Submitter: Dr Mary English, MBChB, Dip Obstetrics (Otago), FRNZCGP
[redacted]

I wish to present my submission in person.

I am a general practitioner, working in Wellington and I have been practicing for 27 years. It has been my privilege to work with patients and their families and alongside other health professionals on cases dealing with chronic and terminal illness.

I support the NZMA and WMA in upholding the ethical ground which underpins our practice. I do not believe that participation in euthanasia and assisted suicide can be ethical behavior for GPs. They are not medical treatments and doctors should not be used to sanitize state-enabled suicide. Perhaps lawyers may wish to lend their respectability to this activity instead.

On a personal note I was closely involved with supporting my younger brother, also a medical doctor, until his death from aggressive cancer , in 2014. Peter was 48 years of age and his last few months were extremely difficult.

In 2015, my family and I have also supported my 28 year old sister in her battle with ovarian cancer and while she has completed 4 cycles of chemotherapy, we await the outcome with the test of time.

As a medical professional, I am totally opposed to the state sanctioned killing of those who are sick and vulnerable, either by assisted suicide or euthanasia.

One day you and I will be sick and vulnerable as we discover what will determine our mortality. We will need to know that our health professionals and society are united in being supportive of us as we become less “useful “ and more “expensive” in terms of assistance needs and financial costs of care.

I have seen at first hand my patients concern about being a burden and I have witnessed that not all families are supportive , willing or able to provide emotional and practical support. It is my strong opinion that legally sanctioning “assisted suicide” and “euthanasia” will tip the balance of presumption by the patient of alleviation and assistance to one of a “duty to family and everyone else” to not be a burden.

The current law and medical services are protective for both the patient and the doctor. After 27 years of practice I have never had any family member say to me that they wished their sick relative had gone and taken their own life or that they wished that I had put an end to their loved ones life.

I worked for 6 years in a Decile 1 school-based clinic with mainly Maori and Pasifika students and I often had to deal with mental health issues .
It is a bizarre contradiction to contrast years of working alongside young people to prevent them from becoming another suicide statistic with legislative moves which expect doctors to assist with or directly carry out the suicide of those who are sick and terminally ill.

I continue to deal with young people dealing with depression and anxiety.
In my experience, the majority of these young people feel an overwhelming despair and inability to cope with their current state of psychic pain and it is the same for those suffering psychic or physical pain and for whom assisted suicide or euthanasia is the preferred way out.

Some argue for the availability of assisted dying as a choice yet our NZ society rightfully abhors the idea of having the same attitude to the young adult who is equally distressed. It is a current assumption of medical practice and public policy that youth suicide is a failure of prevention and that we must always screen for risk and prioritize intervention accordingly, and as a doctor I do. We have had the public awareness campaigns, the high profile fundraisers and on-line support tools.

Despite the best efforts of mental health professionals and family members, people can and do commit suicide if they are absolutely determined to. New Zealand's high suicide rates attest to this fact.

It is both inconsistent and cynical to legally signal that suicide is good for old and/or sick people but bad for young and distressed people. It is no surprise that mixed messages can lead to confusion and that suicide rates in some jurisdictions where euthanasia is permitted have increased. Under the proposed bill , the 19 year old I saw recently, would be able to request that I or a colleague end her life. She could do it without her parents or whanau being consulted or involved.

A more consistent position for the medical profession and for society is the position that gives hope and meaning for both groups.

It is the position where death with dignity is the respect and care expressed in a palliative care setting NOT a pre-arranged, medicalised suicide scenario. It is where the disabled and chronically ill can look forward to a presumption of Assisted Living, NOT Assisted Dying.

The key issue for politicians to consider is not about whether sick and vulnerable people should be *allowed* to commit suicide (they are), but whether the law should permit, require or compel another person to be a party to the suicide or bluntly; to kill another human being .

That other person is a doctor, and most likely a GP. A doctor's vocational brief and core business is to cure sometimes , comfort often and care always. At the heart of the relationship is trust. The law should never permit, require or compel GPs to depart from this by killing our patients.

The committee need to understand that the majority of GPs let alone other specialist doctors, do not understand what this very permissive Bill will ask of them both personally and professionally. Almost all specialities will be affected as any person over the age of 18, with any of hundreds of different types of chronic illness or disability can request this, not just terminal cancer patients.

The bill is highly prescriptive and outlines a series of steps a doctor MUST take once a patient makes a request. The legislation effectively creates a conveyor belt carrying a patient through the process towards death with minimal checks and several significant problems for doctors.

1. It is impossible for a doctor who disagrees with the patient or with doctor assisted suicide to avoid being a party to the process once a patient has made a request. The law will require a GP to refer a patient to a doctor who is willing to carry out the procedure. To do otherwise will be unlawful and liable to prosecution. This amounts to the worst form of state coercion and places doctors in jeopardy. GPs must have full access to conscientious objection, and the freedom and the right to refuse to play any part in doctor assisted suicide. The bill holds an intrinsic injustice when contrasted to the perpetrator doctor in Problem (4) below.
2. The whole process can be carried out by doctors who do not know the patient and the obligations on doctors to inform themselves of the state of mind and surrounding circumstances are weak. A GP could find one of their patients has used doctor assisted suicide after the fact.
3. This bill puts the GP in a conflict between ethics and the law. The law will allow doctors to bring about a patient's death while our professional bodies regard the practice as unethical.
4. There is limited ability to test whether a doctor administering suicide did in fact do so with full patient consent. The defence of good faith means no doctor will be able to be examined and held to account for deaths which were involuntary or where proper process which might have led to a different outcome was not followed. Full immunity is pretty much guaranteed. For any good doctor, one unintended death will always be one death too many. The recent damning statistics from Belgium show a growing number of euthanasia deaths which were never consented to. **So called safeguards have protected doctors who have carried out unlawful killings.** This is a travesty of justice.
5. I submit that this is bad legislation which will subjugate good clinical and ethical practice to explicit state coercion . The lack of true conscientious objection (where a GP can refuse to participate at any stage) means GPs won't be able to protect their vulnerable patients from a prescriptive, enclosed process that propels vulnerable people towards death.

Finally , the legalisation of euthanasia and assisted suicide is the exception rather than the norm and in recent years only Canada, California and Victoria have gone down this path. Recent proposals to legalise have been rejected by the UK , Scotland and New South Wales. Euthanasia is illegal in every US state and assisted suicide is illegal in 45 out of 50 states. Court actions to legalise assisted suicide have been rejected by the appellate courts in Ireland, Scotland, the UK, South Africa and the European Court of Human Rights.

Euthanasia is NOT the norm because giving “choice” to some has correctly been outweighed by predictable negative consequences for many. Legislators have the role of weighing freedoms with consequences. MPs have to decide how many unintended deaths are worth personal choice.