SUBMISSION TO THE SENATE LEGAL AND CONSTITUTIONAL AFFAIRS COMMITTEE CONCERNING CONTENT OF THE MEDICAL SERVICES (DYING WITH DIGNITY) EXPOSURE DRAFT BILL 2014

(A) SUMMARY OF OUR POSITION

We, the undersigned people, congratulate the proponents of the the Medical Services (Dying with Dignity) Exposure Draft Bill 2014. If enacted as legislation, it would mean that an extremely worthwhile and justified medical service could be provided to meet the needs of many people who wish to end life peacefully, humanely and with dignity. In numerous polls and surveys in the past, the vast majority of Australians recognise that there is a clear need for access to such medical services by mentally competent adults who are "… experiencing pain, suffering, distress or indignity to an extent unacceptable to the person…" (as is recognised in S10 of the Draft).

However, even if the provisions of the Draft were to be enacted as legislation, the medical services that are described would still not meet the requirements of many people, for these reasons:

1. It is inappropriate to limit access to the medical service to persons who have a "terminal illness" (S10, S12). We strongly support the provision of the life-ending medical services to such people if they are experiencing pain, suffering, distress or indignity to an extent unacceptable to the person. However, we believe that the medical service should also be available to persons who have medical conditions which engender pain, suffering, distress or indignity to an intolerable extent, but who may not have a "terminal illness".

2. Requiring an evaluation to be made by three medical practitioners (including a psychiatrist) (S12) is unnecessarily complicated. For some patients access to three practitioners, and ones who are in support of the patient's views may be be difficult and the process an involved one. Some patients may not have the time, mobility, finances or energy required to undertake that process.

3. The evaluation by three practitioners reflects decision-making that is based on the medical approach of keeping people alive to the extent that is medically possible, even though the quality of their life may be intolerable from the patient's viewpoint. In contrast, we believe that the evaluation needs to give priority to the patient's views about the quality of their life and whether or not they wish to continue living.

4. In the Draft, one evaluation criterion to be applied by the first medical practitioner is that the person has "considered the possible implications …on his/her family…" (S12(1)(j)). That is inappropriate because the practitioner's focus should be on what is best for the patient, not on the welfare of other persons.

5. S12(1)(e) indicates that if the patient is adjudged as having a "treatable clinical depression" then they will not be able to access the life-ending medical service. We object to this provision because:

i. No definition is provided for "treatable clinical depression" and consequentially its scope may be too broad. There will be patients who have a persisting bleak view and a negative attitudinal set as a consequence of their medical condition and poor quality of life. Such a negative view may be rational and an inevitable outcome of a combination of intolerable health conditions which have been experienced over a considerable period of time. However, it may be inappropriate to classify such patients as having a "treatable clinical depression" and as a consequence depriving them of access to life-ending medical services.

ii. There is no provision for a mentally competent patient to refuse treatment for a condition that the psychiatrist classifies as being "treatable clinical depression". A patient may make a perfectly rational decision to refuse such treatment on the grounds of unacceptability of side effects, or for other reasons. However, that refusal may lead to the patient being deprived of access to life-ending medical services. Similarly, there is no provision for a patient to commence treatment but later to cease treatment on the grounds of unacceptability of side effects, or for other reasons.

(B) MAJOR CHANGES PROPOSED

We propose these major changes to the Draft:

1. Change the body of S10 to: "A person who is experiencing pain, suffering, distress or indignity to an extent that is unacceptable to them may make a Certificate of Request to a medical practitioner to provide dying with dignity medical services for the purpose of ending his or her life."

2. Change S12(1)(c) to:

    (c) the medical practitioner is satisfied on reasonable grounds that:

        i. the person has a medical condition in respect of which he or she is experiencing pain, suffering, distress or indignity to an extent that is unacceptable to them and/or is suffering from a terminal illness; and

        ii. there is no medical treatment that is acceptable to the person as a remedy or cure for the medical condition and/or terminal illness specified in (i) preceding, and

        iii. the only medical treatment that is acceptable to the patient in respect of their medical condition or terminal illness, is treatment that will lead to a dignified, painless and comfortable death, and

        iv. the patient's reasons for rejecting any other medical treatment comprise a rational, considered evaluation, and

        v. the patient is mentally competent.

3. Delete S12(1)(d)

4. Change S12(1)(e) to:

    (e) a second medical practitioner who has qualifications in psychiatry has determined that:

        i. the patient does not have treatable clinical depression (as defined in …..); or

        ii. the patient has depression but there is no treatment for that condition that is acceptable to the patient, and

        iii. in the case of (ii) preceding, the patient understands fully the nature of their depression and the options that are available for treatment, their reasons for rejecting such options comprise a rational, considered evaluation, he or she is able to make a rational, considered decision about the consequences of not commencing treatment or of ceasing treatment, and he or she is mentally competent.

5. Delete S12(1)(j)

SUGGESTED MINOR IMPROVEMENTS TO WORDING

If the changes that are suggested above are not implemented there are some matters of lesser importance to which attention needs to be given:

A. The use of the word "reasonably" in these sections is meaningless, ambiguous and obfuscatory: S12(1)(c) (ii) and (iii)

B. The role of the "second medical practitioner" includes a function that is not included in the role of the first medical practitioner - namely confirming "…that the person is likely to die as a result of the illness." (S12(1)(d)(ii). This begs the question as to when death is likely to occur. This could be replaced simply by: "..that the person has a terminal illness."

    An even simpler approach is to change S12(1)(d) to the following: "(d) a second medical practitioner confirms the conclusions of the first medical practitioner."

CONCLUSIONS

In summary, we feel that if enacted, the provisions in the exposure draft would be welcomed by a vast majority of people within the general community in respect of providing an end of life medical service for people who have an intolerable terminal illness.

However, such enacted legislation would be deficient for these reasons:

a) The provisions need to be broadened to meet the end of life needs of all people who have a medical condition in respect of which he or she is experiencing pain, suffering, distress or indignity to an extent that is unacceptable to them, irrespective of whether or not they have a terminal illness.

b) Access to the medical services should be available to mentally competent patients who may wish to discontinue or to abstain from treatment for depression.

c) The involvement of three doctors is unnecessarily complex.

d) The evaluation model proposed is a medical model rather than a model that gives priority to the patient's perception of their own needs.

e) It is inappropriate for a medical practitioner to require that a patient gives consideration to the wishes of his or her family.

SIGNATORIES

The following signatories are people who agree with the content of this submission:

Michael T Boesen and Jennifer A Boesen

Peter N Atcherley

Charles Karlsen

Dr ME March and Mrs P March

Victor Stevens

Anthony Frederick Bennett and Sandra Jeanette Bennett