

AMA uncovered:

How its own review exposed its assisted dying policy as indefensible

Neil Francis

27th March 2017



Rocking the vote for law reform

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Executive summary

The Australian Medical Association (AMA) has been historically opposed to legislative reform that would permit doctor-assisted dying for patients in unremitting and untreatable extremis. Its hostile position had been expressed through a Position Statement (PS) in effect for at least a decade, although its Code of Ethics has been completely silent on the matter.

The AMA's opposition to doctor-assisted dying has been one of the factors leading to the failure of a number of attempts at assisted dying law reform.

In 2015 the AMA announced a review of its 'policy' on 'euthanasia and doctor assisted suicide,' managed through its Federal Council. The review was conducted from late 2015 and throughout 2016. It included an online survey of more than 3,700 Australian doctors.

The survey methodology contained, however unconsciously, multiple serious design flaws biased against assisted dying: flaws which were brought to the attention of the AMA executive separately by two survey design experts. The executive dismissed the criticisms, incoherently arguing that while the AMA's reviews are "*fully-informed decisions based on well-researched, comprehensive information,*" the survey was "*not formal 'research' as such*" and merely a "*means to engage our members.*"

The AMA relied on selected statistics from the survey to publicly explain the outcome of its review. It also provided its own members a private, detailed report of the review, of which more than half was a comprehensive statistical analysis of the survey.

The 'Survey Limitations' section of the report mentioned several minor issues, but not the significant biases brought to the attention of the executive by experts.

Despite these significant biases against assisted dying, the survey found:

- 68% of doctors said that even with optimal care, complete relief of suffering is not always possible.
- 60% of doctors said that if lawful, euthanasia should be provided by doctors, and more than half of them (total 32%) said that they would indeed practice it.

- 52% of doctors said that euthanasia can form a legitimate part of medical care.
- 50% of doctors *expressly disagreed* with the AMA's statement that "doctors should not provide euthanasia under any circumstances."
- 38% of doctors *expressly disagreed* with the AMA's policy opposed to assisted dying (only half expressly agreed), and 35% of doctors said that euthanasia should be lawful.

In relation to the last point, other scholarly research has found that an additional 25% of Australian doctors are opposed to law reform not because they are opposed to assisted dying itself, but because they would rather practice it in private without regulatory 'interference.' This confirms that more than half of Australian doctors believe assisted dying can be a legitimate and practical part of medical care.

Only AMA members were invited and permitted to participate in the survey, and more than 70% of Australian doctors are *not* AMA members, despite the AMA expressly advancing itself as representing all Australian doctors. Non-members are likely to be more supportive of assisted dying — snubbing AMA membership due to the AMA's 'officially' hostile stance.

During the review process, AMA President Dr Michael Gannon made repeated public statements hostile towards assisted dying, including a statement that doctor assisted dying would offend the Declaration of Geneva. The Declaration has nothing specific to say about assisted dying, and any general Declaration statements Dr Gannon relied upon would be equal arguments against abortion. Yet the AMA accepts abortion practice by doctors.

Finally, in the face of ample evidence (despite the methodological biases) that at least half of the AMA's *own members* favour doctor involvement in lawful assisted dying and deem it legitimate medical care, and 38% of its *own members* expressly disagreeing with its opposed policy, the AMA executive decided to maintain 'official' organisational opposition in the revised PS.

The PS, which was previously named broadly as about 'end of life care', is now exclusively named as about 'euthanasia and physician assisted suicide,' even though it continues its broad coverage. This suggests that, however unconsciously, the executive's attitudes against assisted dying have become more entrenched.

The PS continues to unequivocally state as before that "*The AMA believes that doctors should not be involved in interventions that have as their primary intention the ending of a person's life.*" In announcing the conclusions of its review the AMA has promoted this statement widely and as though it applies to all Australian doctors, most of whom are not AMA members.

Despite the confidence and certainty of the statement, the AMA advises that neither Australian doctors in general nor even its own members are bound by

its PSs. Thus, statements in AMA PSs are more ‘suggestions’ or ‘thought bubbles’ rather than authoritative statements.

More recently, the AMA’s Code of Ethics has been updated, yet remains *entirely silent* on doctor-assisted dying, in curious contradiction of the ‘certainty’ of its PS.

The AMA executive continues to demand deep involvement in the development of a legal framework for assisted dying (despite saying that doctors should not be involved in the practice), yet it has developed no specific frameworks for three other related, already-lawful medical practices: refusal of life-preserving medical treatment, continuous deep sedation until death, and the voluntary refusal of food and fluids.

These discrepancies collectively raise the question as to whether the AMA’s ‘official’ opposition to assisted dying law reform is political rather than medical.

The evidence is clear that the only “*justifiable*” position the AMA executive could have taken was to declare the AMA **neutral** towards lawful assisted dying — a matter of individual conscience for its member doctors.

Australian doctors may well question the AMA executive as to how such a flawed process arrived at the outcome it did, and a collection of questions are posed for the AMA to answer.

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Introduction

The Australian Medical Association (AMA), founded in 1962, is a voluntary-membership professional association for Australian medical doctors. It doesn't regulate medical registration or practice: that is the role of the Australian Health Practitioner Regulation Agency (AHPRA). Nor does it oversee specialist training: that is the role of the medical colleges.

The AMA promotes itself as the premier body “*representing registered medical practitioners and medical students in Australia*,”¹ and expressly states that it is “*the peak body representing all Australian doctors*.”² It states that its Code of Ethics guides ‘*doctor*’ (not just ‘*member*’) professional conduct, yet at the same time states that it “*is beholden to no-one but our members*.”³

While 84% of the Australian public presume that their doctor is an AMA member,³ the AMA states that its membership was around 30,000 of 103,000 AHPRA-registered medical practitioners in 2015, meaning that well under a third — 29.5% by the AMA's reckoning — of Australian doctors are AMA members (Figure 1). Membership is declining.⁴

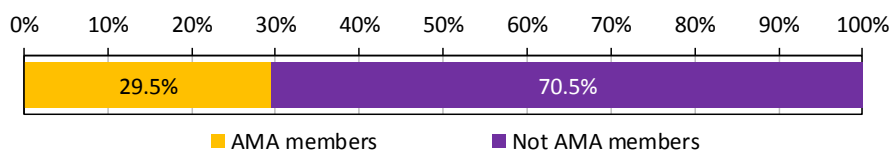


Figure 1: Australian registered medical doctor membership of the AMA

Source: AMA correspondence.

Put another way, well over two thirds (70.5%) of Australian doctors are *not* members of the AMA, and rejection of membership is increasing.

In addition, the AMA claims around 9,000 medical student members in 2015. There were 16,959 enrolled medical students in 2015,⁵ giving a student membership rate of 53.1%. This is despite student AMA membership being free of charge, while membership of the Australian Medical Students' Association—established two years earlier than the AMA— involves a fee *and* points out the free AMA membership on its own subscription page.

The AMA's 2014 annual report reveals that the organisation has net assets of \$19.5m and in 2013-14 an annual gross operating profit of \$3.2m.⁶ It is managed by an elected Federal Council.

In addition to member services, the AMA involves itself in political lobbying, including in recent months about funding public hospitals, opposing the freezing of bulk billing fees, promoting broadband in the bush for medical services, needle and syringe programs in prisons, and advocating for a Centre for Disease Control, tighter restrictions on gun ownership, political leadership to fight obesity including investment in preventative health, and an independent investigation of health care and self-harm on Nauru.

*More than two thirds of registered Australian medical doctors are **not** members of the AMA and membership is declining.*

*Only around **half** of Australian medical students are AMA members, despite **free** subscription, and **promotion** by the students' own medical association.*

Entrenched opposition to assisted dying

Policy opposed to assisted dying

The AMA also politically lobbies about assisted dying. It has an historically-entrenched stance of hostility towards assisted dying law reform.

The AMA holds an entrenched policy opposed to medically assisted dying.

Its position statement on the role of the medical practitioner in end of life care from at least 2007, updated in 2014, states:

“The AMA recognises that there are divergent views regarding euthanasia and physician-assisted suicide. The AMA believes that medical practitioners should not be involved in interventions that have as their primary intention the ending of a person’s life.”⁷

It has been argued that the medical profession’s active opposition of assisted dying law reform is a significant factor in the failure of legislatures to honour the will of electorates in favour of reform.^{8,9}

Well-established need for assisted dying

The need for assisted dying is well-established. The AMA itself acknowledges that not all end-of-life suffering can be alleviated:

“While for most patients in the terminal stage of illness, pain and other causes of suffering can be alleviated, there are some instances when satisfactory relief of suffering cannot be achieved.”⁷

The AMA acknowledges that not all end-of-life suffering can be alleviated, and multiple studies show clear links between this suffering and violent suicide.

There are numerous cases of people suiciding violently as a consequence of being denied a peaceful option, leaving relatives to discover the body and deal with the trauma and its aftermath.

Research published in 2011 found that of UK suicides, 2.1% were in respect of terminal illness and 10.6% in respect of chronic illness.¹⁰

A 2015 report by the Victorian Coroner to the state’s Parliament established that 8.6% of violent suicides were of people who had been denied a peaceful doctor-assisted death in the face of intolerable and unrelievable medical conditions at the end of life.¹¹

Shocking callousness towards patients

In shocking statements on national television in 2013, the AMA, through its Tasmanian representative Dr Gerard McGushin, demonstrated contempt for lawful and compassionate assisted dying.¹²

In a TV news report about potential law reform featuring several Australians who had pleaded for a peaceful, doctor-assisted death in the face of unrelievable and intolerable suffering, Dr McGushin reiterated the AMA’s opposition to assisted dying law reform, stating that:

“Well currently people do, you know, have the option of suicide... that’s something obviously we don’t encourage. But that is a [sic] option.”



Figure 2: Dr Gerard McGushin, spokesperson for the AMA on Channel 10's *The Project* in 2013

The news bulletin voiceover continued in respect of a dying person who was contemplating hastening his own death, “and if family and friends are with him, they’d be prosecuted for assisting him, even if they did nothing to help.”

Dr McGushin further railed against the notion of family presence:

“Who would want to do that anyway? I mean, surely you should be discouraging your family member from taking that... from going through that process.”

If this *doesn’t* mean the AMA says “well you can always suicide, and if you do you’d better do it completely alone,” the AMA must explain itself.

Misinformation published, corrections deleted

The AMA has published negative misinformation about assisted dying, too, and failed to publish corrections. In September 2016 it published an online report¹³ in the *Medical Journal of Australia* (MJA—a wholly-owned subsidiary of the AMA) which fundamentally misunderstood aspects of a scholarly research paper about assisted dying practice in Belgium, where the practice was legalised in 2002.¹⁴ The MJA report suggested amongst other things that there was a deterioration of palliative care consults in respect of assisted dying in Belgium.

An evidence-based rebuttal of the MJA article, detailing how and where it was in error, was published¹⁵ and the MJA asked, via a comment to the original online report, to correct its error. The request, posted by me, a non-AMA member, was deleted and the article left unaltered.

Only when an AMA member posted the same request for correction, did the MJA respond, with further interpretations, entrenching its original opinion. The further interpretation the MJA provided only served to highlight that it had selected data that ‘confirmed’ a hostile stance, further revealed significant bias in its interpretations, and highlighted that it profoundly misunderstood the nature of the research.

The AMA’s sickening alternative to lawful assisted dying? Suffering patients can suicide alone, though the AMA doesn’t “encourage” it.

A second evidence-based rebuttal of the MJA’s misinformation was published,¹⁶ and a second request for correction made on the MJA’s original article page. That request (#13 in Figure 3), was also deleted.

Serious misinformation remains published in the MJA (a wholly-owned subsidiary of the AMA) while evidence-based rebuttals are deleted.

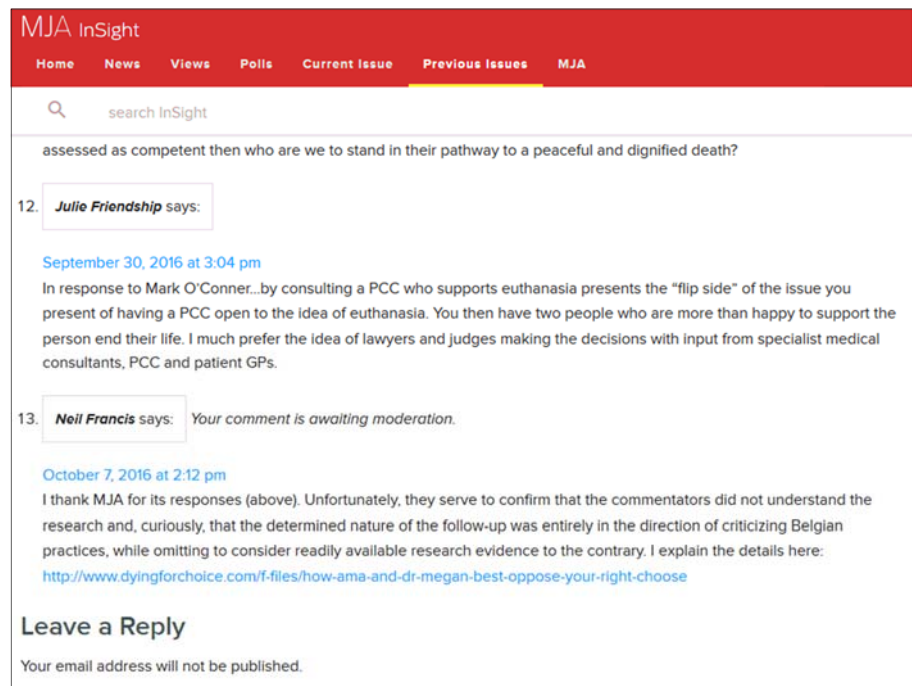


Figure 3: The second post in the AMA’s MJA, requesting correction of misinformation, subsequently deleted.

Consequently, the MJA’s misinformation about assisted dying practice in Belgium remains published as though it is fact, while ignoring and refusing to publish evidence-based corrections.

Periodic policy review

In 2015, Dr Michael Gannon, then Chair of the AMA Ethics and Medico-Legal Committee (now President) announced a periodic review of AMA policy on “euthanasia and physician assisted suicide.”¹⁷

In the first sign of potential bias, the AMA chose to put assisted dying, but not other end-of-life decision making, specifically under the review spotlight. The AMA did not have a policy on “euthanasia and physician assisted suicide” as such: merely some ad hoc statements opposed to it alongside other end-of-life care statements (such as continuous deep sedation and refusal of life-preserving treatment) in a blanket policy document titled “Position statement on the role of the medical practitioner in end of life care.”

Dr Gannon’s announcement of review stated that “*the initial engagement is restricted to AMA members only.*” The process included consultations with AMA State and Territory offices and an invitation via an AMA publication (Australian Medicine) for AMA members to share their views with the Executive by email. The AMA received 53 email responses, of which 32

supported its current policy against assisted dying and 21 opposed the policy: a ratio of 60.4% in support of and 39.6% expressly opposed (Figure 4).

Note: For ease of comprehension of the following data charts, all results have been arranged with attitudes opposed to assisted dying or related medical decisions appearing in red on the left, and supportive views in green on the right.

Only 60% of member email responses agreed with the AMA's own policy statement on assisted dying, with 40% expressly opposed.

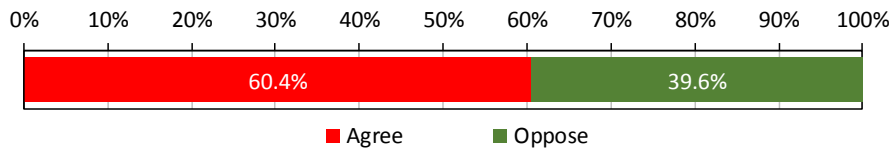


Figure 4: Open-ended email response stances on AMA policy (which is opposed to assisted dying)
Source: AMA Member Consultation Report



Figure 5: AMA (now) President Dr Michael Gannon tweets an Ethics & Medicolegal Committee meeting
Source: Twitter

Further consultation during the review involved a Q&A session held during the AMA's national conference in 2016, and an online survey of AMA members (N = 3,733) in 2016. There was little indication of deliberative consultation of doctors beyond AMA membership, with the exception that the handful of Q&A panel members were specifically selected *not* to represent the AMA.

The remainder of this document covers the online survey of AMA members.

Amateur, deeply-flawed survey design

While the usual opinions and stances were expressed passionately both for and against assisted dying during the Q&A session held at the AMA's 2016 AGM, the online survey was an attempt to establish *quantitatively* the proportions of AMA members holding particular opinions, so as to inform the policy review. Without a *quantitative* objective, there would have been no real rationale for the survey. Indeed, the AMA publicly quotes selected survey percentages (e.g. 18) and has published quantitative results for its members.⁹

In May 2016, having studied the AMA survey questionnaire, I wrote to then AMA President Brian Owler and Ethics and Medico-Legal Committee Chair Michael Gannon, to report numerous substantial weaknesses in the survey design.¹⁹ A respected Fellow of the Australian Marketing and Social Research Society (AMSRS) did the same. We pointed out similar problems, and received similar dismissive responses:

The AMA's top brass resorted to incoherent and indefensible arguments to brush off professional critiques of its substantial survey biases.

"The AMA routinely surveys its members on a variety of issues — these surveys are not formal 'research' as such but are used as a means to engage our members." and in the same reply "...we want to ensure our Federal Council, the body responsible for approving our policies, makes fully informed decisions based on well-researched, comprehensive information." — Brian Owler, AMA President

The incoherence and indefensibility of the President's reply is obvious: if the AMA desires "*fully-informed decisions based on well-researched, comprehensive information*" then why was its member survey, from which the AMA publicly quotes selected response percentages, not "*formal 'research'*" and only used to "*engage members*"? Indeed, the survey occupies more than half of the Consultation final report (18 of 34 pages), and is the only part of the member consultation *expressly* mentioned in the AMA's media release about its 'updated' policy.²⁰

In any case, how could such an amateurish and biased survey be justified in any professional context?

Anchoring bias of existing policy position

The existing (prior to the 2015–16 consultation) AMA position statement on the role of the medical practitioner in end of life care expressly states that:

"All patients have a right to receive relief from pain and suffering, even where that may shorten their life."⁷

The statement then arbitrarily goes on to exclude precisely two methods of shortening life, namely "*euthanasia*" and "*physician-assisted suicide*." It does not object to shortening life by intentionally placing the patient in 'pharmacological oblivion' until they die and which foreseeably hastens death, nor does it mention doctor participation in a patient's voluntary refusal of food and fluids whose purpose is to hasten death.

Sampling bias

Despite Dr Gannon's statement that the "*initial engagement is restricted to AMA members only*" (implying wider subsequent engagement),¹⁷ it is clear from the AMA's internal final report,⁹ that only AMA members were actively engaged and consulted throughout the process and in particular via the online survey; with the possible exception of a handful of doctors on the 2016 AGM assisted dying discussion panel. Most Australian doctors — AMA non-members — were not actively notified, encouraged to participate, or given a voice in either the overall consultation or in the online survey.

The AMA regularly publishes and speaks as "*the peak body representing all Australian doctors.*"² For example, AMA President Dr Michael Gannon recently spoke 'authoritatively' on national television about assisted dying:

"Doctors should not involve themselves in treatments that have as the primary intention the ending of a patient's life," AMA President Dr Michael Gannon told the ABC.²¹

While it is appropriate that the AMA consult its own members about assisted dying policy (and believes that it is *accountable* only to its own members), because the AMA regularly poses itself as generally representing all Australian doctors, excluding most of them from this policy consultation is ethically unjustifiable.

In practice, the AMA online survey of its members generated responses from around 12% of them, who in turn are just 29.5% of all Australian doctors, giving a doctor participation rate of just 3.6% in the online poll (Figure 6).

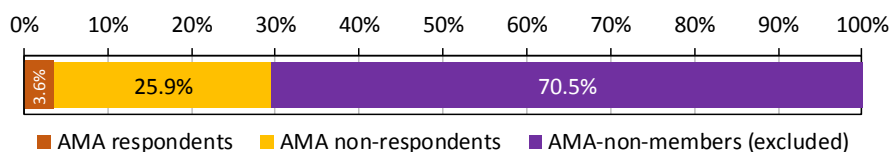


Figure 6: More than two thirds of Australian doctors were *excluded* from participating in the survey

Source: AMA correspondence, AMA Member Consultation Report.

Restricting especially the survey to only AMA members is a *significant sampling bias*. Due to the AMA's well-known entrenched opposition to assisted dying, doctors in favour of assisted dying are significantly less likely to be AMA members (thus not participating), meaning that results would be wrongly biased against assisted dying.

The first, 'exclusive,' report of the AMA's review published by the media (in *The Australian*) boasted that it "*was underpinned by a survey of 30,000 doctors.*"²² What was not mentioned was that only AMA doctors were asked to participate in the survey, and most Australian doctors are not AMA members.

The AMA's exclusion of a large majority of doctors from contributing to 'doctor' policy is ethically unjustifiable.

Another missing sample: public/patient opinion

The AMA states that it is a voice for patients¹ and claims in its final consultation report that it should take into account community attitudes on assisted dying. However, its final report mentions only that there is “emotional” debate, and that “it is understood and accepted that there are differences of opinion amongst doctors regarding euthanasia and physician assisted suicide, just as there is in the wider community,”⁹ implying that the community’s attitudes are not relevantly different from doctors,’ though there is “increased community interest.” No statistics or qualitative details on public opinion are reported or expressly considered.

Indeed, the first media report, with ‘exclusive’ access to the AMA’s research data, claimed that doctors’ “relatively close margin of about 55-45 per cent for and against or undecided on the existing policy [against assisted dying] underlines that doctors are as divided as the public.”²² This statement is profoundly false in regard to public opinion. Failing to identify readily-available quantitative public opinion data is a grave omission of the voice of patients, and creates a false impression.

In fact, Australian public opinion is overwhelmingly in support of assisted dying law reform, and has been in the majority for many decades (Figure 7).

The AMA’s ‘review’ made no serious attempt to engage with patient opinion.

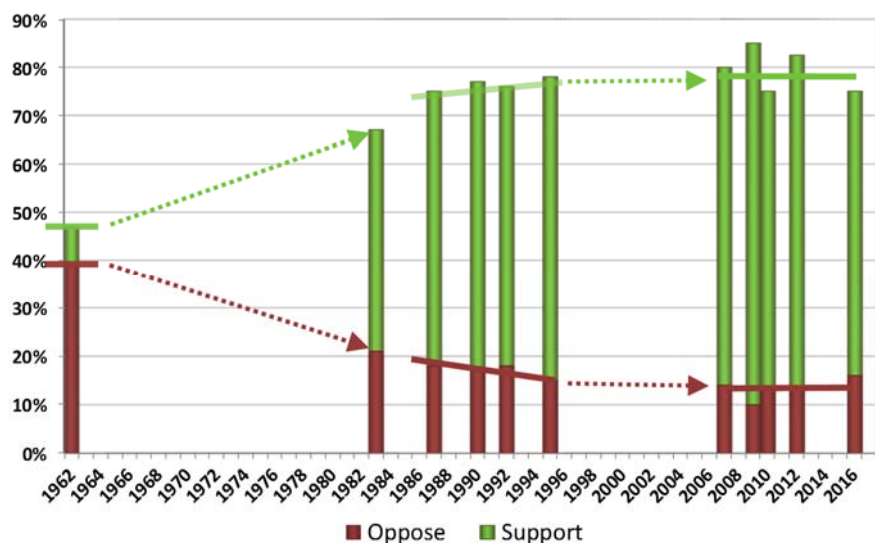


Figure 7: Public support for assisted dying has been in majority for decades
 Sources: Morgan, Newspoll, Australia Institute, Vote Compass and other polls. Note: Methodology differences account for some variation in recent adjacent results.

More recently, Australia Institute²³ and VoteCompass²⁴ research found 75% of Australians supported legalisation of assisted dying with a small minority opposed, while a Newspoll survey found 83% in favour and just 13% opposed.²⁵ It’s hardly surprising then that an AMA Q&A session participant observed that:

“The community is requesting that we change the law. Organisations like the AMA are standing in the way as they think they know better,”⁹

The public are, of course, doctors' *patients*. How astonishing then that the AMA failed to engage in any meaningful way with the attitudes of those whom its members actually serve.

The shortfall in doctor appreciation of patient perspectives is not uncommon. Doctors often underestimate the severity of patient symptoms²⁶⁻³⁰ but want significantly less medical end-of-life care for themselves.^{31,32} Nearly nine out of ten USA doctors would not want intensive end-of-life treatment they provide to others.³³ Yet patient death, despite its inevitability, is often regarded by doctors as a 'failure' of medicine,^{34,35} with many still uneasy even about withholding and withdrawing life-preserving interventions.³⁵

Survey introduction: Definition and language bias

The introduction page to the AMA online survey delivers further significant bias. Firstly, it uses provocative language along with substantively inadequate definitions. The AMA's existing policy on end-of-life decisions states using provocative language that:

*"Euthanasia is the act of deliberately ending the life of a patient for the purpose of ending intolerable pain and/or suffering. Physician assisted suicide is where the assistance of the medical practitioner is intentionally directed at enabling an individual to end his or her own life."*⁷

However, the questionnaire introduction reduces the existing over-simplicity even further. It defines them as:

"Euthanasia is defined as intentionally ending the life of someone with an incurable illness in a painless manner. Physician assisted suicide is where the assistance of a doctor (medical practitioner) is intentionally directed at enabling an individual to end his or her own life."

Note that the definition of euthanasia in the survey introduction omits "intolerable pain and/or suffering", thereby substantially further ambiguating the circumstances relative to its *existing policy*. No explanation is given for this arbitrary change, and weakening, in the survey definition.

Further, neither definition states that it must be the express will or desire of the *patient*, and not of others, to hasten their death, e.g. "*voluntary euthanasia*". This is a major omission.

Question wording and order can profoundly influence the results of a survey. Questions which are method-focused (e.g. doctor-administered or patient self-administered without further context) generate substantially lower respondent approval than questions which provide appropriate context (e.g. terminally ill or experiencing intolerable and unrelievable suffering).³⁶ Australian research indicates that 'the patient voluntarily making a request' is the primary dimension of support for assisted dying, at least amongst the public.³⁷

The AMA's survey introduction suffered from considerable ambiguities, poor definitions, inconsistencies and inappropriate sensitisation.

Another Australian study found similar major effects on concept support (percent in agreement) amongst cancer patients as a function of question wording (Table 1):³⁸

Table 1: Cancer patient question agreement as a function of question wording

Question wording	Agree
Do you believe in a “right to die”?	83%
Do you support the idea of euthanasia ?*	79%
Do you think a person has the right to end their own life if they have a disease that cannot be cured?^	75%
If a referendum were held in Australia, would you vote to legalise euthanasia?	75%
Do you believe that a doctor should be able to assist a patient to die?#	70%
Do you believe it is sometimes right for a doctor to take active steps to intentionally bring about the death of a patient who has requested it?	68%
If a referendum were held in Australia, would you vote to legalise doctor-assisted suicide ?	42%
Do you think doctors should be able to kill their patients?	14%

Source: Parkinson *et al* 2005.³⁸ [Note: My emphases in bold.] * Not further defined, but interpreted by many as ‘assisted death’. ^ Disease not defined. # No defined circumstances.

In introducing the 2016 AMA national conference panel on the topic, Dr Gannon stated expressly, before the panel were seated, that “...for the purposes of this session we’ve referred to euthanasia and physician assisted suicide collectively as *assisted dying*. As you know the AMA is currently reviewing its policy on *assisted dying*...”⁴ He doesn’t explain why the expression ‘assisted dying’ is used around the time of the conference, while the AMA laboriously stuck to ‘euthanasia and physician assisted suicide’ elsewhere (Figure 8; and throughout the AMA member survey).

Further, asking less controversial forms (“euthanasia”) first and more controversial forms (“assisted **suicide**”) afterwards, as the AMA questionnaire does, enhances the ‘contrast effect,’ which lowers respondent approval of the later options through having already said ‘yes’ to a controversial option but now wishing to appear ‘appropriately discriminant’ when asked about options which may be perceived as even more controversial (“suicide”), even if the respondent might otherwise agree.³⁶

The introductory page of the questionnaire once, incidentally, mentions “voluntary euthanasia,” but doesn’t define it. Nowhere else in the questionnaire does the expression “voluntary euthanasia” appear; only the expression “euthanasia.” Nowhere is it defined that the patient must make a voluntary request.



Figure 8: The AMA's inconsistent use of terminology in October 2015 (top), March 2016 (centre) and November 2016 (bottom)

Sources: AMA website^{17,39,40}

Further survey introduction bias

It is mentioned at the bottom of the introduction page — but not within the introductory definitions — that the options are only “relevant to competent adult patients with a terminal illness.” There are good grounds for believing that doctors mostly ignored this statement, because they later enthusiastically answered a question about assisted dying in the *absence* of terminal illness.

The questionnaire introduction further biases respondent answers by expressly defining certain medical interventions as uncontroversial and appropriate: withholding and withdrawing life-prolonging measures, and the doctrine of double effect (DDE)—though they don't refer to it by that name. It further defines that these other decisions are not in any way ‘euthanasia’ or ‘physician assisted suicide,’ even though some respondents might disagree.

Thus, the AMA questionnaire introduction biases the entire questionnaire towards more positive responses to AMA policy and more negative responses regarding assisted dying.

Heavily biased question — non-treatment

The survey then commences with heavily biased questions.

“Do you agree that so long as a doctor acts in accordance with good medical practice, it is clinically appropriate not to initiate life-prolonging measures and/or continue life-prolonging measures?”

This amateur approach suffers from no fewer than four significant biases.

Sampling bias: Firstly, as for the entire survey, only AMA members are asked this question, and the answer is AMA policy. What AMA member is *readily* going to disagree with stated AMA policy if they are unsure?

Anchoring bias: Secondly, respondents have already been told the expected correct answer to the question via the statements on the previous (introduction) page.

Framing bias: Thirdly, the statement mixes the condition of “good medical practice” with a supposed test for “clinically appropriate.” However, as the Medical Board of Australia argues,⁴¹ being ‘clinically appropriate’ actually forms a key component of ‘good medical practice.’ Therefore, these dimensions are not independent and it would be virtually impossible to disagree with such a circular, self-proving, statement.

Acquiescence bias: Fourthly, the question is worded exclusively in the direction of the presumption of agreement “Do you agree...?” Questions must be designed to avoid this bias, at the very least “Do you agree or disagree...?”, or better, “Which option best represents your attitude towards...?”

Given the confluence of four significant biases in favour of agreement, it is hardly surprising then that almost all respondents agreed (Figure 9). What is surprising is that given all the biases, still 2.3% of respondents did not agree.

The first survey question suffered from no fewer than four significant biases.

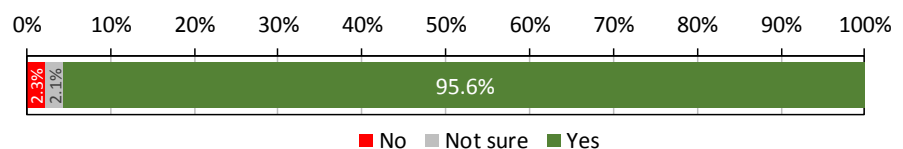


Figure 9: AMA members were told that withholding/withdrawal of medical treatment is appropriate, and asked to agree
Source: AMA Member Consultation Report

Disagreement indicates that these doctors believe, despite any views that may be held by the patient and family, that life-preserving measures must *always* be administered.

A scholarly study of doctors’ attitudes in 2002 (published 2008) found that 97% of Australian doctors would support intensive alleviation of symptoms even if the treatment probably or certainly would end the patient’s life, provided a terminally ill patient requested it. If the patient had *not* made a request, support was reduced to 76% (weighted average).⁴²

Since the AMA survey question is mute on the matter of patient request, the survey result of 96% is most validly compared to an average of the two 2002 results: 86%. While doctor support for intensive alleviation of symptoms may have changed between 2002 and 2016, the data is consistent with the multiple significant bias effects in the AMA survey.

Other research also suggests AMA result bias: A scholarly scientific study found that 6% of Australian doctors would never withhold or withdraw treatment, more than double the AMA's incidence of 2.3%.⁴³

Heavily biased question — DDE

The questionnaire then moved on to a heavily biased question about the doctrine of double effect (DDE). The DDE posits that it is acceptable in certain circumstances to administer medication that will foreseeably hasten the patient's death, but whose only intentions are to relieve suffering. In this manner, it is said that a harm (death) may be acceptable provided only a good (relief of suffering) is intended.*

“Do you agree that so long as a doctor acts in accordance with good medical practice, it is clinically appropriate to administer treatments or other action intended to relieve symptoms which may have a secondary consequence of hastening death?”

This question is subject to the same four significant biases as the previous question, with a similar result (Figure 10: 2.7% disagree), a lower rate than found in the 2008 study (4% disagreed).⁴³

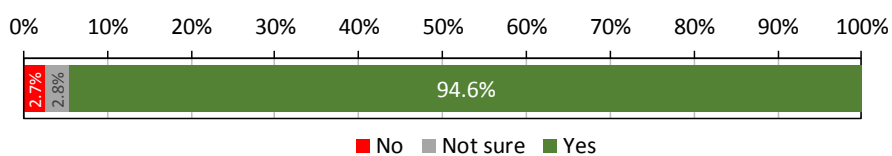


Figure 10: Respondents were told that continuous deep sedation possibly hastening death is appropriate, and asked to agree

Source: AMA Member Consultation Report

While the AMA executive actively sought agreement from its members about its broad end-of-life decision policies (non-treatment and DDE), peer-reviewed and insightful academic research shows that AMA doctor knowledge of the law around these decisions remains poor.^{45,46} Many Australian doctors don't believe that the law is as important as medical and family consensus when making such decisions, and are inclined to ignore the law anyhow.⁴⁷ There is a significant need to improve doctor understanding of the law and its application to medical practice, beyond asking simplistic questions of agreement as the AMA did.

The AMA's survey methodology was superficial and biased towards affirming the status quo.

* For those interested, a more comprehensive discussion of the DDE appears online in Stanford University's *Encyclopedia of Philosophy*.⁴⁴

Can medical interventions always help?

Surveyed doctors were then asked:

“To what extent do you agree with the following statement? ‘There are patients for whom palliative care or other end of life care services cannot adequately alleviate their suffering.’”

The question construction suffers from *mild* acquiescence bias (“To what extent do you agree...”) rather than “Do you agree...” as in the previous two questions, but which would more properly be “To what extent do you agree or disagree...”. This kind of bias is likely to lead to a small (smaller than the previous two questions) yet inappropriate increase in agreement.

Note also that unlike the previous two questions, this question did **not** sensitise the respondent to (did **not** mention) AMA’s *existing* policy on the matter, which states that:

“While for most patients in the terminal stage of an illness, pain and other causes of suffering can be alleviated, there are some instances when satisfactory relief of suffering cannot be achieved.”⁷

Palliative Care Australia (PCA) has also acknowledged that medical and other palliative interventions can’t always help (adopted by National Palliative Care Council in March 1999):

“While pain and other symptoms can be helped, complete relief of suffering is not always possible, even with optimal palliative care.”⁴⁸

Even without being told the AMA’s existing stance, more than two thirds of AMA respondents said that medical interventions cannot always help, and less than a quarter said that they can (Figure 11).

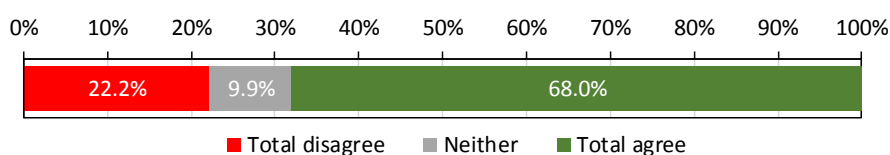


Figure 11: Palliative care and medical treatment cannot adequately alleviate the suffering of some patients
Source: AMA Member Consultation Report.

Despite further erratic bias in the AMA survey, more than two thirds of doctors said that palliative care and other services cannot always adequately alleviate patient suffering at the end of life.

A prior (2002, published 2005) scholarly study of Australian doctor attitudes found 54% agreed with the statement “Sufficient availability of high-quality palliative care prevents almost all requests for euthanasia or assisted suicide”.⁴⁹ While there is a modest ‘agree’ bias in the AMA’s question, it is highly likely that more doctors in 2016, compared to 2002 — especially those familiar with the AMA and PCA policies — are aware that medical interventions cannot help all patients. Nevertheless, the AMA’s final report furnishes no explanation as to why it specifically sensitised respondents to its existing policies on the refusal of medical treatment and DDE, but *not* to its existing policy on the efficacy of end-of-life interventions.

Note: For simplicity, the following charts refer to attitudes about 'euthanasia'. Paired questions about 'physician assisted suicide' have been omitted since results did not suggest substantively different interpretations, although attitudes were generally somewhat more negative.

Heavily biased question — assisted dying

The next AMA question expressly *told* respondents what AMA policy on assisted dying was, and asked them to *agree*.

“Do you agree with the current AMA policy that doctors should not be involved in interventions that have as their primary purpose the ending of a person’s life?”

Notice that the AMA’s questionnaire, after asking about palliative care’s efficacy *without* mentioning current policy and by asking to what *extent* the doctor agrees, then expressly *tells* the doctor the AMA’s current opposed stance to assisted dying and expressly asks if they *agree*. The two questions have identical 5-point Likert (agree/disagree) scales as pre-coded responses, and both have existing AMA policies. Regardless of the poor construction of each individual question, it is illegitimate to vary the construction of similar questions without a meaningful reason.

What the methodology variations suggest is deeply-entrenched hostility towards assisted dying that has flowed through to substantial biases is the survey design. These in turn will result in significantly more negative responses toward assisted dying in later questions than if the AMA’s policy had been revealed later in the questionnaire, *after* doctors had been asked their attitudes about various facets of assisted dying. The AMA’s approach layers not only significant bias in this question relative to the previous one, but also a significant negative sensitisation (sequence) bias to the remainder of the questionnaire.

Despite the very substantial sampling, anchoring and acquiescence biases in favour of the AMA’s policy stance in this question, only half (49.8%) of doctors (AMA members) agreed with it and nearly four out of ten (38.1%) of respondents expressly *disagreed* (Figure 12).

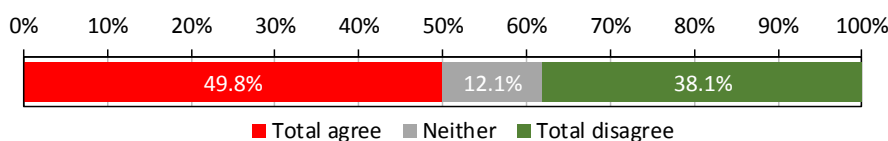


Figure 12: AMA members were told the AMA’s policy on assisted dying and asked to agree with it

Source: AMA Member Consultation Report

The AMA’s survey exhibits not only major biases within questions and illegitimate differential bias between questions, but a significant overall sequence bias — against assisted dying.

Despite the very substantial survey biases in favour of the AMA’s policy on assisted dying, only half of AMA members expressly agreed with it.

The age cohort breakdown of attitudes (Figure 13) is particularly revealing. Agreement with the AMA’s policy is highest amongst doctors 70 years and older — while still one third of them expressly disagreed. These are doctors who are unlikely to be practicing within five years and almost certainly not within ten. Among AMA doctors in their 30s, well under half agreed with the policy. Among those under 30, less than a third agreed with the policy and more than half disagreed.

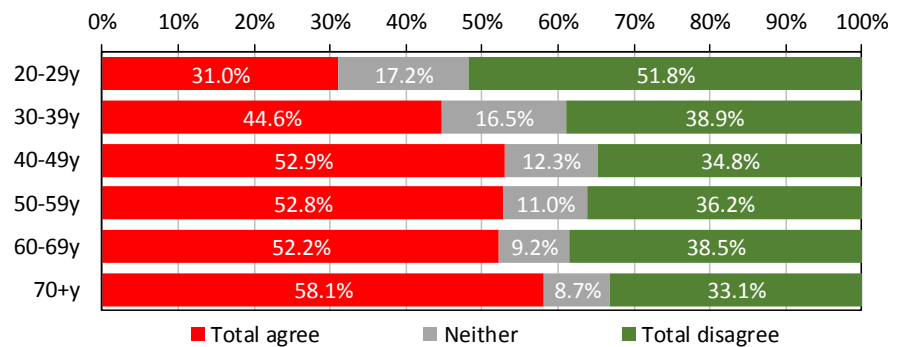


Figure 13: Attitudes toward the AMA’s policy on assisted dying by age group
Source: AMA Member Consultation Report

The AMA’s own research shows how out of touch it is with younger doctors, suggesting its longer-term membership rate is in further peril.

The evidence is clear: the AMA executive has failed to read the signals of substantive and increasing doctor approval of assisted dying. Its policy will be judged recalcitrant and very much on the wrong side of history.

There is hope yet that the AMA may modernise itself into the twenty-first century. At its 2016 AGM, past AMA (Victoria) President Dr Harry Hemley noted the AMA is driven by more hard-core, long-term older members, warning of the AMA’s increasing irrelevance and *political* impotence (Figure 14).⁴ He moved an urgency motion to commission a review and report with “*recommendations for a plan, vision and determination that will lead to re-invigorating and sustaining the AMA.*”

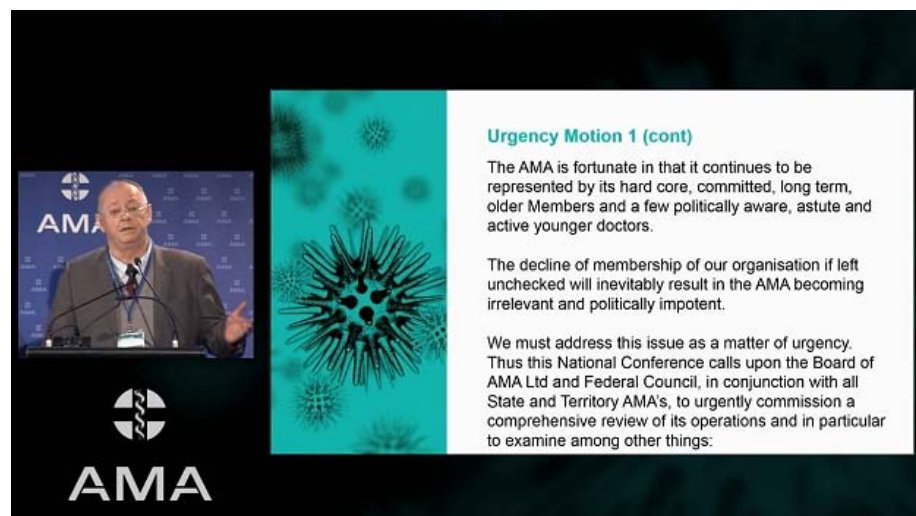


Figure 14: Dr Harry Hemley speaks to the urgency motion to investigate organisational reform

Other questions

Doctor involvement in euthanasia

Having biased AMA members to agree with several AMA policy positions on end-of-life decisions including opposition to doctor-assisted dying, the questionnaire continued with further questions specifically on assisted dying.

“To what extent do you agree with the statement: Doctors should not provide euthanasia under any circumstances.?”

Recall that 50% of respondents agreed, and 38% disagreed, with AMA policy that doctors should never be involved in deliberately hastening a patient’s death. This subsequent question asks much the same thing (doctors should not deliberately hasten death) but *without* the AMA’s hostile policy attached. Despite the now omission of ‘AMA policy’ from the wording, this question still suffers from sampling bias (only AMA members), sequence bias (respondents expressly already made aware of AMA’s hostile policy stance), framing bias (patient request has not been established) and acquiescence bias (“agree with”).

Yet still, *half* (49.6%) of respondents *disagreed* that doctors should never be involved in euthanasia (Figure 15).

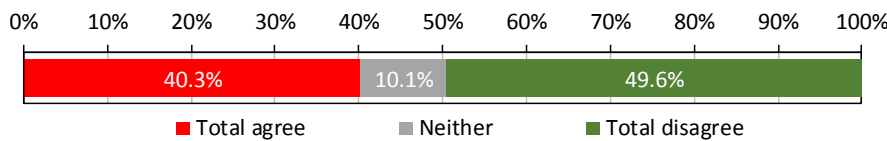


Figure 15: Agreement with “doctors should not provide euthanasia under any circumstances”

Source: AMA Member Consultation Report

The result suggests that the anchoring bias (telling the respondent what policy was) within the earlier question may have swung attitudes 10–12% against assisted dying from their next ‘natural’ position (other biases aside). In comparison, a USA Medscape study found that in 2014, US physician support for assisted dying was at 54%, up from 46% in 2010.⁵⁰

Doctors were also asked, with continued negative sampling, anchoring, framing biases, but now a *positive* acquiescence bias:

“To what extent do you agree with the following statement: ‘Euthanasia can form a legitimate part of medical care.’?”

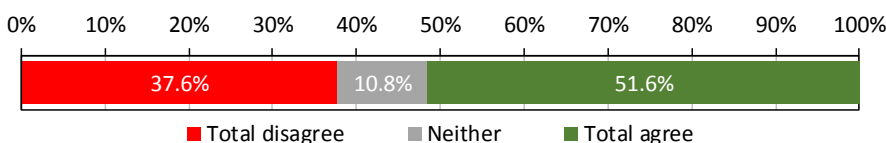


Figure 16: Agreement with “euthanasia can be legitimate part of medical care”

Source: AMA Member Consultation Report

Despite survey bias against assisted dying, half of the AMA’s own members expressly disagreed with its statement that doctors should never provide euthanasia...

...and more than half said euthanasia can form a legitimate part of medical care.

More than half (51.6%) of AMA doctors said that euthanasia can form a legitimate part of medical care (Figure 16), a slightly more positive response than to the previous question.

Legalisation of euthanasia

Respondents were asked about euthanasia becoming lawful.

“Do you believe euthanasia should be lawful in any circumstances?”

Note the ambiguity bias: it is unclear whether the question means ‘in all circumstances,’ ‘in some but not other circumstances,’ or ‘in no circumstances.’ We will assume that most respondents interpreted it with the last meaning.

More than a third of AMA members said euthanasia should be lawful.

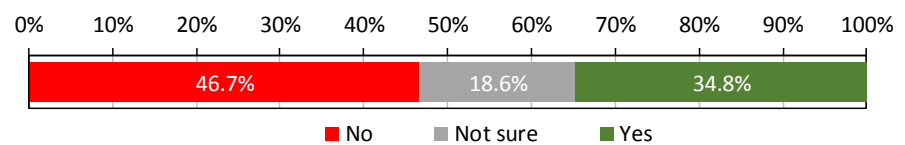


Figure 17: Belief that “euthanasia should be lawful in any circumstances”
Source: AMA Member Consultation Report

Attitudes were similar to those about the AMA’s policy on assisted dying, though slightly less polarized — slightly more unsure and slightly less agreeing and disagreeing (Figure 17). This result is no surprise.

Firstly, in 1995 the then AMA President, Dr Brendan Nelson, stated publicly that assisted dying could be acceptable if practiced privately, i.e. with no structured or standardised oversight (Figure 18).



Figure 18: AMA President in 1995, Dr Brendan Nelson, argues for ‘private’ euthanasia⁵¹

“My attitude is that in those cases, if assisted death is not an unreasonable course, let those individual patients, their families and their doctors make those decisions, and let it occur.” — Then AMA President Dr Brendan Nelson in 1995

Secondly, we already knew from other research that Australian doctors are more opposed to the *legalisation* of assisted dying than they are to assisted dying itself. A 2006 study, analysing Australian doctor attitudes from 1995 and 2000 found that 31–36% of doctors were both opposed to euthanasia and to its legalisation (Figure 14).⁵² A further 25% doctors were not opposed to euthanasia itself yet were opposed to its legalisation. In other words, a quarter of doctors thought ‘private’ euthanasia practice acceptable, but didn’t want the practice legalised.

If we add the 2006 25% ‘euthanasia can be practiced but should not be legalised’ to the AMA’s ‘yes, euthanasia should be legalised’ rate of 34.8%, we reach 59.8%, remarkably similar to the 59.7% AMA result for ‘yes, if euthanasia is legalised, it should be practiced by doctors.’

The 2006 researchers found that the discrepancy between doctors’ views on euthanasia and its legalisation was in significant part due to “*the resistance of doctors to further intrusion by the law and bureaucracy on their clinical and professional autonomy.*” This interpretation was shared by at least one prominent anti-euthanasia campaigner, Professor Nicholas Tonti-Filippini, who said that “*some [doctors] who supported patients ending their lives did not want the legislation because it would create restrictive red tape for something they could already do.*”⁵³

A 2008 Herald-Sun poll of almost 1,800 Victorian doctors found that 45% thought the medical profession should support assisted dying law reform (Figure 19).⁵³

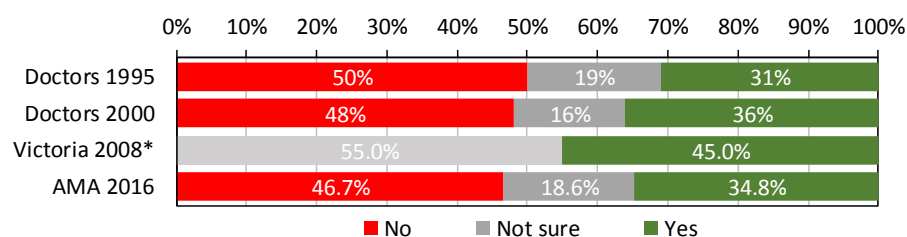


Figure 19: Doctor belief that euthanasia should be legalised

Sources: Cartwright et al 2006,⁵² Herald Sun poll of Victorian doctors,⁵³ AMA Member Consultation Report. * The ‘No’ percentage was not reported, but if ‘Not sure’ was around the typical 18% level, ‘No’ would be around 37%, considerably less than ‘Yes’.

Should lawful euthanasia be provided by doctors?

Doctors were also asked that if euthanasia were to be decriminalised, whether it should be provided by doctors or not.

“If euthanasia were to become lawful, do you believe it should be provided by doctors?”

(Ambiguity bias: Note that it is unclear whether the question is asking “may doctors participate” or “must only doctors participate.” Regardless, a ‘yes’ response is a response opposed to the AMA’s current policy.)

The reason some doctors oppose assisted dying legalisation is not because they are opposed to euthanasia, but would rather practice it in private without bureaucratic ‘interference.’

The results are revealing (Figure 20). Close to 60% of AMA doctors said that euthanasia should or could be provided by doctors if the practice were legalised, substantially more than said it forms a legitimate part of medical practice or believed it could be provided in certain circumstances. AMA President Dr Michael Gannon expressed surprise at this result.²² Less than a quarter (24%) of doctors disagreed.

A significant majority of AMA members said euthanasia should be provided by doctors if legalised.

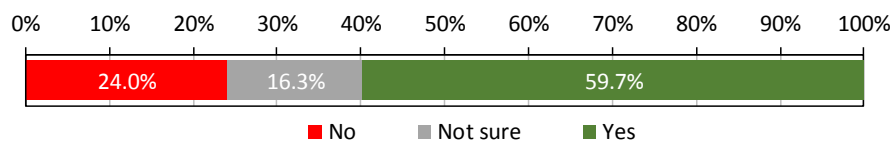


Figure 20: Agreement with “if lawful, euthanasia should be provided by doctors”
Source: AMA Member Consultation Report

This is highly significant: the survey’s previous questions were intrinsically framed by the current criminal context of assisted dying and the AMA’s entrenched opposition to its practice. Therefore, as much as half (26%[†]) of the previous doctor attitudes against assisted dying may be directly attributable to its current unlawfulness.

Circumstances for providing lawful euthanasia

Those who said ‘yes’ to doctors providing euthanasia if it were to become lawful were asked in what circumstances euthanasia could be permitted.

“Under what circumstances do you believe a doctor should be lawfully allowed to provide euthanasia to a competent adult? A terminal illness; An incurable illness associated with unrelievable and unbearable suffering; Other.”

Amongst doctors who believed euthanasia should be provided by doctors if legalised, most thought that it could be provided to patients with “an incurable illness associated with unrelievable and unbearable suffering” (‘In extremis’ in Figure 21), while almost two thirds thought it could be provided for patients with “a terminal illness” (‘Terminal’ in Figure 21). Clearly, in doctors’ opinion, intolerable and unrelievable suffering is crucial for access.

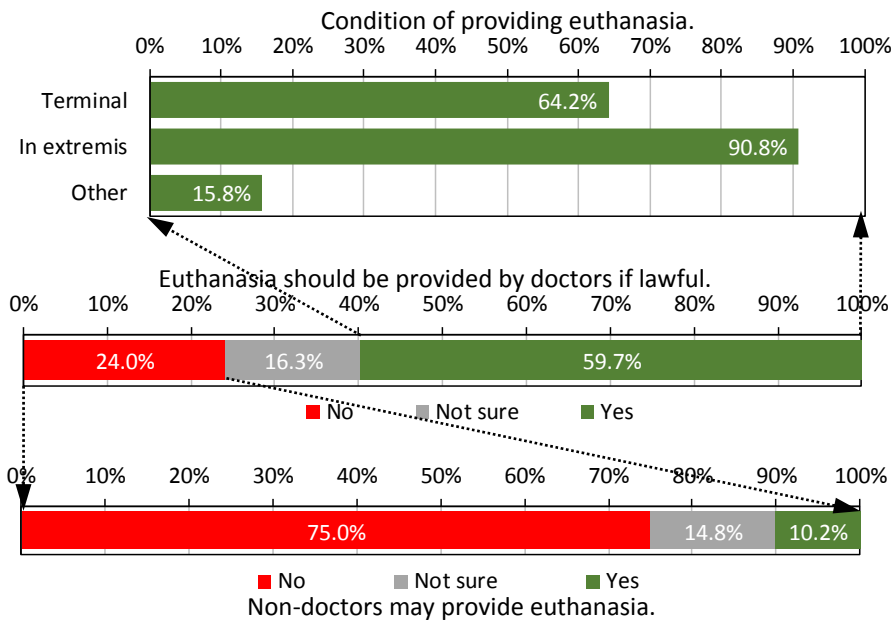
Non-doctors providing lawful euthanasia

Those who said ‘no’ to doctors providing euthanasia if it were to become lawful were asked if it could be provided by people other than doctors.

“Do you believe other persons should be allowed to provide euthanasia?”

Most (75% of) doctors opposed to doctor participation even if lawful, think that no one else should administer euthanasia either; 15% were unsure and 10% thought that others could provide it (Figure 21, lower).

[†] 50% agreeing with AMA’s opposed policy in the current criminal climate, minus 24% saying that doctors should not practice it even if legalised.



Few doctors thought that euthanasia should be provided by anyone other than doctors.

Figure 21: Upper—Circumstances under which lawful euthanasia can be provided by doctors if legalised; Middle—if euthanasia were lawful it should be provided by doctors (from Figure 20); Lower—if doctors ‘must not’ provide euthanasia when lawful, whether other persons may
 Source: AMA Member Consultation Report

Participation if legalised

Respondents were asked, if euthanasia were lawful, whether they would be personally willing to provide it:

“If euthanasia were to become lawful, how likely do you think it would be that you would provide it if requested by a patient in accordance with the law?”

Close to one third (32.0%) of AMA members said they would (Figure 22); slightly more than half of those who said if legal it should be provided by doctors.

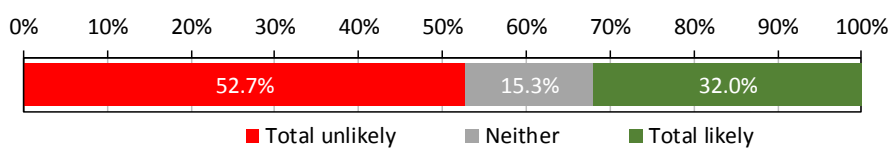


Figure 22: Likelihood of providing euthanasia in accordance with the law
 Source: AMA Member Consultation Report

Around a third of AMA doctors said that they would provide euthanasia if it became lawful.

This is low compared to a 1988 study which found that 40% of Australian doctors would consider providing euthanasia if it were legalised,⁵⁴ and a 2002 study which found that 35% of Australian doctors have or would be willing to provide assisted dying *even in the absence of express legalisation*.⁴³

Given these results and that attitudes toward assisted dying have become more positive in recent years, this suggests that bias in the AMA survey

methodology has substantively underestimated the likelihood of Australian doctor participation, even though close to a third indicated in the affirmative.

Double-barrel question about referrals

Doctors were asked:

“To what extent do you agree with the following statement? ‘If euthanasia becomes lawful, doctors should not be compelled to participate in the practice, either directly by providing the practice or indirectly (for example, by providing a referral to another doctor).’”

Apart from acquiescence bias (“agree with”; “not be compelled”), this is a double-barrel question. First it asks whether doctors must be obliged to participate in administering euthanasia (most would disagree as per Figure 23). The second question is about an obligation to make a referral should the doctor decline to participate. This may have had a much higher acceptance rate than administration of euthanasia, but is obscured by the more controversial half of the question.

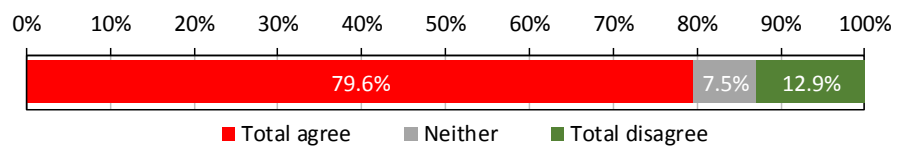


Figure 23: Doctors should not have to participate in euthanasia or refer

Source: AMA Member Consultation Report

The AMA executive drew an indefensible conclusion from a double-barrel question.

The AMA member’s briefing concludes that:

“The majority of respondents believe that doctors should not be compelled to participate directly or indirectly in ... euthanasia.”

The conclusion *may* be reasonably valid for administration, but is almost certainly *not* valid for referrals. The question design makes it impossible to make confident pronouncements about either, since the two were rolled in together.

AMA President's hostile statements during review

The AMA's President since May 2016, Dr Michael Gannon, gave repeated and abundantly clear signals *against* assisted dying *during* the AMA's review process. I was unable to find any public statements of the President which were neutral towards or supportive of assisted dying.

Hostility to a stance of neutrality

In May 2016, Dr Gannon made clear his belief that the World Medical Association's (WMA) Declaration of Geneva outlaws doctor-assisted dying, and that if the AMA became neutral it would 'offend' the Declaration.

*"The AMA will look at its policies and as you've alluded to, one possible outcome is that the AMA might adopt a position of neutrality on the issue. In other words, not have a clearly written policy in accordance with the Declaration of Geneva."*⁵⁵

Here's what the Declaration of Geneva 'oath' says in its entirety that could have anything to do with assisted dying:

"I will maintain the utmost respect for human life."; and

*"I will not use medical knowledge to violate human rights and civil liberties, even under threat."*⁵⁶


It is possible to maintain the utmost respect for human life, while honouring a deeply-held request from a patient for their own assisted death in the face of intolerable and unrelievable suffering. A blanket refusal against assisted death conflates the *right* to life with a *duty* to life in all circumstances.

Recall that slightly more than half of the AMA's own members think that euthanasia *can* form a legitimate part of medical practice, and half expressly *disagreed* with the notion that doctors should not provide euthanasia under any circumstances. These are not trivial, tiny minorities. Clearly, half or more of the AMA's own members either believe that euthanasia doesn't offend the Declaration of Geneva, or that the Declaration is not the most important (or any) guide in their decision making.

Additionally, if these statements of the Declaration were prescriptive or even persuasive against assisted dying, they would be equally or even more so against abortion. Yet the AMA accepts abortion.⁵⁷ Thus the AMA's stance on assisted dying is fundamentally incoherent.

False impression of palliative care 'competition'

In response to an article in *The Australian* "Catholic stance allows eased exit," Dr Gannon tweeted:

 **@amapresident 13 Aug 2016:** Different views society on assisted dying. Hope all agree improved PalliativeCare access a priority @westaustralian

AMA President Michael Gannon made clear his personal belief that euthanasia offends the Declaration of Geneva: while either it doesn't, or is an equal argument to oppose abortion, which the AMA accepts.

The AMA's differing stances on abortion and assisted dying are fundamentally incoherent.

Dr Gannon suggests a faux ‘competition’ between euthanasia and palliative care.

Dr Gannon invokes a popular but false ‘competition’ between palliative care and assisted dying. In jurisdictions where assisted dying has been legalised, palliative care availability has improved (including increases in funding), not deteriorated. Increased funding was a deliberate facet of assisted dying law reform in both the Netherlands and Belgium, and reports from Oregon and Washington indicate improved access there as well.^{58,59}

Nor does Dr Gannon’s statement acknowledge that medical care is supposed to be patient-centred, and the patient may rationally request assisted dying.⁶⁰


The Victorian parliament’s thorough and comprehensive study into end-of-life choices, for example, made numerous recommendations for improvement in and funding of palliative care at the same time as recommending law reform to permit assisted dying in restricted circumstances.⁶¹


And, the AMA and PCA already acknowledge that they cannot help everyone despite the best medical care. It is not a ‘competition.’

Trivialising DDE and apparently speaking for ‘all’ doctors

Dr Gannon also tweeted in support of the ‘doctrine of double effect’ (DDE, an action that is not without contention, as discussed on page 40).

Dr Gannon trivialises the complexity of the DDE, and speaks for ‘all doctors’ despite most Australian doctors spurning AMA membership.

 **@amapresident 24 Aug 2016:** Doctors should be careful, must obey the law and understand their code of #ethics. Double effect is not #Euthanasia

 **@amapresident 6 Sep 2016:** Double effect not #Euthanasia Doc’s must act within the law, their code of #ethics @drajm @cathyo62 @westaustralian

Dr Gannon and the AMA promote DDE as largely uncontroversial. He also asserts here that all doctors should “understand their code of ethics.” While it is ambiguous as to which “code of ethics” he is referring, AHPRA’s “code of conduct for doctors in Australia”⁴¹ has nothing whatever to say about assisted dying, and nor does the AMA’s own official Code of Ethics.⁶² Therefore, it is likely he is referring either to the AMA’s own Position Statement or to the WMA’s Declaration of Geneva (which Dr Gannon posits forbids assisted dying).

Fear-mongering claim of potential patient ‘flood’

In an article in The Australian on 15th September 2016, Dr Gannon said that Victoria could be flooded with interstate patients if it legalised ‘euthanasia’.⁶³ It’s deeply disappointing that the President of the AMA, a well-resourced professional body, failed to acquaint himself with the facts before making this fear-mongering pronouncement.

The Victorian parliament’s own extensive report into the legalisation of assisted dying expressly recommended that:

“only a person who is ordinarily resident in Victoria and either an Australian citizen or a permanent resident may access assisted dying. This

Dr Gannon fear-mongered a patient ‘flood’ if Victoria legalised euthanasia, despite the Parliament’s clear recommendation to limit it to residents.

criteria is designed to prevent people coming from outside Victoria to obtain assisted dying.”⁶¹ (p. 221)

Incoherent rejection over ‘complexity’


In the same article in *The Australian*, Dr Gannon argued against assisted dying, saying it was “extremely complex.”⁶³ If complexity were a reason to oppose anything, the AMA would be opposed to the entire healthcare system: it’s vastly complex. The argument collapses at the slightest inspection.

Indeed, the issues of refusal of life-preserving medical treatment, continuous deep sedation until death, and the voluntary refusal of food and fluids are also complex — especially ethically — yet Dr Gannon does not rail at those, and the AMA has no specific guidelines on them.

Further, his complaint ignores that his objections are already and directly addressed in the Victorian parliament’s comprehensive report into end-of-life decision making.

Indefensible claim of BMA ‘intelligent approach’

Dr Gannon then tweeted in support of the Canadian Medical Association’s (CMA) neutrality towards assisted dying, but also of the British Medical Association’s (BMA) opposition:

 **@amapresident 19 Sep 2016:** Agree @DrSallyCockburn admire #euthanasia work done by @CMA_Docs. Equally careful, compassionate, intelligent approach from @TheBMA #ethics

He commends the British Medical Association’s supposedly “careful, compassionate, intelligent approach” opposed to assisted dying: an approach that has been comprehensively exposed as superficial and ill-informed fear-mongering, fiction, flip-flop and hubris.⁶⁴

Unjustifiable claim of ‘inevitable slippery slope’

Shortly afterwards, Dr Gannon tweeted that extension of any assisted dying law will be ‘inevitably’ expanded over time to include the ‘vulnerable.’

 **@amapresident 1 Oct 2016:** It is inevitable that if #Euthanasia laws are passed, they will over time be expanded to include children, mentally ill, vulnerable #ethic

There is ample evidence to refute Dr Gannon’s claim:

1. A scholarly study found no evidence that assisted dying has a disproportionate effect on patients in supposedly vulnerable groups, including minors, the elderly, women, the uninsured, the lesser educated, those with mental illness, and racial or ethnic minorities.⁶⁵
2. No changes have been made to qualification criteria for assisted dying (there are none) in Swiss legislation since it came into effect in 1942.⁶⁶
3. The USA state of Oregon assisted dying legislation’s eligibility criteria have not changed the since it came into effect in 1997,⁶⁷ though an

Dr Gannon made a facile and indefensible claim about ‘complexity.’


Dr Gannon’s claim that the BMA’s approach to assisted dying is “careful, compassionate, intelligent” is indefensible.


Dr Gannon's claim that any euthanasia law will inevitably be extended is contradicted by the evidence.

- amendment has recently been tabled in the Oregon Senate, yet may not pass.
4. Washington state's legislation, in effect since 2008, has not changed.⁶⁸
 5. The Netherlands' legislated eligibility criteria have not changed since they came into effect in 2002.⁶⁹
 6. Belgium's legislation, in effect since 2002,⁷⁰ changed in 2014 (twelve years later)⁷¹ to modify the qualifying *age* restriction to a *competency* restriction, and to apply additional eligibility criteria for minors. As at the end of 2016, it had been used by a single minor of age 17, just short of the age of majority.
 7. In Australia, the Northern Territory's *Rights of the Terminally Ill Act (1995)* was not extended. Quite the opposite occurred: it was extinguished around eight months after it came into effect.
 8. Canadian Professor Harvey Chochinov, Chair of his government's expert panel which investigated legislative options for assisted dying, confirmed the evidential *absence* of the 'slippery slope' in a keynote address at Swinburne University in Melbourne in November 2016.⁷²

Biased statement about patient trust in doctors

In commenting on a media report of community trust in doctors, Dr Gannon also implied that assisted dying (which he posits the Declaration of Geneva prohibits) would necessarily result in erosion of patient trust in doctors:

 **@amapresident 11 Nov 2016:** Doctors maintain this Trust with everyday care for patients, by upholding #DeclarationOfGeneva @medwma @juliamedew @Rania_Spooner #ethics [and]

 **@amapresident 18 Sep 2016:** Declaration of Geneva, oath taken by Doctors on graduation. #Ethics of humanity, confidentiality #euthanasia @medwma

Dr Gannon, and the AMA's survey, assumed that legalisation of euthanasia may only harm patient trust in doctors, despite readily-available evidence to the contrary.

His assumption is at odds with the facts. People's trust in doctors is very high amongst OECD countries *with* assisted dying laws.⁷³ Indeed, public trust in doctors amongst Swiss, Dutch, and Belgian citizens are three of the top five results, and are significantly higher than Australians' trust in doctors (Figure 24),[‡] showing that the AMA still has some work to do relative to its boast that it contributes to public trust in the medical profession.

In regard to *changes* of public trust in doctors specifically if assisted dying were legalised, several overseas studies provide valuable insights. A 1996 USA study found that amongst the public, 91% would trust participating doctors while only 86% would trust non-participating doctors. A mere 5–8% of the public said they would 'likely' change doctors if theirs participated, while *none* said they would 'definitely' change doctors.⁷⁵

[‡] These results were obtained using consistent methodology across the OECD countries. There is an IPSOS poll in Australian only showing 90% public trust in doctors, but this is *relative* to other professions including clergy, business leaders, union officials and politicians.⁷⁴

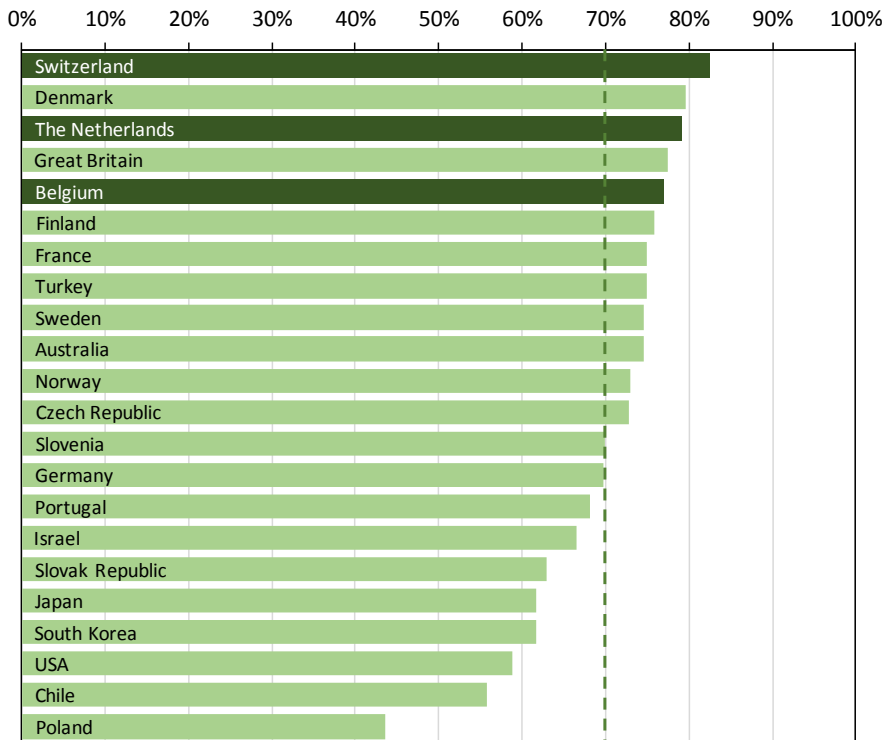


Figure 24: General trust in doctors across 22 OECD countries (dashed line is the mean of all results)

Source: Saarinen et al 2016⁷³

A 2005 USA study⁷⁶ found a majority (58%) of the public thought doctors providing assisted dying would increase trust in doctors, with just 20% believing trust would be diminished; an ‘improved trust’ ratio of almost three to one (Figure 25). A 2009 Swedish study,⁷⁷ where public attitudes towards ‘physician assisted suicide’ (73% in favour, 15% undecided, 12% opposed) are also similar to those in Australia, found that legalisation of assisted dying would increase trust amongst 38%, not influence trust at all among 45%, and would decrease trust among 17% of the public, a ratio of more than two to one towards increased trust. Of the 17% opposed to law reform, 75% indicated that their trust in doctors would decrease. Additionally, a 2015 UK survey, where public attitudes toward assisted dying were also similar, found that a much larger proportion of the public (38%) thought that legalising assisted dying would increase trust in doctors rather than decrease it (12%), an improved trust ratio of more than three to one.⁷⁸

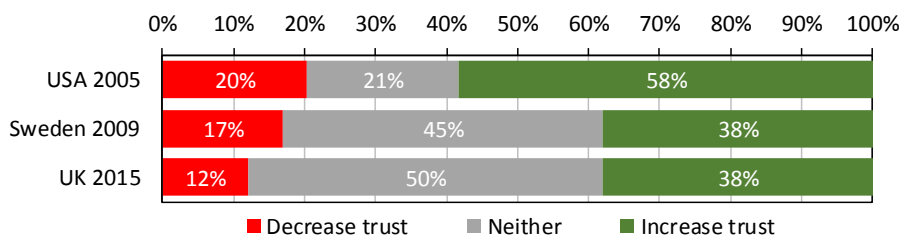


Figure 25: Public attitudes toward how legalisation of assisted dying would affect patient trust in doctors

Sources: Hall et al 2005;⁷⁶ Lindblad et al 2009;⁷⁷ Populus 2015.⁷⁸

In its survey, the AMA asked its members for their opinion on patient trust if euthanasia were legalised:

“To what extent do you agree with the following statement: ‘Allowing doctors to lawfully provide euthanasia will negatively affect the trust patients have in doctors.’?”

Notice that the methodology has (a) negative sampling bias, (b) negative framing bias (“euthanasia” and “negatively affect”), and (c) acquiescence bias (“agree”). Yet despite all these negative biases, still a clear majority (52.6%) of the AMA’s own members expressly disagreed with the statement (Figure 26).

A majority of AMA doctors expressly disagreed with the survey’s biased question that legalisation of euthanasia would only harm patient trust in doctors. Fewer than a third agreed.

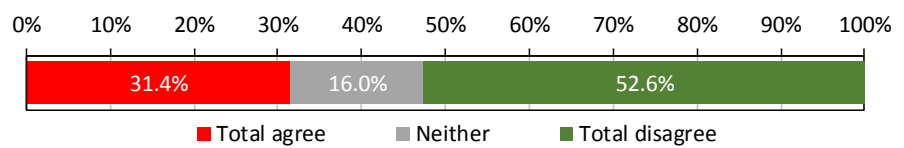


Figure 26: ‘Doctor-provided euthanasia would damage patient trust’
Source: AMA Member Consultation Report

The result is not really surprising: a 2002 study (published 2005) with a similarly biased question (that permitting *voluntary* euthanasia would only “harm the relationship”) also found fewer than a third (30%) of Australian doctors in agreement (the 2016 AMA result with its additional biases was 31.4%).⁴⁹

The AMA (doctor) attitudes were far more polarised than the UK and Swedish public’s: only around a third as many doctors, compared with the public, thought there would be no real change in trust. The AMA polarisation is more like that of the USA public’s.

The net measure of change in trust (‘increased trust’ minus ‘decreased trust’) was very substantially positive in all four studies: positive 38% (USA public), 21% (AMA doctors), 21% (Sweden public) and 26% (UK public).

By plumping solely for a *decrease* of public confidence in doctors, the AMA and its President seem at best unaware of these published facts.


Failure to ask patients about patient perspectives

Amongst the numerous biases in the AMA survey, asking *doctors* about potential *patient* trust in them is perhaps the most grievous sampling bias. Was the AMA executive not interested in the perspectives of patients themselves; only about *doctors’* opinions of patient perspectives?

The AMA asked only doctors, not patients, about a change patient trust in doctors if assisted dying were legalised: a most grievous sampling bias.

Misunderstands or misreports a key statistic

Dr Gannon also misunderstood the AMA's own survey data. In response to a media article erroneously stating that "*most doctors would help terminally ill die: AMA*",²² he tweeted:

 **@amapresident 23 Nov 2016:** In fact, survey says majority want Doctors involved if change to law #Euthanasia. But most doctors would want others to do this work #ethics.

It is true that the AMA survey found a majority of respondents (60%) wanted doctors to provide euthanasia if it became legal (see page 26), but it is false to assert that the survey found 'most doctors would want others to do this work.'

Of those doctors who were opposed to doctor participation even if legal, only 10% of them said non-doctors should be able to provide euthanasia.

And those who said doctors should provide euthanasia if it became legal (60%), roughly half (32%) said they would lawfully provide it (see page 27). But they were not asked if others could or should do this work.

Therefore, there is no survey evidence to support the President's claim that most doctors want others to provide euthanasia, and good evidence to dispute it.

Surprising inconsistency

Many of these facets of Dr Gannon's statements are surprising, since he has also stated how important accurate scientific information is.

 **@amapresident 18 Aug 2016:** Being a doctor is a huge privilege. Also carries responsibility to provide accurate scientific info, act ethically.

Doctors and the public might ask the question:

"Why did the AMA President (and immediate past Chair of the investigating Ethics and Medico-Legal Committee) think it appropriate to repeatedly publicise his personal opposition to euthanasia while the review was in progress, and why did he seem to be unaware of readily-available data on a number of fronts?"

Dr Gannon makes an assertion that is not supported by the AMA survey results.

Why did the AMA President think it appropriate to repeatedly publicise his personal opposition to euthanasia while the review was underway, and miss key readily-available data on a number of fronts?

The 'limitations' section of the AMA's final report failed to mention key significant biases brought to its attention by experts.

The AMA's revised position statement fails 'to be respectful of the views' of a majority of its members: the only 'justifiable' conclusion of its survey was to adopt a stance of neutrality towards doctor-assisted dying.

Biased 'survey limitations'

The AMA's internal final report mentions three shortcomings of the survey: self-selecting respondents, non-completion by some respondents, and 'slightly confusing' wording of 'a few of the questions.'

However, the 'Survey Limitations' section failed to mention the very substantial design biases pointed out to them separately by me and a Fellow of the Australian Market and Social Research Society, and of which they acknowledged receipt.

The public might ask the legitimate question:

"Why did the AMA fail to report multiple, known significant flaws in its research methodology, and was that ethical conduct?"

Comprehensively failed its own standards

The AMA states in its update about the policy review process:

"...the Federal Council's mission is to be respectful of the views of all members, and to be understanding of the passion of those with opposing views, while seeking to find a position which is sensible and justifiable..."⁴⁰

Let's review key survey results (keeping in mind the multiple methodology biases against assisted dying):

- 68% of AMA members said that even with optimal care, complete relief of suffering is not always possible.
- 60% of AMA members said that if lawful, euthanasia should be provided by doctors, and more than half of them (total 32%) said that they would indeed practice it.
- 52% of AMA members said that euthanasia can form a legitimate part of medical care.
- 50% of AMA members *expressly disagreed* with the AMA's statement that "doctors should not provide euthanasia under any circumstances."
- 38% of AMA members *expressly disagreed* with the AMA's policy opposed to assisted dying, and only half expressly agreed.
- 35% of AMA members said that euthanasia should be lawful.[§]

Given the AMA survey results, its continued policy unequivocally opposed to doctor assisted dying is neither "*sensible*" nor "*justifiable*." It comprehensively fails to "*be respectful of the views of all members*." While

[§] Scholarly research, in addition to the AMA poll, indicates that around 25% of doctors are not opposed to assisted dying, but don't want it legalised, preferring instead to practice it in private without regulatory 'interference.'

the revised policy states that “*the AMA recognises there are divergent views,*” only a policy of neutrality would actually *respect* the views of all members.

By continuing to state without reservation in its revised policy that “*doctors should not be involved in interventions that have as their primary intention the ending of a person’s life,*” the AMA executive is thumbing its nose at more than half of its own membership.

And remember that most Australian doctors are not AMA members and are likely to be even less supportive of the AMA’s unjustifiable stance, while the AMA behaves as though it represents them all.

Post-hoc and ad-hoc decision making

In its final report to members, the AMA executive states that “*the results of the consultation process did not yield a mandate for change.*” I was unable, despite intensive research, to find any mention of this standard of decision making criterion — a *mandate for change* — prior to the final report. Indeed, I found no reference to any particular standards of decision making apart from the political ‘mandate’ statement in the final report.

Given the results of its own member survey — more than half saying that euthanasia can be legitimate medical care and should be practiced by doctors if lawful, nearly four in ten expressly disagreeing with the AMA’s policy, and around a third saying they would practice euthanasia if lawful —the AMA executive cannot legitimately argue there was no “*mandate for change*” to its one-sided policy of opposition.

The revised policy statement would be more accurately stated as:

“The AMA executive believes that doctors should not be involved” in assisted dying.

From pro-end-of-life care to anti-euthanasia policy

Perhaps more telling is the reframing of the policy itself.

The AMA’s superseded policy was titled “*Position statement on the role of the medical practitioner in end of life care 2007/14*.”⁷ It makes positive statements about the doctor’s role in good medical practice and the relief of pain and suffering. Within that framework are three statements about (and opposed to) ‘euthanasia and physician assisted suicide.’


However, the revised policy is no longer framed by the role of the medical practitioner in and of life care. It is, in complete contrast, framed by opposition to assisted dying: it is now titled “*Position statement on euthanasia and physician assisted suicide 2016*”, and within that are statements about good medical practice and the relief of pain and suffering, in addition to statements about assisted dying: in other words, the same scope but opposite focus.

Therefore, in the face of compelling evidence from its own members to adopt a position of neutrality, its policy of opposition has become even more entrenched.

At what point did the AMA establish the standard that its review had to generate a ‘mandate for change’?

The AMA Position Statement title changed from framing by support for ‘end of life care,’ to opposition to ‘euthanasia and physician assisted suicide,’ despite having much the same content.

Indeed, President Dr Michael Gannon took care to stamp out a journalist's impression that the AMA had 'softened' its opposition towards assisted dying:

 **@amapresident** 5 Dec 2016: #Euthanasia AMA has not 'softened' pos'n. We want more Govt energy, focus on improving EoL care, access #mentalhealth @Pall_Care_Aus #auspol

The AMA review was utterly silent on the ample evidence that doctor-assisted dying already occurs throughout Australia.

AMA executive fails to address existing practice

In making a blanket statement wholly against doctor-assisted dying, the AMA executive fails to address the issue of existing Australian doctor practice, too. Doctor-assisted dying practice was first formally revealed in the 1980s with 29% of Victorian doctors saying they had taken active steps to hasten a patient's death, including 34% of non-religious, 19% of Catholic, 36% of Anglican and 39% of Jewish doctors.⁷⁹

In the 1990s it was found that 1.8% of all Australian deaths were hastened by doctors, despite its illegality.⁸⁰

A 1994 study found 47% of South Australian doctors had received requests from patients for a hastened death, and 19% had taken active steps to bring about the death of a patient,⁸¹ and a separate study of NSW doctors found almost half had received a patient request and 28% had complied.⁸² A 1996 study found 20% of Australian GPs and 17% of specialists had taken active steps to hasten the death of a patient.⁸³

A 2002 study (published 2008), found that 4.2% of Australian doctors (including 2.9% of Catholic doctors, 2.4% of Protestant doctors, and 5.8% of non-religious doctors) had honoured a patient's assisted dying** request.⁴²

The study also found that 12% of Australian doctors (including 6% of Catholic doctors, 14% of Protestant doctors and 15% of non-religious doctors) would deliberately hasten a patient's death *without* an express request from the patient.

A 2001 study of Australian surgeons found that 36% had given medications in larger doses than for relieving the patient's suffering with the intention of hastening death, and 5.3% had administered a large bolus of medication in response to an unambiguous patient request.⁸⁴

Past AMA President Dr Brendan Nelson was more adamant in 1994, saying that he had helped patients to die, and that:

"Doctors who denied helping patients to die were either inexperienced or dishonest." ⁸⁵

** Either doctor-administered or patient-administered medication. Earlier research may have included other practices such as withdrawal of life-sustaining treatment: yet all had an *intention* to hasten death.

He argued for assisted dying to be practiced privately between the doctor, the patient and the family.

Much more recently in 2015, oncologist Dr Ian Haines agreed with this sentiment, saying that:

“Sometimes the best outcomes are achieved by leaving difficult moral decisions in a grey area for sensible, wise and committed people to work in.”⁸⁶

In principle, these views confirm that some doctors oppose the legalisation of assisted dying *because* they want to practice it without oversight. That’s hardly a recipe for consistent, transparent, quality healthcare practice: what one doctor thinks wise, another may think folly or worse.

The AMA executive thoroughly ignored all this readily-available evidence that assisted dying already occurs at significant rates in Australia. A facile admonition that “doctors must not participate in euthanasia” is hardly meaningful or effective in a context where it has occurred knowingly for decades.

Rational versus irrational decision making

Neither does the AMA review mention that a desire to hasten death in the face of unrelievable and intolerable suffering can be rational, and has characteristics that are the opposite of those of irrational suicides: characteristics such as fully informed, carefully considered, communicated, shared and tested.⁸⁷

Research shows that 89% of South Australian doctors,⁸⁰ 93% of Victorian doctors⁷⁹ and 96% of NSW doctors⁸² believe patient suicide can be rational, a view also shared by USA psychotherapists⁸⁸ and Oregon psychologists.⁸⁹

Yet the AMA makes no distinction between ‘physician assisted suicide’ and ‘irrational suicide.’ Indeed, the word ‘suicide’ without qualification invokes all the negative connotations of irrational suicide, and helps explain why many of the results for ‘physician assisted suicide’ were somewhat more negative than the results for ‘euthanasia’ — which the AMA repeatedly failed to qualify as ‘voluntary’: i.e. by patient request.

The AMA review repeatedly used the provocative term ‘physician assisted suicide’ without distinguishing rational from irrational suicide, or noting that most Australian doctors believe a decision to hasten death can be rational.

No specific guidelines on similar contexts

Further highlighting the AMA executive's fixation on opposing the legalisation of assisted dying, it reviewed its policy on assisted dying and insists that it be consulted on any legalisation framework at the same time as demanding that doctors should not be involved, yet it has *no* specific frameworks for:

1. Refusal of life-sustaining medical treatment;
2. Continuous deep sedation until death; or
3. The voluntary refusal of food and fluids.

1. Refusal of life-sustaining medical treatment

The AMA states in its revised Code of Ethics⁹⁰ that a patient's decision to refuse or withdraw medical treatment should be respected, including even if the treatment is *life-sustaining*:

"2.1.5 Respect the patient's right to make their own health care decisions. This includes the right to accept, or reject, advice regarding treatments and procedures including life-sustaining treatments."

However, the AMA has *no specific guidelines* to inform doctors about appropriate practice for the refusal of life-sustaining treatment, such as assessing the patient's decision-making capacity including mood disorders; the patient perceiving themselves a burden to caregivers; inappropriate persuasion from greedy relatives; dealing with ambiguities in advance care directives and with substitute decision makers; or striking the right balance between helping patients overcome irrational fears that prevent them from pursuing promising treatment options and respecting the different weights people give to the avoidance of pain and suffering.⁹¹

2. Continuous deep sedation until death

The AMA's review failed to address its facile engagement, in its existing policy document, with complex issues of continuous deep sedation at the end of life (also known by many other names⁹²), a practice argued to be defensible via the doctrine of double effect (DDE).

However, the DDE remains controversial especially in regard to context, such as patient mental competence, whether the request comes from the patient, family or others, estimated time to 'natural' death, proportionality, withholding nutrition and hydration, the consequences of deliberately rendering the patient unconscious, doctor hypocrisy, etc,⁹³⁻⁹⁹ and its normative significance has been questioned.¹⁰⁰ Neither the existing AMA position statement nor its review and revision addressed these concerns.

"The Australian Medical Association (AMA) does not have specific guidelines in relation to palliative sedation, continuous deep sedation or terminal sedation." — AMA email after the assisted dying review.

In a travesty of incoherence, the AMA demands a detailed say in development of assisted dying law (while stating that doctors should not be involved in its practice), at the same time it has no specific guidelines for doctor practice on the refusal of life-preserving medical treatment, continuous sedation until death, or the voluntary refusal of food and fluids.

3. Voluntary refusal of food and fluids

Some patients with intolerable and unrelievable suffering, in the absence of life-preserving treatment that can be refused, or the lawful choice of active assisted dying, may resort to refusing nutrition and hydration in order to hasten death: the voluntary refusal of food and fluids (VRFF). Death usually occurs within 14 days, and can be peaceful provided appropriate care is given.


Doctors may provide medical care in support of the patient's decision and trajectory, yet the AMA is completely silent on ethical principles and practical guidelines in these circumstances, which are fraught with the same considerations as the refusal of life-preserving medical treatment and deep continuous sedation until death with DDE.

So, despite the AMA having no specific practice guidelines on the refusal of life-preserving treatment, continuous deep sedation until death with DDE, or VRFF, the AMA executive demands to have a detailed say in how assisted dying practice is formulated, at the same time as saying doctors should not be involved in the practice.

This raises legitimate questions as to the underlying motivations for 'official' organisational opposition to doctors providing assisted dying, and which has been described as "counterproductive political posturing."¹⁰¹

Summary: Questions for the AMA

The AMA claims its brand stands for “trust and links with professionalism, ethics, and standards.”³ President Dr Michael Gannon says that ethics is the most important topic of all in medicine:

 **@amapresident 29 Jan 2017:** Welcome to 1st yr MD students UWA. Start with lecture on medical #ethics. As you should. It’s the most important topic of all @almamater

The following are some questions, including ethical ones, for the AMA to answer:

The conduct and outcomes of the AMA’s review give rise to many pertinent questions, including ethical ones.

1. Why does the AMA, through its Tasmanian representative, think it appropriate to state on national television that dying patients in extremis and without relief can suicide by themselves, even if the AMA doesn’t “encourage” it?
2. Why did the AMA repeatedly delete corrections to its negative MJA misinformation about assisted dying practice in Belgium?
3. Why did the AMA decide to review its “policy on euthanasia and physician assisted suicide” when it didn’t specifically have one? It had a policy on the role of doctors in end of life care.
4. Why did the AMA review comprehensively ignore the substantial secondary data that already exists about the attitudes and practices of doctors and patients in end of life decisions?
5. Why did the AMA not proactively obtain professional advice and assistance with the design and conduct of its doctor survey, and prefer to use such an amateurish one?
6. If the AMA really represents all Australian doctors, why did it expressly exclude more than two thirds of them from its survey?
7. Why did the AMA persistently use inappropriate language and inadequate definitions about assisted dying?
8. Why did the AMA not make any serious attempt to understand patient perspectives beyond superficial statements that ‘opinions are divided’?
9. Why did the AMA not report the multiple significant biases in its survey, which it knew about, in the ‘limitations’ section of its final report?
10. Why did the AMA President consider it appropriate to make multiple statements hostile towards assisted dying while the review was underway?
11. Why did the AMA executive decide to continue to demand doctors not participate in assisted dying, when more than half of its own members said it could be appropriate clinical practice provided by doctors, nearly four in ten expressly disagreed with the policy, and a third said they’d participate if assisted dying were legalised?

12. Why does the AMA consider it appropriate to make repeated categorical, public statements that doctors should not be involved in assisted dying, when its Position Statement is not binding on its own members, let alone all Australian doctors?^{††}
13. How can the AMA justify the incoherence of having an expressly opposed stance to assisted dying in its revised Position Statement while it remains totally silent on the matter in its Code of Ethics, revised at the same time?
14. How can the AMA legitimately demand to be centrally involved in developing an assisted dying framework — in which it says doctors should not be involved — for law reform, when it has no frameworks at all for the similar contexts of refusal of life-preserving medical treatment, continuous deep sedation until death, and the voluntary refusal of food and fluids (all currently lawful and practiced)? When will it develop and publish those?
15. Why does the AMA continue to present itself to the media and the public as representing all Australian doctors, when more than two thirds of them are not members?
16. Will the AMA include a formal analysis and critique of this deeply flawed policy review as part of its modernisation efforts in order to rebuild its brand value and stem the falling tide of its membership? That is, is the AMA prepared to learn from its mistakes?

^{††} The AMA's Code of Ethics is not binding even on its own members, either. So when the Code states "don't engage in sexual, exploitative or other inappropriate relationships with your patients," that's merely a 'suggestion' or 'recommendation' rather than an 'obligation' as a member of the AMA.

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