A critical analysis of the End of Life Choice Bill 2013

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Abstract

Aim This paper aims to alert medical practitioners to the legal and ethical problems that passage of the End of Life Choice Bill (which seeks to legalise euthanasia and physician-assisted suicide) would have for them in New Zealand. Although sponsor MP Maryan Street withdrew the Bill on political grounds in October 2013, she has pledged to reintroduce the Bill after the next Parliamentary elections and remains committed to its objectives.

Method A clause by clause analysis of the Bill was undertaken from a clinical perspective, following the sequence of requesting, validating, providing and reporting episodes of euthanasia or physician-assisted suicide rather than following the administrative sequence in which the Bill has been drawn up for Parliamentary debate. Where possible, the experience of other jurisdictions where these end of life options are legal has been drawn upon to enable inferences to be drawn as to the likely effects of the legislation.

Results The analysis supporting this paper reveals that the legislation would:
make it possible for virtually any person over the age of 18 to request and receive euthanasia provided they took care in the way they phrased the request,
expose medical practitioners who attempted to deter applicants too vigorously to the possibility of legal action on the grounds of attempting to frustrate the applicant’s wishes,
compromise the ability of practitioners to opt out on conscience grounds,
allow the easy circumvention of reporting requirements for each event,
provide minimal protection against some people suffering euthanasia without consent or request, and
exempt medical practitioners providing euthanasia services from prosecution for any action in the provision of such services, even if they were negligent. The branch of medical practice that specialises in killing people would be the least regulated of all.

Conclusion If passed into legislation, the End of Life Choice Bill will create the most momentous changes to clinical practice and the regulation of certain professional activities of medical practitioners that this country has ever seen. Whether they choose to be or not, sooner or later every medical practitioner will be affected by the legislation. It therefore behoves every medical practitioner to examine and understand this Bill and its implications.

The End of Life Choice Bill whose objective was to legalise euthanasia and assisted suicide in New Zealand was introduced to Parliament’s ballot system for Private Members Bills in 2012 by its sponsor, MP Hon Maryan Street.
It was withdrawn in September 2013 on the grounds that it would not receive serious attention if drawn for debate in an election year. Ms Street has however pledged to reintroduce the Bill after the next Parliamentary election and remains committed to its objectives. It is therefore important that medical practitioners should have a thorough understanding of what the Bill intends.

The purpose of this paper is to critique the Bill as it stood on withdrawal in order to provide a clinician’s perspective on it. The sequence of the analysis follows the process of requesting, validating, providing and reporting an episode of euthanasia or physician-assisted suicide, rather than the administrative sequence in which the Bill is drawn up.

**Purpose of the Bill**

The stated purpose of the Bill is to provide individuals aged 18 years and over, with a choice to end their lives under certain circumstances and to receive medical assistance to “give effect to their choice”.

**Making the request**—Section 7 is headed *Request made in person for medically assisted death*. Subsections 1) and (2) specify that requests must be in writing and signed by the applicant. The request must be confirmed no sooner than 7 days later before further action can be taken. However, subsection(3) allows that an applicant who is unable to write or confirm a request in writing may instead mark, with an X, a request or confirmation written on their behalf by some other person; or they may make a request “by other means” which *may* be recorded in writing by another person. The “certifying medical practitioner” (CMP), i.e. the medical practitioner who receives the request, must certify that s/he believes that the written (or other) record of the request “properly records the wishes of the applicant.”

**Comments**—The purpose of regulations in a Bill such as this that authorises citizens to kill one another under certain conditions is to prevent abuse of the powers and procedures it legitimises. Protection is sought in the voluntary and personal nature of applications as in subsections (1) and (2). Subsection (3) however, provides a loophole in the regulations in that it leaves open an avenue for an interested third party, e.g. a family member, to make the request on behalf of applicants who either have never learned to read or write or who are prevented from doing so by some physical or cognitive impairment. The “other means” does not rule out an oral request being conveyed to the CMP. The CMP will have the responsibility of determining whether the request is a spontaneous one, made without coercion. That will be impossible in many cases, especially where the application is made by a third party and there is no written record of the applicant’s wishes.

**Grounds for the request**—Section 6 entitles a person to receive medical assistance to end his or her life if he or she:

- Is mentally competent (for comment on the definition of ‘competency’ see under discussion of sections 8 and 9 below)
- Suffers from either “a terminal disease or other medical condition likely to end his or her life within 12 months” OR
Suffers (from) an “irreversible physical or mental medical condition that, in the person’s view, renders his or her life unbearable.”

Comments—

- The Bill assumes the infallibility of diagnosis. But diagnoses are made on the basis of probability. Not everyone diagnosed with terminal cancer, for example, will have it. There are records of people being euthanized who did not have the “terminal disease” they were thought to have. If euthanasia is legalized, over time, many will suffer the same fate. The sponsors of this Bill are apparently prepared to accept some ‘collateral damage’ in the pursuit of their cause. Yet New Zealand prohibited capital punishment in 1961 largely on the grounds that one innocent life taken in error was one too many.

- All the experts agree that it is not possible to forecast with certainty that a person is going to die within 12 months, even in the case of terminal cancer. Even 6 months is problematic. Studies have shown that only 20% of prognostic predictions made by competent physicians were within 33% of actual survival. Prognosis is an uncertain art. Some people will be euthanized on the basis of a pessimistic or incorrect prognosis. Moreover, if lethal drugs are going to be prescribed so far ahead of an expected death, there is no mechanism for accounting for them in the event that they are not used. In Oregon, since inception of the legislation, 36% of people who received lethal prescriptions under the Death With Dignity Act as reported in 2011, died of their disease and did not take the drugs. What happened to them? No-one knows, and, as with this Bill, there is no mechanism for finding out.

- Euthanasia could be justified by the descriptors offered in 6 (1) (b)(ii) for a wide range of non-terminal human conditions, including loneliness, depression, poor family relationships, tired of living, feelings of helplessness, demoralisation syndrome, loss of dignity, post-traumatic stress disorder and fear of future pain. Many people, not all of them seriously ill will fall under this category where, as in Belgium and Holland, euthanasia becomes a panacea for all manner of social ills-including unsuccessful sex-change operations. The deciding factor is how the patient feels. In this respect, this Bill offers what it took the Dutch 30 years to accomplish.

- People contemplating suicide will have a ready state-funded avenue to achieve the end they desire. A week’s reflection before confirming a request is a very short time: one could hardly for example imagine it to be sufficient to allow the pain of a jilted teen-age lover to be alleviated. We will have the contradictory situation of being a society concerned deeply about the suicide rate on one hand, yet providing a state-approved means of facilitating suicide on the other.

- There is no definition of the term ‘unbearable.’ It is a very subjective emotion. If it is meant to be a subtle allusion to pain, it fails. There is growing awareness in the pro-euthanasia movement that modern approaches to symptom relief no longer make intolerable pain a plausible reason for euthanasia. In the first 10 years of Oregon’s legal assisted suicide programme, not one request was on account of actual unbearable pain.
Role of the certifying medical practitioner (CMP)

Section 8: On receiving an application, the CMP must:

- Encourage the applicant to consult with family/friends and seek professional counselling, but also “must advise the applicant” that they are not obliged to consult family or friends.

Section 9 (1)(a): The CMP must complete a certificate (which will be devised) relating to the following matters. He/she must:

- Certify that s/he “believes that the request properly records the wishes of the applicant” (Section 7 (4)) and has been duly confirmed (Section 9 refers to this as a “valid” request.)
- Certify that the applicant has made a valid request to end his or her life and confirmed that request.
- Certify that the applicant genuinely does wish to end his or her life
- Certify that no coercion was placed on the applicant to make the request or confirmation.
- Confirm that the applicant has the medical condition specified in the request.
- Certify that s/he has advised the applicant of all the other medical options available, including palliative care.
- Certify that s/he has encouraged and advised the applicant as required in section 8 (see above).
- Certify that the applicant is mentally competent.

Comments—

- A great deal of responsibility is placed on the CMP. It will not be easy to uncover, particularly in the case of old and frail people, whether there has or has not been coercion to apply for euthanasia, given the well-recognised reluctance of dependent people to admit being abused by their families. A review in Oregon in 2007 found that 45% of people requesting assisted suicide included being a ‘burden’ as one of the rationales behind the request.\textsuperscript{12}
- There is no requirement for professional counselling or psychiatric assessment prior to termination in this Bill. Depression may have an adverse impact on decision-making. It encourages a desire for hastened death thoughts.\textsuperscript{13} No mention is made in the Bill about the need to diagnose depression: indeed, depression could well be a legitimate ground for applying for euthanasia. In any case, psychiatrists are clear that attempting to diagnose depression in circumstances such as this can be very difficult.\textsuperscript{14}
- Confirming the diagnosis or condition may also prove to be difficult. Moreover there is no requirement for any of the medical practitioners involved
to document the reasons and evidence for their opinions, hence no audit of the thoroughness or otherwise of the doctor-patient interaction will be possible. This leaves it open for lazy, incompetent or euthanasia-friendly doctors to cut corners when doing assessments.

- There is no provision for insisting on a trial of palliative care for patients with a terminal illness before proceeding to euthanasia. Yet it is well recognised that when a person’s fears in the realms of the physical, psychological, social or spiritual domains are identified and assuaged in the hospice situation, their request for euthanasia is often not repeated. There is not even a requirement to advise the applicant’s family or significant others who might have the time, energy and motivation to explore them with the applicant, of other treatment options. Indeed in this Bill, such actions could be regarded as illegal according to Section 7:5: which states: “No family member or friend of the applicant can annul the applicant’s request”.

- There is nothing in the Bill to prevent the applicant’s own medical practitioner from suggesting euthanasia as a therapeutic option. Any such suggestion would be illegal in Holland.

- What happens if the doctor’s enquiries, e.g. through social workers, reveal a history of elder abuse and s/he declines the application? The Bill is silent on this matter. But we do know from the Oregon experience that a good deal of ‘doctor shopping’ goes on in such circumstances, aided and abetted by voluntary agencies specialising in promoting and facilitating assisted suicide.

Meaning of mental competency

Section 5 (1) states that “for the purposes of this Act, a person is mentally competent if he or she has the ability to understand the nature and consequences of a request to end his or her life, in the knowledge that the request will be put into effect and mentally incompetent has a corresponding meaning”. (2) A person is presumed to be mentally competent unless the contrary is shown.

Comments—The test is whether the person has the ability to understand, not whether they do actually understand. Thus a passing score in a screening test for cognitive function such as the Mini Mental Status Score would meet the criterion laid down, yet individuals may not have complete understanding of the process they have set in train or which have been set in train for them by a third party.

Role of the second medical practitioner (SMP)

Section 10. The CMP is required to refer the applicant to a second medical practitioner (SMP) together with all relevant medical information s/he has relating to the applicant and the certificate made under section 9 (1)(a). The SMP is required to:

- Confirm that the applicant has the medical condition that was specified in the request. S/he does this by examining the certificate prepared by the CMP with all other relevant information. S/he is required to make his/her own enquiries and examine the applicant.
• If there is agreement, s/he completes a certificate to that effect and gives it to the CMP.

Comments—

• The SMP is not required to check that the applicant has a genuine wish to end his/her life, nor to check if there is any coercion, nor to check whether the applicant has been informed of all the alternatives to euthanasia. In the majority of cases, the SMP will be a medical practitioner previously unknown to the applicant with all the barriers to intimate communication such a relationship embodies. More likely than not the SMP will be one of the euthanasia friendly practitioners whose identities will, over time, become known to the community.

• Note that the Bill is silent as to what happens if there is disagreement between the CMP and the SMP. But doctors will have to be very careful as to the extent they attempt to persuade an applicant against going ahead with euthanasia because if that person laid a complaint against the doctor on the grounds that he or she was attempting to frustrate their wishes, then under section 30 (1) an offence has been committed that could result in a summary conviction and a term of imprisonment “not exceeding three months or a fine not exceeding $10,000 or both”. So doctors could risk being convicted of attempting to persuade patients not to be killed. It is not beyond the realm of possibility that a test case would be brought against a doctor soon after the passage of the Bill in order to warn all doctors of their duties under the legislation.

• As is the case with the CMP, there is no requirement for the SMP to document his/her findings or reasoning used to reach the conclusions s/he comes to, hence no audit, either medical or legal, will be possible.

Request by means of End of Life Directive (ELD)

Sections 11–19 These sections cover the making of ELDs and the protocols for applications for euthanasia made as the result of activating a previously made ELD. The procedures are virtually identical to those involved in making a new request. In preparing such directives, the provisions listed in Sections 8 and 9 apply. The major differences are that:

Section 13(2). Once prepared, the ELD is sent to the Registrar of End of Life Directives and Medically Assisted Deaths who enters it in a register that will be established and sends a copy to the person to whom the ELD relates. ELDs expire five years after being entered in the register but may be renewed at five yearly intervals unless the person concerned becomes mentally incompetent.

Section 14 allows the person concerned to vary or cancel an ELD but restricts the power of any other person to do so on behalf of the applicant.
Section 17 enables the person to whom the ELD relates to appoint one or more persons to act as advocates whose task it is to ensure compliance with the applicant’s requests as listed in the ELD

Comments—ELDs are good in theory but can be problematic in practice. Difficulties arise where the medical condition assumes a form that was not envisaged when the ELD was prepared, there are differences of opinion between the guardians as to the circumstances in which it should be triggered, or if the applicant wishes to take back control.

Carrying out medically assisted death

Section 20 stipulates that the procedure cannot be carried out unless all the certificates completed under sections 9 and 10, 18 and 19 have been “provided”.

Section 21 gives the applicant the right to choose the method of assisted suicide or euthanasia—“to the extent that it is feasible”—when it is to be carried out, by whom, where and who else may be present.

Section 22 covers the procedures involved in assisting death. These include: provision of oral medication if the person can swallow, or using a gastric tube if one is in place, or, if the person is unable to take drugs into the stomach, the attending medical practitioner “must administer the life-ending medication.” If the person elects to delay the procedure or take the drugs privately the medical practitioner is not required to be present when the medication is consumed. In the case of people who are mentally incompetent and have a registered ELD, the attending medical practitioner is not required to attempt to discuss the choice of route of administration with him/her.

Section 23 allows the medical practitioner to delegate the procedure to another person if the person about to be euthanized requests that someone else should participate or assist in the procedure.

Comments—

- In some sections the Bill assumes that a medical practitioner will be present to administer the fatal dose but there is actually no requirement for this and there are some conditions in which a doctor does not have to be present (22 (5)). Moreover the applicant has the power to decide who will be present during the procedure. The absence of a medical practitioner raises the question of who would manage any serious side-effects or complications of the procedure. On the basis of overseas experience these will occur in up to 20% of cases.\(^\text{16}\) The fact that the medical practitioner does not have to be present also introduces the possibility of abuse of the system, most likely by family members who have an interest in expediting the process. Elder abuse is very prevalent throughout the Western World and well recognised in New Zealand.

- Although the supporters of this Bill claim that it is based on the Oregon-style Physician Assisted Suicide model, the fact that medical practitioners are authorised under some conditions to administer the fatal medication makes it quite clear that this Bill is about both assisted suicide and euthanasia. In the absence of any supervision and given the disparity in power between doctor
and patient, and in the presence of an audience that is sympathetic to euthanasia—or none—and because the chief witness is dead, there is in fact nothing whatsoever to moderate a medical practitioner’s approach to causing the subject’s death by the fastest and most convenient route, namely IV injection. Some have made the point that at the fatal moment the decision about the mode of euthanasia will be the doctor’s and not the patient’s. Not many doctors will have the resources to wait around for one half to one hour to supervise a death due to drug ingestion.

Requirements after completion of the procedure

Section 24 requires that the medical practitioner must send a report to the Registrar within 14 days of the completion of the procedure. This report must contain the following information.

- The name of the medical practitioner.
- The name and last known address of the deceased.
- The place where the procedure was carried out.
- The date and time of the procedure.
- The means by which it was carried out.
- An assurance that the medical practitioner had informed the person of their rights.

In addition the following should be attached:

- The certificates given by the CMP and the SMP.
- A copy of the ELD if the procedure was carried out in accordance with the ELD provisions in the Act.

Section 25 The medical practitioner who signs the death certificate “must include the person’s underlying disease or condition as the cause of death”.

Comments—

The reporting format will no doubt be as simple as possible since experience in Holland and Belgium is that a major reason for non-compliance with the requirement to report events is the amount of paper-work required. There is a similar problem in Oregon. There, the Public Health Division admitted that reporting is so haphazard that it has no idea how the law is being applied.

The Bill appears to require that the Death Certificate be falsified in cases of assisted suicide or euthanasia. It is not clear whether this is to meet the requirements of Insurance Companies or is an attempt to hide the extent of the practice, or both. It is conceivable that the falsification of death certificates could facilitate the concealment of the use of euthanasia if the attending physician chose not to report it to the registrar. In Holland and Belgium the rates of unreported euthanasia procedures are high. There is no reason to think it would be any different in New Zealand.
Section 34 The Registrar must report annually to the Review Body. The report consists of numbers: total deaths, number by self-administration, number with oral medications not self-administered, number by ‘other means’, number after ELD etc.

**Comments**—There is no provision for reporting any complications arising during the procedures so no learning from the experience of others will be possible. No mechanism is provided for reporting or investigating non-compliant behaviour by medical practitioners: indeed there is no mechanism for detecting it.

**Legal consequences**

Section 26:

- Confirms that it will be legal for a person to receive medical assistance to end their life under this Act.

- Grants immunity from civil or criminal liability to any person “for any act done or omission made while acting in good faith when assisting or participating in implementing any aspect of this Act.” This applies despite the person having “inadvertently failed to comply fully with any requirement of this Act.”

**Comments**—Here, despite all the assurances about legislating for a tight protective safety net around the practice of assisted suicide or euthanasia, we discover that there is a huge gap in it that nullifies all other ‘safeguards’. Anybody, professional or lay person, participating in euthanasia or assisted suicide is fully protected under the law from any consequences whatsoever of their acts providing that they shelter under the mantra “I was acting in good faith” (a ‘good faith’ attempt to meet the requirements of the law is virtually impossible to disprove because it is entirely subjective.) Moreover, they are protected even if they fail to comply fully with the requirements of the Act. This allows enormous flexibility in the use of euthanasia and assisted suicide with no possibility of anyone being called to account. In Holland and Belgium, a similarly vague phrase: “force majeure” (there was no option) has been used by doctors for years to justify any kind of application, even euthanizing people who had not requested or consented to it—which is actually illegal there—and escape prosecution.21,22

New Zealand medical practitioners who kill patients under the guise of euthanasia will be protected from disciplinary proceedings by Hospital Boards, The Health and Disability Commissioner, the Medical Council and even the police. They will have far greater protection under the law than will the medical practitioners who treated the patient prior to their request for euthanasia.

**Conscience clause**—Section 27 allows people not to participate “directly or indirectly in any aspects of this Act”. A person who refuses to participate does not have to give any reason for refusing. However, a medical practitioner who receives a request for euthanasia but declines to be involved, must refer the person to another medical practitioner who is willing to comply with the person’s request and carry out medically assisted death in accordance with the Act. A medical practitioner who is
asked by a CMP to be a SMP but does not wish to be, must advise the CMP and return any material relevant to the case that has been given him/her by the CMP.

**Comments**—This is a non-protective conscience clause. After giving an assurance in 27 (2) that no one is obliged to participate either “directly or indirectly” under the Act, subsection 3 requires that people who apply to an opting-out medical practitioner must be referred on to a compliant one. If this is not participating ‘indirectly’ what is? Presumably, a medical practitioner who refused to refer could be prosecuted under Section 30 and fined or imprisoned or both on the ground that he or she was frustrating the expressed wishes of the applicant.

The section implies that some medical practitioners will become recognised as euthanasia-friendly as has happened in Oregon and elsewhere. It is likely that voluntary organisations will set up advisory and assistance schemes to direct potential applicants for euthanasia to these doctors. This has happened in Oregon, Belgium and Holland.

**Summary**

- The proposed legislation would make it possible for virtually any person over the age of 18 to request and receive euthanasia provided they took care in the way they phrased the request.
- Medical practitioners who attempted to reason with applicants could be subject to legal action on the grounds of attempting to frustrate the applicant’s wishes.
- The conscience clauses are seriously flawed.
- The reporting requirements could be easily circumvented.
- There would be minimal protection against vulnerable people being euthanized involuntarily or non-voluntarily.
- Medical practitioners would be exempt from prosecution for any action in the provision of euthanasia, even if they were negligent. The branch of medical practice that specialises in killing people would be the least regulated of all.
- It is hard to escape the conclusion that the ‘safeguards’ built into the Bill are designed to facilitate access to assisted suicide and euthanasia rather than protect patients from their unlawful use.

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