Submission from the Ethics Subcommittee, Medical Oncology Group of Australia
To
Senate legal and Constitutional Affairs legislation Committee
Re
Exposure Draft of the Medical Services (Dying with Dignity) Bill 2014

**Introduction**

The Medical Oncology Group of Australia (MOGA) is the peak body representing medical oncologists in Australia (Cancer specialists whose primary cancer treatment modality is systemic therapy as part of multimodality care). The Ethics Committee of MOGA has been asked to make a submission to this enquiry on behalf of MOGA whilst recognising that there will be a wide diversity of opinions within the membership of MOGA. Although medical oncologists have expertise in managing patients with terminal illnesses each may have a personal view on the rights of patients with terminal illness to seek euthanasia and will enter the debate along with other members of society. Each clinician is an independent moral agent. We will particularly focus on the section encompassing the rights of the terminally ill.

**Definitions**

As a matter of definition we would characterise voluntary active euthanasia as responding to a request to end a life. This definition does not include withdrawing active treatment from a terminal patient where that treatment will not prevent death and therefore may constitute a burden without benefit, or the provision of adequate symptom control where the primary aim is comfort and not an intention to hasten death.

A terminal illness has no precise definition but would usually be characterised as one where death from an incurable illness is expected to occur within weeks and almost certainly in less than six months. This is generally what is used for other medical situations, such as admission to a hospice. The terminal nature of the illness should be determined as objectively as practical. Using cancer as an example, the diagnosis should be proven by biopsy and a prognosis provided by the patient's own cancer specialist and at least one other cancer specialist not directly involved in the patient's care.

The assessment of treatable clinical depression, not a terminal condition but can be associated with diagnosis of cancer, should be made by an independent and expert psychiatrist, and not solely based on the patient's reaction to their current diagnosis.

**Patient issues**

Most oncologists would agree that for patients facing death our major emphasis would be that resources are available to ensure that each patient can receive palliative care and counselling to explore options for what would continue to make life valuable. The patient must have been provided with these resources for at least several weeks before making their decision. This goes further than Section 12(1)(h) of the Exposure Draft that merely wants the information that these services exist a condition for considering a person's request for euthanasia. We would want to ensure that the patient actually receives these services. It is only then that the "unacceptability" of "pain, suffering, distress or indignity" could be judged.

Pain is often the major symptom quoted in examples of suffering but it is with physical symptoms that the most significant advances have been made in their control. Also, patients may accept some physical symptoms in order to preserve other aspects of their lives such as lucid communication. Often relieved of physical responsibilities with declining physical ability patients may concentrate on other aspects which give meaning to life such as relationships or spiritual wellbeing. The reflections with counsellors may explore options for a continued value to life. For example, patients may believe that they are valued for what they do whereas they should know that others actually value them for being. It is important to explore options for pursuits that give meaning to a life since the inverse of a life of poor quality is not death but a life of better quality that is acceptable to the patient.

It is usually estimated that well delivered palliative care will relieve the suffering of 95% of patients referred for this support. This means only a small minority would wish to consider or undertake euthanasia. It is a proper subject for public reflection whether in an economically rationalist society legislating for the ability to choose euthanasia for a minority may expose others who wish to be fully supported by health care resources until their natural death, would be at increased risk of those resources not being made available.

**Medical Practitioner Issues**

We would support provisions that medical practitioners should be able to express their own moral position whether that means not being mandated to respond to a request for euthanasia or the inverse, responding to a request and being protected by law for their actions.

**Conclusion**

MOGA would like to primarily emphasise the importance of palliative care and counselling to determine what can be of value at the end of life, being available to every patient facing the terminal phase of an illness. The question of legislating for euthanasia will continue to be a matter for individual opinion and societal debate.