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Medical Oncology Group of Australia position statement and membership survey on voluntary assisted dying

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Abstract

The controversial topic of voluntary assisted dying (VAD) is receiving significant attention at state government levels and in the community. Acknowledging potential legalisation of VAD, the Medical Oncology Group of Australia (MOGA) undertook a survey of members to inform the development of a position statement on the subject. All MOGA members were invited to complete an anonymous online survey. The survey comprised 12 closed-response categorical questions. Descriptive statistics were used to summarise the survey data. Majority views expressed in the survey would form the basis of a MOGA position statement on VAD. A total of 362 members completed the questionnaire, representing 55% of the membership; 47% of respondents disagreed with VAD; 36% agreed with VAD and the remaining members (17%) were 'neutral'. A clear majority position was not established. Only 14% agreed that physicians involved in VAD should be required personally to administer the lethal medication; 94% supported conscientious objection of physicians to the VAD process; 95% agreed that a palliative care physician consultation should be required and 86% agreed with the need for the involvement of specialist psychiatry medical services before a patient can be deemed as suitable for VAD. The MOGA membership expressed a range of views on the topic of VAD. A clear majority-held view to support a MOGA position that either supports or opposes VAD was not established. The position statement that flows from the survey encourages informed debate on this topic and brings into focus important considerations.

Introduction

On 29 November 2017, legislation to legalise voluntary assisted dying (VAD) was passed by the State Government of Victoria. From mid-2019, patients considered to be terminally ill will be able legally to request and receive a lethal drug to end their lives. The Voluntary Assisted Dying Bill 2017 was debated in the Upper House of the NSW State Government on 16 November 2017 and failed to pass by the narrowest of margins, a single vote. The controversial topic of VAD is receiving significant attention at state government levels and in the community. The potential impact on clinical practice is major.

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VAD involves a physician prescribing medication to a patient with the explicit intention of causing premature death. VAD may be requested by a patient with a terminal illness, such as advanced terminal cancer, who judges that the burden of living with his/her illness is greater than their perception of any benefit in continuing to live. VAD is not the withdrawal of burdensome treatments that are no longer effective. Withdrawal of treatment is part of standard medical care where any treatment that is judged to be causing more harm than benefit is discontinued.

The Medical Oncology Group of Australia (MOGA) is a special society of the Royal Australasian College of Physicians. It comprises almost 700 members, all medical oncologists (specialist physicians and advanced physician trainees in medical oncology). MOGA is the peak professional body representing the medical specialty of medical

oncology in matters of health policy, education, research, service delivery and professional support.

Acknowledging the possibility of legalisation of VAD, and in response to concerns raised by members holding positions on both sides of the debate, MOGA undertook a process to develop a position statement on the subject. A survey of members on the subject of VAD was conducted to evaluate the overall membership view, seeking to determine majority positions. The survey results were used to justify the MOGA position statement on VAD. The position statement was developed and endorsed by the MOGA Executive Committee. The statement was prepared with the involvement of the MOGA Ethics Subcommittee. Evidence on the subject was reviewed.

The following statements represent the MOGA position on VAD:

1 MOGA recognises that individually held positions on VAD differ and understands that medical oncologists in Australia have diverse views on this subject. MOGA neither opposes nor supports VAD as a legally acceptable practice in specifically defined situations.
2 MOGA supports the involvement of palliative care specialists in the care of patients with advanced cancer. All patients wishing to access VAD should receive optimal symptom management and achieving this should involve specialised palliative care input.
3 A voluntary process requires the patient requesting VAD has the capacity to make this decision, without the influence of cognitive impairment or mental disease. Psychiatry involvement in determining patient competence for consenting to VAD should be required.
4 The determination of an accurate prognosis needs to be carefully considered and should involve appropriately trained medical specialists that are aware of all the treatment options, both currently available and emerging therapies. Therapeutic advances can improve the prognosis and an up-to-date knowledge is required. A medical specialist with a detailed knowledge of the disease in question and all the treatment options should be required to be involved in the evaluation of the patient who has requested VAD.
5 If VAD were to be legalised, there must be comprehensive support and training of healthcare professionals who will be involved in the process.
6 In the setting of advanced incurable cancer, current clinical practice aims to maximise a patient's quality of life until death. Quality of life includes physical, psychosocial and spiritual well-being. Medical oncology together with the speciality of palliative care plays an important role in maintaining this quality of life. We encourage all medical oncologists to work closely with palliative care teams to achieve the agreed goals of care.
7 MOGA strongly supports the right of individual medical oncologists to decline any involvement in the process of VAD. MOGA absolutely supports the conscientious objection of physicians to the VAD process.
8 We acknowledge that there will be a range of views on the topic of VAD. We encourage informed debate on this topic as new considerations emerge.

MOGA membership survey on VAD

The MOGA member survey on VAD was an initiative of the MOGA Executive Committee. The development of the survey included input from the MOGA Ethics Subcommittee. There were no other parties involved. MOGA sought to understand the views of its members before preparing a position statement on VAD. The survey ascertained individual members, personal position on VAD from an ethical, moral or philosophical perspective. The survey also explored members' views regarding some practical aspects of the process of VAD. The MOGA survey on VAD was conducted during the period that the Victorian Bill to legalise VAD was being considered by the Lower House of state parliament. The Bill had not yet passed the Lower House at the time of completion of the survey.

All members of MOGA were sent an invitation by email, inviting them to complete an anonymous online survey. The survey was expected to take 10 min to complete. All data were captured and collated electronically. The survey comprised 12 closed-response categorical questions. The survey was pilot tested by the MOGA Executive Committee and the MOGA Ethics Subcommittee. Descriptive statistics were used to summarise the survey data.

Results

A total of 362 members completed the questionnaire, representing 55% of the membership.

Questions

What is your philosophical/ethical/moral position on VAD?

This was considered the dominant question in terms of establishing a MOGA position on VAD. Results are shown in Figure 1; 47% of respondents disagreed with VAD; 36% of respondents agreed with VAD and the remaining members (17%) were 'neutral'. The 'neutral' response was assumed to indicate that members were undecided or that they did not hold a view. A clear majority position was not established. We cannot be sure of the views of the remaining 45% of members. It may hold true that those not participating in the survey are

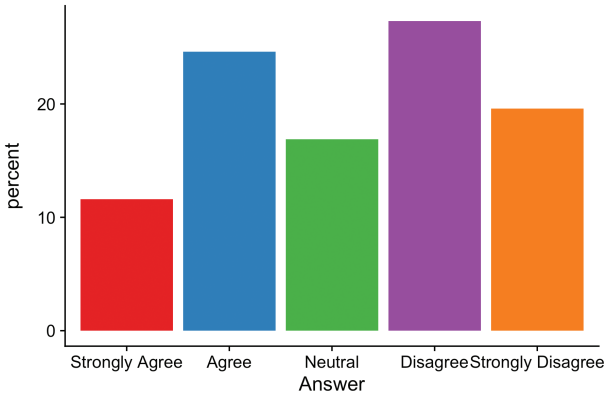

Figure 1 Medical Oncology Group of Australia members stance on the general philosophical approach to voluntary assisted dying.

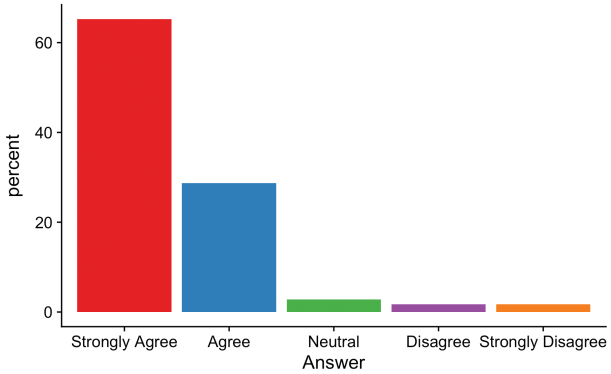

Figure 2 Medical Oncology Group of Australia members stance on the option of physicians to opt out of voluntary assisted dying.

more likely to hold neutral views or may view the topic as 'too hard'. The MOGA Executive Committee accepted that the membership expressed diverse views on VAD. On the basis of these results, MOGA decided that it would not put forward a position that either opposes or supports VAD.

Subsequent questions were set up with the assumption that VAD was legal, there are adequate protections for the vulnerable, and physicians were not obligated to violate their personal ethical views. These questions examined the mechanics of VAD and assumed that education had been provided to physicians about how to write appropriate prescriptions for VAD. All the described VAD methods have been or are currently in use in various jurisdictions.

Do you agree that physicians who have an ethical objection to VAD should be able conscientiously to object to participate in the process?

The overwhelming majority (94%) of MOGA respondents supported conscientious objection of physicians to the VAD process. Results are shown in Figure 2.

What is your position on legislation about VAD requiring physicians participating in VAD to write a prescription for the patient to self-administer a lethal medication?

This question explored views on physician involvement in VAD, particularly through the preparation of a script to enable the self-administration of a lethal medication. Assuming VAD was legalised, 32% of respondents supported this VAD process and 48% did not.

Would you personally be prepared to write a prescription for a lethal medication that a patient assessed as suitable for VAD would self-administer?

This question examined the move from the abstract idea of writing a script to the concrete idea of the personal involvement of the oncologist in the preparation of the prescription of a lethal medication that the patient will self-administer. Assuming VAD was legalised, the majority of members (approximately 80%) would not be prepared to write a prescription of this type. However, 20% would write the prescription and a further 36% would refer the patient on to someone that would write the prescription. The responses provide an indication that medical oncologists prefer either not to be involved at all in these prescriptions or refer patients on to someone else that they know is prepared to write such a prescription. Results are shown in Figure 3.

What is your position on that legislation requiring physicians participating in VAD to dispense personally a lethal medication to the patient?

The majority (62%) of responding medical oncologists expressed a preference that physicians not be required to be involved in dispensing lethal medication. Only 17% indicated that they agree that physicians be required personally to dispense lethal medication as part of the VAD process.

What is your position on that legislation requiring physicians participating in VAD personally to supervise the administration of a lethal medication to the patient?

The majority (55%) of responding medical oncologists expressed a preference that physicians participating

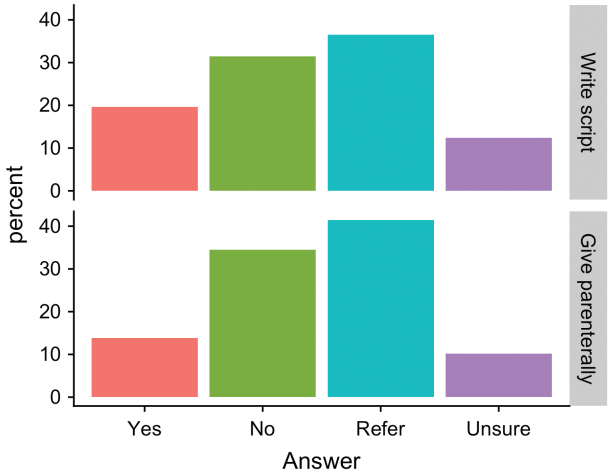

Figure 3 Personal involvement in voluntary assisted dying (VAD). The facets of the graph reflect whether the Medical Oncology Group of Australia member would personally be prepared to write a prescription for a VAD medication, and personally be prepared for a parenteral administration of a VAD medication.

in VAD not be required personally to supervise the administration of lethal medication as part of the VAD process; 29% agreed that physicians participating in VAD be required to supervise the administration of the lethal medication. The results demonstrate mixed views but the majority of responding medical oncologists expressed a preference that physicians not be required to supervise the process of administration of a lethal medication.

What is your position on that legislation requiring physicians participating in VAD personally to monitor the patient until death?

A total of 37% of respondents agreed and 50% disagreed that the legislation should require that physicians personally monitor the patient until death. Membership view on this matter was varied without a clear majority.

What is your position on that legislation requiring physicians participating in VAD personally to administer a lethal medication parenterally?

Only 14% of responding medical oncologists agreed that physicians involved in VAD should be required personally to administer the lethal medication. The majority (65%) disagreed with this VAD process requirement. Results are shown in Figure 3.

Would you personally be prepared to administer a lethal medication parenterally for a patient assessed as suitable for VAD who is unable to self-administer?

This question examines personal active engagement in the VAD process, with immediate effect, rather than exploring opinion regarding broader physician involvement. Only 14% of medical oncologist respondents stated that they would be prepared to administer a lethal medication themselves. However, 41% would refer the patient considered suitable for VAD to another person who would administer the medication.

Do you think that patients should be required to have a consultation with a palliative care physician before they could be considered suitable for VAD?

Only 3% of medical oncologists disagreed with this; 95% agreed that a palliative care physician consultation should be required before a patient can be deemed as suitable for VAD. The remaining 2% were neutral. Results are shown in Figure 4.

Do you think that patients should be required to have an assessment by a psychiatrist to determine competence before they could be considered suitable for VAD?

The majority of medical oncologists (86%) agreed with the need for the involvement of specialist psychiatry medical services in the determination of patient suitability for VAD. Only 8% disagreed and 6% were neutral. Results are shown in Figure 4.

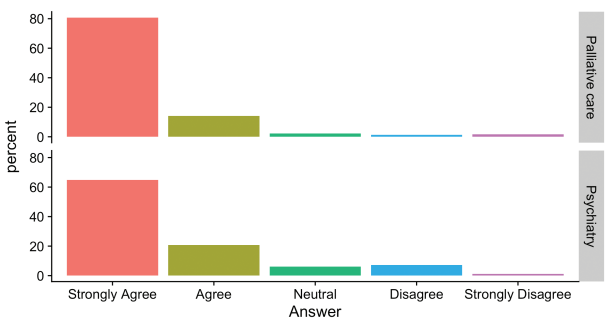

Figure 4 Medical Oncology Group of Australia members views on involvement of other specialist medical services in the voluntary assisted dying (VAD) assessment process, in particular palliative care (should a patient requesting VAD be required to have a palliative care review) and psychiatry (should a patient requesting VAD be required to have a psychiatry review).

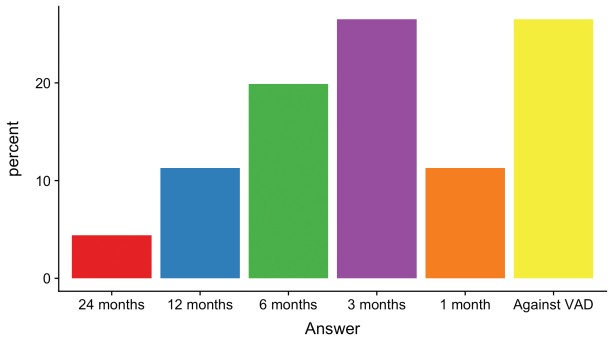

Figure 5 Medical Oncology Group of Australia members opinion on life expectancy (prognosis) for acceptance of voluntary assisted dying (VAD).

For a patient with a terminal illness who wishes to access VAD, what predicted remaining lifespan is appropriate for them to be considered eligible for VAD?

This question tries to establish a prognosis considered acceptable for VAD, meeting the 'terminal condition' requirement; 26% of respondents did not provide a time frame, as this question allowed respondents not to provide a prognosis limit but instead indicate that they do not support VAD under any circumstance. For the remainder, 52% indicated that a prognosis of less than 3 months should be required to allow VAD. Only 6% supported VAD when the prognosis was greater than 12 months. Results are shown in Figure 5.

The key findings of the MOGA membership survey are described in Table 1. The full version of the survey questions, survey results and associated figures are available on the MOGA website (http://moga.org.au/VAD survey).

This is the first survey of Australian medical oncologists to explore attitudes towards VAD. Surveys of oncologists from other parts of the world have revealed variable rates of approval or acceptance of VAD and euthanasia.[1–5] A survey of the attitudes of randomly selected Victorian doctors, not specifically oncologists, published 30 years ago reported that the majority supported active voluntary euthanasia.[6] A subsequent survey of registered medical practitioners from New South Wales and Australian Capital Territory also reported that the majority held the view that euthanasia laws should be changed.[7]

The membership survey findings formed the basis of the MOGA position statement on VAD. No other surveys were conducted. The position statement was developed through an equal and collaborative contribution of members of the MOGA Executive Committee and the MOGA Ethics Subcommittee.

Table 1 Key findings of the Medical Oncology Group of Australia (MOGA) membership voluntary assisted dying (VAD) survey

1	47% of medical oncologists did not agree with VAD from a moral/ethical or philosophical perspective. 36% did agree with VAD and 17% were neutral. This spectrum of responses indicated that there was a diversity of views without a clear dominant position.
2	Conscientious objection was strongly supported.
3	Involvement of palliative care physicians in the process, should it become legal, was strongly supported.
4	Involvement of specialist psychiatry services in the VAD process, should it become legal, was strongly supported.
5	Diverse views were expressed regarding the role of the physician in the process and the practicalities of the process.
6	The majority of responding medical oncologists expressed a preference that physicians not be required to be involved in either dispensing lethal medication or supervising the process of administration.
7	Less support was observed when the scenario required direct oncologist involvement.
8	Medical oncologists were more likely to refer patients to another rather than be involved directly with VAD.
9	Of those that answered the question regarding prognosis, 52% indicated that a prognosis of less than 3 months should be required to allow VAD.

Discussion

MOGA recognises that VAD is a subject of current political and community debate. The association wishes to expand on the position statement with additional commentary on the topic of VAD. There are several important issues related to VAD that deserve careful consideration.

The decision to request VAD must be a patient's own decision after exploring other options with their medical advisors and counsellors. The risk of coercion needs to be carefully considered by the healthcare professionals caring for the patient.[8,9] Spill over to 'involuntary assisted dying' must be prevented. In an economically rationalist society, there would have to be safeguards for the majority of individuals who do not wish to pursue VAD that give absolute assurance that they are free to make that choice, a choice that may allow the use of resource intensive end-of-life care.

If VAD is legalised, the risk to healthcare professionals must also be considered, including emotional burden, professional stigma and possible legal repercussions if the process is disputed. The healthcare facility or institution that permits VAD also accepts the risk of stigma at an institutional level as a reputational hazard. A practical and safe framework for the conduct of VAD is required. Such frameworks have been implemented in other countries, but each pose risks and challenges.[10]

A further issue of concern is the increased rates of suicide in the community as a whole that have been reported in some jurisdictions that have legalised VAD,

possibly because of changing views about the acceptability of suicide.[11]

Patients may 'change their mind' on VAD, and the process of determining VAD suitability should allow for this.

Bringing medically assisted dying into the ethos and practice of physicians and oncologists irrevocably changes and may undermine the relationship between patient and the healthcare professional.

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