Inquiry into aged care, end-of-life and palliative care, and voluntary assisted dying

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What would you like to tell the committee?

As set out below

Please attach extra pages as required

Publication of your comments:

The committee may publish your comments as a submission. For comments provided by individuals, the committee will first remove personal contact details such as phone numbers, street addresses and email addresses.
I agree with the publication of my comments as a submission ◯ **Yes**

Request for the comments to be treated confidentially by the committee:

If you have provided personal information or other information you would like to be kept confidential by the committee and not published, please explain briefly your reasons why:
N/A

Are you providing comments on behalf of others or an organisation? ◯ **Yes**

If yes, please tell us the name of the person or persons or organisation**: Dying with Dignity Victoria**

Their daytime phone number: 03 9784 0503

What is your relationship with that person or persons, or your role in the organisation?

I am its president

I am authorised by The Committee of Dying with Dignity Victoria **to provide these comments on their behalf**

Signature:…….. Date: ……9 April 2019

Submission to the 2019 Inquiry into aged care, end-of-life and palliative care and voluntary assisted dying

Held by the Queensland Parliamentary Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee

Contents

1. Executive summary

Palliative care has been reasonably successful in easing pain in the terminally ill, and is a valuable service to the community. However it cannot relieve all forms of suffering at end of life, and does not address the issue of intolerable suffering from ailments which are not terminal.

This submission supports a position that, while recognizing the valuable work done by palliative care, there also should be voluntary assisted dying ("VAD") available to the community. The criterion for the availability of VAD should be suffering which is both intolerable and unrelievable. This would include cases of advanced incurable illnesses, noting also that loss of dignity is a serious matter for many. Safeguards should be sufficient to protect the vulnerable.

As an aside, we agree that no individual, group or organisation should be compelled to either participate or not participate in an assisted death of a sufferer.

2. Palliative care, and its limitations

Palliative care has grown to a world-wide specialty with strong government support. It is one of the most important developments in modern medicine. It aims to provide compassionate and holistic care for the terminally ill.

Many providers of palliative care contend that such care deals very effectively with pain in the terminal patient. However, the successful relief of pain is contested by Australia's most eminent pain specialist, Professor Michael Cousins, who said in 2010 that ten per cent of cancer pain was so difficult to treat at the end of life that some patients were given drugs to sedate them to unconsciousness, culminating in death over several days to a week. The Australian Government *Palliative Care Outcomes Collaboration Study (*October 2014) records that only just over 50% of patients with moderate to severe pain become pain-free.

But breathlessness, cachexia, (wasting, weakness, immobility, dependence), anorexia, nausea and vomiting, incontinence, ulceration, discharge and odour are common, far more difficult to palliate, and all may impact on dignity. And this list does not begin to address psychological, social and existential suffering, described by Francis Norwood as 'social death'. It is not surprising that palliative care does not entirely succeed with the palliation of suffering. Intolerable and unrelievable suffering is common in terminally ill persons, and often escalates as death approaches; some suffering is only relieved by death.

3. The case for voluntary assisted dying

This submission is based on the assumptions that

- The Australian society does not want individuals to experience unnecessary suffering;
- a particular case of unnecessary suffering is where
  (a) an individual is dying from a terminal illness, and
  (b) the accompanying suffering is unrelievable.

The conclusion is that when an individual is in such a situation, this society should grant a request for assisted death. Limitations are set out in 7.(Safeguards).

4. Community support for voluntary assisted dying

Community support - many surveys, especially Roy Morgan 2017

http://www.roymorgan.com/findings/7373-large-majority-of-australians-in-favour-of-euthanasia-201711100349

The Roy Morgan report contains "Historical Trends: Should a doctor be allowed to give a patient a lethal dose?"

In 1962 when Roy Morgan first asked this question the population was divided – more favouring allowing a doctor to give a lethal dose (47%) than not (39%) and 14% undecided. Support increased consistently over the years to 1996.

Since the 1996 survey there has also been a marked increase in support of allowing doctors 'giving a lethal dose'. Now a large majority of 85% of respondents say a doctor should be allowed to 'give a patient a lethal dose' compared to 74% of respondents in 1996.

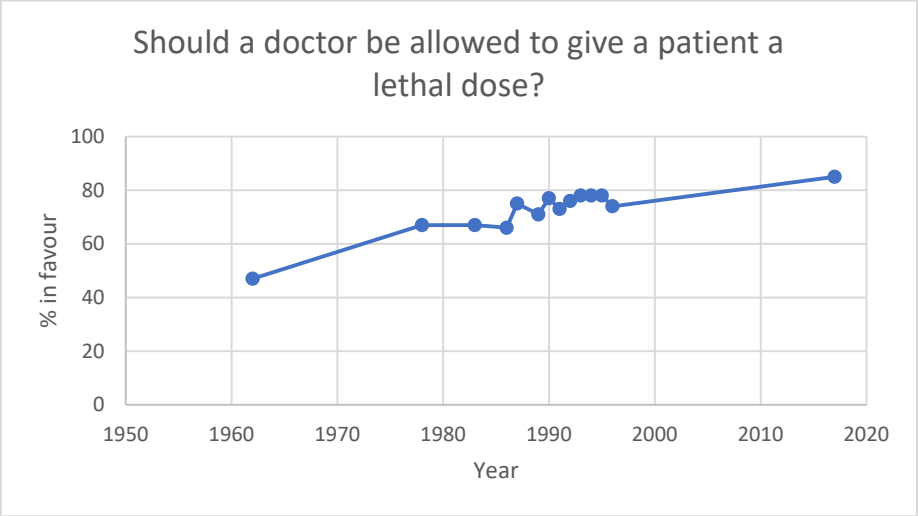
Questions:

"A question on hopelessly ill people experiencing unrelievable suffering. If there's absolutely no chance of a patient recovering, should the doctor let the patient die – or should the doctor try to keep the patient alive as long as possible?

"Respondents who answered were then asked: "If a hopelessly ill patient with no chance of recovering asks for a lethal dose, should a doctor be allowed to give a lethal dose, or not?"

The results from the latter question were

Month	Year	Give lethal dose	Not give lethal dose	Undecided	Total
Oct	1962	47	39	14	100
Nov	1978	67	22	11	100
Sep	1983	67	21	12	100
Apr	1986	66	21	13	100
Apr	1987	75	18	7	100
Apr	1989	71	20	9	100
Jul	1990	77	17	6	100
Jul	1991	73	20	7	100
Mar	1992	76	18	6	100
May	1993	78	15	7	100
May	1994	78	13	9	100
Jun	1995	78	14	8	100
May	1996	74	18	8	100
Nov	2017	85	15	-	100



The results of other surveys are set out in Appendix A.
They show a consistent pattern of high, and growing, community support for assisted dying.

5. Input from religious groups

There has been widespread opposition from the church hierarchies. As Section 116 of the Constitution of Australia precludes the Commonwealth of Australia from making laws for … imposing any religious observance, … we contend that rulings from the churches are at best applicable only to their members? Some examples of Christian dogma follow: -

5.1 Roman Catholicism

https://catholicherald.co.uk/news/2017/11/17/euthanasia-is-always-wrong-pope-francis-tells-doctors/

> "From an ethical standpoint," the Pope said, "withholding or withdrawing excessive treatment is completely different from euthanasia, which is always wrong, in that the intent of euthanasia is to end life and cause death."

https://cruxnow.com/vatican/2018/10/01/love-can-make-darkness-of-euthanasia-disappear-pope-says/

Rome - Caring for the sick, especially those near death, cannot be reduced simply to giving them medicine, but must include providing healing and comfort that gives their lives value and meaning, Pope Francis said.

> "Serene and participatory human accompaniment" of terminally ill patients is crucial at a time when there is a "nearly universal" push for legalizing euthanasia, the pope said.
>
> "Especially in those difficult circumstances, if the person feels loved, respected and accepted, the negative shadow of euthanasia disappears or is made almost non-existent because the value of his or her being is measured by the ability of giving and receiving love and not by his or her productivity," he told participants in a five-day conference on ethical health care at the Vatican.

http://www.vatican.va/roman_curia/congregations/cfaith/documents/rc_con_cfaith_doc_19800505_euthanasia_en.html

The value of human life

> "…3. Intentionally causing one's own death, or suicide, is therefore equally as wrong as murder; such an action on the part of a person is to be considered as a rejection of God's sovereignty and loving plan. …"

5.2 Anglican

http://socialissues.org.au/euthanasia/anglican_church/

"What has the Anglican Church said about euthanasia?

2016 – Resolution passed at the Synod of the Anglican Diocese of Sydney (Resolution 17/2016)

Recognising that all life is precious in God's sight and that deliberately ending a human life is wrong, Synod views with deep concern the possibility that the Voluntary Euthanasia Bill 2016 may pass the South Australian Parliament shortly.

Further Synod –

(a) rejects the false notion that euthanasia represents dying with dignity;

(b) recognises that euthanasia represents a deep and fundamental change to society's commitment to caring for people at their most vulnerable, and that the elderly in particular will be exposed to possible medical error and abuse;

(c) believes that euthanasia will fundamentally change the doctor-patient relationship by undermining the trust inherent in that bond and the "do no harm" purpose of medical care;

(d) supports the maintenance and if possible extension of funding available to palliative care units of South Australian hospitals, and respectfully urges Members of the South Australian Parliament to oppose the Bill."

5.3 There are religious groups which support VAD

The organisation Christians Supporting Choice for Voluntary Euthanasia (http://christiansforve.org.au/ provides the following:

> *… the term 'sanctity of life' appears nowhere in the bible. Interpreting selected passages of the bible to mean so is a personal matter for the individual. It's a human construction. One could equally interpret other passages of the bible to authorise or justify selling daughters into slavery or putting whole peoples to the sword.*

6. "When doctors disagree …"

Doctors are perhaps in the best position to assist those who are suffering. Their training is directed to both the evaluation of condition of the individual, the treatment required to alleviate that suffering, and the means to do so.

However attitudes vary greatly across the profession. In view of penalties for breaking the law, doctors who assist those seeking to die have generally been careful to avoid the publicity which has surrounded assisted death.

Surveys of doctor's attitudes include the following: -

In 2001, Douglas et al. reported a survey of 683 Australian surgeons, revealing that 36% prescribed drugs for the relief of a patient suffering with the intention of hastening death, and more than half did so without explicit request from the patient. 54% believed that it was morally acceptable in some circumstances to hasten death to relieve suffering. (*MJA*, 2001: 175;508)

In 2007, Neil et al. reported a survey of 854 Victorian doctors. 53% of these doctors supported the legalisation of voluntary euthanasia. Of doctors who had experienced requests from patients to hasten death, 35% had administered drugs with the intention of hastening death. (*Journal of Medical Ethics*, 2007:33;721).

The professional bodies show a range of positions. For example, the submission by the Royal Australian College of Physicians ("RACP") states "…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. …"

In contrast, the Royal Australian College of General Practitioners (RACGP) made no submission, but on the day after the passage on the Victorian bill in the lower house the then president Dr Seidel made statements resulting in the headline "RACGP welcomes moves to allow terminally ill Victorian patients to die with dignity and respect".

7. Safeguards where VAD is available

The widely accepted position is that any legislation should address topics such as the possibility of pressure from relatives, or the request for death when that request is prompted by a mental health problem that is amenable to treatment.

There are many summaries of potential problems, and their resolution. The Victorian bill provided for the most stringent set of tests, in that it covered all those in place elsewhere in the world, and then added some.
From https://www2.health.vic.gov.au/hospitals-and-health-services/patient-care/end-of-life-care/voluntary-assisted-dying/community-and-consumers

> "A person's choice to access voluntary assisted dying must be:
> voluntary (the person's own choice) and
> continuing (their choice stays the same) and
> fully informed (the person is well-informed about their disease, and their treatment and palliative care options). …
> People choosing to access voluntary assisted dying must meet the following requirements:
> 1. They must have an advanced disease that will cause their death and is:
> likely to cause their death within 6 months (or within 12 months for neurodegenerative diseases like motor neurone disease) and
> causing the person suffering that is unacceptable to them.
> 2. They must have the ability to make a decision about voluntary assisted dying throughout the process.
> 3. They must also:
> be an adult 18 years or over
> have been living in Victoria for at least 12 months
> be an Australian citizen or permanent resident. …"

Further requirements are that two doctors, one of whom is a specialist, need to be involved, and that a VAD Review Board which reports to parliament will oversee and regularly review the VAD process.

8. Some claims against assisted dying

Prediction: **Destruction of trust between doctor and patient**

Quotation*: Such legislation should be opposed on the following grounds: ... (ii) it destroys the traditional relationship of trust between doctor and patient;* - Mr Hann MLA, Medical Treatment Bill, 6 May 1988, Assembly p.2249, quoting Rev Carter.

Outcome to be expected if claim were correct	***Actual outcome***
Patients would reduce their visits to doctors.	Per capita visits to doctors have increased, not decreased.*

*In the 12 years to FY2014, there was a 37% increase in the number of Medicare funded services provided in Victoria, and an increase of almost 100% in the Medicare spending per capita over that period, from $416.7 to $830.9. http://medicarestatistics.humanservices.gov.au/statistics/mbs_item.jsp

Prediction: **Coercion by avaricious relatives to refuse treatment**

Quotations:

There will be no waste of time in Committee. The government will consider argument. However, it is not assisted by public comment that says that if the Bill is passed old people will have forms refusing treatment shoved under their noses to sign so that they will prematurely die and their relatives will get their money. The Hon D R White MLC, Medical Treatment Bill (No.2), 3 May 1988, Council p.1020.

... It would be particularly obnoxious if powers of attorney were to be abused by persons expecting an inheritance and the death of a patient were to be hastened by neglect or even starvation. ... Mr Williams MLA, Medical Treatment Bill, Assembly p.2257.

Outcome to be expected if claim were correct	***Actual outcome***
Prosecutions and complaints for investigation would be made to Victoria Police and to health officials and minister.	There is no record of any prosecutions or complaints of the nature described.*

*DWDV holds letters from 2014 from the then Chief Commissioner of Police and Health Minister, advising no record of any prosecutions or complaints made against avaricious relatives inducing refusal of treatment under the MTA by an ill/elderly person.

Prediction: **Palliative care will be under-funded**

Quotation*: There is also a danger that there would be reduced investment in improving palliative care by research and reduced need seen to increase the availability and access to palliative care.* Mrs Terri Kelleher, President, Australian Family Association, Proof Committee Hansard, 15 October 2014, p.16.

Outcome to be expected if claim were correct	***Actual outcome***
Reduced per capita spending on palliative care**.**	Palliative care has received increased funding over the years since 1988.*

*'The government has committed $34.4 million new funding over four years for palliative care in the 2011–12 State Budget.' *Strengthening palliative care: Policy and strategic directions 2011-2015*

'In 2005 and 2011 additional growth funding was allocated... in 2013–14 DHHS' funding for palliative care provision was approximately $111.1 million.' *Palliative Care*, Victoria Auditor-General's report , April 2015

'There was a 49% increase in palliative care-related separations between 2001–02 and 2010–11. ... Over the 5 years to 2011–12, the MBS benefits paid for all palliative medicine specialist services more than doubled … This equates to an average annual rate increase of 21.1%.'

Palliative care services in Australia 2013, Australian Institute of Health and Welfare.

Claim	DWDV response
Medical training is designed to save life, not take it.	Medicine has two aims – to preserve life and alleviate suffering. However, under certain circumstances, medicine may not be able to preserve life, therefore alleviating suffering becomes the legal and ethical priority.
Some ageing people may be seen as a burden to their families who may seek to coerce them into 'choosing' VAD.	Patients can already be coerced into refusing or withdrawing treatment. A formal, safe and secure process is needed, with effective safeguards that will protect the vulnerable (see p. 10).
Patients may change their minds after a request for VAD (see 9.2).	A cooling-off period will be essential (except in the terminal phase of a terminal illness), and requests for VAD must be properly witnessed. Knowing VAD will be available removes the need to act hastily and make an immediate decision.
VAD will be available to anyone, regardless of circumstances.	We propose VAD should be available only to a mentally competent adult who is terminally ill or has intolerable, unrelievable suffering. It should not be available to people suffering clinical depression, as they may lack the capacity to decide. Choosing to die because of intolerable and unrelievable suffering near the end of life can be rational, but a psychological illness alone would not justify VAD.
Some patients will have religious convictions about the sanctity of life.	Religious convictions are to be respected, but it is not acceptable for the religious beliefs of some individuals to be imposed on others in a secular society. Patients have the right to make their own difficult end of life decisions.
With life prolonged, a cure may be found for the patient's disease.	Whilst this may be the case, the immediacy and intolerability of some suffering cannot wait for a possible future cure.
VAD devalues life.	Each person has the right to self-determination in choosing whether they preserve life or obtain medical assistance to end their life. Relieving intolerable suffering for someone who is dying respects life and quality of life.
A slippery slope (1) - permitting VAD will lead to various abuses that are currently contained.	With sufficient safeguards, abuse can be minimised. There is anecdotal evidence that abuse is occurring now. Putting in place a rigorous, formal, safe and secure process with VAD being available only to competent adults who provide informed consent will prevent abuse. The Oregon system has had a demonstrated absence of abuse.
Slippery-slope (2) - assisted suicide legislation can be readily widened.	Presumably any such widening could take place only under legislation from parliament.
Alleviation of suffering by 'killing' the patient is sinful or unworthy.	It is important to use the proper words to describe the process of VAD, which is justifiably ending suffering, not killing. Using such emotive words trivialises the suffering that people are forced to endure, and demonstrate a lack of compassion.
The needs of the dying are covered by palliative care and the provisions of the Medical Treatment Act.	Nearly all palliative care specialists agree that not all pain can be relieved by palliative care. The Medical Treatment Act allows for the withdrawal of treatment, but has no provision to assist those in great pain who are not in the final phase of a terminal illness.
There is no way to guarantee the absence of coercion.	People are now coerced into intolerable suffering. The greater good for the greater number is better served by the availability of a suitably regulated way to end suffering.
A desire to harvest organs may become a reason for VE.	Stringent legal safeguards will prevent this.
'God will decide when I die.'	Many in our society do not believe in God. There are also many who do, but who also see the regulated and compassionate ending of unendurable suffering as consistent with their belief.
Few medical practitioners are trained or qualified to assess patients who ask for assisted suicide.	We suggest that this matter be addressed with training, to be provided for in the relevant legislation.

9. The legislative process for VAD

Voting in the Victorian parliament took place late in 2017.
In view of the level of community support, the voting by the Coalition of not even 25% in favour in the Legislative Assembly shows a disregard for the wishes of their constituents. A move driven perhaps by a wish to pander to a conservative minority, or perhaps by the notion that an opposition must oppose, regardless of the merits of an issue.

The process was plainly not a conscience vote. The resulting legislation, passing the Legislative Council only after much concession, ignores existential suffering, and has restrictions that appear unduly onerous.

Some alternatives are set out below: -

(a) Canada - What the Supreme Court sought
From https://scc-csc.lexum.com/scc-csc/scc-csc/en/item/14637/index.do
Essentially: Prohibiting physician-assisted dying for competent adults who seek such assistance as a result of a grievous and irremediable medical condition that causes enduring and intolerable suffering deprives these adults of their right to life, liberty and security of the person.

Prohibition deprives some individuals of life, as it has the effect of forcing some individuals to take their own lives prematurely, for fear that they would be incapable of doing so when they reached the point where suffering was intolerable. Leaving them to endure intolerable suffering, it impinges on their security of the person.

(b) Canada -Implemented
http://www.parl.ca/DocumentViewer/en/42-1/bill/C-14/royal-assent
Eligibility for medical assistance in dying: Essentially
At least 18 years of age and capable of making decisions;
Having a grievous and irremediable medical condition;
Having made a voluntary request for medical assistance in dying.
A grievous and irremediable medical condition is defined as meeting all of the criteria of
a serious and incurable illness, disease or disability;
an advanced state of irreversible decline in capability;
the illness causes enduring physical or psychological suffering that is intolerable to them and that cannot be relieved under conditions that they consider acceptable; and
their natural death has become reasonably foreseeable

(c) A Western Australian initiative
https://www.abc.net.au/news/2018-11-12/voluntary-euthanasia-legislation-announced-by-wa-government/10488400
Death must be 'reasonably foreseeable'
The committee's recommendation would allow a doctor to administer lethal medication where a person was physically incapable of doing so, but was eligible under the proposed voluntary euthanasia model.
Under the model, death would need to be a "reasonably foreseeable" outcome of the condition suffered by the patient. A patient would also have to have "decision-making capacity" at the time of making a choice to die, be aged over 18, ordinarily reside in WA and be assessed by two doctors. However, the committee also recommended health practitioners not be forced to engage in voluntary euthanasia, should the practice be legalised.
The recommendations were backed by all bar one member of the committee, with Liberal MP Nick Goiran providing a dissenting minority report and describing "assisted suicide" as "a recipe for elder abuse".

10. Contact Details

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11. Appendices

Appendix A Analysis of data on support for assisted dying law reform

Over many years surveys of Australian have shown a high, and generally growing support for assisted dying. The summary below is from number of such surveys, and compares with the results in 4.

Assisted Dying Opinion Poll Results - Australia

Polling body	Year	Yes%	Question
Newspoll	2007	80	Thinking now about voluntary euthanasia, if a hopelessly ill patient, experiency unrelieavble suffering, with absolutely no chance of recovering asks for a lethal dose, should a doctor be allowed to provide a lethal dose, or not?
Newspoll	2009	85	As in 2007
Australia Institute	2010	75	This question is about voluntary euthanasia. If someone with a terminal illness who is experiencing unrelievable suffering asks to die, should a doctor be allowed to assist them to die?
Newspoll	2012	83	Thinking now about voluntary euthanasia, if a hopelessly ill patient, experiency unrelieavble suffering, with absolutely no chance of recovering asks for a lethal dose, should a doctor be allowed to provide a lethal dose?
Australia Institute	2012	71	This question is about voluntary euthanasia. If someone with a terminal illness who is experiencing unrelievable suffering asks to die, should a doctor be allowed to assist them to die?
ABC Vote Compass	2013	75	Terminally ill patients should be able to legally end their own lives with medical assistance.
Essential Media Communications	2014	66	When a person has disease than cannot be cured and is living with severe pain do you think should or should not be allowed by law to assist the patient to commit suicide if the patient requests it?
Ipsos Mori	2015	73	What do you think of doctor-assisted dying? Do you think it should be legal or not for a doctor to assist a patient aged 18 or over in ending their life, if that is the patient's wish, provide that the patient is terminally ill (where it is believed they have 6 months or less to live), of sound mind, and where they have expressed a clear desire to end their life?
Essential Media Communications	2015	72	As in 2014
ABC Vote Compass	2016	75	Terminally ill patients should be able to legally end their own lives with medical assistance.
OmniPoll	2017	75	If a terminally ill patient, asks a doctor for a lethal dose, should a doctor be allowed to provide a lethal dose, or not?
Essential Research	2017	73	If someone with a terminal illness who is experiencing unrelievable suffering asks to die, should a doctor be allowed to assist them to die?
Roy Morgan	2017	85	If a hopelessly ill patient with no chance of recovering asks for a lethal dose, should a doctor be allowed to give a lethal dose, or not?

See

https://theconversation.com/factcheck-qanda-do-80-of-australians-and-up-to-70-of-catholics-and-anglicans-support-euthanasia-laws-76079

https://www.dwdv.org.au/documents/item/210

https://www.theguardian.com/society/2017/sep/01/voluntary-assisted-dying-supported-by-73-of-australians-poll-finds

http://www.roymorgan.com/findings/7373-large-majority-of-australians-in-favour-of-euthanasia-201711100349

Appendix B Doctors for assisted dying

B.1 Royal Australian College of General Practitioners

https://www.racgp.org.au/yourracgp/news/media-releases/racgp-welcomes-moves-to-allow-terminally-ill-victorian-patients-to-die-with-dignity-and-respect-(1)/

"RACGP welcomes moves to allow terminally ill Victorian patients to die with dignity and respect" 20 October 2017

The Royal Australian College of General Practitioners (RACGP) has welcomed the passing of the voluntary assisted dying bill in the lower house of Victorian parliament this morning after comprehensive and contemporary discussion about the issue.

RACGP President Dr Bastian Seidel said he is satisfied that ethical and professional issues associated with voluntary assisted dying have been appraised appropriately in the bill.

"The voluntary assisted dying bill is about meeting the needs of terminally ill patients with incurable medical conditions who do not find answers in palliative care," Dr Seidel said.

"Those patients are dying and we should allow them to die with dignity and respect.

"The RACGP is satisfied that appropriate safeguards for patients, relatives, and medical and health practitioners have been put in place in the legislation.

"The RACGP is also satisfied that the principle of conscious objection has been upheld, which means that medical practitioners have a choice of not participating in the voluntary assisted dying process.

"Assuming this bill also passes the upper house, we urge other states and territories to consider the Victorian law as a legislative blueprint. Pragmatically, there needs to be a nationally consistent approach."

The RACGP recommends that further support needs to be offered to patients and practitioners, as well as communities at large, around this issue.

"A timeframe of 18 months from Royal Ascent to implementation is therefore realistic and welcome," Dr Seidel said.

Dr Seidel also commends the Ministerial Advisory Committee and Professor Brian Owler on the considerate report on voluntary assisted dying that informed the draft legislation.

B.2 Doctors support end-of-life choice

The Age 25/10/16' by Farrah Tomazin

"Almost half of a number of doctors surveyed say they would help a terminally ill person commit suicide if that patient was suffering intolerably, in the latest sign of growing momentum towards voluntary euthanasia. …"

Appendix C Doctors against assisted dying

C.1 WMA Statement on Physician-Assisted Suicide

https://www.wma.net/policies-post/wma-statement-on-physician-assisted-suicide

Adopted by the 44th World Medical Assembly, Marbella, Spain, September 1992 and editorially revised by th4.e 170th WMA Council Session, Divonne-les-Bains, France, May 2005 and reaffirmed by the 200th WMA Council Session, Oslo, Norway, April 2015

"Physician-assisted suicide, like euthanasia, is unethical and must be condemned by the medical profession. Where the assistance of the physician is intentionally and deliberately directed at enabling an individual to end his or her own life, the physician acts unethically. …"

C.2 Australian Medical Association

https://ama.com.au/media/euthanasia-and-physician-assisted-suicide

AMA President, Dr Michael Gannon, said today that the AMA is proud to be a member of the WMA, and was one of its founding members when it was established in 1947.

Of the WMA's 109 constituent National Medical Associations, 107 oppose Euthanasia and Physician Assisted Suicide," Dr Gannon said.

"The AMA's Position Statement is largely in line with the WMA policy in stating that *'doctors should not be involved in interventions that have as their primary intention the ending of a person's life'*.

https://twitter.com/amapresident/status/920223729434554368?ref_src=twsrc%5Etfw%7Ctwcamp%5Etweetembed%7Ctwterm%5E920223729434554368&ref_url=https%3A%2F%2Fwww1.racgp.org.au%2Fnewsgp%2Fprofessional%2Fassisted-dying-laws-passed

A President @amapresident

Intellectual case for #Euthanasia #VAD bankrupt. Don't forever alter society 'coz few powerful people see parent die

C.3 The Medical Journal of Australia

https://insightplus.mja.com.au/2017/10/palliative-care-euthanasia-and-physician-assisted-suicide/

"… The term "voluntary assisted dying" conceals the true nature of what is proposed in the bill before the Victorian parliament. The patient's dying is not assisted; rather, a doctor is required to kill the patient or to help the patient commit suicide. The word "voluntary" attempts to emphasise the patient's autonomy. Ironically, EPAS legislation weakens patient autonomy by devaluing the final stages of life. Further, overseas experience has shown that supposed safeguards within these laws do not effectively guard the autonomy of those most vulnerable to the extension of these laws.

In an attempt to make EPAS publicly acceptable, its proponents sanitise the language, using euphemisms such as "voluntary-assisted dying" and "go gentle". However, the inconvenient truth remains that at the heart of EPAS, the action of the doctor is to end a patient's life or assist patients to kill themselves. This has profound ramifications for all health professionals. "Do not kill" has been a core ethical principle of every civilisation and the practice of medicine; we violate it at society's peril. …"

Professor Douglas Bridge is an Emeritus consultant at Royal Perth Hospital, clinical professor in the University of Western Australia's School of Medicine and Pharmacology, a consultant physician with WA Country Health Service, and is past president of the Chapter of Palliative Medicine, Royal Australasian College of Physicians.

Appendix D Our submission to the 2015 Victorian Inquiry

In July 2015 we made a submission to an inquiry by the parliament of Victoria into End of Life Choices. See https://www.parliament.vic.gov.au/file_uploads/LSIC_pF3XBb2L.pdf

for the final report, and
https://www.parliament.vic.gov.au/images/stories/committees/lsic/Submissions/Submission_625_-_Dying_with_Dignity_Victoria.pdf for our submission.