

18 October 2017

The Principal Research Officer
Select Committee on End of Life Choices
Legislative Assembly
Parliament House
PERTH WA 6000

By email to: eolcc@parliament.wa.gov.au

Dear Dr Purdy

Re: Inquiry into End of Life Choices

The Royal Australian and New Zealand College of Psychiatrists (RANZCP) welcomes the opportunity to contribute to the Joint Select Committee's Inquiry into End of Life Choices.

The Royal Australian and New Zealand College of Psychiatrists (RANZCP) is a membership organisation that prepares doctors to be medical specialists in the field of psychiatry, supports and enhances clinical practice, advocates for people affected by mental illness and advises governments on mental health care. The RANZCP is the peak body representing psychiatrists in Australia and New Zealand and as a bi-national college has strong ties with associations in the Asia-Pacific region.

The RANZCP has almost 6000 members including more than 4000 qualified psychiatrists and around 1500 members who are training to qualify as psychiatrists. The RANZCP Western Australia Branch (WA Branch) represents over 450 members, more than 340 of whom are qualified psychiatrists.

In our submission to the Committee, the WA Branch has focused on identifying issues regarding mental illness and psychiatry as they relate to end-of-life considerations for the consideration of the Committee.

The WA Branch makes four recommendations:

- 1. That palliative and mental health services are properly resourced as a priority*
Alleviating suffering is not possible without adequate services. Service levels for consultation-liaison psychiatry, older adult mental health, and palliative care are of concern, particularly outside of major metropolitan hospitals.
- 2. The establishment of a Clinical Reference Panel on end of life choices*
If changes to current legislation is to be pursued the WA Branch recommends the establishment of a clinical reference panel to advise on the development of end of life

choices legislation.

3. Allow time for comprehensive consultation on end of life choices

The timeframe for response on this important issue requires sufficient time for proper consideration. If legislation is to be developed, more time must be given to consultation in order to achieve a validity of process and an outcome accepted by most of society.

4. Sensitivity to the needs of vulnerable populations during end of life choices discussions

This debate must be conducted with sensitivity of the impact it may have on vulnerable populations. People in palliative care, older adults, and people with a history of trauma and institutionalisation may be in need of additional support during this process.

Close consultation is needed with people with terminal and chronic illness, carers and families. In any consultative process the views of Aboriginal people, people from culturally and linguistically diverse communities, the LGBTI community and other groups who may be marginalised should be actively sought and considered.

The RANZCP WA Branch considers that the primary role of medical practitioners, including psychiatrists, in end-of-life care is to facilitate the provision of high-quality patient-centred care. The RANZCP WA Branch notes the need for increased investment in palliative care to improve access to high-quality end-of-life care, including greater integration of services and improved access to home-based palliative care.

The RANZCP WA Branch would like to reiterate the need for appropriate support to be provided to everyone involved in voluntary assisted dying including patients, their families/carers and the medical practitioners.

Given the short time frame for consultation for this Inquiry the RANZCP WA Branch would welcome the opportunity for further consultation.

If you would like to discuss any of the issues raised in the submission, please contact Zoe Carter, WA Branch Policy Officer via zoe.carter@ranzcp.org or by phone on (08) 9347 6429.

Yours sincerely



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Royal Australian and New Zealand College of Psychiatrists
Western Australian Branch



The Royal
Australian &
New Zealand
College of
Psychiatrists



Joint Select Committee on End of Life Choices
Inquiry into end of life choices

October 2017

Improve the mental health of the community

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About the Royal Australian and New Zealand College of Psychiatrists

The Royal Australian and New Zealand College of Psychiatrists (RANZCP) is a membership organisation that prepares doctors to be medical specialists in the field of psychiatry, supports and enhances clinical practice, advocates for people affected by mental illness and advises governments on mental health care. The RANZCP is the peak body representing psychiatrists in Australia and New Zealand and as a bi-national college has strong ties with associations in the Asia-Pacific region.

The RANZCP has almost 6000 members including more than 4000 qualified psychiatrists and around 1500 members who are training to qualify as psychiatrists. The RANZCP Western Australia Branch (WA Branch) represents over 450 members, more than 340 of whom are qualified psychiatrists.

Psychiatrists are clinical leaders in the provision of mental health care in the community and use a range of evidence-based treatments to support a person in their journey of recovery.

Introduction

The RANZCP welcomes the opportunity to provide feedback to the Joint Select Committee on End of Life Choices' inquiry into the need for laws in Western Australia to allow citizens to make informed decisions regarding their own end of life choices.

In our submission to the Committee, the WA Branch has focused on identifying issues regarding mental illness and psychiatry as they relate to end-of-life considerations.

Background

While physician assisted suicide (PAS) or euthanasia are not clearly articulated in the terms of reference for the Joint Select Committee, the parliamentary debate surrounding the establishment of this committee has guided our inclusion of information that we believe should be considered if such options were to be legalised. This submission from the WA Branch should not be taken as explicit or implied support of the legalisation of PAS.

The WA Branch acknowledges the Australian Medical Association's (AMA) position that doctors should not be involved in interventions that have the primary intention of ending a person's life (AMA, 2016).

The terminology used by the WA Branch in this submission statement is based on the psychiatric and medical literature regarding voluntary assisted dying (RANZCP, 2016).

PAS is sometimes also called 'physician assisted dying', 'physician assisted death' or 'physician aided dying'. PAS refers to situations where doctors prescribe, but do not administer, lethal substances to informed patients who have a terminal illness or a grievous and irremediable medical condition and have the legal capacity to decide that they may end their own lives at a time of their own choosing.

By contrast, 'euthanasia' refers to the act of deliberately ending another person's life at his or her request. If a doctor prescribes or supplies the drug at the patient's request, this constitutes 'PAS' whereas if a doctor administers a drug to bring about a patient's death at the patient's explicit request, this constitutes 'euthanasia' (Naudts et al., 2006). Euthanasia is not considered in this submission.

There is a significant body of literature around the wish to hasten death which should be taken into account in any discussion of this important and complex area (Monteforte-Royo et al., 2012).

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The RANZCP strongly believes that suffering related to non-terminal illness should not be the sole basis for PAS and supports exclusion from legislation (RANZCP, 2017a).

The RANZCP considers that in end of life care, the primary role of medical practitioners, including psychiatrists, is to facilitate the provision of quality patient-centred care. In the final stages of people's lives, palliative care should strive to provide the best quality of life and allow patients to die in comfort and with dignity. Specialist palliative services must be adequately resourced and widely available if people are to be able to access quality end of life care.

Assess the current practice being used within the medical community to assist a person to exercise their preferences for the way they want to manage their end of life when experiencing chronic and/or terminal illnesses, including the role of palliative care

Current practice for assisting a person to exercise preferences at the end of their life

For people who are at the end stages of their life as a result of chronic or terminal illness, currently the choices in available WA revolve around the type and duration of treatments and include:

- not initiating life prolonging treatment
- not continuing life prolonging measures
- administration of a treatment or other action intended to relieve symptoms which may have a secondary consequence of hastening death.

In their position statement *Euthanasia and Physician Assisted Suicide*, the AMA notes that where a doctor acts in accordance with good medical practice the forms of management at the end of life listed above do not constitute euthanasia or physician assisted suicide (AMA, 2016).

These choices may be expressed directly or via an Advanced Health Directive to a treating team by a person with capacity to make decisions about their care or through a substitute decision maker, such as a person with Enduring Power of Guardianship.

The extent to which a person and/or their supporters is able to exercise these choices to achieve a particular care goal (for example relief from suffering) is dependent on the following:

- Knowledge of available services
 - Awareness of treatment, palliation and psychiatric services
 - Relevant to services as well as individuals
- Availability of services
 - Access to services where person is living
 - Services are culturally safe
 - Appropriate services are funded and resourced
- Capacity to choose
 - Person has legal capacity to consent
- Ability and supported avenues for communicating choice

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- People have access to information that is understandable to them
- Staff are trained to ask, and discuss treatment options
- Patients and their families are supported in having difficult conversations around care
- Processes such as advanced health directive or enduring power of attorney are available

Palliative Care and Mental Health

The overwhelming majority of mental disorders are non-terminal illnesses. Where adequate resources are provided for psychiatric and medical care, unrelievable suffering is rare. The WA Branch does not support mental illness forming the sole basis for PAS.

There are, however, complexities regarding co-morbidity that require consideration in discussion of end of life choices.

Co-morbidity

While all psychiatrists have training in working with co-morbidity, consultation–liaison psychiatrists specialise in the treatment of mental illness in the context of physical illnesses. An important component of the consultation–liaison role is in supporting medical services and staff in providing treatment that encompasses mental health.

In situations where a patient has a terminal condition causing suffering, there is a risk that symptoms of mental ill health may be mistaken by a doctor not trained in psychiatry for an ‘understandable’ reaction to their condition.

Furthermore, treatment for mental health issues can help to relieve the experience of physical pain, due to the interaction of biological and psychological systems (RANZCP, 2017b).

It is of ongoing concern to the WA Branch that consultation–liaison services are underfunded and are therefore not sufficient to meet the needs of the population. Consultation–liaison is not only underfunded in tertiary hospitals, it is practically inaccessible in other service settings.

Outside of the public hospitals there is no access to public liaison psychiatry services for palliative care patients. Given that the majority of palliative care patients are cared for at home or in a hospice setting, the majority of patients have no access to this care. This is significant as a large portion of these patients have either untreated mental health comorbidities or psychiatric side effects of their terminal illness or the treatments provided for these illnesses.

When referred to mainstream mental health services, it is rare for patients requiring palliative care to be accepted and treated as they are often deemed to fall outside the core business of mental health services or the services feel that they lack the required expertise. This leads to a large number of people going untreated, or alternatively transferred to tertiary hospitals.

Likewise, people who are unable to be managed in palliative care settings due to psychiatric symptoms such as agitation, aggression, mood lability, psychotic symptoms, are transferred to tertiary hospitals to access palliative care.

Adequate support for consultation–liaison services is essential in ensuring people with chronic and terminal illnesses are able to alleviate or manage psychological suffering. It is arguable that patients are

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currently able to fully exercise choice regarding end of life care where such services are unavailable or poorly understood.

Older people and end of life care

Australia's oldest citizens, those aged 80 and above, are the age group most likely to die as a result of suicide (ABS, 2012). This has led to a misconception that suicide in older people is largely driven by suffering associated with chronic, debilitating or terminal illness (McKay, 2014), whereas the aetiology of suicide is complex and usually multifactorial. (RANZCP, 2016).

The WA Branch is concerned that this misconception may lead individuals to erroneously conflate suicide with PAS. While the latter may be an understandable choice in the context of unbearable suffering, suicide is a tragic outcome for individuals who suffer from mental illness. Given the disastrous consequences for the individuals, families and communities of those who suicide, or attempt suicide, it is imperative that the implementation of PAS be accompanied by stringent safeguards to ensure that older people considering suicide are not given access to PAS, as well as an expansion of suicide prevention programs to target older persons (RANZCP, 2017b).

Older adult mental health are vulnerable to absorption into mainstream mental health services where the needs of this cohort are not well understood. With an ageing population and rising numbers of people adversely affected by dementia it is pertinent to note that the need for specialist older adult mental health expertise and services requires careful planning.

A PAS framework must take into consideration the under-diagnosis and under-treatment of depression and suicidality in older people (RANZCP, 2017b).

Dementia

Whilst the dementias are considered to be terminal illnesses, the RANZCP's position remains that mental illnesses should not form the sole basis for PAS.

There is growing evidence to suggest that people who develop dementia under the age of 70 are at increased risk of suicide, especially if there are symptoms of depression and anxiety, meaning that they might, in some circumstances, consider PAS.

The clinical course of a person diagnosed with dementia may be highly variable (the prognosis may vary from 3 months to 20 years) and can be often unpredictable. Dementias have hard-to-determine causes (often multifactorial i.e. multiple contributors) and fluctuating courses.

Patients with dementia frequently develop co-existing mood and anxiety disorders, which are often responsive to appropriate treatment. With treatment, it may be possible to improve the symptomatic function of people suffering dementia even without mood or anxiety symptoms for a limited period of time (RANZCP, 2017a).

Carers and families of people with dementia experience can experience high levels of stress and are vulnerable to mood and anxiety disorders. Psycho-social and environmental support for people with dementia, their carers and families are particularly important and should be adequately resourced.

The RANZCP strongly supports good quality assessment, care and support mechanisms for people of all ages with dementia, their carers and families (RANZCP, 2016).

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Palliative care conclusion

The WA Branch recommends palliative care to achieve the best quality of life during the final stages of patients' illnesses and allow patients to die with dignity. However, without the adequate resourcing and accessibility of palliative care, the legalisation of PAS may present a perverse incentive for patients suffering enduring and unbearable suffering caused by a serious and incurable condition to choose to end their life, rather than have their pain alleviated.

Furthermore, in the view of the WA Branch, it is essential that palliative care teams and other clinicians working with patients with chronic or terminal illnesses are supported by relevant psychiatric services such as consultation–liaison or psychiatry of old age.

The implementation of a PAS framework should therefore be accompanied by evaluation of the palliative care sector and increased support to ensure patients are not enduring suffering that is treatable when appropriate services are available.

Review the current framework of legislation, proposed legislation and other relevant reports and materials in other Australian States and Territories and overseas jurisdictions

The parliamentary debate surrounding the Joint Select Committee on End of Life Choices indicates that PAS may be introduced as part of proposed legislation. In this context, the WA Branch notes that capacity, mental illness and co-morbidity will require particular consideration.

Most other jurisdictions around the world have some requirement for exclusion of an untreated mental health diagnosis or cognitive impairment prior to legal approval to pursue PAS. Given the serious medico-legal implications, these assessments are necessarily detailed and often require collection of extensive background history, liaison with family/carers and health professionals.

The WA Branch also notes that, due to the often rapidly changing manifestations of mental illness, proper assessments are best undertaken by clinicians with the benefit of extended interactions over a significant period of time with the individual in question. As such, the views of psychiatrists and/or other mental health professionals with established therapeutic relationships with individuals seeking PAS should be sought wherever possible (RANZCP, 2017b).

The WA Branch strongly supports a framework which mandates consideration of psychiatric assessment of patients whose decision-making capacity is in question regarding a PAS request.

Capacity assessments, mental illness and co-morbidity

Traumatic brain injury, addictions, dementia and delirium may all confound assessments of capacity and non-psychiatrically trained doctors 'are not well placed to recognise the presence of these conditions in the medically ill population' (Ryan, 2012).

People suffering from mental disorders may manifest significant fluctuations in their cognitive function over short periods of time and may also vary in decision-making capacity depending on the matter being addressed (RANZCP, 2017a).

For a person with co-existing physical and mental illnesses, ensuring adequate decision-making capacity in the context of PAS may therefore pose significant challenges.

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Psychiatrists have specific skills and expertise to assess decision-making capacity as well as to identify psychiatric illnesses and to assess suicidal ideation in patients, including the terminally ill.

Although psychiatrists have extended skills in capacity assessment as it relates to mental illness, the WA Branch recognises that in some circumstances other specialists may be better qualified to undertake capacity assessment. An understanding of the illness, treatment options and risks of those options underpins capacity assessment. Particularly where treatment is concerned with rare, unusual illness or procedures the treating specialist may be better placed to assess capacity.

Therefore, in a workup for PAS, the role of the psychiatrist may be to undertake a psychiatric assessment to exclude untreated mental illness with the decision as to the most appropriate specialist to assess capacity being the local treatment team.

There may, however, be significant practical barriers to psychiatrists carrying out mandated assessments of all patients seeking access to PAS in a timely way. Access to a psychiatrists with relevant specialist expertise such as consultation–liaison or old age psychiatry can be variable given existing resource constraints. This is of particular concern in a population that is defined by their limited life expectancy (RANZCP, 2017b).

Additionally, due to resourcing and access issues, consultation–liaison psychiatry services are currently not able to see many patients with a therapeutic need for psychiatric assessment at the end of life (to enable detection and treatment of mental health comorbidities which may impact on their burden of suffering and thus on their desire to pursue PAS). It would be very concerning to see a situation by which current critically stretched services are expected to absorb the significant burden of complex medico-legal assessments, when earlier access to therapeutic intervention may have removed the need for this.

The WA Branch recognises that in order to mitigate these risks there would need to be increased support of non-psychiatrically trained doctors to recognise diminished capacity and refer patients for assessments in the context of PAS when compared with refusals of care. The RANZCP training program includes advanced competencies in capacity assessment and therefore psychiatrists are well placed to support upskilling colleagues.

The WA Branch suggests that training be provided to non-psychiatrically trained professionals by psychiatrists with relevant expertise, and that resources be developed covering:

- screening tools for mental disorders and neuropsychiatric conditions
- other risk factors to look out for, including vulnerable populations, such as older, isolated women, who may seek access to PSA more often
- guidance on the appropriate use of telehealth, noting its potential to increase access but also to compromise the integrity of assessments
- how to interact with families/carers, and what to do when a patient does not wish to involve their family

Consider what type of legislative change may be required, including an examination of any federal laws that may impact such legislation

The WA Branch would welcome a review and standardisation of legislation across Australia in this important area.

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The right of medical practitioners to choose their degree of involvement in Physician Assisted Suicide

While psychiatrists see the assessment and treatment of patients who are considering suicide as a core part of their role, they may not wish to take on a 'gatekeeper role' in a potential Physician Assisted Suicide. Research shows that while some 64% of British psychiatrists agree that psychiatric assessments are important in the Physician Assisted Suicide context, only 35% would be willing to carry out such assessments (Shah et al., 1998). A recent pilot survey of RANZCP WA Branch members indicated a similar trend.

The WA Branch therefore strongly recommends that practitioners who hold a conscientious objection to PAS are not required to provide this service, and their choice in this matter is explicitly protected by legislation.

Medical practitioners are obliged to demonstrate respect for patients' values and assist patients to access care which is consistent with their values and wishes. Practitioners could potentially fulfil this obligation by referring the patient as soon as possible to another practitioner who is able to provide the appropriate assessment.

Clinical Reference Panel

The impact that changes end of life choices legislation will have on clinicians is profound. Given the professional, ethical and practical implications, adequate time and weight needs to be given to consultation with the medical professionals that will be affected.

Reviewing the current framework of legislation, proposed legislation, reports, scientific literature and other materials across multiple jurisdictions and then considering the legislative changes required is worthy of more consideration possible within the timeframe given for submissions to this committee.

In considering the above, and in drafting new legislation to increase the range of end of life choices, the WA Branch therefore recommends the establishment of a clinical reference panel. A clinical reference panel would also be able to ensure any proposed legislation is pragmatic and implementable given existing resources.

A clinical reference panel may also be of assistance in considering a broad range of issues including:

Consumers, carers and family in care and decision making

- How to embed principles without creating legislation that is unworkable in practice.

Implementation

- Governance and documentation requirements.
- As with any change in legislation there needs to be adequate training of the workforce required to undertake the necessary actions associated with the legislation.

Capacity

- The issue of capacity becomes even more of a critical consideration in the consideration of Physician Assisted Suicide.
- People with certain mental disorders may manifest significant fluctuations in their cognitive function over short periods of time. Capacity to make an informed decision depends on the matter being

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addressed and is task specific and situation sensitive therefore any legislative instrument used for assessment of decision-making capacity needs to take these factors into consideration.

Substitute decision making

- Where individuals are covered by Advanced Health Directives, Enduring Power of Attorney and Enduring Power of Guardianship the implications for those individuals and their families and their treating teams and individual clinicians will need careful consideration by the clinical reference panel.

Lethal medications

- If the use of lethal medications in a PAS context is to be considered, the WA Branch recommends that close attention is paid to the provisions for monitoring and managing such drugs.
- The WA Branch notes that it is important not to be dissuaded from additional monitoring mechanisms by the argument that other prescription and household items can cause death. Reducing access to means of suicide has been shown to be one of the most effective approaches to suicide prevention and this medication may pose a greater risk to public safety than other medicines and household items that may be misused to cause death.

Recording cause of death

- In order to properly assess and evaluate the impact of any PAS legislation mechanisms for identifying and investigating PAS will need to be established. A clinical reference panel would be of assistance in identifying appropriate mechanisms that are practical to implement.

Resources

- Additional resources will be required if due diligence is to be carried out in medico-legal assessments. The WA Branch is very concerned that the introduction of PAS legislation may mean that the scarce existing resources in consultation–liaison and palliative care are diverted from providing timely service to people with treatable illness into providing the medico-legal assessments. The impact of the administrative burden that was imposed by the implementation of the *Mental Health Act 2014* has been felt across mental health services and the WA Branch would recommend that this situation be avoided.

Debate on end of life choices

While end of life choices are an important discussion for the community, the Western Australian Branch would like to note our concern regarding the negative impact of a potentially divisive public debate regarding end of life choices on vulnerable members of the WA community.

In Victoria, the media has detailed some agonising deaths in the lead up to a conscious vote on voluntary assisted dying legislation. The fear of experiencing unalleviated pain has been exacerbated by these stories, and palliative carers have reported that these stories have been distressing for people with terminal illnesses.

The Western Australian Branch also notes that discussion of end of life choices that involve physician assisted suicide or euthanasia may be particularly distressing for people with a history of trauma associated with institutionalisation and recommends close and respectful consultation with consumer and advocacy groups representing people with disability, mental health consumers, health consumers, care leavers and people in the criminal justice system.

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The WA Branch would recommend ensuring that support for carers and suicide prevention programs for older adults are adequately resourced and consider that additional resources may be needed to provide support during this particular debate.

Recommendations

The WA Branch reiterates our position that in end of life care the primary role of medical practitioners, including psychiatrists, is to facilitate the provision of quality patient-centred care. In the final stages of people's lives, palliative care should strive to provide the best quality of life and allow patients to die in comfort and with dignity. Specialist palliative services must be adequately resourced and widely available if people are to be able to access quality end of life care.

The WA Branch recommends:

RECOMMENDATION ONE: That palliative and mental health services are properly resourced as a priority

Alleviating suffering is not possible without adequate services. Service levels for consultation–liaison psychiatry, older adult mental health, and palliative care are of concern, particularly outside of major metropolitan hospitals.

RECOMMENDATION TWO: The establishment of a Clinical Reference Panel on end of life choices

If changes to current legislation are to be pursued the WA Branch recommends the establishment of a clinical reference panel to advise on the development of end of life choices legislation.

RECOMMENDATION THREE: Allowing time for comprehensive consultation

The timeframe for response on this important issue requires sufficient time for proper consideration. If legislation is to be developed, more time must be given to consultation in order to achieve a validity of process and an outcome accepted by most of society.

RECOMMENDATION FOUR: Sensitivity to the needs of vulnerable populations

This debate must be conducted with sensitivity of the impact it may have on vulnerable populations. People in palliative care, older adults, and people with a history of trauma and institutionalisation may be in need of additional support during this process.

Close consultation is needed with people with terminal and chronic illness, carers and families. In any consultative process the views of Aboriginal and Torres Strait Islander peoples, people from culturally and linguistically diverse communities, the LGBTI community and other groups who may be marginalised should be actively sought and considered.

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