



The Royal Australasian
College of Physicians

Submission to Parliament of Victoria's Standing Committee on Legal and Social Issues Inquiry into End of Life Choices July 2015

The Royal Australasian College of Physicians (RACP) welcomes the opportunity to contribute to the Inquiry into End of Life Choices. The RACP is currently developing a position statement on quality care at the end of life and once this is completed will also develop a position statement on euthanasia, physician assisted dying and palliative sedation. While this policy work is underway, the RACP has drawn on the Australian and New Zealand Society of Palliative Medicine (ANZSPM) position statement on *The Practice of Euthanasia and Assisted Suicide*¹ and consultations with key Fellows and College bodies to inform this submission.

Executive Summary

Good end-of-life care is increasingly being recognised as an important aspect of medicine. It is defined as patient-centred, coordinated medical care with emphasis on rational investigation, rational prescribing that prioritises quality of life, as well as de-prescribing. Evidence indicates that good end of life care is associated with a number of positive outcomes for the patient, their family and carers, such as a better quality of life and lessened psychological burden.

Every patient has a right to access timely, equitable, good quality end-of-life care, including **access to specialist palliative care where necessary**. As clinicians we have a duty to deliver the best quality care to our patients at the end of their life. Palliative care provision does not include the practices of euthanasia or assisted suicide.

As our members' expertise is medical rather than legal, the RACP is particularly focusing on addressing the first part of the terms of reference for this inquiry – *the current practices being utilised within medical community to assist a person to exercise their preferences for the way they want to manage their end of life*. The RACP plans to address the more substantive ethical issues related to end of life care in its planned work on euthanasia, physician assisted dying and palliative sedation.

Background

Increasingly, good end-of-life care is becoming a critical aspect of medicine. More people are dying from terminal illness or chronic diseases due to the significant gains in life expectancy and advances in modern medicine over the last century.²

In some international jurisdictions, choices regarding end-of-life care have been extended to include euthanasia and assisted suicide, in addition to palliative care. However in Australia, the practices of euthanasia and assisted suicide are unlawful in all states and territories, while the provision of appropriate palliative care is lawful.

The topics of euthanasia and assisted suicide are highly contentious and divisive in Australia, raising a number of ethical, social, legal and religious concerns.³ Strong

ethical arguments for and against the legalisation of euthanasia and assisted suicide are well-articulated in medical literature, public discourse, and proposed state legislation.

Good End-of-Life Care: Definition, Benefits and Elements⁴

People are 'approaching the end of life' when they are likely to die within the next 12 months. The health care that people receive towards, and at the end of life can significantly impact the person, their surviving family members and friends as well as health care staff and services.

Evidence reveals that good end-of-life care leads to a better quality of life for the patient before death; a better death from both the patient's perspective and that of their family; and reduction in the use of unwanted, inappropriate and ineffective treatment. Furthermore, he or she is at less risk of suffering pain caused by ineffective or inappropriate treatments. All these benefits, in turn, lessen the psychological burden of the patient as well as that of their family, carers and health professionals involved in their care.

Good end-of-life care is characterised by patient-centred, coordinated medical care with emphasis on rational investigation, rational prescribing that prioritises quality of life, as well as de-prescribing. It also includes access to high quality palliative care, assistance with advance care planning and other services to support the patient, their family and carers. As a result, good end-of-life care enables patients nearing the end of their life to live as well as possible and ensures that the patient's carers get the support they need at this difficult time.

Such care has to be tailored to the needs, values, preferences and circumstances of each person. A focus on providing comfort and maximising the quality of the patient's remaining days based on sympathetic consideration of the patient's preferences, goals, religious beliefs and dignity is crucial. This is complemented by paying skilled attention to physical and emotional elements of well-being for the patient and his or her social needs. The role of carers and family, in cases where patients are not competent to make decisions about matters such as withdrawal of treatment, must be recognised. In a paediatric context, the role of parents as decision-makers for their children must also be recognised, as well as the increasing competence that adolescent patients develop over time in making decisions about their own care.

Of equal importance is that the same standards of care should be offered to all patients at the end of their life. Delivery of quality, patient-centred end of life care requires the attitude, knowledge and skills that physicians employ in other aspects of health care provision. In other words, the standards of care must entail the fundamental constituents of investigation, prescribing and management, which are founded in rational assessment and careful consideration of all aspects of the situation of the patient and their family or carer/s.

Timely and equitable access to good end-of-life care

It is vital that, regardless of the disease or illness, patients receive high quality end-of-life care. Evidence shows that inequitable access to consistent, good quality end-of-life care for certain groups of people persists. Examples include Aboriginal and Torres Strait Islander populations, non-cancer patients and older people living in residential aged care facilities. Inconsistent care is more prevalent in rural and remote communities in Australia.⁵

Every patient should have timely and equitable access to high quality end of life care including specialist palliative care services where required. Every effort should be made to ensure that good quality end-of-life care is reinforced throughout the health care system. Essential components of the provision of good quality end-of-life care necessitate that all physicians be proficient in diagnosing dying or the risk of dying; delivering patient-centred care; knowing when to withdraw and withhold treatment; managing symptoms; and providing carer and family support all the way through to bereavement. It should be noted that ANZSPM have strongly stated that the practices of euthanasia or assisted suicide are not part of the Palliative Medicine discipline.

All physicians have a duty to provide good quality end of life care for their patients. Therefore, the RACP is committed to:

- Quality of life and quality of end of life care for patients;
- Open and honest communication with patients about impending death;
- A doctor-patient relationship based on openness, trust and good communication (therefore we would not support any policy decision that may erode this trust);
- The positive contribution a physician can make to end of life care; and
- Acknowledging and respecting different cultural preferences and approaches to death and dying and providing culturally sensitive end of life care.

Euthanasia and Assisted Suicide

There are a diversity of views within the RACP on euthanasia and assisted suicide, and currently the RACP has no established position. However, many RACP members consider that the practices of euthanasia and physician-assisted suicide are not within the professional boundaries, nor authority of physicians. The RACP notes the World Medical Association Declaration on Euthanasia which states that deliberately ending the life of a patient is unethical:

"Euthanasia, that is the act of deliberately ending the life of a patient, even at the patient's own request or at the request of close relatives, is unethical. This does not prevent the physician from respecting the desire of a patient to allow the natural process of death to follow its course in the terminal phase of sickness." Reference: World Medical Association (1987) *WMA Declaration on Euthanasia - Adopted by the 39th World Medical Assembly, Madrid, Spain.* Available from: <http://www.wma.net/en/30publications/10policies/e13/> [last accessed 24/06/15]

Management of Actively Dying Patients

In line with ANZSPM's position, the RACP agrees that the following actions physicians may undertake in their management of actively dying patients **do not constitute** euthanasia or physician-assisted suicide:

- a) Refusing life-sustaining treatments: Patients with capacity have the right to refuse treatment including the provision of medically assisted nutrition and/or hydration.
- b) Withholding or withdrawing treatments that are not benefiting the patient: physicians have a duty to consider the benefits and harms of any treatments including the provision of medically assisted nutrition and/or hydration before instituting them. The benefits and harms of ongoing treatment should also be regularly reviewed.
- c) Providing appropriate palliative sedation to manage refractory symptoms
- d) Titrating treatment to relieve symptoms