ANZCA
AUSTRALIAN AND NEW ZEALAND COLLEGE OF ANAESTHETISTS

FPM
FACULTY OF PAIN MEDICINE ANZCA

Submission to the Justice Select Committee on the End of Life Choice Bill

February, 2018

To serve the community by fostering safety and high quality patient care in anaesthesia, perioperative medicine and pain medicine.

Table of contents

1. Executive Summary

The End of Life Choice Bill was introduced to the New Zealand Parliament on June 8, 2017 and having passed the first reading on December 13, 2017, is now being considered by the Justice Select Committee. The Bill gives people with a terminal illness or grievous and irremediable medical condition the option of requesting assisted dying. The Justice Select Committee has invited public submissions to the End of Life Choice Bill and the Australian and New Zealand College of Anaesthetists (ANZCA) has prepared a response which addresses a number of key issues raised by particular sections and clauses of the proposed Bill. ANZCA cannot comment on the need for laws in New Zealand allowing assisted dying, and considers this is an issue for the New Zealand government and public to determine. However, ANZCA considers it has a responsibility to provide feedback on any proposed legislative framework regarding assisted dying, to ensure that the proposed legislation protects patients and health practitioners as much as possible.

ANZCA's position on the issues raised in the End of Life Choice Bill has been developed in response to requests for input into proposed assisted dying legislation in several Australian jurisdictions during 2017. As part of this process, ANZCA sought wide feedback across Australia and New Zealand to reflect the views of ANZCA and Faculty of Pain Medicine fellows, trainees, specialist international medical graduates individually and as members of key committees in relation to key relevant issues.

The issues of legalised assisted dying and end of life choices is a very important one for anaesthetists and specialist pain medicine physicians who may be involved from time to time in end of life discussions and decisions.

ANZCA approaches the issue of assisted dying from the perspective of patient advocacy:

- to protect patients' rights and to ensure that patients can exercise these rights; and
- from a health advocacy standpoint, to ensure that research into palliative care is not an unintended casualty of this process.

ANZCA is also concerned to ensure that medical practitioners, in particular anaesthetists and specialist pain medicine physicians, are protected appropriately under any legislation, and not required to undertake activities which they deem inappropriate or contrary to their personal beliefs or their professional responsibilities towards their patients.

Broad themes in relation to ANZCA's position on assisted dying are:

Involvement of medical colleges

- Prescribed information that medical practitioners provide those considering their end of life choices should be a guideline only in any legislation.
- Specialist expertise required for medical practitioners to participate in assisted dying must be guided by input from medical colleges.

Specialist expertise required

- Medical practitioners should receive appropriate education and be trained as part of their continuing medical education to develop the skills needed to participate in assisted dying and to provide appropriate advice to those seeking it.

Patient choice

- The process should be patient-centred.

- Alleviation of patient suffering should take priority; no period of intolerable suffering is 'acceptably short'.
- A patient suffering debilitating pain may be unable or unwilling to travel long distances to seek appropriate advice and care and those living in rural and remote areas should have the same rights and choices as an individual living in a metropolitan area.

Legal protections for medical practitioners

- A medical practitioner should be allowed to be present at the time the patient self-administers the lethal dose of medication if this is requested by that patient.
- A medical practitioner treating a patient who has chosen to self-administer a lethal dose of medication should be obliged to follow and respect the patient's wishes, and to act with the high degree of professionalism that is expected when providing usual care.
- The recorded cause of death should be the underlying disease process or primary diagnosis that made the patient eligible for an assisted death.
- An assisted death should not be reportable if undertaken in accordance with the legislative requirements, as the cause of death is known and legal in this scenario.
- Unusual or suspicious circumstances surrounding a death should be dealt with in the usual manner, including a report being made to the coroner.
- A report to any oversight body should facilitate practitioner support, rather than investigation.
- An oversight body should refer a matter to another agency (such as the Coroner's Court) when there are concerns about irregularities including: acting outside the scope of practice; acting outside the law; family coercion; or misuse of a lethal drug.
- This oversight body should not have investigatory powers and any investigation should be conducted by existing independent agencies.

Palliative care

- Legalised assisted dying must not become a substitute for good palliative care nor diminish research into palliative care.
- Support should be shown for the concept of death with dignity and comfort and the right of terminally ill patients to receive expert palliative care.
- There should be resourcing for alternative therapeutic and palliative care services and for rural and remote areas, including access to suitably qualified healthcare professionals.
- ANZCA notes that the Health Select Committee's 2017 report on Petition 2014/18 identified that there is inequitable access to palliative care across New Zealand, particularly in rural and provincial areas. It also identified demand for palliative care services is expected to increase significantly; there is a shortage of palliative medicine specialists; the palliative care medical and nursing workforce is ageing which will lead to sustainability issues; and palliative care in New Zealand is lacking resources. Measures must be put in place to address these concerns and invest in equitable access to high quality palliative care across New Zealand, to ensure that voluntary assisted dying does not become a choice patients make based on lack of access to palliative care.

Safeguards

- All safeguards in any proposed legislative framework should be applied meaningfully and not just as an administrative process to complete.
- Safeguards to protect vulnerable patients are crucial.
- 'Subtle coercion' and the difficulty in identifying it are of concern. Family members or parties known to have an interest, including pecuniary interests, in whether the patient lives or dies should not be able to be witnesses to the request process.
- There must be additional safeguards that protect both the patient and the medical practitioner involved in all cases of self-administered medication.
- The form of storage and the location of the lethal dose of medication must be documented to ensure accurate accounting of whether or not the patient has ingested it.

Conscientious objection

- Participation by medical practitioners and health services in an assisted death should be voluntary with no need for any objection to be qualified.
- There may be difficulties in compelling medical practitioners with a conscientious objection to make a personal referral to another medical practitioner when a patient requests assisted dying information or assistance. Some medical practitioners will consider such a referral to be a violation of their personal values.

Rural and remote considerations

- People in rural and remote areas are disadvantaged by inter-related issues of distance, travel and access to services. For example, as mentioned above, in 2017 the Health Select Committee identified that rural and provincial areas have inequitable access to palliative care.
- Medical practitioners who live in rural and remote areas and who agree to be part of the assisted dying process may face ostracism by the community where they live and practise.
- A patient suffering debilitating pain may be unable or unwilling to travel long distances to seek appropriate advice and care but should have the same rights and choices as an individual living in a metropolitan location.
- Rural patients may be disadvantaged by difficulties of access to services (for example, a palliative care physician or palliative care services, obtaining two independent medical reviews and psychiatric or other specialist referral), and difficulties in accessing their wishes due to lack of access to advanced care plans, living wills, and statements on electronic health records in urgent care situations.
- Mechanisms should be developed to ensure access to information on assisted dying at any medical facility a patient might present to (in their own community or in a centre away from home in cases of a rapid deterioration or trauma while travelling).

Other aspects of assisted dying and end of life choices

- Mandatory psychiatric assessment for all patients considering assisted dying and their end of life choices is not necessary. Psychiatric assessment should be required only where there is reasonable doubt or concern relevant to the patient's capacity so that support can be provided in borderline or complex cases.

- Predictions for end of life are often inaccurate and any timeframe used in eligibility criteria (such as life is likely to end within six months) should be applied with caution to avoid prolonging suffering.
- At least two appropriately qualified practitioners from different specialties (including general practice) who are appropriately trained in the legislative requirements should undertake the patient assessments and provide information.
- As the dispenser of the lethal dose of medication from a community or hospital pharmacy, the pharmacist will play a key role in the understanding of, and adherence to, the legislation.
- Ongoing discussions with the community should be encouraged and facilitated alongside the discussions regarding assisted dying, such as the issue of 'futile surgery' (surgery which is unlikely to extend quality of life) as part of the spectrum of discussions around respecting the rights of the patient to accept death.
- How the process should be governed will be influenced by some details yet to be determined, such as the type of medications used. Further consultation may be required as these details are established.
- It could be useful to establish an advisory group for medical practitioners to provide support with issues related to assisted dying independent from the legal process.
- It may occasionally be necessary to provide pain relieving procedures and/or anaesthesia (and surgical) services to an individual who has chosen and been approved for assisted dying. Consideration must be given to either suspension of such wishes during the acute period of medical care (as in advanced care directives) or a specific acknowledgement of the limitations of resuscitation to be undertaken. This is in recognition that an individual may not 'have reached the time' for ending his or her life.
- Consideration must be given to the obligations of, and legal protections for, health practitioners (including paramedics) in cases where the lethal dose of medication is not effective for any reason, particularly in the absence of the patient having an advanced care directive.

2. About ANZCA

The Australian and New Zealand College of Anaesthetists (ANZCA) is the professional organisation for specialist anaesthetists (fellows) and specialist anaesthetists in training (trainees) in Australia and New Zealand.

ANZCA was formed in 1992 following 40 years as a faculty of anaesthetists of the Royal Australasian College of Surgeons. ANZCA is now a world-renowned institution in anaesthesia and pain medicine that has taken a leading role in many areas of anaesthesia, pain medicine and intensive care medicine. These include:

- Being recognised as a world leader in the treatment of pain by establishing the specialty of pain medicine through its Faculty of Pain Medicine.
- Setting high professional standards for patient safety through professional documents and other advocacy activities.
- Answering key questions in medical research by recruiting more than 30,000 patients to help with $A25 million worth of studies for the ANZCA Clinical Trials Network and other research through the ANZCA Research Foundation, which in 2018 alone is funding research worth $1.7 million.
- Training highly skilled future fellows in anaesthesia and pain medicine.
- Hosting more than 30 medical education events annually including the College's flagship event, the ANZCA Annual Scientific Meeting.
- Supporting anaesthesia in developing nations such as Papua New Guinea with clinical and educational visits, and the seeding of the Essential Pain Management program now being taught in 53 countries.
- Establishing intensive care medicine as a specialty by instituting training and accreditation programs through a joint Faculty of Intensive Care, and then by helping found the College of Intensive Care Medicine of Australia and New Zealand.

ANZCA, including FPM, is committed to high standards of clinical practice in the fields of anaesthesia, perioperative medicine and pain medicine. As the education and training body responsible for the postgraduate training programs of anaesthesia and pain medicine for Australia, New Zealand and parts of Asia, the College believes in ongoing continuous improvement and strives to ensure that its programs represent best practice and contribute to a high quality health system.

ANZCA's mission is to serve the community by fostering safety and high quality patient care in anaesthesia, perioperative medicine and pain medicine. From this mission flows three major objectives:

- To promote professional standards and patient safety in anaesthesia, perioperative medicine and pain medicine.
- To promote training and education in anaesthesia, perioperative medicine and pain medicine.
- To advance the science and practice of anaesthesia, perioperative medicine and pain medicine.

ANZCA fellows and trainees

At December 31, 2017 there were 721 active and 86 retired fellows and 244 trainees in New Zealand, and 5,302 fellows (of whom 667 are retired) and 1,268 trainees in Australia.

3. About FPM

The Faculty of Pain Medicine (FPM) is the professional organisation for specialist pain medicine physicians (fellows) and specialist pain medicine physicians in training (trainees).

The Faculty is responsible for the training, examination and specialist accreditation of specialist pain medicine physicians and for the standards of clinical practice for pain medicine in Australia and New Zealand. Formed in 1998, the Faculty is the first multidisciplinary medical academy in the world to be devoted to education and training in pain medicine. Although part of ANZCA, the Faculty's fellowship and representation remains multidisciplinary at all levels. It arose out of collaboration between five participating bodies – ANZCA, the Royal Australasian College of Physicians (RACP), the Royal Australasian College of Surgeons (RACS), the Royal Australian and New Zealand College of Psychiatrists (RANZCP) and the Australasian Faculty of Rehabilitation Medicine (AFRM) of the RACP.

In 2005, the discipline was recognised in Australia as a medical specialty in its own right and was accredited as a scope of practice in New Zealand in 2012. This recognises the importance of the problem of unrelieved pain in the community and the need for a comprehensive medical response through education, training and practice.

The field of pain medicine recognises that the management of severe pain problems requires the skills of more than one medical craft group. Such problems include:

- Acute pain (post-operative, post-trauma, acute episodes of pain in "medical conditions").
- Cancer pain (pain directly due to tumour invasion or compression, pain related to diagnostic or therapeutic procedures, pain due to cancer treatment).
- Persistent (chronic) pain (including over 200 conditions described in the International Association for the Study of Pain (IASP) *Taxonomy of Chronic Pain 2nd Edition*, such as phantom limb pain, post-herpetic neuralgia, mechanical low back pain). More than one in five adults (21%) experience chronic pain in New Zealand.

In Australia and New Zealand, a career in pain medicine is generally obtained by qualifying as a Fellow of the Faculty of Pain Medicine, Australian and New Zealand College of Anaesthetists (FFPMANZCA). Pain specialist training is also open to vocationally registered general practitioners and other specialists.

Fellows of FPM have a wide knowledge of the clinical, sociopsychobiomedical and humanitarian aspects of pain and are well placed to follow a developing and challenging career path.

In 2016, world recognition for the Faculty was achieved through the awarding of the 2017 American Academy of Pain Medicine's (AAPM) Robert G. Addison, MD Award given in recognition of outstanding efforts to foster international co-operation and collaboration on behalf of the specialty of pain medicine. The European Pain Federation is now also using FPM's revised curriculum as the basis for its diploma.

FPM fellows and trainees

At December 31, 2017 there were 34 active and one retired FPM fellows and nine FPM trainees in New Zealand, and 340 FPM fellows (of whom 24 are retired) and 64 FPM trainees in Australia.

4. ANZCA response to the End of Life Choice Bill

The End of Life Choice Bill was introduced to the New Zealand Parliament on June 8, 2017 and having passed the first reading on December 13, 2017, is now being considered by the Justice Select Committee. The Bill gives people with a terminal illness or grievous and irremediable medical condition the option of requesting assisted dying.

The Justice Select Committee has invited public submissions to the End of Life Choice Bill and ANZCA has prepared a response which addresses a number of key issues raised by particular sections and clauses of the proposed Bill. The issues of legalised assisted dying and end of life choices is a very important one for anaesthetists and specialist pain medicine physicians who may be involved from time to time in end of life discussions and decisions.

As mentioned above, ANZCA cannot comment on the need for laws in New Zealand allowing assisted dying, and considers this is an issue for the New Zealand government and public to determine. However, ANZCA considers it has a responsibility to provide feedback on any proposed legislative framework regarding assisted dying, to ensure that the proposed legislation protects patients and health practitioners as much as possible. ANZCA's position on the issues raised in the End of Life Choice Bill has been developed in response to requests for input into proposed assisted dying legislation in several Australian jurisdictions during 2017. As part of this process, ANZCA sought wide feedback across Australia and New Zealand to reflect the views of ANZCA and FPM fellows, trainees, specialist international medical graduates individually and as members of key committees in relation to key relevant issues.

For each of these issues, the relevant section of the End of Life Choice Bill is presented followed by ANZCA's comments.

4.1 Interpretation

Part 1:	**Preliminary provisions**
Section 3:	**Interpretation**
In this Act, unless the context requires another meaning – **assisted dying** means the administration by a medical practitioner of a lethal dose of medication to a person to relieve his or her suffering by hastening death	

ANZCA comment:

The definition of assisted dying in the Bill is unclear. The above definition suggests assisted dying involves a medical practitioner administering the lethal dose of medication. However, section 15 (3) (a) of the Bill lists the following methods for the administration of a lethal dose of medication:

i) ingestion, triggered by the person
ii) intravenous delivery, triggered by the person
iii) ingestion through a tube
iv) injection

Options i and ii contain the phrase "triggered by the person." It is not clear what triggered by the person means, for example whether it is a verbal instruction to the medical practitioner to proceed, or whether it is the person self-administering the lethal dose. If it is referring to a verbal instruction, it is unclear why options iii and iv are not also to be triggered by the person.

If the phrase "triggered by the person" is actually referring to self-administration of the lethal dose, then the definition of assisted dying needs to acknowledge that self-administration (not just medical practitioner administration) is a component of assisted dying.

It needs to be absolutely clear throughout the Bill about whether it is referring to self-administration of a lethal dose, or administration by a medical practitioner of a lethal dose. It is important to understand that many practitioners have expressed discomfort with the role of a health practitioner actively administering a lethal dose of medication.

4.2 Meaning of a person who is eligible for assisted dying

Part 1:	**Preliminary provisions**
Section 4:	**Meaning of person who is eligible for assisted dying**

In this Act, **person who is eligible for assisted dying** means a person who—

(a) is aged 18 years or over; and

(b) is-

(i) a person who has New Zealand citizenship as provided in the Citizenship Act 1977; or

(ii) a permanent resident as defined in section 4 of the Immigration Act 2009; and

(c) suffers from-

(i) a terminal illness that is likely to end his or her life within 6 months; or

(ii) a grievous and irremediable medical condition; and

(d) is in an advanced state of irreversible decline in capability; and

(e) experiences unbearable suffering that cannot be relieved in a manner that he or she considers tolerable; and

(f) has the ability to understand-

(i) the nature of assisted dying; and

(ii) the consequences for him or her of assisted dying.

ANZCA comment:

Definition of a terminal illness

ANZCA's position is that prospective predictions for end of life are often inaccurate and any minimum timeframe should be applied with caution, as these create the risk of prolonging avoidable suffering. Overall, no greater specificity is required as "end of life" is subjective, difficult to predict and uncertain.

Alleviation of patient suffering should take priority; no period of intolerable suffering is "acceptably short". Critically, a patient's perception of their intolerance to suffering and their decision to end their life are more important than a specified time in days or years. A higher degree of specificity should not inadvertently block reasonable access to assisted dying if this legislation is to be enacted.

An option to consider is "duration" or "reasonable medical judgement" may be determined by multiple specialists regarding a trajectory of deteriorating health (measurable and inexorable, with death within weeks or months being a predictable outcome).

Definition of eligible person's ability to understand

The proposed definition relates solely to the person's understanding of assisted dying.

ANZCA suggests further consideration regarding the sufficiency of this definition should be given, for example specifically including reference to the person's ability to:

- understand the facts relevant to the illness or condition.
- understand the medical treatments and other options available to them, including palliative care.
- retain the information to the extent necessary to make the decision.
- communicate the decision in some way (speech, gestures or other means).

4.3 Conscientious objection

Part 2:	**Assisted dying**
Section 6:	**Conscientious objection**
(1) This Act does not require a person to do anything to which the person has a conscientious objection. (2) **Subsection (1)-** (a) applies despite any legal obligation to which the person is subject, however the obligation arises; and (b) does not apply to the requirement in **section 7(2).**	
Section 7:	**Effect of conscientious objection**
(1) This section applies when- (a) a person tells the attending medical practitioner under **section 8(1)** that the person wishes to have the option of receiving assisted dying; and (b) the attending medical practitioner has a conscientious objection. (2) The attending medical practitioner must tell the person that- (a) the medical practitioner has a conscientious objection; and (b) the person may ask the SCENZ Group for the name and contact details of a replacement medical practitioner. (3) If the person chooses to have the replacement medical practitioner, references in this Act to the attending medical practitioner mean the person's replacement medical practitioner, except in **subsection (2) and section 8(1).**	

ANZCA comment:

ANZCA's position is that medical practitioner participation in assisted dying should be voluntary and that there should be no need for an objection to be qualified. Should a practitioner hold an objection, they should declare this to the patient at the first consultation where it becomes highly likely that the patient has a life threatening illness that is unable to be treated to remit the condition, and may progress to a condition involving suffering before death. The practitioner should be required to honour a request to refer the patient to an appropriate medical practitioner or to the SCENZ Group (as per Section 7 (2) (b) of the Bill).

Some medical practitioners may view being required to refer to another practitioner as a violation of their personal values. An alternative could be that medical practitioners with a conscientious objection could register their objection with an accessible government body (as per Part 3, cl 19 of the Bill). This would also be useful for patients, who should be able to access a practitioner willing to participate in assisted dying in such a circumstance.

4.4 Making and confirming a request

Part 2:	**Assisted dying**
Section 8:	**Request made**

(1) A person who wishes to have the option of receiving assisted dying must tell the attending medical practitioner of his or her wish.
(2) The attending medical practitioner must—
(a) give the person the following information:
(i) the prognosis for the terminal illness or grievous and irremediable medical condition; and
(ii) the irreversible nature of assisted dying; and
(iii) the anticipated impacts of assisted dying; and
(b) talk with the person about his or her wish at intervals determined by the progress of his or her terminal illness or medical condition; and
(c) ensure that the person understands his or her other options for end of life care; and
(d) ensure that the person knows that he or she can change his or her mind at any time; and
(e) encourage the person to talk about his or her wish with others such as family, friends, and counsellors; and
(f) ensure that the person knows that he or she is not obliged to talk to anyone; and
(g) ensure that the person has had the opportunity to talk about his or her wish with those whom he or she chooses; and
(h) do his or her best to ensure that the person expresses his or her wish free from pressure from any other person by—
(i) talking with other health practitioners who are in regular contact with the person; and
(ii) talking with members of the person's family approved by the person; and
(i) complete the first part of the prescribed form requesting the option of assisted dying by recording the actions he or she took to comply with paragraphs (a) to (h).

ANZCA comment:

The legislation should provide guidelines on what information a medical practitioner must provide, but the actual content should be prescribed by the specialist medical colleges with guidance based on using elements of the proposed list.

ANZCA proposes that this information should include discussion about:

- difficulty of predicting likely time course, change in symptoms, response to treatments and what new treatment modalities may soon be available.
- palliative care options.
- the consequences of taking an incomplete or ineffective dose of the lethal medication.

There should be a provision for the patient to acknowledge that the information received is adequate.

Resources should be developed that can be used to assist in providing the information required under legislation to patients. These resources should be disease-specific and evidence-based internet resources made accessible to the public via Ministry of Health and medical college websites. All resources must have multilingual options.

Part 2:	**Assisted dying**
Section 9:	**Request confirmed**

(1) This section applies after **section 8** is complied with.
(2) If the person wishes to proceed, the attending medical practitioner must give the person the prescribed form requesting the option of assisted dying.
(3) The person must—
(a) sign and date the second part of the form; or
(b) be present when the second part of the form is signed and dated as described **in subsection (4).**
(4) The second part of the form may be signed and dated by a person other than the person to whom it relates if—
(a) the person to whom it relates cannot write for any reason; and
(b) the person to whom it relates requests the other person to sign and date it; and
(c) the person who signs and dates the part notes on it that he or she did so in the presence of the person to whom the form relates; and
(d) the person who signs and dates the part is not—
(i) a health practitioner caring for the person to whom the part relates; or
(ii) a person who knows that he or she stands to benefit from the death of the person to whom the part relates; or
(iii) a person aged under 18 years; or
(iv) a person with a mental disability.
(5) The attending medical practitioner must—
(a) be present when—
(i) **subsection (3)(a)** is complied with; or
(ii) **subsections (3)(b) and (4)** are complied with; and
(b) collect the form; and
(c) send the completed form to the registrar.

ANZCA comment:

ANZCA concurs that requests should be made by the patient by declaration or written consent. There may be situations where a patient is unable to make a written request (for example end-stage motor neurone disease). Recordings of consent (video or audio) could be used for patients no longer able to write. Whether the request is made in writing or by other means, there should be a witness.

Family members or parties known to have an interest, including pecuniary interests, in whether the patient lives or dies should not be able to be witnesses to the request process. ANZCA suggests the patient is interviewed by a number of experts (medical and otherwise) on at least two occasions, separated by at least a week and separate from family and friends.

Medical practitioners should be involved in terms of providing medical advice to the patient. However, ANZCA queries whether the involvement of other professional groups (such as the legal profession) has been considered. It may be that the legal profession is better placed to assist with compliance with legal processes.

4.5 Medical opinion

Part 2:	**Assisted dying**
Section 10:	**First opinion reached**
(1) This section applies after **section 9** is complied with. (2) The attending medical practitioner must reach the opinion that— (a) the person is a person who is eligible for assisted dying; or (b) the person is not a person who is eligible for assisted dying; or (c) the person would be a person who is eligible for assisted dying if the person's competence were established as described in **section 12.** (3) The attending medical practitioner must— (a) complete a prescribed form recording his or her opinion; and (b) send the completed form to the registrar.	
Section 11:	**Second opinion reached**
(1) This section applies if the attending medical practitioner reaches the opinion described in **section 10(2)(a) or (c).** (2) The attending medical practitioner must— (a) ask the SCENZ Group for the name and contact details of an independent medical practitioner; and (b) ask the independent medical practitioner for his or her opinion on whether the person is a person who is eligible for assisted dying. (3) The independent medical practitioner must— (a) read the person's files; and (b) examine the person; and (c) reach the opinion that— (i) the person is a person who is eligible for assisted dying; or (ii) the person is not a person who is eligible for assisted dying; or (iii) the person would be a person who is eligible for assisted dying if the person's competence were established as described in **section 12.** (4) The independent medical practitioner must— (a) complete a prescribed form recording his or her opinion; and (b) send the completed form to the registrar; and (c) send a copy of the completed form to the attending medical practitioner.	

ANZCA comment:

ANZCA concurs that a patient who requests assistance should be assessed by at least two appropriately qualified practitioners and makes the further the recommendation that they be from different medical specialities (for example, palliative care, oncology, or the patient's usual GP).

At least one of the two medical practitioners must have experience and expertise in the disease, illness or medical condition expected to cause the death of the person making the assisted dying request.

Any healthcare provider involved should be appropriately trained in the legislative requirements of assisted dying.

Part 2:	**Assisted dying**
Section 12:	**Third opinion reached, if necessary**

(1) This section applies if—
- (a) the following situation exists:
  - (i) the attending medical practitioner reaches the opinion described in **section 10(2)(a)**; and
  - (ii) the independent medical practitioner reaches the opinion described in **section 11(3)(c)(iii)**; or
- (b) the following situation exists:
  - (i) the attending medical practitioner reaches the opinion described in **section 10(2)(c)**; and
  - (ii) the independent medical practitioner reaches the opinion described in **section 11(3)(c)(i)**; or
- (c) the following situation exists:
  - (i) the attending medical practitioner reaches the opinion described in **section 10(2)(c)**; and
  - (ii) the independent medical practitioner reaches the opinion described in **section 11(3)(c)(iii)**.

(2) The medical practitioners must jointly—
- (a) ask the SCENZ Group for the name and contact details of a specialist; and
- (b) ask the specialist for his or her opinion on whether the person is competent.

(3) The specialist must—
- (a) read the person's files; and
- (b) examine the person; and
- (c) reach the opinion that—
  - (i) the person is competent; or
  - (ii) the person is not competent.

(4) The specialist must—
- (a) complete a prescribed form recording his or her opinion; and
- (b) send the completed form to the registrar; and
- (c) send a copy of the completed form to—
  - (i) the attending medical practitioner; and
  - (ii) the independent medical practitioner.

ANZCA comment:

ANZCA does not feel it is necessary to mandate psychiatric or psychological assessment for all patients considering assisted dying, but such assessment should be an option available to a medical practitioner in the assisted dying process.

Psychiatric or psychological assessment should be required only where there is reasonable doubt or concern relevant to the patient's capacity (for example, cognitive impairment or significant decline, evidence of psychiatric illness or existing psychiatric treatment) so that support can be provided in borderline or complex cases.

ANZCA would support a requirement for a set of standard assessment tools to determine cognitive capacity and whether a psychiatric assessment is required. A psychiatric assessment would then determine that a patient (a) is not suffering from a psychiatric disorder which might impact on valid decision-making and (b) has the intellectual capacity to make an informed decision. In circumstances such as substance abuse, a psychiatrist or addiction medicine specialist may be required to certify that the patient is not under the influence of drugs that may affect cognitive ability to make this particular decision regarding assisted dying.

4.6 Making a positive decision

Part 2:	**Assisted dying**
Section 14:	**Positive decision made on request**

(1) This section applies if—
- (a) the following situation exists:
  - (i) the attending medical practitioner reaches the opinion described in **section 10(2)(a)**; and
  - (ii) the independent medical practitioner reaches the opinion described in **section 11(3)(c)(i)**; or
- (b) the following situation exists:
  - (i) a specialist is asked for his or her opinion under **section 12(2)(b)**; and
  - (ii) the specialist reaches the opinion described in **section 12(3)(c)(i)**.

(2) The attending medical practitioner must—
- (a) tell the person that the person is a person who is eligible for assisted dying; and
- (b) discuss with the person the progress of the person's terminal illness or grievous and irremediable medical condition; and
- (c) discuss with the person the likely timing of the assisted dying; and
- (d) make provisional arrangements to be available to administer the medication at the time indicated.

ANZCA comment:

Part (2)(d) implies that the attending medical practitioner will administer the lethal dose of medication. As mentioned above about part 1 (3) of the Bill, many practitioners have expressed discomfort with the role of a health practitioner actively administering a lethal dose of medication.

Additional safeguards should be required when a medical practitioner administers the lethal dose of medication. These safeguards must protect both the patient and the medical practitioner involved.

Parts (2) (c) and (d) refer to planning a time for the assisted dying, and making provisional arrangements for the attending medical practitioner to be available to administer the medication at the time indicated. ANZCA recommends these clauses need to be carefully considered, as making arrangements for timing of administration by a medical practitioner, may inadvertently place the patient under undue pressure.

4.7 Medication

Part 2:	**Assisted dying**
Section 15:	**Medication chosen**

(1) This section applies after **section 14** is complied with.
(2) When the person wishes to exercise the option of receiving assisted dying, he or she must tell the attending medical practitioner.
(3) The attending medical practitioner must—
- (a) tell the person about the following methods for the administration of a lethal dose of medication:
  - (i) ingestion, triggered by the person:
  - (ii) intravenous delivery, triggered by the person:
  - (iii) ingestion through a tube:
  - (iv) injection; and
- (b) ask the person to choose one of the methods; and
- (c) ask the person to choose the time at which he or she wishes the medication to be administered; and
- (d) ensure that the person knows that he or she can change his or her mind at any time.

(4) At least 48 hours before the chosen time of administration, the attending medical practitioner must—
- (a) write the appropriate prescription for the person; and
- (b) advise the registrar of the method and time chosen; and
- (c) provide the registrar with the prescription.

(5) The registrar must check that the process in **sections 8 to 14** has been complied with.
(6) If the registrar is satisfied that the process in **sections 8 to 14** has been complied with, the registrar must—
- (a) co-sign the prescription for the person; and
- (b) provide the co-signed prescription to the attending medical practitioner.

ANZCA comment:

Section 15 (3) of the Bill needs to clarify which of the methods listed are self-administered and which are administered by a medical practitioner. Also, there must be disclosure in the legislation of the type, dose and formulation of the lethal dose of medication to be administered and of the alternative methods that may be used if the patient is unable to self-administer or ingest or absorb the lethal dose of medication.

As discussed above, it also needs to be clear what "triggered by the person" means and whether this is referring to self-administration or not. If it is referring to self-administration, restricting intravenous delivery to self-administration rather than also allowing medical practitioners to provide intravenous delivery where required, would be too limiting.

ANZCA's position is that the documentation required to effectively monitor a prescribed lethal dose of medication should be minimal and not place undue pressure on either prescriber or patient; for example, as per the Oregon State Public Health Division's Pharmacy Dispensing Record Form (see http://bit.ly/2npd7v9).

As the dispenser of the lethal dose of medication from a community or hospital pharmacy, the pharmacist will play a key role in the understanding of, and adherence to, assisted dying legislation. Monitoring a prescribed lethal dose of medication will involve controls related to dispensing, safe storage and medical practitioner actions.

Approval to proceed from the registrar must be provided expediently.

Part 2:	**Assisted dying**
Section 16:	**Medication administered**

(1) This section applies after **section 15** is complied with.
(2) At the chosen time of administration, the attending medical practitioner must ask the person if he or she chooses to receive the medication.
(3) If the person chooses not to receive the medication, the attending medical practitioner must—
- (a) remove the medication from the room; and
- (b) return the medication to the pharmacist who dispensed it; and
- (c) complete a prescribed form recording the actions taken to comply with **paragraphs (a) and (b)**; and
- (d) send the completed form to the registrar.

(4) If the person chooses to receive the medication, the attending medical practitioner must administer it by—
- (a) providing it to the person, for the methods described in **section 15(3)(a)(i) and (ii)**; or
- (b) providing it, for the methods described in **section 15(3)(a)(iii) and (iv)**.

(5) The attending medical practitioner must—
- (a) be available to the person until the person dies; or
- (b) arrange for another medical practitioner to be available to the person until the person dies.

(6) For the purposes of **subsection (5)**, the medical practitioner is available to the person if the medical practitione
- (a) is in the same room as the person; or
- (b) is not in same room as the person but is in close proximity to the person.

ANZCA comment:

This clause states the attending medical practitioner will administer the lethal dose of medication and be in the same room (or nearby) until the person dies. As noted in the response to Part 2 cl 14 above, many practitioners have expressed discomfort with the role of a health practitioner actively administering a lethal dose of medication.

This clause also appears to mandate medical administration and supervision of death, and does not allow the person the option of independent self-administration, for example at home, alone or with family. ANZCA notes that in other jurisdictions (such as Victoria, Australia) assisted dying legislation is based on self-administration, where the person is provided a prescription for the voluntary assisted dying substance that they can fill from a pharmacy, and then store in a locked box until the time they decide to use it. It is only

when the person is physically incapable of administering or digesting the substance, that a medical practitioner may become involved with administration. In that scenario, extra safeguards are also in place, including that the medical practitioner can only administer the substance after a request from the person and in the presence of an independent witness.

Based on the above, ANZCA urges the Justice Select Committee to carefully consider the following issues with part 2 section 16 of the Bill:

- Why has independent, self-administration of the lethal substance not been included as the primary option for administering the medication?
- Why is it assumed that it should be a medical practitioner that administers the lethal dose of medication?
- What safeguards will be in place to protect both the patient and the medical practitioner in all cases of medically-administered medication? ANZCA recommends that as well as asking the person whether they choose to receive the medication, an impartial witness should also be present to ensure the medication has been administered at the request of the patient, and that the legally required paperwork has been completed and signed off to indicate this.

Part 2:	**Assisted dying**
Section 18:	**Unused medication returned**

(1) **Subsection (2) or (3)** applies if—
(a) a prescription is written under **section 15(4)(a)**; and
(b) the medication is not dispensed before the person for whom the prescription was written dies.
(2) If the attending medical practitioner holds the prescription when the person dies, he or she must—
(a) destroy it; and
(b) complete a prescribed form recording the action taken to comply with **paragraph (a)**; and
(c) send the completed form to the registrar.
(3) If the registrar holds the prescription when the person dies, he or she must—
(a) destroy it; and
(b) complete a prescribed form recording the action taken to comply with **paragraph (a)**.
(4) **Subsection (5)** applies if—
(a) a prescription is written under **section 15(4)(a)**; and
(b) the medication is dispensed but not used before the person for whom the prescription was written dies.
(5) The attending medical practitioner must—
(a) return the medication to the pharmacist who dispensed it; and
(b) complete a prescribed form recording the action taken to comply with **paragraph (a)**; and
(c) send the completed form to the registrar.

ANZCA comment:

As noted, the pharmacist will play a key role in the understanding of, and adherence to, assisted dying legislation. Monitoring a prescribed lethal dose of medication will involve controls related to dispensing, safe storage and medical practitioner actions.

ANZCA recommends for consideration that:

- prescribed lethal doses of medication are dispensed, held and administered under careful control to enable tracking at all times.
- lethal doses of medication could be held in a lockable receptacle or safe in the house.
- management of the medication should prevent inadvertent ingestion (for example by a child) or deliberate ingestion by a third person.
- the legislation takes into consideration that time-restricting possession of the drug may place the patient under undue pressure.

4.8 Reporting a death

Part 2:	**Assisted dying**
Section 17:	**Death reported**

(1) Within 14 working days of a person dying as a result of the administration of medication under **section 16**, the attending medical practitioner must send the registrar a report in the prescribed form containing the information described in **subsection (2)**.

(2) The information is—

(a) the attending medical practitioner's name; and
(b) the person's name; and
(c) the person's last known address; and
(d) the fact that the person died; and
(e) a description of how the attending medical practitioner complied with **section 14(2)**; and
(f) which of the methods described in **section 15(3)(a)** was used; and
(g) a description of the administration of the medication; and
(h) whether any problem arose in the administration of the medication and, if so, how it was dealt with; and
(i) the place where the person died; and
(j) the date and time when the person died; and
(k) the name of the medical practitioner who was available to the person until the person died; and
(l) the names of any other health practitioners who were present when the person died.

(3) The registrar must send the report to the review committee.

ANZCA comment:

ANZCA recommends that the underlying disease process or primary diagnosis that made the person eligible for assisted dying is also reported to the registrar.

4.9 Oversight and review

Part 3:	**Accountability**
Section 19:	**SCENZ Group**

(1) The Director-General must establish the SCENZ Group by appointing to it the number of medical practitioners the Director-General considers appropriate.
(2) The functions of the SCENZ Group are—
(a) to make and maintain a list of medical practitioners who are willing to act for the purposes of this Act as—
(i) replacement medical practitioners:
(ii) independent medical practitioners:
(b) to provide a name and contact details from the list, when this Act requires the use of a replacement medical practitioner or independent medical practitioner, in such a way as to ensure that the attending medical practitioner does not choose the replacement medical practitioner or independent medical practitioner:
(c) to make and maintain a list of health practitioners who are willing to act for the purposes of this Act as specialists:
(d) to provide a name and contact details from the list, when this Act requires the use of a specialist, in such a way as to ensure that neither the attending medical practitioner nor the independent medical practitioner chooses the specialist:
(e) to make and maintain a list of pharmacists who are willing to dispense medication for the purposes of **section 16**:
(f) to provide a name and contact details from the list when **section 16** is to be applied:
(g) in relation to the administration of medication under **section 16**,—
(i) to prepare standards of care; and
(ii) to advise on the required medical and legal procedures; and
(iii) to provide practical assistance, if assistance is requested.
(3) The ministry must service the SCENZ Group.

ANZCA comment:

ANZCA supports the establishment of a group such as SCENZ to establish and maintain a list of practitioners and pharmacists willing to act for the purposes of the Act as noted in our response to Part 2 cl 6 above.

Part 3:	**Accountability**
Section 20:	**Review committee**

(1) The minister must appoint an end of life review committee consisting of—
(a) a medical ethicist; and
(b) a medical practitioner who practises in the area of end of life care; and
(c) another medical practitioner.
(2) The review committee has the following functions:
(a) to consider reports sent to it under **section 17(3)**; and
(b) to report to the registrar about its satisfaction or otherwise with the cases reported; and
(c) to recommend actions that the registrar may take to follow up cases with which the review committee was not satisfied.

ANZCA comment:

Consideration should be given to the potentially devastating effect on a practitioner of enduring a process of investigation. The assisted dying process will fail to retain support of medical practitioners if inappropriate investigations (for example, vindictive claims by an 'opposing' relative) are not prevented.

Part 3:	Accountability
Section 22:	Review of operation of Act
(1) Three years after the commencement of this Act, the ministry must start a review of the operation of this Act and must complete it within 6 months of starting it. (2) Every 5 years after the date of the last review, the ministry must start another review of the Act and must complete it within 6 months of starting it. (3) Every review must consider whether any amendments to this Act are necessary or desirable. (4) Every review must be the subject of a report to the minister. (5) The minister must present every report to the House of Representatives as soon as practicable after receiving it.	

ANZCA comment:

A regular review of the Act and its policy objectives by an independent governance committee could be considered.

Also, annual reporting on any cases and issues that arose, should be considered.

4.10 Other issues

Part 4:	Related matters
Section 25:	Effect of death under this Act
A person who dies as a result of the provision of assisted dying is taken for all purposes to have died as if assisted dying had not been provided.	

ANZCA comment:

The recorded cause of death should be the underlying disease process or primary diagnosis that made the person eligible for assisted dying.

Part 4:	Related matters
Section 26:	Immunity in civil or criminal proceedings
A person is immune from liability in civil or criminal proceedings for acts or omissions in good faith and without negligence in providing or intending to provide assisted dying.	

ANZCA comment:

ANZCA strongly supports the concept that medical practitioners (and others) acting in good faith and without negligence in accordance with the Act are immune from liability in civil or criminal proceedings.

As well as protecting medical practitioners in terms of liability, ANZCA also suggests that consideration be given in the legislation to protect medical practitioners from harassment. Examples provided include making it an offence to protest within a certain radius of where assisted dying services are accessible and making it an offence to publish the personal details of practitioners providing this service.

5. Contact details

Australian and New Zealand College of Anaesthetists

5 Willeston Street

Wellington 6011

PO Box 25506, Featherston Street

Wellington 6146

New Zealand National Committee Chair:

Dr Jennifer Woods

chair@anzca.org.nz

General Manager, New Zealand:

Ms Heather Ann Moodie

gm@anzca.org.nz

+ 64 4 499 1213