



Investigation into ending one's life in New Zealand

New Zealand Medical Association

Submission to the Health Select Committee

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The NZMA is New Zealand's largest medical organisation, with more than 5,500 members from all areas of medicine. The NZMA's mission is to provide leadership of the medical profession, and to promote professional unity and values, and the health of all New Zealanders.

An integral part of the NZMA's leadership role is our Code of Ethics,¹ which sets down principles of ethical behaviour for the medical profession and recommendations for ethical practice. While we acknowledge that there is a range of opinions within the medical community, it is the NZMA's view² that euthanasia and doctor-assisted suicide are contrary to the ethics of the profession:

The NZMA is opposed to both the concept and practice of euthanasia and doctor-assisted suicide.

Euthanasia, that is the act of deliberately ending the life of a patient, even at the patient's request or at the request of close relatives, is unethical. Doctor-assisted suicide, like euthanasia, is unethical.

The NZMA, however, encourages the concept of death with dignity and comfort, and strongly supports the right of patients to decline treatment, or to request pain relief, and supports the right of access to appropriate palliative care.

In supporting patients' right to request pain relief, the NZMA accepts that the proper provision of such relief, even when it may hasten the death of the patient, is not unethical.

This NZMA position is not dependent on euthanasia and doctor-assisted suicide remaining unlawful. Even if they were to become legal, or decriminalised, the NZMA would continue to regard them as unethical.

Scope of investigation

In response to a petition received by the Health Select Committee, the Committee has announced it will undertake an investigation into ending one's own life in New Zealand which will consider various aspects of the issue, including the social, medical, cultural, financial, ethical and philosophical implications.

The Committee has stated that it will investigate:

1. The factors that contribute to the desire to end one's life.
2. The effectiveness of services and support available to those who desire to end their own lives.
3. The attitudes of New Zealanders towards the ending of one's life and the current legal situation.
4. International experiences.

¹ NZMA Code of Ethics, 2014. Available from <https://www.nzma.org.nz/publications/code-of-ethics>

² NZMA Position Statement on Euthanasia, 2005. Available from http://www.nzma.org.nz/_data/assets/pdf_file/0004/16996/Euthanasia-2005.pdf

This scope suggests that the investigation will encompass all aspects of suicide, both assisted and unassisted, but could exclude euthanasia – being a deliberate act undertaken by one person with the intention of ending the life of another person in order to relieve that person’s suffering.

Given that the petition asked the House to investigate attitudes towards the introduction of legislation which would permit medically-assisted dying, our submission will focus on euthanasia and doctor-assisted suicide. We also include definitions and information at the end of this submission (as answers to common questions).

As noted above, the NZMA’s mission includes promoting the health of all New Zealanders. Our commitment to the health of all New Zealanders reflects the social contract the medical profession has with the community which is underpinned by ethical commitments and altruism. Our position on euthanasia is primarily about the ethical practice of medicine and the protection of vulnerable people, and our submission will therefore reflect both professional and societal considerations.

Patient autonomy and end of life decisions

The medical profession respects and supports patient autonomy, and the NZMA welcomes the discussion on choice in end of life decisions. Patients already have the explicit statutory right to refuse medical treatment.³ The Code of Patient Rights also states that every consumer has the right to refuse services and may use an advance directive in accordance with common law.⁴

Relying on the principle of autonomy of the patient to choose to end one’s life can, however, ignore real uncertainties and vulnerabilities which influence people to make certain decisions about their lives. Fear of future pain, incapacity, or the desire not to become a burden to others are examples of uncertainties and concerns that might drive a decision to end one’s life without taking the opportunity to test those assumptions.

The doctor-patient relationship and ethical obligations

The NZMA’s Code of Ethics⁵ requires that doctors always bear in mind the obligation of preserving life wherever possible and justifiable, while allowing death to occur with dignity and comfort when it appears to be inevitable. Allowing death to occur is fundamentally different from a deliberate act that has the primary intent of terminating life. We are of the view that permitting individuals to end their lives with the assistance of a doctor – even where that assistance is limited to assessment, verification or prescribing – is contrary to the ethics of medical practice and would profoundly alter the ethos within which medical care is provided. If doctors are authorised to purposefully terminate a person’s life, or help terminate a person’s life, however carefully circumscribed the situation, they acquire an additional role that is contrary to the nature of the doctor-patient relationship.

The obligation of preserving life does not mean, however, that doctors must attempt, or patients accept, burdensome or futile treatments, or treatments that do not offer a reasonable

³ Section 11 of the New Zealand Bill of Rights Act 1990 “everyone has the right to refuse to undergo any medical treatment.”

⁴ <http://www.hdc.org.nz/the-act--code/the-code-of-rights>

⁵ <http://www.nzma.org.nz/publications/code-of-ethics>

hope of benefit. Similarly, allowing death to occur in comfort encompasses situations where treatment is provided to relieve pain and distress, even when it may have the secondary effect of hastening death.

The role of palliative care

Modern palliative care is aimed at improving the quality of life of patients facing terminal illness where care focuses on the prevention and relief of pain, nausea, shortness of breath and other symptoms, alleviation of psychological and spiritual suffering, and supporting the patient and their family in the final stage of life. It affirms life and regards dying as a normal process, and intends neither to hasten nor postpone death.

Euthanasia or doctor-assisted suicide has the potential to diminish our focus on comprehensive and compassionate end of life care provided by palliative care clinicians and facilities. The quality of New Zealand's palliative care is considered to be world leading,⁶ and we should be continuing to strive to ensure that New Zealanders have good and timely access to this care.

The experience of palliative care experts and providers as they support patients and their families through the end stages of life must be acknowledged and listened to when considering factors that contribute to the desire to end one's life when faced with terminal illness. They are witnesses to what can be achieved for the person in palliative care, both in terms of physical and emotional care. They have also experienced first-hand how attitudes and desires can evolve and change during care.

Euthanasia or doctor-assisted suicide is antithetical to the role of palliative care and the commitment to address suffering and provide care until the very end of life. Further, it is our view that a contributing factor to public support for euthanasia is that the assistance which good palliative care can provide is not well understood. Addressing this, and meeting the need for good access to well-resourced palliative care, are aspects the Select Committee must include in its deliberations.

We note that the Minister of Health recently welcomed new guidance⁷ on providing the best possible care for people during their last days of life, stating "*It's important that New Zealanders have access to quality, personalised and compassionate palliative care*"⁸. To achieve this and the vision and goals of the New Zealand Palliative Care Strategy 2001, a greater investment in palliative care services is required. We therefore strongly recommend that the Government increase funding to ensure access for everyone who needs palliative care – whether provided by hospitals, rest homes, primary care teams or hospices.

Clinical considerations

Decisions to end one's life in situations where there is the prospect of disease-related death or grievous and irremediable illness are premised on the assumption of an accurate diagnosis and prognosis.

⁶ <http://www.economistinsights.com/healthcare/analysis/quality-death-index-2015>

⁷ Te Ara Whakapiri: Principles and guidance for the last days of life – Ministry of Health December 2015

⁸ <http://www.beehive.govt.nz/release/improved-palliative-care-guidance>

While advances in diagnostic tools and improvements in knowledge regarding the progression of disease continue, it is still an inexact science. Errors occur and individuals can still prove all of the experts wrong. According to *The American Journal of Medicine*⁹ and *BMJ Quality and Safety*,¹⁰ published studies indicate misdiagnoses occur anywhere from 10–15% of the time.

Likewise, while there are a large number of papers published in the medical literature on attempts to find prognostic markers in advanced disease, they in fact confirm that a high level of accuracy is not attainable. While averages can be determined across populations, it is impossible to predict where an individual's life expectancy lies within the range, and there are always exceptional cases where a person lives much longer than the population data would suggest.

The administration of euthanasia or doctor-assisted suicide also gives rise to potential complications. A Dutch study¹¹ reported difficulties in administering the lethal drugs in 10% of assisted suicides and 5% of euthanasias; complications such as vomiting and muscles spasms in 7% of assisted suicides and 3% of euthanasias; and cases where death took an unexpectedly long time (up to 7 days) in 15% of assisted suicides and 5% of euthanasias. Reports from Oregon¹² also highlight long intervals between ingestion and death – up to 104 hours with a median of 25 minutes – and also report that six patients woke up post ingestion. It is of interest that none of the six re-attempted assisted suicide following its failure to achieve death.

Requiring a doctor to determine mental capacity is also challenging in the context of euthanasia or assisted suicide decision making. There is no absolute test for mental capacity, and patients that appear completely mentally competent may not in fact be so. For example, evidence given to the UK Select Committee on physician assisted dying showed that 30% of people with motor neuron disease were, after careful neuropsychological testing, found to be cognitively impaired.¹³

Challenges with any proposed legal framework

It is our view that it would be impossible for any law designed to protect the voluntary nature of euthanasia or assisted suicide to be completely effective in ensuring that individuals make decisions free from any pressure to do so. Subtle emotional coercion from relatives might be present but not identified, and self-imposed pressure may also be a factor if the individual feels euthanasia is something that they ought to consider rather than becoming a burden on family and others. The 2014 annual report on Oregon's Death with Dignity Act 17 years post

⁹ Berner ES, Graber ML. Overconfidence as a cause of diagnostic error in medicine. *Am J Med.* 2008 May;121(5 Suppl):S2-23. doi:10.1016/j.amjmed.2008.01.001.

¹⁰ Graber ML. The incidence of diagnostic error in medicine. *BMJ Qual Saf* 2013;22 Suppl2:ii21-ii27. doi:10.1136/bmjqs-2012-001615. http://qualitysafety.bmj.com/content/22/Suppl_2/ii21.long

¹¹ Groenewoud JH, van der Heide A, Onwuteaka-Philipsen BD, et al. Clinical problems with the performance of euthanasia and physician-assisted Suicide in The Netherlands. *N Engl J Med* 2000;342:551-6.

¹²<http://www.nejm.org/doi/full/10.1056/NEJM200002243420805>
¹²<http://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Documents/year17.pdf>

¹³ Assisted Dying for the Terminally Ill Bill – First Report, 2005. House of Lords. Report HL 86-II; <http://www.publications.parliament.uk/pa/ld200405/ldselect/ldasdy/86/8607.htm#a30> para 125; full report <http://www.publications.parliament.uk/pa/ld200405/ldselect/ldasdy/86/8602.htm> .

enactment reports that 40% of patients choosing to use the law cite concerns about being a burden as part of the reason they want to end their life.¹⁴

A legislative safeguard that is often proposed is the requirement to have two doctors provide sign off prior to a euthanasia or assisted suicide. We do not, however, believe that this would provide any real protection as it is likely that only small numbers of doctors would consider active involvement in euthanasia. The small number of doctors that might make this part of their medical practice are likely to refer to those who will support their recommendations. This would inevitably lead to ‘doctor shopping’. It would also mean that the prescribing doctor may have only been involved with the patient for a short period of time, and therefore have no in-depth knowledge of the patient’s emotional state and personal or family circumstances. The Oregon experience demonstrates these points with one doctor writing 12 prescriptions (8% of the total lethal drug prescriptions issued in 2014) and duration of the patient-physician relationship recorded as short as one week.

Given that even the most carefully crafted legislation will be unable to ensure infallible safeguards, the gravity of the risk in question – a wrongful death – is of sufficient magnitude to override many of the arguments for the legalisation of euthanasia, including patient choice.

For the medical profession, being involved in a wrongful death of this nature has serious implications for the doctor who could conceivably be subject to criminal charges. The social contract between the medical profession and the community is also at stake if wrongful deaths arising from the practice of euthanasia and doctor-assisted suicide ultimately damage society’s confidence in the profession’s commitment to integrity, morality and altruism.

Implications for society

Laws are more than just regulatory instruments. They also convey important societal messages. Legalising euthanasia or assisted suicide, even in limited circumstances, would help normalise suicide across society, including among youth. This would be of major concern given New Zealand’s high rates of suicide in this group and the efforts underway towards preventing youth suicide.

We also believe that legalisation of euthanasia or doctor assisted suicide would change the way we regard death and the care of the dying for everybody, not just those who would choose euthanasia. If we allow doctors to be death-bringers as well as life savers, then the characteristics we produce in doctors, and other health professionals, will fundamentally change. They will not necessarily presume in favour of life and a patient may not be able to trust in this presumption, and the option of choosing to end life will be ever present in medical care.

The ‘routinisation’ of assisted dying in clinical practice is evident in the escalating numbers in the countries that allow it. In Belgium, deaths under their 2002 Euthanasia Act almost doubled in four years (an increase of 89%), from 953 reported in 2010 to 1,807 in 2013. Euthanasia now represents 1.7% of all deaths in Belgium.¹⁵ Similar incremental rises have

¹⁴ Oregon Public Health Division Dept Human Sciences. Oregon’s Death with Dignity Act: Annual Report 2014 <https://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Documents/year17.pdf>

¹⁵ Commission Fédérale de Contrôle et D’évaluation de L’euthanasie Sixieme Rapport aux Chambres Législatives (Années 2012-2013)

been reported in the Netherlands, with around one death in 30 now the result of doctor-assisted suicide.¹⁶

Of most concern, however, is the protection of vulnerable people. It is of note that the High Court of Ireland determined that a relaxation of the ban on assisted suicide would be inimical to the public interest in protecting the most vulnerable members of society, stating that “The evidence from other countries shows that the risks of abuse are all too real and cannot be dismissed as speculative or distant.”

Conclusion

The NZMA commends the Select Committee in its efforts to consider all aspects of this very complex and challenging subject. The rights of patients to personal autonomy in their health care is an underpinning principle of our health services in New Zealand, and is universally acknowledged and supported by doctors and other health professionals. There are, nevertheless, some matters where ethics and other societal considerations must necessarily place limitations on that autonomy.

Our analysis of both the ethical and practical issues raised by euthanasia and doctor-assisted suicide confirms our view that these practices would be harmful to individuals, especially vulnerable people, and society. A change in the law to allow euthanasia or doctor-assisted suicide, no matter how circumscribed, would also profoundly alter the role and responsibilities of the medical profession and the doctor-patient relationship. We believe that acting with the primary intention to bring about death cannot be reconciled with the core medical ethical principles of beneficence and non-maleficence, and is therefore not supported by the NZMA.

We hope this submission is of assistance to the Select Committee. We would like to have the opportunity for an oral hearing to speak to our submission and answer any questions the Committee may have.

Yours sincerely



Dr Stephen Child
NZMA Chair

Common questions

What is euthanasia?

Euthanasia, or voluntary euthanasia more specifically, is where lethal drugs are administered to the patient at the patient's request.

¹⁶ Regional euthanasia review committees 2013 Annual Report. Available from https://www.euthanasiemissie.nl/Images/Annual%20report%202013_tcm52-41743.pdf

What is doctor- (physician) assisted suicide?

Doctor- or physician-assisted suicide is where a patient self-administers lethal drugs supplied by a doctor. The doctor or other member of the health care team may or may not be present when the patient takes the drugs. For it to be considered assisted suicide rather than euthanasia, the patient must take the action of self-administration.

Is withdrawal of withholding of treatment euthanasia?

Withdrawal of treatment, with the knowledge that death will follow, differs from the administration of a lethal medical intervention with the objective of causing death prior to the natural dying process.

What is palliative sedation?

In medicine, palliative sedation (also sometimes referred to as terminal sedation) is the practice of relieving distress in a terminally ill person in the last hours or days of a dying patient's life, by means of a continuous intravenous or subcutaneous infusion of a sedative drug.

Palliative sedation is considered when the patient is clearly distressed, all other symptom-relieving measures have failed, and the ongoing symptoms are therefore determined to be refractory. The level of sedation is titrated to achieve removal of distress and this intervention involves interdisciplinary collaboration in conjunction with the patient and carer and/or family members.

Sedation of this type may be subject to the principle of 'double effect', which is the dual effect of intentional relief of suffering and increased risk of hastening death. In clinical practice, however, palliative sedation does not usually alter the timing or mechanism of a patient's death, as refractory symptoms (those that cannot be controlled by tolerable therapy) are most often associated with very advanced terminal illness.

How is palliative sedation different from euthanasia?

The primary intent of palliative sedation is to sedate the dying patient so that they do not experience distress and do not suffer due to specific refractory and intractable symptoms. The intent is NOT to deliberately hasten the dying process. Palliative sedation is also guided by the principle of proportionality, ie, the benefits of any intervention should outweigh the burdens of that intervention. In particular, this requires that interventions with any risk of harm be administered only to the degree necessary to confer the desired amount of therapeutic benefit.

Palliative sedation is therefore clearly demarcated from euthanasia. The intention is sedative in nature and is aimed at, and designed, to reduce the patient's consciousness of severe symptoms. The sedative intention is related to, and evidenced by, adherence to various ethical parameters. The sedatives are administered only when the symptoms have become intractable, in accordance with the principle of proportionality, and when the patient is terminal, such that the expected loss of life duration is nil or minimal.

Is the NZMA's position consistent with medical associations in other countries?

Yes – the world's professional medical associations overwhelmingly oppose voluntary euthanasia and assisted suicide.

The World Medical Association: euthanasia, that is the act of deliberately ending the life of a patient, even at the patient's own request or at the request of close relatives, is unethical. Physician-assisted suicide, like euthanasia, is unethical and must be condemned by the medical profession.

The World Medical Association reaffirms its strong belief that euthanasia is in conflict with basic ethical principles of medical practice, and

The World Medical Association strongly encourages all National Medical Associations and physicians to refrain from participating in euthanasia, even if national law allows it or decriminalises it under certain conditions.

The Australian Medical Association: medical practitioners should not be involved in interventions that have as their primary intention the ending of a person's life.

The American Medical Association: strongly opposes any bill to legalise physician-assisted suicide or euthanasia, as these practices are fundamentally inconsistent with the physician's role as healer.

The British Medical Association: opposes assisted dying in all its forms.

Are there alternative pathways that do not involve doctor participation?

An alternative professional group with appropriate training could be authorised to undertake euthanasia and related activities including assessment and prescribing. While this would protect the doctor-patient relationship and ensure that the role of the doctor is not changed or undermined, the societal questions and challenges outlined in this submission would still remain and perhaps be intensified by separating the act of assisted dying from more comprehensive health care skills.

What do people mean by 'the slippery slope'?

The 'slippery slope' argument contends that the acceptance of certain practices, such as doctor-assisted suicide and voluntary euthanasia, will invariably lead to the acceptance or practice of concepts that are currently deemed unacceptable such as non-voluntary euthanasia.

While the idea of New Zealanders ever accepting non-voluntary euthanasia seems highly improbable, the experience of the few overseas jurisdictions that have legalised euthanasia and/or doctor-assisted suicide demonstrates that initial limitations are ultimately loosened and eligibility extended. Examples include extending rights to those with mental illnesses, those with chronic but not terminal disease, those with disabilities, and children. In 2006 the Netherlands agreed that "being over the age of 70 and tired of living" was an acceptable reason for requesting euthanasia, and in 2014 Belgium amended its euthanasia laws to remove all age restrictions. Neither of these developments were envisioned by the parliaments and the people of those countries when euthanasia laws were passed in 2002.