SUBMISSION ON EXPOSURE DRAFT OF THE MEDICAL SERVICES (DYING WITH DIGNITY) BILL 2014

Prepared by
COTA National Office

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COTA Australia
GPO Box 1583
Adelaide SA 5001

Prepared by
Jo Root
National Policy Manager

Authorised by:
Ian Yates AM
Chief Executive

COTA

COTA Australia is the peak national policy body of older Australians. Its members are the eight State and Territory COTAs (Councils on the Ageing) in NSW, Queensland, Tasmania, South Australia, Victoria, Western Australia, ACT and the Northern Territory. COTA Australia focuses on national policy issues from the perspective of older people as citizens and consumers and seeks to promote, improve and protect the circumstances and wellbeing of all older Australians, promote and protect their interests, and promote effective responses to their needs.

INTRODUCTION

COTA welcomes the opportunity to provide comment to the Committee on this exposure draft.

Within COTA, at the national and State and Territory levels there have been many debates on the issues around voluntary euthanasia. It is an issue which often comes up in discussions with older people. It is interesting to note that when the then Minister for Mental Health and Ageing undertook his national series of conversations with older people about aged care in 2011 people raised many aspects of having greater control over the end of life process as well as the issue of voluntary euthanasia.

Some of the State and Territory COTAs have been active participants in discussions around advanced health directives, end of life care and voluntary euthanasia, seeing their role as one of facilitating community discussion on these issues. We went out to all the State and Territory COTAs asking them for their views on the legislation and their comments are included in this submission.

After much deliberation COTA has decided that it will take a neutral position on the issue. We know that there are divergent views on this issue across the COTA membership and the older population more generally and have decided that it is a matter of personal conscience.

For that reason we are not commenting on whether or not the Commonwealth should legislate on this issue but rather looking at the principles that should be applied if there were to be agreement to have such legislation and how the legislation proposed meets those principles.

ISSUES

We have attached the submission by COTA Tasmania to the proposed model for Voluntary Assisted Dying which was considered by the Tasmanian Parliament in 2013 as this raises many concerns that are also relevant to this legislation. They make the important point that it is imperative that older people’s wishes and beliefs be respected. We have also included COTA's position statement on palliative care as the COTA Tasmania submission references it.

Dying with dignity

COTA has some concerns around the use of the term dying with dignity in this context. It could be taken to imply that the only way to die with dignity is to use these services. COTA believes that everyone should have the right to die with dignity regardless of the cause of or setting for their death. All end of life care should have that as its goal and many people die with dignity without medical intervention that hastens that death. This Bill is only addressing medical intervention to assist with dying.

We suggest that the title of the Bill should be amended to better reflect the idea that it is about assisting people to die. The Tasmanian proposal in 2013 used the term "Voluntary Assisted Dying" and there are many variations on that that better reflect the intent of the legislation.

Definitions

COTA thinks the definition in Clause 4 of illness which includes "degeneration of mental… faculties" is not consistent with the requirement to be of sound mind and competent at the time of making a request. We think this needs to be clarified.

We also think that requirement for "treatment to be unacceptable to the person" needs to be clarified.

Choice

The COTA Tasmania submission stresses the need for people to make an informed choice about care options, including assisted dying. We think clause 12 in the proposed legislation which outlines the pre-conditions to providing dying with dignity medical services are robust and provide for a number of checks and balances to ensure the person understands the decision they are making

One issue which always comes up in discussion is around knowledge of and access to appropriate palliative care. This is covered in clauses 12(1)(h)(I) and (ii)and again in 12(2).

We note the requirement at 12(2) that possibly a fourth medical practitioner could be involved to give information on palliative care options if the designated first practitioner does not have special qualifications in the field of palliative care. We think this may be too onerous and does not acknowledge that it could be difficult for people living in areas without access to specialist palliative care services. It could also be seen as taking away an element of choice from the person who wants to have access to medical services to assist them to die.

We are concerned that the requirement in 13(3) which says the medical practitioner must not proceed if they think palliative care options have not been exhausted talks only about pain and suffering does not mention quality of life.

The meaning of “to a level acceptable to the person” in this clause needs to be clarified. It also does not address the issue of what should happen when the palliative care options referred to are available but “the person” does not wish to accept them? We also think this provision could be considered to undermine much of the rest of the legislation and take the choice to access services away from the individual. It does not meet the basic test of respecting people’s wishes.

The draft legislation does not discuss the role of advanced health directives in showing peoples wishes on treatment under certain circumstances. The existence of an advanced health directive indicates the person has thought about quality of life issues associated with certain medical conditions. We are not suggesting that people could include a request to access dying with dignity in their health directive but we think some consideration should be given to its existence particularly in relation to 13(3).

We have some concerns with clause 12(1)(j) which requires the medical practitioner to be satisfied the person has considered the implications for their family. This undermines the basic principle of respecting an individual’s right to choose. It is also not clear how the medical practitioner could satisfy themselves with regard to this.

Assessment

The exposure draft includes a three tiered approach involving three medical practitioners one of whom is a qualified psychiatrist. Whilst fully endorsing the need for a thorough process that gives a person many opportunities to change their mind we are concerned that this may unreasonably slow up the process, particularly for people living in rural and remote areas.

In particular we are concerned that many people have limited access to medical services and would struggle to access a psychiatrist. It may be simpler if they are in hospital but we know 70 per cent of people want to die at home and so we need to have a model that works well for people who are achieving that goal. We think a GP who has had an ongoing relationship with the person might be well placed to do an assessment of mental health.

Administrative arrangements

It is not clear to COTA why clause 17 gives the Secretary (of the Department of Health) the right to refuse a claim for providing the services. Provided that all the provisions of the Act have been met and the medical practitioner has kept all the records listed in clause 19 then it should not be a discretionary process.

This possibility could inhibit the medical practitioner’s willingness to perform the service as they would not be sure they would be paid. It also may leave open the need for the family or estate to pay for the service.

Other Issues

One concern that has been raised by COTA members is that the legislation seems designed for people living in cities who have ready access to palliative care and other medical facilities. It ignores the fact that many people in outer regional, rural and remote areas of Australia simply don’t have access to those services. Whilst it could be argued that people without access to some palliative care services might find it easier to meet provisions such as clause 13(3) they would certainly find it hard if not impossible to find the three medical practitioners required to allow a certificate of request to go forward.

People from culturally and linguistically diverse backgrounds living in non-metropolitan areas may be further disadvantaged because of the need in clause 13(2) for an interpreter with professional qualifications. This could be overcome by the telephone interpreter service but it would still be more difficult.

CONCLUSION

COTA does not have an opinion on whether or not this legislation has should go forward. What we have tried to identify are some issues that need to be addressed to improve the legislation if it does so.