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The Australian & New Zealand Society of Palliative Medicine Inc. ABN 54 931 717 498

The Hon. Greg Donnelly MLC
Deputy Opposition Whip in the Legislative Council
Parliament House
Macquarie Street
Sydney NSW 2000

21 September 2017

Dear Mr Donnelly

Proposed NSW legislation on assisted dying

We are writing to you on behalf of the Australian and New Zealand Society of Palliative Medicine (ANZSPM) with regard to the proposed draft NSW legislation on assisted dying. Our purpose is to inform you of the published views of our members with respect to euthanasia and physician assisted suicide.

ANZSPM is a specialty medical society that facilitates professional development for its members and promotes the practice of palliative medicine, in order to improve the quality of care for people with life threatening illness. Our members are medical practitioners who provide care for people with a life-threatening illness and include palliative medicine specialists, palliative medicine training registrars and other doctors such as general practitioners, oncologists, haematologists, intensivists, psychiatrists and geriatricians. Ninety-three (93) of our members are currently based in NSW, out of nearly 500 members across Australia and New Zealand.

ANZSPM has published a *Position Statement on Euthanasia and Physician Assisted Suicide*, produced following a survey of our members to ensure that the statement is reflective of member views, with the most recent review in late 2016. The Position Statement is available on the ANZSPM website: www.anzspm.org.au (also **attached** for reference).

Key points in the ANZSPM Position Statement that we wish to draw your attention to are:

- There remain significant deficits in the provision of palliative care in Australia, including in NSW as highlighted in the recent NSW auditor-general report (http://www.audit.nsw.gov.au/publications/latest-reports/palliative-care).
- ANZSPM advocates, and its members deliver, excellent quality care for people living with life threatening illness by proactive assessment, treatment and prevention of physical, psychological, social and spiritual concerns; and support for caregivers.
- For people who are requesting assisted dying, particular care is needed to ensure that access to high quality care that addresses symptom control and other issues, including specialist palliative medicine referral, is available.
- According to international best practice, the discipline of Palliative Medicine does not include the practices of euthanasia or physician assisted suicide.

- ANZSPM does not support the legalisation of euthanasia or physician assisted suicide, but recognises that ultimately these are matters for government to decide having regard to the views of the community and, critically, informed by appropriate research and consultation with the medical community, including palliative medicine practitioners.

Key recommendations:

The proposed legislation fails to address that the pressing need is to address those deficits in palliative care, that have far reaching and serious negative impacts on the quality of life and decision-making for people at the end-of-life and their carers. We commend the NSW Government for the recent investment of $100M in palliative care services, which is aimed to improve confidence and choice for people at the end of life, but more is needed.

We are concerned that the legislative proposal will divert attention away from the larger problem of service gaps for the broader population of people currently receiving end-of-life care in NSW, for whom the priority is access to high quality palliative care and support.

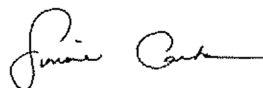
ANZSPM calls on the NSW Government and Members of the Legislative Council to continue to urgently focus their attention on health reform and investment which will immediately strengthen palliative and end-of-life care including:

- remedying shortages in the palliative care workforce (including in the specialist medical, nursing and allied health fields),
- ongoing training for the generalist health workforce,
- policy directions which support and value advance care planning and patient preference,
- initiatives to support high quality palliative care regardless of setting (hospitals, community, residential aged care) to ensure improved access to high quality care for all people with life threatening illness, and
- increased carer support including opportunity for quality respite care to address the important issue of the sense of being a burden which is a concern held by many people at the end of life.

We would appreciate the opportunity to meet with you in person to discuss these critical matters further. Please contact Simone Carton (Chief Executive Officer) on 0414 454 646 or by email simone.carton@anzspm.org.au to arrange a meeting.

Yours faithfully,

Prof Meera Agar
President



Simone Carton
Chief Executive Officer

Encl.
ANZSPM Position Statement on the Practice of Euthanasia and Physician Assisted Suicide

ANZSPM

Position Statement

The Practice of Euthanasia and Physician Assisted Suicide

Preamble

As the peak body for Palliative Medicine in Australasia, the Australia and New Zealand Society of Palliative Medicine (ANZSPM) has prepared this position statement reflecting the majority view of its members. ANZSPM acknowledges that, as with the diversity of opinion in the general and medical communities across Australia and New Zealand, there are divergent views on euthanasia and physician assisted suicide within its membership.

At the date of approval of this document, it is acknowledged that the practices of euthanasia and assisted suicide are illegal acts in both Australia and New Zealand, although these practices remain on the political and legislative agenda in several jurisdictions.

Background

ANZSPM is a specialty medical society that facilitates professional development and support for its members. ANZSPM promotes the discipline and practice of Palliative Medicine in order to improve the quality of care of patients with palliative diagnoses, and support their families.

ANZSPM members are medical practitioners. They include Palliative Medicine Specialists, doctors training in the Palliative Medicine discipline, General Practitioners (GPs) and doctors who are specialists in other disciplines such as oncology.

In preparing this statement, ANZSPM acknowledges:

(a) the Australian Medical Association Position Statement *Euthanasia and Physician Assisted Suicide* published in November 2016;

(b) the New Zealand Medical Association Position Statement *Euthanasia* approved 2005; and

(c) the *Euthanasia and Physician Assisted Suicide Position Statement* published by Palliative Care Australia and updated August 2016.

Statement

1. Palliative Care is an approach that improves the quality of life of patients and their families facing the problems associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual.[1] In accordance with best practice guidelines internationally,[2] the discipline of Palliative Medicine does not include the practices of euthanasia or physician assisted suicide. ANZSPM activities are limited to the Palliative Medicine discipline.

2. ANZSPM does not support the legalisation of euthanasia and physician assisted suicide, but recognises that ultimately these are matters for government to decide having regard to the will of the community and, critically, informed by appropriate research and consultation with the medical community, including palliative medicine practitioners.

3. If these practices are legalised in the Australasian context, ANZSPM endorses international guidelines reaffirming that they are not part of best practice palliative care. ANZSPM will continue to advocate for and, through its members, deliver good quality care for the dying, and this does not include the practice of euthanasia or physician assisted suicide.

4. Patients have the right to refuse life sustaining treatments including the provision of medically assisted nutrition and/or hydration. Refusing such treatment does not constitute euthanasia.

5. Good medical practice mandates that the ethical principles of beneficence and non-maleficence should be followed at all times. The benefits and harms of any treatments (including the provision of medically assisted nutrition and/or hydration) should be considered before instituting such treatments. The benefits and harms of continuing treatments previously commenced should be regularly reviewed. Withholding or withdrawing treatments that are not benefitting the patient, is not euthanasia.

6. Treatment that is appropriately titrated to relieve symptoms and has a secondary and unintended consequence of hastening death, is not euthanasia.

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[1] WHO (2002) http://www.who.int/cancer/palliative/definition/en/. Accessed on 11 October 2009

[2] Such as the European Association for Palliative Care's White Paper on standards and norms for hospice and palliative care in Europe: part 1, *European Journal of Palliative Care*, 2010, 17(1): http://www.eapcnet.eu/LinkClick.aspx?fileticket=uW_JGKKvpZI%3d&tabid=167

7. Palliative sedation for the management of refractory symptoms is not euthanasia.[3]

8. Requests for euthanasia or assisted suicide should be acknowledged with respect and be extensively explored in order to understand, appropriately address and if possible remedy the underlying difficulties that gave rise to the request. Appropriate ongoing care consistent with the goals of Palliative Medicine should continue to be offered.

9. When requests for euthanasia or assisted suicide arise, particular attention should be given to gaining good symptom control, especially of those symptoms that research has highlighted may commonly be associated with a serious and sustained "desire for death" (e.g. depressive disorders and poorly controlled pain). In such situations early referral to an appropriate specialist should be considered.[4 5]

10. Despite the best that Palliative Care can offer to support patients in their suffering, appropriate specialist Palliative Care to remedy physical, psychological and spiritual difficulties may not relieve all suffering at all times.

11. ANZSPM acknowledges the significant deficits in the provision of palliative care in Australia and New Zealand, especially for patients with non-malignant life limiting illnesses, those who live in rural and remote areas, residents of Residential Aged Care Facilities, the indigenous populations and those from culturally and linguistically diverse backgrounds.

12. ANZSPM advocates for health reform programs in Australia and New Zealand to strengthen end of life care by remedying shortages in the palliative care workforce (including in the specialist medical, nursing, and allied health fields), ensuring improved access to appropriate facilities and emphasising the role of advance care plans and directives.

13. ANZSPM advocates for increased carer support for respite care to decrease the sense of burden for many patients at the end of life.

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[3] http://www.biomedcentral.com/1472-684X/9/20, European Association for Palliative Care (EAPC) framework for palliative sedation: an ethical discussion, Accessed 8/3/2013.
[4] Breitbart W. Suicide risk and pain in cancer and AIDS patients. In: Chapman CR, Foley KM, eds. Current and Emerging Issues in Cancer Pain: Research and Practice. New York, NY: Raven Press; 1993:49-65.
[5] Chochinov HM, Wilson KG. The euthanasia debate: attitudes, practices and psychiatric considerations. Can J Psychiatry. 1995;40:593-602.

Definitions

Palliative Medicine is the study and management of patients with active, progressive, far-advanced disease for whom the prognosis is limited and the focus of care is the quality of life.[6]

Palliative Care as defined by the World Health Organization[7] is an approach that improves the quality of life of patients and their families facing the problems associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual.

Palliative care provides relief from pain and other distressing symptoms; it

- Affirms life and regards dying as a normal process;
- Intends neither to hasten nor postpone death;
- Integrates the psychological and spiritual aspects of patient care;
- Offers a support system to help patients live as actively as possible until death;
- Offers a support system to help the family cope during the patient's illness and in their own bereavement;
- Uses a team approach to address the needs of patients and their families, including bereavement counselling, if indicated;
- Enhances quality of life, and may also positively influence the course of illness; and
- Is applicable early in the course of illness, in conjunction with other therapies that are intended to prolong life, such as chemotherapy or radiation therapy, and includes those investigations needed to better understand and manage distressing clinical complications.

Euthanasia is the act of intentionally, knowingly and directly causing the death of a patient, at the request of the patient, with the intention of relieving intractable suffering. If someone other than the person who dies performs the last act, euthanasia has occurred.[8]

Assisted suicide is the act of intentionally, knowingly and directly providing the means of death to another person, at the request of the patient, with the intention of relieving intractable suffering, in order that that person can use that means to commit suicide. If the person who dies performs the last act, assisted suicide has occurred.[9]

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[6] Pallipedia: http://pallipedia.org/glossary/term.php?id=196. Accessed on 11 October 2009

[7] WHO (2002) http://www.who.int/cancer/palliative/definition/en/. Accessed on 11 October 2009

[8] Adapted from International Task Force on Euthanasia www.internationaltaskforce.org/definitions.htm. Accessed 11 October 2009

[9] Adapted from the International Task Force on Euthanasia www.internationaltaskforce.org/definitions.htm. Accessed 11 October 2009