ROYAL AUSTRALASIAN COLLEGE OF SURGEONS RACS

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Professor Brian Owler
Chair, Ministerial Advisory Panel
Voluntary Assisted Dying Bill

Assisteddying.frameworkresponses@dhhs.vic.gov.au

10 April 2017

Dear Professor Owler,

Voluntary Assisted Dying Bill Discussion Paper

I write in response to the *Voluntary Assisted Dying Bill Discussion Paper* released

As the leading advocate for surgical standards, professionalism in surgery and surgical education in Australia and New Zealand, the Royal Australasian College of Surgeons (RACS) is committed to taking informed and principled positions on issues of public health at both state and federal levels. RACS represents more than 7000 surgeons and 1300 Surgical Trainees and International Medical Graduates (IMGs) across Australia and New Zealand.

The Victorian Regional Committee of RACS would like to offer the following comments on the key issues raised in the discussion paper:

The person

If an assisted dying law was to come into effect then the protection of the person must be the key consideration.

The current four-part test for assessing capacity must form a mandatory part of accessing an assisted dying framework. The assessment of a person's capacity must be clearly recorded in their medical record by the medical practitioner undertaking the assessment. Where capacity is being assessed for assisted dying then the involvement of a second medical practitioner should also be a requirement.

In all cases, capacity should be assessed at the time of each request for assisted dying being made to ensure it is current.

Any medical practitioner involved should have the flexibility to refer the person to an appropriate specialist if they deem it necessary.

Access and eligibility

It is difficult to set a clear and absolute timeframe on a person's end of life.

When assessing this, it is appropriate that the medical practitioners involved in the patients care are in general agreement that the patient is at their end of life.

All medical practitioners involved in a patients care should also be in general agreement regarding the patient's trajectory and condition allowing for a reasonable level of difference of opinion between practitioners.

Making a request

It is essential that any request is made voluntarily and without any form of coercion or influence on the person.

As assessment for capacity should also assess the voluntary nature of the request and, where possible, the medical practitioner should be able to have a discussion directly with the patient.

Where required, an independent interpreter should be made available to persons making a request, as should an independent social or pastoral care worker.

Properly informed

Patients should be properly informed before any medical treatment is undertaken in any setting.

The list of prescribed information provided by the Parliamentary committee is appropriate and should include the collection and recording of any additional information the medical practitioner deems appropriate.

As part of this process the Department of Health and Human Services (DHHS) in Victoria should ensure that there are appropriate educational materials developed for medical practitioners, patients and families/friends/carers.

We also recommend that financial support for and the availability of palliative care/hospice services across the state be increased. This is particularly important for services provided in the community to ensure that anyone who wishes to die at home is able to do so with the appropriate support from professional care services. Improved access to and the provision of best practice palliative care will ensure that people have better options for their end of life care.

Confirming a request

At least one doctor should have specialist expertise and knowledge in the patient's illness.

Appropriate support for all medical practitioners involved in this process must be available, including the ability to seek advice from colleagues. Where a medical practitioner is working in an isolated area, remote support options should also be available and supported by DHHS.

Conscientious objections

No medical practitioner should be required to be involved in assessing a patient's request for assisted dying if they do not wish to be involved.

It is reasonable to expect that a medical practitioner be required to declare as early as possible in the process that they have a conscientious objection. A medical practitioner's involvement in any stage of the assisted dying process should not preclude them from expressing an objection to continuing their involvement at a later time.

Lethal doses of medication

All medical practitioners must be able to object to administering a lethal dose of medication, even if they have been involved in the patient's request to access assisted dying.

Where a medical practitioner is involved in the administration of a lethal dose of medication, additional safeguards are appropriate including an assessment of capacity, assessment of the voluntary nature of the request and confirmation that the patient understands the implications of their request at the time of the administration.

A lethal dose of medication should only be available by prescription in line with current Drugs, Poisons, and Controlled Substances regulations for highly controlled drugs.

It would be reasonable for DHHS to develop an information sheet to accompany the dispensing of such medication. This information sheet should be separate to the standard information provided inside the medication by the pharmaceutical company. It should

- Be in plain English,
- Be well laid out and easy to read,
- Be available in multiple languages,
- Be provided at the time the medication is dispensed,
- Outline appropriate storage of the medication,
- Outline appropriate disposal of the medication if it is not used, and
- Include any other relevant information.

This information should be provided at the time the medication is dispensed.

Oversight

Appropriate oversight of any assisted dying framework is vital.

The membership of the Review Board should be broad and include multiple practitioners from each discipline with expertise in different areas. Where required, a panel should be convened from the available expertise. Every member of the panel should be provided with education and training prior to be appointed.

Provision of information to the Review Board should happen as it is collected (e.g. when the patient makes a request, when a prescription is written, when a prescription is dispensed). This will reduce the administrative burden involved in chasing information after the fact and allow greater tracking and analysis of access and utilisation of an assisted dying framework.

Detailed information collected by the Review Board should be made available, in a de-identified manner, for research purposes in addition to the required reporting to Parliament.

Liability and insurance

Detailed discussion with the medical insurance industry must be held prior to the implementation of any framework. There must be clear guidance on the potential effects, legally and financially, of medical practitioners or health care organisations who are involved in this process.

If an assisted dying law is passed then any medical practitioner in Victoria who is involved in the process in accordance with the Act should be free from investigation or penalty, criminally or civilly, or from medical oversight bodies such as AHPRA.

Additional considerations

Once drafted an Exposure Draft of any Voluntary Assisted Dying legislation should be made available for the industry and public to review prior to its introduction into Parliament.

There should be the ability to make submissions to the draft legislation with an appropriate time-frame allowed for these responses.

Given the complex nature of such a framework it is also appropriate to ensure an extended implementation date so that medical practitioners and the public have time to understand their rights and responsibilities and how the framework will operate. It is incumbent on DHHS to develop and promote appropriate materials in consultation with the industry.

RACS appreciates the opportunity to comment on this Discussion Paper. We hope the above information is meaningful and useful and we look forward with strong interest to seeing how the consultation progresses with this significant issue. If you would like to discuss further please contact me via the RACS Victorian Regional Office.

Yours sincerely

Mr David Love, FRACS
Chair, Victorian Regional Committee
Royal Australasian College of Surgeons

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