Evaluation of the Report on Euthanasia for the New Zealand Medical Association by Grant Gillett

Jack Havill, Libby Smales, Miles Williams, Frank Kueppers

We write concerning the Report on Euthanasia for the New Zealand Medical Association by Grant Gillett. His report, for many of us, proved difficult to read. It is both confusing and confused, sometimes conflating relevant and irrelevant issues, and parts of it are inaccurate. His claims are not well supported by the copious data available in the public domain.

Gillett’s claims to represent other doctors are debatable. The NZMA is an organisation to which fewer than 50% of doctors subscribe; clearly it does not represent all of us, nor has it seen fit to obtain the current views of its membership. We congratulate the NZ Nurses Organisation which has done so, and has issued a new position statement favourable to Voluntary Assisted Dying (VAD) to support the views of its membership.

What 70–80% of New Zealanders want, according to repeated surveys, are sound, well-drafted laws with appropriate safeguards to enable sane, rational, dying adult New Zealanders to be able to access help to end their lives; when, where and with whom they choose; in order to end or avoid irreversible suffering that is unbearable to them. Either by taking appropriate prescribed medicine themselves or by accessing medical help to do so. These principles and safeguards are well described in the End of Life Choice Bill (David Seymour) at present in Parliament, and the first reading has now been passed by a large majority.

To address some of the themes in Gillett’s paper:

1. Hippocratic Oath and sanctity of life—the Hippocratic Oath is now rarely used, although the basic assumption “in favour of life” is still a central tenant to medical practice. However, for the individual, life is precious only when it is worthwhile. An existence of unbearable suffering is not one many of us would choose, and in this situation death is not the worst thing.

2. Hospice/palliative care (H/PC)—there need be no conflict between H/PC and VAD as shown in other legalised jurisdictions eg, Belgium, Oregon, the Netherlands and Canada. They can and do work together in synergy. Where legalisation of VAD has occurred, referral to H/PC is often a mandatory part of the process of accessing such help, and VAD advocates support of the development of excellent H/PC. As a result, H/PC funding has increased and the quality of the services has improved. However, it has been shown across the world that H/PC cannot prevent all suffering. An Australian study in 2016 showed that 10–20% of patients on H/PC programs experience unbearable pain/suffering as they die. H/PC is generally good at providing pain relief, however, pain is no longer the most feared issue. Fears of being helpless/hopeless and unable to end it rate higher. Furthermore, there is, as elsewhere, a major shortage of palliative care experts in New Zealand, H/PC
remains relatively underfunded and access to care and quality of care is variable. Four times as many patients die in rest homes as in hospice, and often the expertise available to prevent suffering is totally inadequate.6

3. Vulnerable patients—there is no evidence that vulnerable patients are at risk of abuse from VAD. Government reports, studies and information from the major patient advocacy groups (including disabled and elderly representatives) clearly demonstrate this fact.7 Data from Oregon suggests that those who access their legislation are the better educated, not the poor, elderly or disabled.6 Gillett suggests that “life ending acts without explicit consent” are a problem in Belgium. The authors in the first reported study in 2010 which suggested that this is relatively common, have gone back and made a more detailed study. They reported in a second paper in 2014 that most of these patients were simply having symptom treatment with the usual drugs, ie, sedative drugs, similar to what New Zealand doctors often give at the end of life, not euthanasia drugs.9

4. Conflating suicide with VAD—irrational suicide is totally different from VAD. Irrational suicide—such suicide is impulsive, often violent and causes extreme distress to family and friends. Almost always the mental condition which leads to the act is treatable and hence reversible. VAD is where at the request of the patient, the physician prescribes appropriate medication, which the patient takes themselves to end their life, or the physician directly administers the medication, usually intravenously. Both types of VAD are beneficial to the patient, prevent suffering, are a compassionate act from the doctor, respectful of the patient's autonomy, a logical extension of medical treatment and allow the relatives and friends to say goodbye before the ravages of disease and intense sedation make this impossible. They also allow some ceremony and spiritual and religious involvement. Knowing that such an option is available to them also gives the patient peace of mind; even if eventually they do not use it, it improves quality of life and may promote prolongation of life. Irrational suicide replaces life with death, but VAD replaces a bad death with a good one.

Quote: “It is insulting to assume that patients who request VAD are clinically depressed. Most are just realistic. They know what lies ahead and they would rather not continue with it. Let’s be honest; despite our best efforts, some deaths are simply too horrible to believe.”10

5. Does VAD encourage irrational suicide?—There is no evidence that VAD encourages suicide. Luxembourg, Switzerland and Belgium have decreased rates. Oregon statistics are the same as they were more than 10 years prior to legalisation. The Netherlands rate (10/100,000) is the same as 10 years prior to legalisation, and is lower than most of the other European countries not legalised, and New Zealand, which is over 15/100,000 includes the highest teen suicide rate in the world.

6. Bonding between patients and relatives at end of life—while this time can undoubtedly be a precious time, it can also be a time of unbearable suffering for the person dying and for those who care about them and for them; each bad death affects many people. In the submissions to the Select Committee on Assisted Dying there are over 1,000, describing exactly such deaths, written by relatives who have been left with horrible memories. Such traumatic deaths are never forgotten and cast a long shadow.

7. Abandonment of the patient—Gillett states that “many people need support and reassurance that they are not being abandoned”. Possibly the worst form of abandonment is when the doctor because of his/her ideology refuses to listen and act on the request of the patient for help to die. There
is abundant literature from legalised jurisdictions to show that when the doctor listens and offers help, that individuals feel a sense of empowerment, and the reassurance of a way out helps them with the remainder of their life, often prolonging it. Furthermore, they develop a strong trust in their doctor. Katherine Morris, Surgical Oncologist, New Mexico, describes her experience supporting the above where she assisted some patients to die.11

8. Severe brain damage and severely compromised children—Gillett discussed both these issues at length, and although interesting in themselves, they are irrelevant to proposed VAD legislation in New Zealand, which requires a minimum age of 18 and the patient to be competent.

9. Futility—Gillett explores the academic ethical issues around futility. Suffice it to say that both H/PC and VAD accept that some situations are clearly futile and alter the directions of their treatment, as do many doctors in their routine practice, eg, withdrawal of life support in intensive care.

10. What do doctors and nurses really think about VAD?—The limited evidence we have from surveys of New Zealand doctors is that 35–50% support VAD.12–14 The NZ Nursing Organisation (70,000 members) has a position statement supporting VAD, as does the Australian Nursing Federation. Surveys have indicated that 65–70% of nurses in New Zealand are supportive of VAD.14 Formal evidence is only part of the picture, and anecdotal evidence suggests that many doctors are neutral or supportive but fear admitting this openly in the current organisational climate.

Gillett suggests that doctors are not at all supportive and should keep out of the area of assisted dying due to the moral problems. To many doctors the moral issues associated with not being able to relieve suffering in the way that the patient wants, constitute a greater moral burden, and some disobey the law and deliberately help patients die illegally.15 The Royal Australian College of General Practitioners now supports VAD as does the Australian Medical Students Association—the coming generation of doctors.

The Canadian Medical Association (2014) states that “physicians are committed to providing high-quality care at the end of life. They are also committed to maintaining their patients’ quality of life. There are rare occasions where patients have such a degree of suffering, even with access to palliative and end of life care, that they request medical aid in dying. In such a case, and within legal constraints, medical aid in dying may be appropriate. The CMA supports patients’ access to the full spectrum of end of life care that is legal in Canada. The CMA supports the right of all physicians, within the bounds of existing legislation, to follow their conscience when deciding whether to provide medical aid in dying...”.

It is obvious that there is gathering support from doctors across the world, and this increases as legalisation occurs and doctors realise that abuse is not occurring.

To conclude, it is unfortunate that the NZMA has given approval to this Gillett paper on euthanasia. The report is not independent, in that Gillett is an overt opponent of VAD, and furthermore has been on the Ethical Committee of the NZMA, which has also consistently opposed VAD. With the strong likelihood that VAD will be legalised in both New Zealand and Australian States in the near future, it is important that medical practitioners and representative bodies such as the NZMA and Colleges recognise the expressed community need and are involved in the changes necessary to draft good safe legislation in response.
Competing interests:
Nil.

Author information:
Jack Havill, Retired Intensive Care Specialist, Waikato; Libby Smales, Palliative Care Physician and Grief Counsellor, Hawkes Bay; Miles Williams, Consultant Cardiologist Hawkes’ Bay DHB, Hawke’s Bay; Frank Kueppers, Uro-Oncologist, Canterbury DHB, Christchurch.

Corresponding author:
Dr Jack Havill, 130 Mahoe St, Hamilton 3206.
jackhavill@outlook.com

URL:

REFERENCES:
1. End of Life Choices. Horizon Research, Listening to New Zealand. May 2017
5. Palliative Care Report. Wollongong University Health Services Unit 2016. (see submission by Dr Libby Smales to Health Select Committee on Assisted Dying).
6. Submission to Select Enquiry on Assisted Dying 2016 by Dr Lannes Johnson.
7. Submission to Select Enquiry on Assisted Dying 2016 by Andrew Denton.
11. Katherine Morris, Submission to NZ Health Select Enquiry on Assisted Dying.