RECENT VICTORIAN LEGISLATION

1. MEDICAL TREATMENT , PLANNING AND DECISIONS ACT 2016
2. VOLUNTARY ASSISTED DYING ACT 2017

Voluntary euthanasia or voluntary assisted dying

- What is the difference?
- Why is it important?
- Relation to suicide

MTPD&T Act 2016

- Commenced March 2017
- Replaces Medical Treatment Act
- Medical Enduring Power of Attorney replaced by MEDICAL TREATMENT DECISION MAKER (but prior MEPAs endure)
- Significant difference is the statutory validation of Advance Care Directives (legal written direction of your future medical treatment). (DWDV Workshops).

MTPD&T Act 2016

- Involvement of a MTDM or application of an *advance care directive (ACD)* only occurs if you have lost mental capacity.
- An ACD overrides any decision by a MTDM.
- If you do not have a MTDM or ACD, your doctor(s) will make medical decisions; while they can take advice from family members, they are not obliged to follow it.

VOLUNTARY ASSISTED DYING ACT 2017

- Becomes operative on June 19, 2019

- Allows competent persons with a terminal illness and intolerable suffering to make a request to their doctor for assistance to end their life by self-administration of medication. The request must be enduring and not made under duress.
- This is a complex piece of legislation (143 clauses, 8 statutory forms).

PERSON MUST MAKE A REQUEST

- A doctor cannot raise the question of VAD, or suggest it as a treatment option.

  A doctor can respond to requests for information about end of life options,
- which could include possible further treatments which have not been considered, palliative care, refusal of medical treatment, voluntary refusal of food and fluids, or voluntary assisted dying.

TERMINAL ILLNESS

- Defined in the Act as an illness that is expected to cause death within weeks or months, but not exceeding 6 months
- Except in the case of neuro-degenerative illness (MND, MS, Parkinson's disease) – 12 months

- *** Prognosis is extraordinarily difficult, but
- changes over time (one negative response is not the end of the matter).

TERMINAL ILLNESS

- Must be associated with advanced, incurable and progressive illness
- Which is causing [intolerable] suffering that cannot be relieved in a manner that the person considers tolerable
- [the person is the judge of ‘intolerable’ suffering].

DECISION-MAKING CAPACITY

- This terminology is often equated with mental competence, or ‘sound mind’ – it relates to the ability to make and understand decisions.
- It involves four criteria –
- 1. understand the information relevant to the decision relating to the access to voluntary assisted dying and the effect of the decision;
- 2. retain the information to the extent necessary to make the decision;
- 3. use or weigh the information as part of the process of making the decision;
- 4. communicate the decision and the person’s views and needs as to the decision in some way, including by speech, gestures or other means.

DECISION-MAKING CAPACITY

- Every person is presumed to have capacity unless there is evidence to the contrary
- Every doctor, in every consultation, is making an overt, or at least intuitive, assessment of capacity. In the context of VAD, this assessment is quite specific.
- If the doctor has any doubt about capacity, he/she must refer to a specialist (usually a psychiatrist) for an expert opinion.

SUMMARY OF REQUEST CRITERIA

- 1. Individual must make a clear and unambiguous request
- 2. have a terminal illness
- 3. have decision making capacity
- 4. have intolerable suffering
- 5. be fully informed about all medical options and the process of VAD
- 6. be making a persistent request
- 7. have no indication of coercion or duress
- * Whether a doctor thinks the request is unwise is irrelevant.

SUBJECTIVITY

- In some respects these criteria involve some subjectivity, but this can be resolved.
- 1. An enduring persistent request – one repeated over TIME
- 2. Terminal illness – will become less subjective over TIME
- 3. Mental capacity – can be clarified by repeated testing over TIME.
- In fact, any uncertainties can be resolved by repeated examination over TIME.

AFFIRMATION BY A SECOND DOCTOR

- All of the above criteria, must be confirmed by a second doctor.
- Either the first (the co-ordinating doctor) or the second (the consulting doctor) may request a psychiatric opinion re mental capacity, or a specialist opinion re diagnosis and/or prognosis.
- Any doctor may refuse a request on the basis of either moral attitude, lack of expertise in the relevant condition, or unavailability.

EXCLUSIONS

- The Act excludes assistance to persons with dementia, and persons with a **solely** psychiatric or mental illness.
- Persons with dementia do not qualify because by the time dementia could be diagnosed as terminal, all decision-making capacity has been lost.

CRITERIA FOR MEDICAL ACCEPTANCE

- 1. Both doctors must be fellows of a specialist college (they may be GPs, members of RACGP)
- 2. They must have had 5 years medical experience after college certification.
- 3. At least one must have ‘relevant experience and expertise’ in the [specific] disease.

Thus the availability of qualified and sympathetic doctors is unclear, and this may cause particular problems in more remote areas.

POTENTIAL PROBLEMS

- In many cases, the criteria will be clearly met, but there will be occasions of subjectivity which will take TIME to resolve.
- Finding two affirming doctors may be a problem –
- (a) Catholic Healthcare has indicated that its institutions (and doctors employed by them) will not co-operate.
- (b) Palliative Care Australia has shown opposition to the Act.
- (c) any doctor can refuse a request on moral (or any) grounds
- (d) not every doctor can accept a request

OTHER DIFFICULTIES

- 1. Witnessing final written request – two witnesses required – not financial beneficiaries, nor employees of medical or care institutions – “bring your own”
- 2. Nomination of a ‘contact person’ who has formal responsibilities for unused medications.
- TIME

PROBLEMS OF TIME

- The first (co-ordinating) doctor is allowed 7 days in which to consider accepting the first request
- a minimum of 9 days must elapse from date of first request to provision of VAD. There is no limit on how long an assessment may take.
- If the co-ordinating doctor considers either a psychiatric or specialist (or both) is necessary,

  obtaining those appointments and assessments will take time.

  All of these phenomena also apply to the consulting doctor's assessment.

PROBLEMS OF TIME (cont)

- The final written declaration requires two independent witnesses
- A contact person must be appointed
- Application must then be made to the DHSS for an assisted dying permit
- A pharmacist must dispense the medication in a locked box.

*IT SHOULD BE CLEAR THAT THIS PROCESS MAY TAKE SOME TIME (MINIMUM 9 DAYS, BUT POTENTIALLY MANY MORE).

PROBLEMS OF TIME (cont)

- It follows that this is not a process to leave to the last minute (clause of exception)

- **CONSEQUENT ADVICE**

- DO NOT LEAVE A FORMAL REQUEST TILL LATE IN THE DAY
- IF YOU ARE GIVEN A DIAGNOSIS OF A SERIOUS POTENTIALLY LIFE THREATENING ILLNESS, COMMENCE A CONVERSATION WITH YOUR DOCTOR(S).

CONSEQUENT ADVICE

- This conversation alerts your doctor about your end of life views. Discuss your advance care directive with him/her and your family
- Ask questions to establish your doctor's attitude **IF** you were to make a formal request and satisfied the criteria.
- If your doctor has a negative view, you may wish to establish connection with another doctor.

CONSEQUENT ADVICE

- There is a complex witnessing process requiring two witnesses who are not beneficiaries, only one may be a family member, and medical practice, hospital and care employees cannot witness.
- A contact person needs to be appointed.
- This person may be one of the witnesses.

CONSEQUENT ADVICE

- If your doctor is supportive, you might ask does he have the relevant experience and expertise in your condition to assist – if not, does he know a specialist to whom he can refer you.
- Early communication and preparation are essential.

THE VAD PROCESS

- The VAD process requires a person who meets the criteria to self-administer the lethal medication (essentially by mouth, or PEG tube).
- Injection by the doctor is only possible when self=administration is not possible due to a rare inability to ingest or absorb medication.
- Negotiations are taking place with the TGA to allow doctors to prescribe a quick-acting barbiturate (nembutal or seconal) to be prescribed in the specific circumstances of this law.

THE VAD PROCESS

- Careful anti-emetic (anti-vomiting) preparation is highly advisable.
- Because the drug is taken by mouth, and must pass into the digestive tract and be absorbed, there is some variation in the time for sleep and then death.
- However, in the vast majority if cases, sleep will occur within 3-5 minutes. Death usually occurs within 15 to 30 minutes, occasionally sooner or longer. With the appropriate preparation and correct dose, failure is exceptionally rare. It is a very peaceful, calm and dignified end to life.
- It can occur at home accompanied by family, and friends if desired, and allows for a profound goodbye.
- The doctor need not be present, but some find it comforting if their doctor is present.

THE DOCTORS' ROLE

- This legislation does place a number of onerous administrative responsibilities, and creates some difficult decisions for your doctors.
- Please be aware of this and treat them kindly and with respect.
- If your initial request for assistance is rejected, you may enquire as to why – a later request may be successful.

COMMUNICATION WITH DWDV

- DWDV is intent on developing a register of doctors who are supportive, and doctors who are opposed, to the legislation. This could be beneficial to members and the public who are having trouble finding assistance.
- If you obtain some valuable information about medical attitudes, please consider informing the DWDV office.
- DWDV will not release information about doctors without their consent.