Physician Assisted Dying—a Survey of Waikato General Practitioners

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I write in reply to David Richmond's critical letter (NZMJ 3 July) about my previous paper (NZMJ Feb 2015) reporting General Practitioner (GP) Attitudes to Physician Assisted Dying (PAD).

Regarding whether the GPs knew what was being asked, each GP was provided with the ‘Explanatory Note’ which was part of the ‘Maryan Street End-of-Life Choice Bill’, and which defined very clearly what ‘assistance to die’ meant: ie, it involved either giving the patient a drug to take themselves, or drug directly administered by the doctor with the intention of ending their life.

Euphemistic language

Richmond’s comments about using the term PAD instead of ‘killing’ are typical of his letters elsewhere. I make no apology for that. Murder is not the same as PAD. Murder is violent, unwanted, does not respect the victim’s autonomy and is regarded universally as morally abhorrent. PAD is ethically totally different in that it is requested by a mentally competent patient; is compassionate in that it relieves unbearable suffering; respects the patient’s autonomy; and allows the patient to say farewell to their friends and relatives while still conscious. It may be regarded as an extension of medical treatment.

Safeguards from abuse

This issue is an important one, but Richmond’s often stated view is that safeguards are always inadequate, and this is proved by information from Belgium. This is simply incorrect. The information he presents about assisted suicides in Belgium is out-of-date, as showed by two later papers from the same authors he quoted, following further detailed analysis of 2007 Belgium reports.

To quote:

“Most of the cases we studied did not fit the label of ‘non-voluntary life-ending’ for at least one of the following reasons: the drugs were administered with a focus on symptom control; a hastened death was highly unlikely; or the act was taken in accordance with the patient’s previous wishes”.

That doesn’t say that there are not some cases of hastening of death without explicit request. In Belgium, in 2013, these amounted to 1.7% of the survey sample (6,188 patients), not 33% as stated by Richmond. The figures also represent a significant decrease from those before legalisation occurred, so it can hardly be argued that it is a result of legalisation of PAD. Hastening of death without explicit
consent also happens in New Zealand of course—and occurs in approximately 4–5% of patients treated in end-of-life situations by New Zealand GPs. This is done by compassionate doctors, although the practice is strictly illegal and not reported. Belgium has been an admirable example of a country where what actually happens is reported and should be respected for that.

It would be to the advantage of New Zealanders if David Richmond would stop scaremongering and trying to frighten politicians, medical practitioners and the public with poorly evidenced statements.

REFERENCES: