skill, discretion,

appropriate referral and judgement of the two doctors.

At a time when blind "faith in doctors" has mostly disappeared from clinical governance, this seems counterintuitive to modern medical culture. I have to wash my hands and insert an IV under supervision of a clinical nurse every year to prove that I have not forgotten how during the last 12 months. Under this Bill, I could be relied on – after relatively brief online training – along with one of the other partners in my anaesthetic practice to:

- Diagnose or confirm a terminal illness;
- Discuss treatment options and palliation in that context;
- Detect coercion or abuse from carers, and witnesses;
- Estimate prognosis and proximity of death;
- Moderate my own advice to the patient from a position of power;
- Decide if the patient's assumed capacity should be challenged;
- Refer on to others at my discretion;
- Detect any fraud in relation to diagnostic results and residency requirements;
- Submit a lot of forms;
- Prescribe and administer (if requested) the lethal substance;

All for a patient I may have no prior relationship with, at a fee of my choosing, and possibly wrapped up in a minimum nine-day timeframe.

Every year, there are doctors stood down from practice pending inquiry, doctors sued for negligence, doctors that steal and misuse drugs, doctors dismissed from state employment, and doctors struck off for unprofessional conduct including financial misfeasance. Some even go to jail.

We know vulnerable patients are abused and neglected by carers, with the Aged Care Royal Commission detailing gruelling examples of what some defenceless Australians have to face toward the end of life. Families argue constantly over wills and money.

These are not controversial observations, though they might jar with those who are simply trusting that everyone will have a patient's best interests at heart, because that is how they would act themselves. These realities are why society must have robust prospective safeguards when the system is to assist someone to die.

We will seek to redress what many survey respondents see as a shortfall in the main safeguards by promoting amendments to the Bill before it is considered in the Legislative Council – not because our faith in all, or even many, of our colleagues is at an all-time low, but because we live in a real world that is imperfect.

We have not finished discussing the detail of amendments but likely foremost among them will be:

- Practical independence between the practitioners as in the Netherlands;
- Mandatory involvement of a doctor who has "relevant expertise and experience in the disease, illness or medical condition expected to cause the death" - as in Victoria; and
- Further opinions where there is no previous knowledge of the patient.

We did ask what you thought of our advocacy thus far and 73 per cent of you rated us '5' or above, the most frequent assessment being an '8', which shows much room for improvement. I hope this will come with constant willingness to communicate, and present a diversity of views.

I welcome your feedback: **@drajm** on Twitter; email **drajm@me.com** or call me any time on **0419 941 274**. ■

Reference: (1) Regulating voluntary assisted dying in Australia: some insights from the Netherlands. Onwuteaka-Philipsen, Willmott, White. doi: 10.5694/mja2.50310

(2) Death on demand? An analysis of physician-administered euthanasia in The Netherlands Robert Preston. British Medical Bulletin, Volume 125, Issue 1, March 2018, Pages 145-155. https://doi.org/10.1093/bmb/ldy003

AMA (WA) INVOLVED & ENGAGED THROUGHOUT THE VAD DEBATE

Fighting for a safe, workable law: AMA (WA) President Dr Andrew Miller appeared on current affairs show *Flashpoint* to discuss WA's Voluntary Assisted Dying Bill, which is currently before State Parliament. He joined a panel that included GP Dr Alida Lancee, host Tim McMillan, journalist Jenna Clarke, WA Director of the Australian Christian Lobby Peter Abetz and Amber-Jade Sanderson MLA.

Involved and engaged: Then AMA (WA) President Dr Omar Khorshid addresses the media after giving evidence to the Joint Select Committee on End-of-Life Choices in 2018.

Taking the lead: Dr Andrew Miller moderates a panel of doctors and health experts at the AMA (WA) End-of-Life Choices Symposium in May 2018

Australian Medical Association (WA)
Published by Agorapulse [?] · 5 August at 10:45

In the week that Legislation on Voluntary Assisted Dying will be introduced to the WA Parliament, the AMA (WA) reiterates its concerns about the recommendations contained within the final report of the Ministerial Expert Panel on VAD.

Level 2

AMAWA.COM.AU
Disappointing & Unsafe | AMA WA
The Australian Medical Association (WA) has expressed deep concern...

ABC NEWS

Doctors may face prosecution for discussing euthanasia with patients over phone, computer

By Jacob Kagi
Posted Fri 23 Aug 2019, 8:05am

"Medico-legally, doctors are quite rightly conservative and we have long experience of being investigated for far less than this. We need to sort that out before we introduce anything in Western Australia."

- AMA (WA) President Andrew Miller

Australian Medical Association (WA)
Published by Agorapulse [?] · 6 August at 16:07

The AMA (WA) has called on the State Government not to rush the community in its consideration of the VAD Bill, which has been introduced into State Parliament today.
AMA (WA) President Dr Andrew Miller said the proposed legislation was fundamentally flawed, lacked essential safeguards and oversight.
https://www.amawa.com.au/ama-wa-warns-rushed-vad-bill-is-u.../

AMAWA.COM.AU
AMA (WA) warns rushed VAD Bill is unsafe for patients & families | AMA WA
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The West Australian

In the News: WA NEWS PAGE 13 OPINION POLITICS AFL BUSINESS FLASHPOINT LATEST

POLITICS > STATE POLITICS

Australian Medical Association fears WA euthanasia laws will be rushed

Peter de Kruijff The West Australian
Tuesday, 19 March 2019 6:10PM

"There does need to be a robust debate once the legislation is written so Parliamentarians know where their constituents stand. It's important they (MPs) get the time and they get the decision right."

- AMA (WA) Immediate Past President Dr Omar Khorshid

VAD BILL EXAMINED

The only definitive survey on WA's Voluntary Assisted Dying Bill 2019 with an unprecedented 1500+ respondents

Over the past month the Australian Medical Association (WA) has conducted the largest ever survey of Western Australian doctors to determine the views of the medical profession on WA's Voluntary Assisted Dying Bill (2019), currently before State Parliament.

More than 1500 doctors – both AMA (WA) members and non-members – responded, making this survey significantly larger than any previous attempt to discover the views of any other group or profession on VAD. Even the Ministerial Expert Panel on voluntary assisted dying heard from fewer people.

Securely conducted by independent company TrueVote, this is a very significant consultative step in our involvement in the current debate on VAD. We decided it was vital that we ask you, the doctors of WA, about this legislation which has the doctor-patient relationship at its core.

We have always acknowledged that there are mixed views in the community and within the medical profession on this issue. Your comments made as part of this survey again demonstrate the range of views on this vital matter.

They also clearly demonstrate, whatever your leaning on the basic issues of euthanasia, your concern about much of the Bill – its safety, workability and the lack of a firm enough connection to accessible palliative care.

It is important that the profession continues to be involved in public and political debate on the legislation. This is a matter of great importance to WA, and indeed Australia, as other states and territories start to look at similar draft legislation.

We have been involved in the debate on VAD since the very beginning.

Immediate Past President Dr Omar Khorshid along with other Council members and AMA (WA) staff, have spent countless hours preparing submissions and presenting to Parliamentary Committees and expert panels.

Last year, the AMA (WA) held a major symposium on VAD. Attended by almost 200 members, it was an occasion for members to be involved and their views to be heard, and we arranged for a number of international speakers to attend.

We have had many meetings with politicians and of course, have received extensive media coverage about concerns with the workability and safety of any VAD regime.

The pages that follow carry the detailed results of the AMA (WA) VAD Survey, which are divided into four main issues.

We have also summarised the survey outcome of each question and, following the positive reaction of our decision to run a selection of comments about the matter in the August issue of *Medicus* (the AMA (WA)'s monthly magazine), we have done this again.

Thank you for your involvement in this matter to date. We hope to be coming back to you in a few weeks to ask for your assessment of the final draft Bill once we see the amendments that surely must come during debate in the Legislative Council.

On your behalf, we have made and we are determined to continue to make the voice of all doctors heard on the VAD Bill 2019. The AMA (WA) will respond to the profession and make its voice heard on this vital issue. ■

MEDICAL PRACTITIONER ISSUES

THE NEED FOR AN INDEPENDENT SPECIALIST IN THE PATIENT'S DISEASE

The WA Bill must provide for a VAD eligibility assessment that ensures requirements such as prognosis, available treatment options and how the disease/treatment may affect decision-making capacity, can be appropriately assessed. At least one of the two doctors involved in the process must have relevant expertise and experience in the primary disease, illness or medical condition expected to cause the death of the person being assessed.

In its VAD Bill survey, the AMA (WA) asked (members and non-members):

Do you think at least one of the two doctors involved in the process should be a specialist in the patient's disease, as is the case in Victoria?

1217 doctors | 264 doctors | 59 doctors

***Bottom line:* Large majority – no one can be an expert in all terminal diseases and rapidly evolving treatment options, so a relevant specialist must be involved.**

Do you think that the patient should be informed by an independent specialist in their disease about treatment options before they can access VAD?

1250 doctors | 242 doctors | 34 doctors

***Bottom line:* Very large majority – an independent specialist who is qualified to inform a patient of all their options is the gold standard for any VAD system.**

Victorian Act: Either the coordinating medical practitioner or each consulting medical practitioner must have relevant expertise and experience in the disease, illness or medical condition expected to cause the death of the person being assessed [VAD Act 2017, (Vic), s10 (3)].

WA Bill: The only requirements for medical practitioners are that they are either:

- Specialist registered, having practised for at least one year as the holder of specialist registration; or
- General registered, having practised for at least 10 years as the holder of general registration; or
- An overseas trained specialist with limited or provisional registration.

In addition, practitioners involved in VAD must comply with the as-yet undetermined requirements to be published on the Department of Health's website.

By failing to place parameters around a doctor's specific clinical specialty and knowledge, the WA Bill overlooks the fact that medicine has more than 20 specialty areas of practice, all recognised by AHPRA as distinct fields of specialist skill and expertise.

In the course of treating patients, modern medicine often requires the input of several doctors with specialised skills and knowledge to accurately diagnose and prognosticate. VAD should be no different and to safely determine eligibility, a patient should be assessed by an independent specialist in their disease.

INITIATING VAD DISCUSSIONS

The VAD Bill 2019 (WA) should include a prohibition on health practitioners initiating discussions with patients, reflecting the Victorian legislation.

In its VAD Bill survey, the AMA (WA) asked (members and non-members):

Do you think that registered health practitioners should be prohibited from initially suggesting the option of VAD?

54% YES — 820 doctors

44% NO — 669 doctors

3% N/A — 43 doctors

***Bottom line:* Majority of doctors want the same provision as Victoria.**

Victorian Act: A registered health practitioner who provides health services or professional care services to a person must not, in the course of providing those services to the person, initiate discussion about VAD with that person. [VAD Act 2017 (Vic), s8].

This prohibition exists to ensure that there can be no suggestion of coercion from health professionals towards vulnerable patients who hold the opinion and advice of the health professional in high regard.

WA Bill: No such prohibition or limitation exists.

In fact, a proposed amendment to the WA Bill by Labor MP Anthony Buti, which would have prevented doctors raising VAD with a patient, was voted down.

Some doctors have expressed resentment about such a limitation interfering in the clinical conversation. This may explain in part why the support for this suggestion is not as strong as for other changes to the Bill, along with doctors not thinking that it is as important a safeguard.

SHOULDN'T NEGLIGENCE COUNT?

The WA Bill must expressly exclude legal protections for persons who act negligently.

In its VAD Bill survey, the AMA (WA) asked (members and non-members):

Do you think that a patient or their family should be able to sue (bring a civil claim), or AHPRA should be able to investigate, negligent acts or omissions by a doctor performing VAD assessments or services?

63% YES — 952 doctors

31% NO — 462 doctors

6% N/A — 96 doctors

***Bottom line:* Significant majority – patients should be able to take action for negligence if the doctor does not perform to a reasonable standard in the provision of VAD services. It is unclear if negligence will be protected in WA given the difference to the Victorian Act.**

Victorian Act: A medical practitioner must act in good faith and without negligence to be 'not guilty' of an offence, or liable for any civil proceeding. [VAD Act 2017 (Vic), s80].

WA Bill: There is no express reference to 'negligence'. The Bill protects persons who in good faith act in accordance with the Bill, or believe on reasonable grounds that the process of VAD is done in accordance with the Act.

Under the system proposed, any wrongdoing would be difficult to detect due to the prohibitions on reporting VAD as the cause of death on the medical death certificate and the lack of a pre-death oversight mechanism. It is foreseeable that patient carers or advocates may not even be aware that the individual has sought and/or accessed VAD.

ALL DOCTORS ARE COMPELLED TO ACT

While doctors can conscientiously object and some are not eligible to provide VAD, ALL doctors are required to act in some way to a VAD request.
The VAD Bill must ensure that all medical practitioners who are not legislatively able to provide VAD services are exempt from the onerous notification requirements. There should only be a requirement to inform patients making a request, that the doctor is unable to act as a consulting or coordinating practitioner in accordance with the Act.

In its VAD Bill survey, the AMA (WA) asked (members and non-members):

Do you think that some classes of doctors should be exempt from all responsibilities to perform acts under the VAD Bill, for example doctors in training, administrators or those who are never involved in end of life care?

91% YES 1396 doctors

7% NO 107 doctors

2% N/A 32 doctors

Bottom line: **Overwhelming majority – non-qualifying doctors should be exempt from duties under the proposed law.**

The WA VAD Bill defines medical practitioners as persons registered under the Health Practitioner Regulation National Law (Western Australia) in the medical profession (other than as a student). Consequently, all medical practitioners in WA, even an intern on their first day of work or our incumbent Director General of WA Health, are required by the proposed VAD legislation to:

- inform the patient whether they accept or refuse the request, in accordance with s19(3), (4) or (5);
- provide information to the patient within two business days, in accordance with s19(4)(b) or (5)(b);
- record the request and acceptance or refusal in the patient's medical record, including reason for refusal and whether patient provided with required information, in accordance with s20; and
- inform the VAD Board by submitting appropriate forms, in accordance with s21.

In their haste to draft the WA Bill, the government has failed to appropriately manage the burden placed on the medical profession, providing a simplistic approach to such a complex area. Consequently, all medical practitioners must take some form of action on a VAD request irrespective of their experience, current role or views on the issue.

- There *does not* need to be an existing therapeutic relationship between the patient and the medical practitioner;
- The request *does not* need to be made in the context of a medical consultation or therapeutic conversation between the medical practitioner and the patient;
- The patient *does not* need to meet VAD eligibility requirements.

All medical practitioners *must comply* with these provisions. Failure to comply may constitute professional misconduct or unprofessional conduct and/or result in severe financial penalties.

INDEPENDENCE OF DOCTORS & THE NEED FOR A PRE-EXISTING THERAPEUTIC RELATIONSHIP

The WA Bill must ensure that the two or more doctors who are involved in a patient's VAD journey are independent of one another. This means the two doctors should have no pre-existing or current business/financial/working arrangements as well as no close personal relationship. Further, if neither doctor has a pre-existing relationship with the patient, they should seek corroboration from family and treating doctors.

In its VAD Bill survey, the AMA (WA) asked (members and non-members):

Do you think that the two doctors approving VAD need to be independent of each other in the sense that they do not have a business or personal relationship, other than collegiate?

Bottom line: **Very large majority – patients deserve an independent second opinion as part of the VAD process, and there is no appetite for clinics dedicated to this function.**

Do you think if neither of the two doctors have a pre-existing therapeutic relationship with the patient, referral to a third independent specialist, or the patient's usual doctor, should be mandated as an extra safeguard?

Bottom line: **Large majority – a third doctor, preferably one who knows the patient, should be involved if neither of the two VAD doctors have had previous contact with the patient.**

WA Bill: A lack of safeguards means a case could foreseeably arise where one doctor works for the other or both work in the same practice, which presents an inherent conflict.

There is no requirement that the doctor must know the patient accessing VAD, or must speak with their family or support network about their VAD request. Without the valuable insight provided by a pre-existing doctor-patient relationship, issues such as loneliness, 'not wanting to be a burden', prior history of domestic violence or other social issues, in addition to the familial minefield of financial beneficiaries, are very difficult to establish and discount, for any doctor. The requirement of a truly independent doctor is a safeguard that would mitigate somewhat against these difficulties, and therefore must be an express provision in the legislation.

PROCESS ISSUES

PERMIT APPROVAL & VAD BOARD

A fundamental safeguard to any VAD regime is a body with oversight and approval functions for each VAD request, in conjunction with an appropriate timeframe between an individual's first request and VAD administration.
WA's VAD Board *must* have explicit powers and be required to:
- **issue a permit only after due consideration to ensure that decisions are clinically appropriate, legal, robust and supported by scientific evidence;**
- **provide an extended timeframe, beyond the currently proposed nine days, from first request to VAD;**
- **monitor individual requests to prevent doctor-shopping and assist individuals who are deemed ineligible for VAD.**

This should include intervention to ensure current treatment and clinical management strategies are appropriate, decision-making capacity assessment has been complied with, and there has been an assessment by a specialist in the disease or condition that the patient is suffering from.

In its VAD Bill survey, the AMA (WA) asked (members and non-members):

Do you think there should be a permit approval process BEFORE access to VAD, as is the case in Victoria?

***Bottom line*: Large majority – permits should be required as in Victoria.**

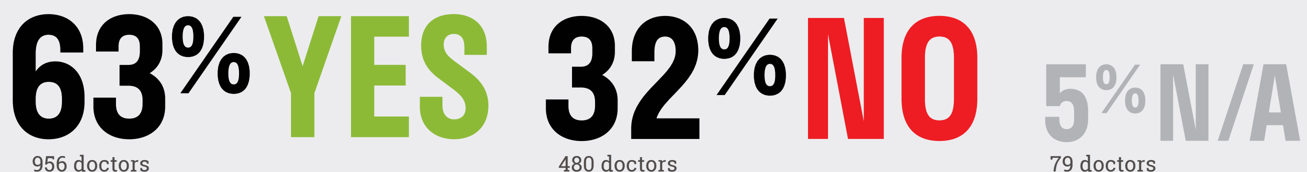
Should there be a limit on the number of doctors the patient can see while seeking VAD?

***Bottom line:* Significant majority – patients should not be able to seek unlimited opinions on VAD.**

Do you think that nine days is an appropriate or safe minimum timeframe in which to complete required assessment to access VAD, especially where there is no pre-existing doctor-patient therapeutic relationship?

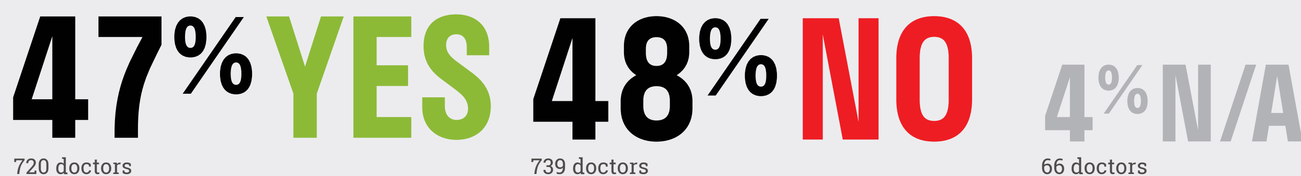
***Bottom line:* Majority – nine days is not long enough, especially given the lack of proposed safeguards.**

Do you think that given the volatile nature of a patient's state of mind around terminal diagnosis and end of life care, a longer "cooling off" period should be required?



***Bottom line:* Significant majority – longer cooling-off period is required.**

Do you think that imminent death as a result of the disease is a reasonable reason to hasten the VAD process?



***Bottom line:* Evenly split vote on whether imminent death should hasten the VAD process.**

Victorian Act: The Victorian Ministerial Advisory Panel considered a permit approval system would provide an opportunity for an independent review to ensure process compliance. Consequently, before prescribing the VAD medication, the coordinating medical practitioner must apply for a permit to be issued by the Department of Health and Human Services. The permit application must be processed within three business days. [VAD Act 2017 (Vic), s48 & 49].

WA Bill: No pre-VAD permit system exists. While the Victorian permit system is primarily bureaucratic in its function as opposed to a clinical review or decision-making body, the AMA (WA) maintains that a Board with oversight and decision-making functions would provide for a safer system.

Given the current proposed eligibility criteria outlined in the WA Bill, especially concerning disease prognosis and timeframe to death, a nine-day minimum between the first and final assessment is very short. The accompanying risks of the brief time period are amplified in the absence of a Victorian-style pre-VAD administration permit approval, which provides a degree of independent oversight to ensure process compliance.

Without a permit, even if it is just a process oversight mechanism, a number of touted 'safeguards' in the WA Bill may only be validated (or invalidated) after an individual has died as a result of VAD.

DECISION-MAKING CAPACITY

The WA Bill should include a mandatory referral to a psychiatrist, or appropriately qualified health professional, for mental health/or capacity assessment before access to VAD.

In its VAD Bill survey, the AMA (WA) asked (members and non-members):

Do you think a referral to a psychiatrist for mental health and/or capacity assessment should be mandatory before access to VAD?

***Bottom line:* Majority – capacity should be confirmed, not assumed.**

Fundamental to whether an individual can access VAD, is their decision-making capacity. Assessment of decision-making capacity at the end of life is complex. Capacity may be affected by the treatments involved in managing the illness or in the relief of pain as part of appropriate palliative care or condition management.

The WA VAD Bill states that all patients are presumed to have decision-making capacity in relation to VAD unless the patient is shown not to have that capacity. [VAD Bill 2019 (WA) s.6(3)]

In its submission to the Parliamentary Joint Select Committee, the RANZCP WA Branch stated: "Where there is some question regarding capacity or the potential of treatable mental illness, then the RANZCP WA Branch would support a framework in which it is mandatory to consider psychiatric assessment."

TIMEFRAME TO DEATH & DISEASE PROGNOSIS

The WA Bill should ensure that for a patient to access VAD, their disease must be incurable and it must be expected to cause death within weeks or months, not exceeding six months, or 12 months for neurological conditions.

In its VAD Bill survey, the AMA (WA) asked (members and non-members):

Do you think that death needs to be EXPECTED rather than PROBABLE within the timeframe?

829 doctors | 612 doctors | 92 doctors

Bottom line: **Majority support for consistency with Victorian position.**

Do you think that, as in Victoria, the disease should be reasonably regarded as incurable before patients can access VAD?

1158 doctors | 308 doctors | 57 doctors

Bottom line: **Large majority – disease should be incurable to access VAD.**

WA's expansive VAD eligibility threshold sets the bar too low, particularly when considering the other lack of safeguards that are currently proposed, including specialist knowledge in disease or the need to have two independent medical practitioners assessing eligibility.

WA Bill: Proposes eligibility for VAD to be assessed on the basis that the disease will, on the balance of probabilities, cause death within a period of six months. [VAD Bill 2019 (WA) s15(1)(c)(ii)].

Victorian Act: Presents the concept of proximity to death and state of condition expected to cause death, in language and criteria that are more restrictive than the criteria outlined in the WA VAD Bill.

The requirement that the disease, illness or medical condition is "expected to cause death within weeks, not exceeding six months", as opposed to "on the balance of probabilities, cause death within a period of six months", means that there must be a greater degree of certainty that death will occur in the Victorian timeframe. [VAD Act 2017 (Vic), s9(1)(d)(iii)]

Further, in Victoria, the disease must be reasonably regarded as "incurable", a requirement that is absent in WA. This may be due to complexity around what can be regarded as curable, but it does undoubtedly widen the scope, possibly in some unintended broad ways.

Fundamentally, it means it is possible for someone with a condition that can be easily treated and cured to access VAD, which is something beyond what the Parliament and the community are probably expecting and something a majority of our survey respondents oppose.

SAFEGUARDS TO PROTECT AGAINST ABUSE & COERCION

All potential conflicts of interest must be addressed by the WA Bill. It must be clear that witnesses have to be completely independent of, and unconnected to, the doctors involved in the process (e.g. not employed by the doctors).
The government must enable pathways and support services to better detect and manage patients at risk of coercion. Contacting next of kin, allowing one family member to be a witness, and involving the patient's usual doctor would help to identify these risks for vulnerable populations, such as those in aged care. Operators of health facilities and their employees or contractors should not be allowed to act as witnesses.

In its VAD Bill survey, the AMA (WA) asked (members and non-members):

Do you think that the two witnesses to the patient's written request for VAD need to be independent of the doctors involved, in the sense that they do not have a business or personal relationship with the doctors?

1232 doctors | 236 doctors | 61 doctors

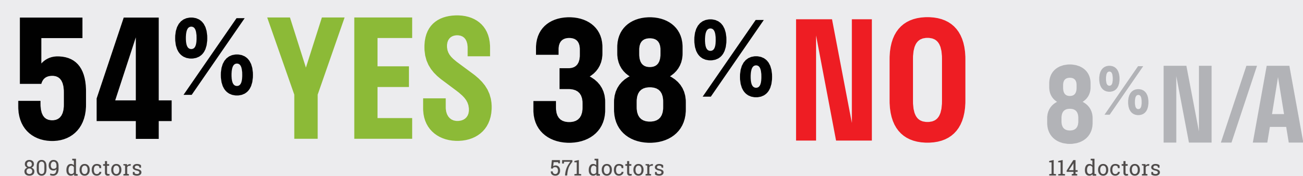
Bottom line: **Very large majority – witnesses should not work for the doctors.**

Do you think that there are certain groups of vulnerable patients, such as the elderly, for whom next of kin verification should be mandated?

955 doctors | 470 doctors | 90 doctors

Bottom line: **Significant majority – next-of-kin contact should be mandated for particularly vulnerable groups e.g. those in aged care.**

Do you think a discretionary referral by the two doctors is an adequate mechanism to detect abuse by carers or other domestic/elder abuse, deception, identity theft, financial incentives, and other non-medical issues?



809 doctors | 571 doctors | 114 doctors

Bottom line: **Majority – the two doctors can be responsible for detecting non-medical factors.**

The Final Report of the Select Committee into Elder Abuse found that there are up to 75,000 older people at risk of elder abuse in WA. Legislative safeguards are essential to protecting this vulnerable group of individuals, particularly when the community in general is not well educated on the specific signs of elder abuse, nor of the extent of the problem in the community.

The State Government must address elder abuse and patients at risk of coercion.

The requirement that there be witnesses to a patient's

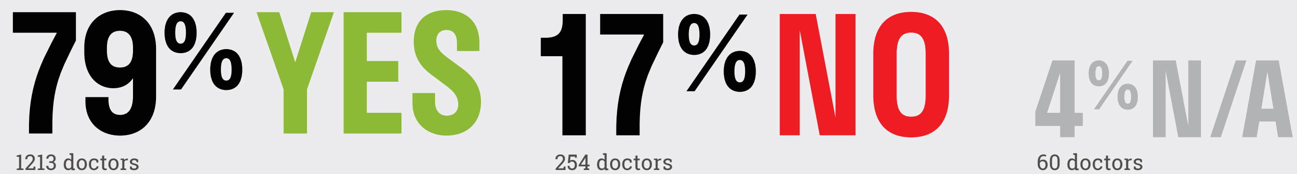
Continued on page 14

NATIONAL CONSISTENCY

The WA Bill should reflect the safer model provided by the Victorian legislation and ensure a nationally consistent approach to VAD.

In its VAD Bill survey, the AMA (WA) asked (members and non-members):

Do you think that any WA law regarding VAD should be consistent as far as possible with all states that implement VAD, so that patients and practitioners are dealing with the same laws, regardless of which state they access the VAD process from?



1213 doctors | 254 doctors | 60 doctors

***Bottom line*: Large majority – nationally consistent laws are preferred to prevent confusion and jurisdiction shopping by patients.**

Victoria's VAD scheme started to allow, under certain conditions, Victorians to end their lives from June 2019. The WA Ministerial Expert Panel looked to Victoria as a useful guide but pointed to WA's larger geographical area and smaller, more diverse population, to make recommendations "appropriate for Western Australia".

WA Bill: Differs from Victorian legislation in a number of areas. For a process that requires oversight, scrutiny and data collection to protect public safety, nationally inconsistent and fragmented legislative regimes prevent clear and consistent nationwide monitoring.

National consistency, particularly when there is a national registration and accreditation system for registered health practitioners, is important to ensure consistent practice and monitoring standards. A nationally consistent approach to VAD also prevents VAD "preferred jurisdiction" and protects doctors and patients who move interstate or who work or utilise health services across the country.

Continued from page 13

SAFEGUARDS TO PROTECT AGAINST ABUSE & COERCION

written request for VAD, provides a safeguard for people who may be vulnerable to abuse and coercion and is aimed at ensuring witnesses do not have a conflict of interest in witnessing the declaration.

However, the WA VAD Bill's restrictions on eligible witnesses exclude beneficiaries, all family members and the coordinating and consulting practitioner, which raises two issues of concern:

- It is possible that a vulnerable individual can access VAD without next of kin being aware of the request, the approval and administration of VAD.
  Victoria's witness requirements do not prohibit all family involvement in the VAD process, as not more than one witness may be a family member of the person making the written declaration, therefore not discounting all family involvement in the process. [VAD Act 2017 (Vic), s35(2)]
- The WA Bill [s42(2)] fails to exclude individuals who have a business or personal relationship with the doctor, or a relationship with the patient that may make it inappropriate for them to witness a VAD request.

Victorian safeguards exclude individuals directly involved in providing health services or professional care services to the person making the declaration, or responsible for the day-to-day operation of any health facility at which the person making the declaration is being treated or resides.

ADMINISTERING VAD

The WA VAD Bill should provide for Directly Observed Administration through a service coordinated by the VAD Board. This is the best way to provide sufficient oversight to ensure VAD eligibility requirements are enduring up to the point of administration and to maintain strict control over VAD substances.
In the event that self-administration at home is permitted, there must be safeguards implemented to ensure enduring eligibility and administration should only be by the patient themselves to ensure it is voluntary, unless they are prevented by incapacitation.

In its VAD Bill survey, the AMA (WA) asked (members and non-members):

Do you think that it is reasonably safe for a patient who has been approved for VAD to store the substance at home indefinitely prior to administration or death from other causes?

376 doctors 1100 doctors 48 doctors

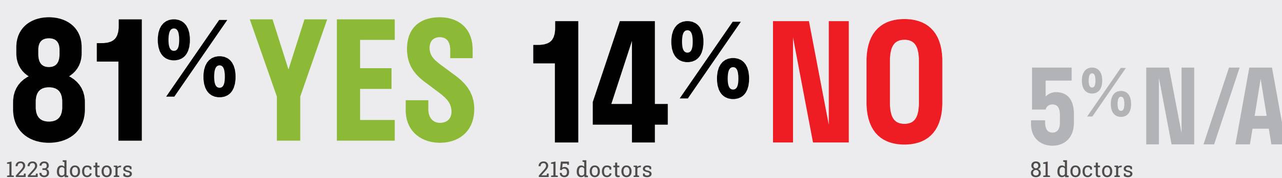
Bottom line: **Large majority – keeping the substance at home indefinitely is unsafe.**

If a significant period, say three months, elapses after dispensing, should the patient be reassessed for capacity, to ensure their request is enduring, that there is lack of coercion, and that they act voluntarily?

1204 doctors 228 doctors 81 doctors

Bottom line: **Very large majority – reassessment for capacity after three months is advisable.**

Do you think that administration should be only by the patient themselves to ensure it is voluntary, unless they are prevented by incapacitation, as in Victoria?



1223 doctors 215 doctors 81 doctors

Bottom line: **Very large majority – voluntariness can only be assured by self-administration; doctors prefer Victorian model.**

The safest model for delivery of VAD would be a government-run, VAD Board-coordinated service that included a facility for the delivery of VAD as well as an outreach service for patients in rural and regional areas and patients who choose to die at home.

WA Bill: To be eligible for VAD, an individual must have decision-making capacity, act voluntarily and without coercion, and their request for VAD must be enduring.

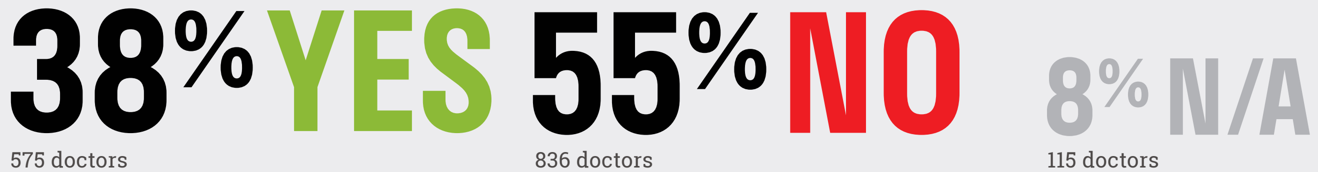
None of these requirements can be satisfied at the point of self-administration, if the patient can store the substance at home indefinitely prior to administration. It also increases the risk of VAD substances being abused or sold for use other than for the person who has been approved for VAD. S4 and S8 drugs currently stored at home by these patients are not infrequently misappropriated in the community.

TELEHEALTH & THE COMMONWEALTH CRIMINAL CODE

The State Government needs to strictly define the proposed operation and implications of "audiovisual communication" as a means of being assessed for VAD. The WA Government must also seek and publish advice on the interaction of the Commonwealth Criminal Code and the WA VAD Bill, and expressly indemnify doctors for any Commonwealth penalty that flows from actions taken under legislation if enacted.

In its VAD Bill survey, the AMA (WA) asked (members and non-members):

Do you think whatever the legality of practice at Commonwealth law, that video calls (e.g. Skype) should be allowed for ALL consults in this process?



575 doctors 836 doctors 115 doctors

Bottom line: **Majority – at least some face-to-face assessment is required.**

Do you think there are unusual situations such as remoteness, where video calls should be allowed for some consults in this process?

1169 doctors 296 doctors 71 doctors

Bottom line: **Large majority – in certain situations, some consultations of the VAD process conducted by video call would be appropriate.**

Do you think that the State should indemnify doctors for any Commonwealth penalty that flows from actions taken under this legislation?

1304 doctors 130 doctors 97 doctors

Bottom line: **Very large majority – if the State wants VAD, it needs to indemnify doctors for any Commonwealth legal action that could result.**

Telehealth currently offers Western Australians living in rural and remote WA the opportunity to access healthcare services in limited circumstances. Clinical safety, technology and service capacity are some of the reasons that telehealth services are only available for certain specialist services.

The WA Bill introduces an expansive system of "audiovisual communication" for VAD. The AMA (WA) contends that it would be impossible for any medical practitioner to assess an individual as eligible for VAD services via "audiovisual communication", as it is limited clinically in numerous ways, including:

- Appropriate expectations regarding the type of diagnosis that can be provided via audiovisual communication;
- Reviewing and monitoring clinical responsibilities, acknowledging the fact that medical professionals will potentially be responsible for a large number of patients over an expansive range of locations;
- Establishing appropriate training and workforce support systems;
- Support for health professionals in the event of a medical error that is a result of an inherent limitation in the provision of care through telehealth services, where physical examination is not possible.

If the WA Bill is passed and audiovisual communication is permitted, patients may not be able to secure a timely appointment with their doctor, but will be able to access VAD.

Advice from the Victorian Government states that "providing patients with information about voluntary assisted dying over the telephone, via email or through the use of telehealth could be a breach of the Commonwealth Criminal Code." Section 474.29A of the Commonwealth Criminal Code makes it an offence to use a carriage service for distributing material that encourages or provides practical information about suicide.

While the WA Bill states that VAD is not suicide (s11), in the event of a conflict between state and federal law, federal law prevails. Moreover, the explanatory memorandum in the WA Bill expressly states that s11 is for the purposes of the law in WA.

Doctors cannot be left in a position where they are threatened with criminal charges for providing VAD-related information, which could include those doctors who are not participating, but responding to a VAD request only.

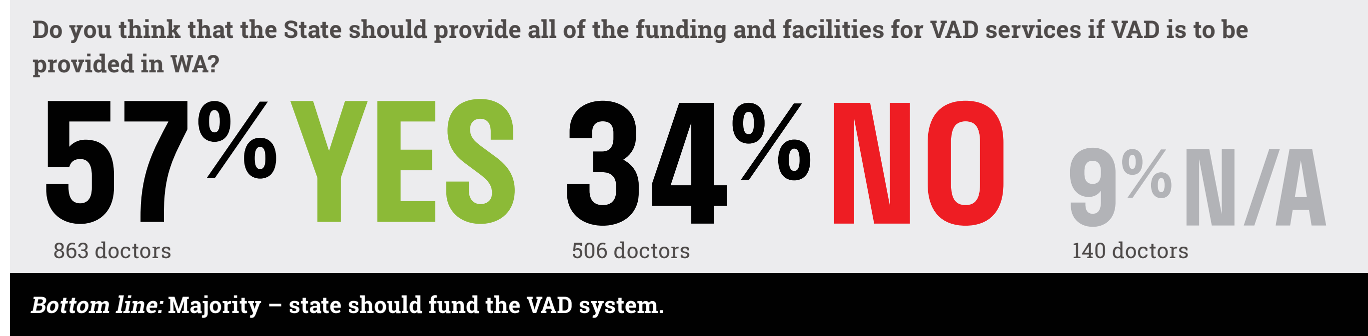
FUNDING ISSUES

REGIME OF FEES & CHARGES

If the WA Bill is legislated, VAD services should be publicly funded and administered with no out-of-pocket costs to patients. This requires a legislative regime that prohibits entrepreneurial gain.

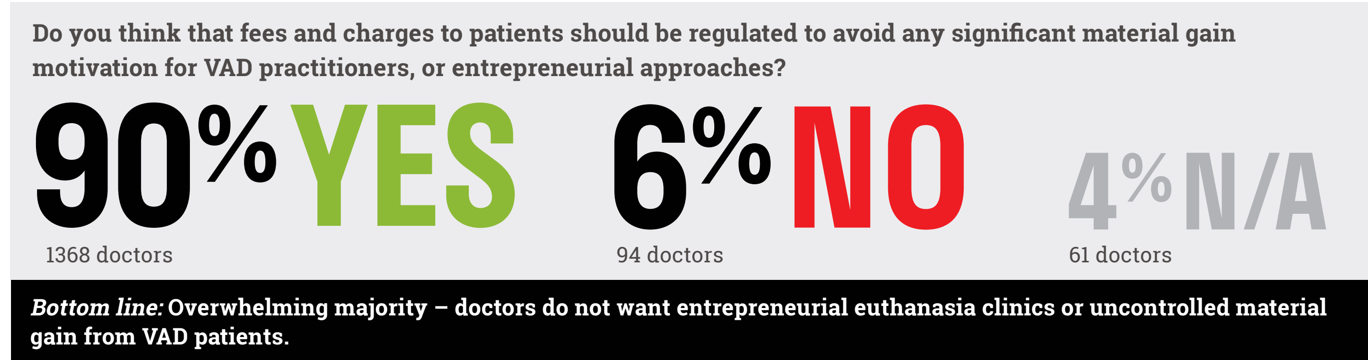
In its VAD Bill survey, the AMA (WA) asked (members and non-members):

Do you think that the State should provide all of the funding and facilities for VAD services if VAD is to be provided in WA?



Bottom line: **Majority – state should fund the VAD system.**

Do you think that fees and charges to patients should be regulated to avoid any significant material gain motivation for VAD practitioners, or entrepreneurial approaches?



Bottom line: **Overwhelming majority – doctors do not want entrepreneurial euthanasia clinics or uncontrolled material gain from VAD patients.**

To prevent motivation of material gain, there should be provisions to limit patient fees, and entrepreneurial business structures (e.g. commissions should be expressly prohibited by the WA Bill). Independence of the doctors in the process is one important factor, but given the vulnerability of these patients, a strict non-profit regime should be in place.

PALLIATIVE CARE

If legislated in WA, all patients requesting VAD must be assessed for their palliative care needs and the adequacy of any current management as part of the process.

Palliative care is a human right. The VAD Bill must be accompanied by complete per capita funding to objective industry standards for resources and training in palliative care across WA.

In its VAD Bill survey, the AMA (WA) asked (members and non-members):

Do you think that all patients should be offered accessible palliative care prior to, or at the same time as VAD?

91% YES — 1398 doctors

6% NO — 97 doctors

2% N/A — 35 doctors

Bottom line: **Overwhelming majority – palliative care must be accessible, both financially and geographically, and delivery must be timely.**

Do you think that conversations and information about palliative care should be provided by palliative care specialists or by doctors with training in palliative care?

80% YES — 1208 doctors

16% NO — 242 doctors

4% N/A — 68 doctors

Bottom line: **Very large majority – palliative care must be accessible; balanced information should be provided by those with expertise.**

Do you think that the State Government should provide special support to patients outside metropolitan areas to ensure there is equitable access both to healthcare and to VAD services as part of the VAD Bill?

90% YES — 1370 doctors

6% NO — 84 doctors

5% N/A — 72 doctors

Bottom line: **Overwhelming majority – palliative care services must be accessible in regional and remote areas of WA. Regional patients deserve the same level of access and support as those in metropolitan areas.**

The AMA (WA) advocated for significant increases in spending on palliative care in WA, long before the debate on voluntary assisted dying (VAD) began. Our repeated calls along with those of others in the sector, have gone largely unfulfilled by governments of all political persuasions.

However, on the eve of the State Budget 2019-20, the McGowan Government announced a $41 million increase for palliative care and end-of-life choices – spread over five years. With $5.8 million of that funding earmarked for end-of-life choices, this package brings the total investment by the State Government for palliative care services over the next four years to $206.2 million. This is around a third to a half of what we are told we should have.

For example the University of Notre Dame's Chair of Palliative Medicine Research Professor David Kissane AC says WA needs an additional $100 million a year spent on palliative care over and above the circa $50 million allocated per annum.

It has been reported that Western Australia has:

- the lowest number, per capita, of inpatient palliative care beds in Australia;
- just 15 full-time equivalent palliative care specialists, when we are in need of 50 or more to match Victoria per capita; and

- just one in three Western Australians needing palliative care get timely access to these services in the format of their choice.

It is therefore disingenuous to talk of removing suffering, unless we also fix palliative care. We know that most patients will never access VAD. However, most will need palliation, including those who do want VAD.

While GPs form the backbone of palliative care services, they are often reluctant to become involved without the eco-system of back-up that palliative care specialists and community nurses provide. As a result, the regions are especially impacted by the lack of adequate palliative care services.

The WA Palliative Medicines Specialist Group outlines specialist support in the regions:

- Pilbara: one visit a year;
- Kimberley: six one-week visits per year;
- Geraldton: 10 single-day visits per year; St John of God Hospital Geraldton offers in-patient care at an eight-bed hospice for both public and private patients.
- The Wheatbelt: 12 single-day visits per year;
- Kalgoorlie: one day per month;
- Esperance: once every three months;
- Bunbury: two specialists run a 10-bed hospice and an outpatient clinic;
- Albany: one palliative care physician funded for six hours a week, with only three hours a week to run an outpatient clinic. Albany Community Hospice is an eight-bed in-patient palliative care service open to both public and private patients.

One of the key concerns is ensuring that long into the future, decision-makers do not view VAD, even subliminally, as more cost-effective, practicable or indeed more compassionate than the adequate provision of palliative and other care services. Properly funded palliative care will continue to serve most patients with terminal conditions very well, and VAD should never be discussed with a patient without the availability of palliative care and other management options being assured first. Patients may not want palliative care, but they certainly need to have that option accessible and it needs to be the government's priority. ■

References available upon request.

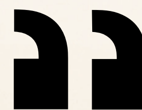
Survey percentages have been rounded to the nearest whole number.

DOCTORS SHARE THEIR VIEWS

COMMENTS FROM THE AMA (WA) VAD SURVEY 2019

The lack of appropriate palliative care is, I believe, a key driver in the development of VAD. Rather than improving palliative care for the population of WA, which will benefit the many, we instead are concentrating resources on the few.

Palliative care should be available, accessible and offered but this does not require a change to the proposed legislation as the requirement to inform about it is sufficient and the patient can decide if they wish to proceed. Ensuring it is available is a health system issue, not one for this legislation. NB: Many GPs offer excellent palliative care without it being under the banner of formal palliative care.



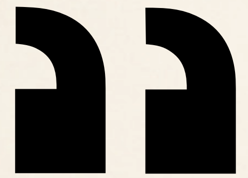
Patients should have a palliative care and psychiatric assessment prior to VAD, provided by a consultant level medical professional.

Palliative care should be offered to all patients with terminal conditions – these services are invaluable and should be expanded. However, a patient should not be required to receive palliative care in order to have VAD; this is a matter of personal choice for the patient.

DOCTORS SHARE THEIR VIEWS

COMMENTS FROM THE AMA (WA) VAD SURVEY 2019

There are so many inducements and secondary benefits to VAD that I cannot see it as ever being safe. The proposed VAD laws should be scrapped.



The doctors involved are expected to detect possible coercion/abuse. You cannot pick up something you do not know. You will never diagnose a case of multiple sclerosis if you have not seen or read about it. How many of us even as treating doctors have picked up abuse in a relationship, if the victim does not speak up? How often have we not even suspected it?

As a cancer specialist who is intimately involved with death due to terminal disease, I have been proven wrong in my projected time scales again and again. Death is not as predictable or expected as morning and evening.

We cannot design a perfect screening system, we must aim for reasonable.

A psychiatric evaluation should be mandatory.

The independent VAD panel should be the ones making the final decision including investigation of coercion.

VAD is a serious and irreversible option for a patient to pursue and for a medical practitioner to provide/perform/enable. Just like there is rigorous training and multiple checks and permits required in all other areas of medicine, so too should there be for VAD.

I strongly believe that all VAD cases should be approved by an independent panel, not by any medical practitioners involved in the assessment. This could mirror either late term abortion or mental health tribunal panels.

Very dangerous, to have two 'qualifying doctors' who do not even know the patient. Six hours of video training is laughable; wait for the wrongful death suits.

You don't necessarily need to be an oncologist for example to know your patient is dying of metastatic disease.

Ideally – three doctors should be involved in the process. One is applying doctor; second, the specialist involved in care; and third is the independent psychiatrist (for capacity assessment and mental health disorders screen) for everyone.

Why should VAD be an exception to best practice, which is to fully inform our patients about all their options? Our duty of care is to make sure patients are fully informed about their options for treatment, whatever the condition.

The VAD discussion needs to be initiated by the patient every time. It is not a discussion medical practitioners should be initiating at all.

DOCTORS SHARE THEIR VIEWS

COMMENTS FROM THE AMA (WA) VAD SURVEY 2019

In my experience as a GP, domestic/elder abuse and influence is often very subtle. It is not necessarily 'detectable' and patients can be coached or influenced to say the right things in order to avoid 'detection'.

The WA legislation seems to have respect for doctors that the AMA apparently does not. If the two doctors are true doctors – qualified and registered – who have gone through years of peer review to get their qualifications and registration, then this should be enough. The question is, how confident is the AMA in its doctors and if it isn't, then what it is it doing about it?

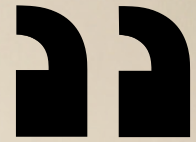
Within the Bill there may be areas of ambiguity. Perhaps the doctors who involve themselves in VAD should indemnify themselves through greater premiums with their own MDOs, like other practitioners whose work involves increased risk.

Standard indemnity arrangements should continue for VAD activities. If the doctor is salaried by the State and the patient is public then state indemnity should continue to apply. If it's private practice, then the doctor's MDO should cover.

Again, if you are burdening doctors with this task, they should be able to work safely, not fearing the consequences under the law of the country that is making them do it.

For those with a conscientious objection there should be an opt out clause. The doctor who chooses this path should then be obliged to say he does not agree on conscientious grounds and should take no further part in advising the patient. He/she should offer the patient the option of continuing care at their hand, or suggest they find another doctor. This more or less presumes a liability for doctors to publicly declare their conscientious position.

There is clearly potential for patients' decision-making to be influenced by the way in which this option is presented to them. Many patients will take decisions based on their trust in a health professional's opinion or even feeling they should comply.



Evidence (including local WA research) shows that doctors and other health professionals are reluctant to discuss end of life issues such as palliative care and goals of patient care. Any further barrier to discussion of these issues should be avoided (e.g. a doctor who is concerned about having advance care planning discussions with a patient in case they are misinterpreted as initiating discussion about voluntary assisted dying).

Doctors in training should not be obliged. They do not necessarily have the skills to be able to discuss thoroughly or the experience to understand alternatives or implications.

Doctors are notoriously poor at predicting life expectancy. There needs to be objective evidence of physical decline before a death is EXPECTED.

If the arguments to support the provision of VAD are cogent then it follows that the Commonwealth Law will need to be amended, and this will be achieved.

I think the probability of death should be removed. This requirement excludes people with severe but not immediately terminal illnesses that cause significant distress and disability (e.g. catastrophic spinal injuries, slowly progressive neurodegenerative diseases etc.). In my experience, these are the patients who are more likely to have a persistent desire for death, whereas patients expected to die within 6-12 months, in my experience, typically no longer have an ongoing desire for death after they receive adequate palliative care.

This will be an enormous burden for doctors who regularly deal with dying patients (e.g. Oncology, palliative care) and the timeframe is wildly unrealistic.

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