

Dear Victorian Member of Parliament

We the 60 undersigned senior specialists from Melbourne teaching hospitals, write to you in regards to the Victorian Voluntary Assisted Dying (VAD) legislation, which was developed from the report from the ministerial advisory panel on Voluntary Assisted Dying (July 2017)<sup>i</sup>. As medical practitioners we can see many potential problems with the model set out.

We have deep concerns that if it is implemented, Victoria will see the misapplication of VAD to patients with undiagnosed mental illness, impaired capacity or who are under the influence of coercion or other unconscious motivations. The proposed safeguards against these issues may reduce but cannot prevent wrongful deaths as a result of the misapplication of the legislation.

Of most concern to us, the current model for VAD in Victoria does not require consideration of the presence of active mental illness as a contraindication to approving VAD and nor does it require the treatment of it. Mental illness is common in patients with a terminal illness and can significantly impact on their symptoms near the end of their life. Up to one third of cancer patients and those with

progressive degenerative neurological conditions experience depression. Suicidal thoughts are a common part of a depressive illness and depression is well known to impair decision making. Depression can be difficult to recognise, diagnose and treat. Even after training, GPs recognise only 39% of depressed patients in their practices<sup>ii</sup> and oncologists only 33% of their cancer patients<sup>iii</sup>. Despite high rates of depression in patients with terminal illness, experience in other jurisdictions where VAD is performed has shown that as few as 5% of patients are referred to a psychiatrist. We are concerned that the current plans for VAD in Victoria will allow depressed patients to choose to end their life where if their depression were adequately treated they may firstly be alleviated of some of their symptoms and secondly may instead choose to engage with active palliative care instead of seeking VAD.

A decision to access voluntary assisted dying is complex, requiring a person to have a well-developed capacity for abstract reasoning. Assessing decision-making capacity can be difficult and require repeated assessments over a prolonged period of time by a specialist clinician. At times, formal neuropsychiatric evaluation is required. We are concerned that the recommendations from the advisory panel allow assessment of capacity by doctors who are not experts in this area and with potentially just one consultation with the patient.

Patients with terminal illnesses, particularly older patients, are vulnerable to coercion in VAD requests<sup>iv</sup>. Coercion could potentially affect any stage of the VAD process from the initial request, whether the dose of life-ending medication is taken and when it is taken.

The exact prevalence of coercion is unknown and likely under-reported, however case studies demonstrate its existence in other jurisdictions with controls similar to those proposed in Victoria<sup>v</sup>. Unfortunately, different forms of abuse of the vulnerable is common in our communities, with up to 6% of all older adults and 25% of vulnerable adults experiencing some form of physical, emotional or financial exploitation each month<sup>vi</sup>. Given exploitation and abuse of the vulnerable is often subtle and hidden in the home, no safeguard or legislation can possibly prevent family or friends from coercing a patient to undergo VAD. Even in the absence of coercion it would be understandable for patients to come to think that they are a burden on their family and should end it all for their family's sake.

In the proposed Victorian VAD model, there will be no requirement for genuine engagement with palliative care services. Some people may access VAD without knowing fully how palliative care could address their concerns and relieve suffering whilst maintaining a sense of control over their situation. Under the proposed model, a person can apply for VAD if their illness causes suffering that cannot be relieved in a manner tolerable to them. Two doctors can make that assessment, neither of whom needs formal training in the management of terminal diseases. Most GPs, and indeed most specialists in many fields, do not have the training or the experience to know of and properly advise a patient about the best practice palliative care options available to them. Assessing suffering and the treatments available requires specialised skills, such as those of a palliative care physician, who could more readily address a patient's suffering.

Australia has very good palliative care services however many miss out due to inadequate resourcing. It is estimated that there is an unmet demand of palliative services care of up to 40%<sup>vii</sup>. Investment in palliative care will have a much greater impact for ending pain and distress for patients with terminal illnesses in our state than making VAD legal.

Determining how long a person has to live is not an exact science and is a challenge even for the most qualified doctors. The Victorian model provides for a patient to request assisted suicide if they are expected to die within 12 months. At 12 months, the margin for error significantly increases and many clinicians would find it a difficult assessment to make. Patients are at risk of ending their life when they could potentially have several more years to live.

Assisted suicide and euthanasia are public health care interventions. Australia's National Health and Medical Research Council has clear guidelines on the steps required to develop and implement a new intervention, including sufficient evidence to underpin it, pilot testing, and exploring the implementation and health resource costs. If it passes the parliament, Victoria's assisted suicide model will be legalised without any formal review of its application and impact. No other major health care intervention would be introduced in this way.

Other concerns that we have about the proposed model for VAD in Victoria include:

- the lack of requirement for involvement of the patient's primary care provider or specialist;
- the requirement for doctors to provide incomplete or

misleading information in the death certificate in that they are not to include the true cause of death (ingestion of lethal medicine)

- the recommendation that VAD not affect life insurance claims and the associated legal issues that will no doubt arise as well as the potential for financial exploitation of this situation;
- the dangers to others of having a lethal medication distributed to a potentially uncontrolled environment and
- the lack of success of full reporting of monitoring of VAD in other jurisdictions where it has been legalised<sup>v</sup>.

The UK House of Commons, two years ago, overwhelmingly rejected VAD legislation with even tighter controls to that being proposed in Victoria. The

conclusion of many in that parliament was that it couldn't be made safe, no matter how many safeguards were in place, and that wrongful deaths would result. We implore you to consider the protection of the most vulnerable members of our society and vote no to the proposed Victorian legislation. We believe that the focus of our parliament and health services should be turned to ensuring that all Victorians receive the highest standards of palliative care available through improved funding, organisation and research.

If there is the opportunity, we would be keen for some of us to be able to discuss these concerns with you further in person.

Yours sincerely,

Dr John Daffy on behalf of the 60 senior specialists

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<sup>i</sup> Ministerial Advisory Panel on Voluntary Assisted Dying, State of Victoria, Department of Health and Human Services, July 2017.

<sup>ii</sup> Thompson C, Kinmonth AL, Stevens L, Peveler RC, Stevens A, Ostier KJ, Pickering RM, Baker NG, Henson A, Preece J, Cooper D, Campbell MJ: Effects of a clinical-practice guideline and practice-based education on detection and outcome of depression in primary care: Hampshire Depression Project randomized controlled trial. *Lancet*. 2000, 355: 185-191. 10.1016/S0140-6736(99)03171-2.

<sup>iii</sup> Passik SD, Dugan W, McDonald MV, Rosenfeld B, Theobald DE, Edgerton S: Oncologists' recognition of depression in their patients with cancer. *J Clin Oncol*. 1998, 16: 1594-1600.

<sup>iv</sup> British Geriatrics Society Position Paper 'Assisted dying for the terminally ill Bill BGS response to the House of Lords'. [[http://www.bgs.org.uk/Publications/Position%20Papers/psn\\_terminally\\_ill\\_bill.htm](http://www.bgs.org.uk/Publications/Position%20Papers/psn_terminally_ill_bill.htm)]

<sup>v</sup> Physician-assisted suicide: a review of the literature concerning practical and clinical implications for UK doctors Madelyn Hsiao-Rei Hicks. *BMC Family Practice*, 2006 7:39

<sup>vi</sup> Cooper C, Selwood A, Livingstone G. The prevalence of elder abuse and neglect: a systematic review. *Age Ageing*. 2008 Mar;37(2):151-60.

<sup>vii</sup> Swerissen, H and Duckett, S., 2014, *Dying Well*. Grattan Institute ISBN: 978-1-925015-61-4