

**To: Justice Committee, Select Committee Services, Parliament Buildings,  
WELLINGTON**

**Submission to: The End of Life Choice (Euthanasia) Bill (Justice Committee Secretariat,  
2018)**

As a practicing psychotherapist and counsellor in the Hospice setting and also providing psychotherapy in private practice, I work with people who suffer from a life limiting illness and who are coming to terms with the meaning of their illness, their symptoms, existential distress and death.

I do not support the End of Life Choice (euthanasia) Bill (Justice Committee Secretariat, 2018) due to the static nature of its intent to provide people with the option of terminating their life without considering the wider context, including temporal context, of their total suffering (Cassell, 1999). The bill appears to lack consideration for the time required for people to come to terms with the complex information and evolving psychological, spiritual and emotional processes unique to their individual situation.

Medical, psychiatric, cognitive and behavioral approaches are often used to assess current-moment explicit symptoms without considering the longer view of the adjustment process of the person through their illness as they make sense of their physical, emotional and spiritual pain and other phenomenological suffering. An inherent problem with the positivist quantitative research approach that supports these models of care is that it misses the implicit phenomenological experience of total suffering hidden from view only to emerge when the patient is given time and space in the context of a specific kind of trusting therapeutic relationship. The scientific method has failed to address the human experience of coming to terms with death and dying while overvaluing statistically validated evidence. Patients I see are seldom interested in the scientific facts, rather they are focused on the meaning and emotional experience of what is happening to them and their future.

Being in the unique position to see people regularly over time and being part of the evolving psychological, spiritual and emotional meaning of their suffering, patients have demonstrated to me how they can initially have a wish to terminate their life, and then with time and specialist support, feel very differently about their situation. Patients voice their appreciation for having time and space to experience changes that allow alternative views of their suffering and situation, providing them with different options and allows them to live what remains of their life as fully as possible with satisfaction and dignity.

Despair, helplessness, powerless and hopelessness are part of the transformation process, not the end of it. For these feelings to transform clinicians are required to tolerate this experience without trying to fix or change it through interventions. This is a difficult task for carers who have been trained to 'help' or relieve symptoms. It is, after all, also a human response to want to fix someone's suffering, and more so if our training suggests we can. The non-intuitive response to those who are suffering and wanting to die is somewhat unique to the palliative care field but is well embedded in the psychotherapy and related fields historically. If this well founded view is dismissed from the euthanasia debate we risk excising our humanity for the sake of expediency and the instant fix fantasy, often and inadvertently endorsed in the medical field.

Due to service constraints most healthcare providers do not have the luxury of extended and more individualized and in-depth assessment and treatment of patients with complex less-obvious suffering. I have been witness to patients transforming their view of their suffering and wish to die through comprehensive and total care that addresses, not only the explicit physical and psychological symptoms but also their unique individual fears such as the fear of loss of dignity, fear of dying alone, fear of loss of control, fear of being a burden etc. which when given time and space to process can transform a persons view on living or dying. Most health services do not have resources to spend the time required to support this transformation. I am reminded of a person referred for palliative care with a protracted eating disorder. Clinician's with limited resources could not provide the time or in-depth care required to address the hidden suffering. Euthanasia was considered at that time but with the needed support the client now lives a fulfilling life.

Providing the service to assist people through the complex adjustment process and transformation of the meaning of symptoms and suffering is not the quick or cheap option that euthanasia provides. Caring for people though this process requires slowing things down and tolerating our own discomfort and not projecting our own beliefs and values onto patients or influencing them with the power intrinsic to our role. Contemporary ideas of what a 'good death' entails is confused and is culturally and individually determined in a complex political environment (Walter, 2003). As Margot Schwass (2011) explains, we have evolved to a medicalize death in New Zealand and the authority and power of the Doctor role imposes on individual and cultural beliefs. This power of the clinical role influences the individual and family preferences for what is a good death, even when doctors/clinicians are conscious of the impact of the power in their role. Again, finding the preference of the patient beyond the fears and obligations they experience while overwhelmed with the task of processing all that dying means is not the task of the doctor as they unintentionally have a conflict of interest and impact on patients' belief because of the inherent power of their role. They cannot be experienced as neutral because of this and because the role of doctor will be used to administer the euthanasia procedure.

If health providers do not have the resources to spend the time required to uncover the less conscious suffering of a person, decisions will be made in reaction to minimal superficial information resulting in poor treatment decisions. If decisions to euthanize are made under these circumstances people will die without the opportunity to work through their suffering or to change their mind.

The items;

*Part 2 section 8 (e) "encourage the person to talk about his or her wish with others such as family, friends, and counsellors; Part 2 section 8 (f) ensure that the person knows that he or she is not obliged to talk to anyone" (Justice Committee Secretariat, 2018)*

do not assign the importance of the need for patients to process their experience before making a decision with the available specialist input. While well founded in its ability to assist patients, talking cures are often ascribed lower order importance by doctors. "Encouraging"(Justice Committee Secretariat, 2018) assigns this part of the euthanasia process to 'optional' and so less important than the quick fix solutions. The End of Life Choice (euthanasia) Bill (Justice Committee Secretariat, 2018) seems to assume that the

doctor can accurately assess that the patient has adequately processed the complex information and situation they are in, with all this means consciously and unconsciously. This of course is very difficult to assess without time and a trusting therapeutic relationship while minimising the impact of the the power and authority of the clinical role. This specialist skill is unique to those with training in unconscious process.

I appreciate that not all people understand or want the opportunity to experience this rewarding transformation, however most people I see are not aware that this opportunity exists. Those who have not experienced this transformation process or work from modernist, positivist, quantitative research based or cognitive/behavioral world views usually do not accept its legitimacy, will sideline this as 'alternative' or categorize it as not cost effective. The risk with the End of Life Choice (euthanasia) Bill (Justice Committee Secretariat, 2018) is that people die without the knowledge that their physical, emotional, psychological, existential and spiritual distress may be transformed into something different and manageable through comprehensive care from treatment teams with specific expertise to provide this care.

The ability to make a good decision regarding ending ones own life is about more than "Capacity". People of sound mind and capacity, when struggling with dying or their symptoms can respond to this with a want for it to be over. Repeatedly, patients, in hindsight comment on their previous state of mind and how they were not in a position to make a clear decision but were driven by their distress, confusion, desperation and/or fears. We are not always aware of what constitutes our distress while we are immersed in the distress and time and processing is needed to gain clarity; clarity that may only be seen in hindsight.

The End of Life Choice (euthanasia) Bill (Justice Committee Secretariat, 2018) is a shortsighted, media fueled emotional reaction and ill informed attempt to solve a social problem which parallels the "too hard basket" of mental health and suicide in New Zealand, when those making political decisions do not carry the full depth of understanding required to address these complex issues. The simplicity of euthanasia is seductive to those wanting a simple solution to a complex and uncomfortable problem in our society; caring for those in pain and suffering that is not fully understood and which requires resources to expose and uncover the veiled fears and misunderstandings to allow for a more fully informed personal, natural death preference.

Sincerely,

Lindsay Gutsell

## References

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