



Australian Medical Association (WA)

**AMA (WA) Responses to
Questions on Notice -
Joint Select Committee on
End of Life Choices**

28 February 2018



Questions arising from public hearing

1. In relation to the Victorian branch of the Australian Medical Association, what sort of adjustments have they made as an association now that the end-of-life legislation has passed in Victoria?

The AMA (Victoria) have advised us that the only adjustments made so far relate to providing a member to the Implementation Advisory Group. They are currently attending confidential meetings for which the AMA (Victoria) are asked to give feedback on specific matters.

The AMA (Victoria) have also emphasised in their Budget submission the importance of the enhancement of palliative care services. As in WA, this is a huge issue in rural and regional areas and one of the persisting concerns around Voluntary Assisted Dying (VAD) – that it will be an easier and more accessible option than excellent palliative care.

Questions provided before the hearing but not answered due to time constraints

Terminal sedation and palliated starvation

9. The Committee has heard evidence that other than the requisite recording of medications administered, instances of terminal sedation are not specifically recorded into the patient's medical record. In your view should an instance of terminal sedation be formally noted in a patient's medical record?

Good medical practice would dictate that all interventions and medications be documented in the patient record, along with the rationale for carrying them out.

Futility

15. Could you elaborate on the distinction in relation to a doctor's decision to withdraw or withhold life sustaining treatment as futile and voluntary assisted dying when a patient decides that continuing their life is futile?

The AMA (WA) believes that there is a clear distinction between withdrawing or not offering a life-prolonging treatment, and actively administering medication to end that person's life.



Questions arising from submission

21. Your reference for the statement that 68% of Australian's preference is to die at home is a survey conducted by Palliative Care Australia in 2011 which reports that only 41% of those surveyed indicating that they would prefer to die at home. Are you aware of any other source for the data cited, and if so could you provide the reference?

This figure comes from the Grattan Institute report *Dying Well* (2014). Based on various papers on the subject, the authors determined that the figure is between 60 and 70%. Regardless of the exact figures, it is important to respect an individual patient's wishes when they are made clear in discussions around the end of life. Additionally, the wishes of patients will change over time and these must be responded to.

22. A recent report claims that later research indicates that most patients with chronic disease and their carers would prefer to be cared for at home until death is imminent, and then access a more supported environment. Would you comment on whether that is an accurate representation of your experiences of people with chronic diseases?

It may indeed be appropriate to transfer a patient to a supported environment as death becomes more imminent, or to de-escalate if there is an event beyond the ability of people in home environment to deal with, and manage this in a tertiary environment. As a health system we should be able to provide that care.

23. Your submission refers to the AMA's 2016 survey of members. The results of the survey are quite difficult to follow. For example, you state that 62 per cent of respondents would not provide physician-assisted suicide while the AMA website reports "50 per cent of doctors agreed that doctors should not be involved in euthanasia or physician assisted suicide".

a. Could you elaborate on the different questions that were posed and which prompted the 62 per cent and 50 per cent responses referred to above?

One question is theoretical support for the statement that doctors should not be involved in euthanasia or physician assisted suicide (50%). The other question asked whether doctors would you provide euthanasia (62% said they would not).

b. Could you please provide the Committee with a copy of the 2016 survey questions and the results?

This survey is property of the Federal AMA and not in the remit of AMA (WA) to distribute. However, we have outlined the key outcomes from the survey in relation to WA members below:

1. **50% agreed** with the **current AMA policy** that doctors should not be involved in interventions that have as their primary purpose the ending of a person's life.
(35% disagreed, 15% neither agreed nor disagreed.)



2. The statement that doctors **should not provide physician assisted suicide under any circumstances** was more split:

44% agreed, 47% disagreed and 9% were undecided

3. **53%** of doctors said that physician assisted suicide **should not be lawful** in any circumstances. **29%** said it should be.

-- In a follow up question, 'if physician assisted suicide were to become lawful, do you believe it should be **provided by doctors?**' **51% said yes** and 31% said no.

4. **85%** of WA doctors **agreed** that if physician assisted suicide becomes lawful, **doctors should not be compelled to participate** in the practice, either directly by providing or indirectly e.g. by referral

5. To the statement 'if physician-assisted suicide were to become lawful, how likely do you think it would be that you would provide it if requested by a patient in accordance with the law?':

44% were not likely at all, 18% were unlikely – **62% total**
9.6% were very likely, 15.3% were likely – **25% total**

24. You have indicated in your submission that only 1% of doctors in Canada have taken up the practice of assisted dying. However, your submission appears to rely upon evidence for this figure from only one province (Quebec) and the opinion was expressed only two months after assisted-dying came into effect in Quebec. Would you like to comment?

This illustrated the slow uptake when legislation was passed.

In our conversations with Professor Jocelyn Downie, a well renowned expert in health law and assisted dying legislation in Canada – she noted that there are approximately 125 doctors in Canada who are members of CAMAP; Canadian Association of MAID Assessors and Providers; but between 200-400 providers in total. This is a small minority of doctors.

Advance Care Planning

25. Studies have shown that there is a low uptake of formal advance care planning (ACP) instruments in Australia (at 14% of adults) and that it is lower in WA than other Australian jurisdictions (at 7.5%). Are you able to comment on why the uptake in WA is so low?

Uptake of advance care planning is the responsibility of the health profession as well as the wider community. For patients and the community, it is important to be aware of what advance care planning is and isn't, to be proactive in our own planning; and to have these discussions with our family and carers. Better community education would help to dispel some of the myths and fears around advance care planning which is likely a factor in the low uptake.



For medical practitioners, lack of time is a common barrier in advance care planning. These discussions take time, and both GPs and other specialists are time poor in each consultation. Training may also be limited for some doctors – not only the practical aspects of advance care planning, but acknowledging that it can be a challenging topic to raise, particularly when a patient is well. Lastly, remuneration is a potential disincentive as there is no item for advance care planning. Having a specific MBS item number for advance care planning, requiring GPs to add a documented Advance Health Directive may improve uptake.

26. Should there be more community education about advance care planning?

The AMA (WA) believes that community education would be a valuable way to encourage greater uptake of advance care planning. This may be done through public marketing campaigns, such as information in public hospitals, aged care facilities, or GP surgeries.

27. Do medical practitioners receive continuous training in advance care planning?

Ongoing training is available for medical practitioners to upskill in advance care planning, including through the AMA (WA). However, uptake is variable and it is ultimately to the responsibility of doctors to seek it out.

In specialties outside of palliative care and general practice, there needs to be better education in how to interpret and enact advance care plans.

28. When and how do medical practitioners incorporate advance care planning into their practice?

Advance care planning ideally needs to be done when a patient is well. It is a process which takes time, which makes it inherently best suited to GPs.

29. Do you think that medical practitioners generally are familiar with both common law and statutory Advance Health Directives (AHDs)?

Medical practitioners are generally aware of how AHDs are applied. Knowledge of the legislation itself is variable. When there are disputes between family members and the AHD, doctors need to be confident in their understanding of their obligations and rights under the law.

30. The Committee has received evidence that some medical practitioners have a lack of understanding regarding AHDs and substitute decision-making.

a. What do you think is unclear for practitioners?

There can be uncertainty around hierarchy of decision-making. In acute settings the default is often to do more to avoid any litigation, particularly if there is conflict between family members and the AHD.

b. Can you recommend how this situation might be improved?

Education around AHDs and decision making for doctors in all specialties is essential.



31. In your view would it assist medical practitioners if there was a central electronic register for AHDs?

There is certainly potential for this, particularly if there was a prompt to alert doctors upon the admission of a patient with an AHD. While this should not replace discussions between doctors and competent patients at the beginning of any treatment episode, it would have a place particularly in the acute setting and where patients have reduced capacity.

32. Is there any reason why medical practitioners may prefer a patient to make an advance care plan as opposed to a legally binding statutory AHD?

Advance care planning is a process, not an endpoint. This process involves working with patients and families, understanding their values and priorities. We know that these wishes change over time as a patient's condition changes and ACPs should be reviewed. ACPs are also about facilitating open discussion and shared decision making.

An AHD can be one part of the advance care planning process. They are one static piece of paper at one point in time and should be revisited. There are difficulties with AHDs sometimes in that they are often based on a checklist, are hard to interpret and ambiguous in direction depending on who reads it.

We recommend that doctors continue to have discussions about preferences with their patient, which is an ongoing advance care planning process.