

Item of business :

End of Life Choice Bill

Submission name :

Dr Janet Vaughan

Comments

I am a General Practitioner working in a South Auckland general practice.

the **wording** of the Bill relies on subjective judgement and interpretation. "OR a grievous and irremediable medical condition" is **highly subjective and who gets to define this?**

I am concerned about "slippage" that is, the tendency for **looser interpretations of legislation** as one off situations or complex situations arise where definitions are challenged. A simple GP example: who says when a person is capable of work in the case of a WINZ medical benefit. GPs all see patients who we know could work but they choose not to for a variety of reasons that are not directly due to their chronic medical condition, so we have a conversation with the patient about working, sign the form and hope that WINZ brings their case up for review because we doubt that an external doctor will support them being on the WINZ medical benefit. The termination of pregnancy legislation at the time it was drafted was designed to prevent septic abortion and to offer termination of pregnancy to those who were in severe medical or social circumstances - today, despite no change in the legislation we have abortion on demand because, with a loose interpretation of "mental distress", it is available to all. Most of us have grown used to the way we enact the legislation and manage it, however the termination of an adult person's life is a very severe outcome when interpretation of the wording of the legislation loosens.

I am concerned by the way the bill exonerates those doctors who participate in assisted suicide as long as they acted in "good faith" (again, a subjectively interpret-able word) but if a **GP** feels that the patient is not served well by assisted suicide because there are other factors in the situation that are driving the request such as fear or feeling of being a burden that the patient is not recognising, they can be **liable to prosecution** if they choose to work with the patient over time on these other factors and **do not commence the patient on the assisted suicide pathway shortly after the request is made.**

I am concerned that this **Bill supports individual autonomy over the implications of such a bill on the more vulnerable members of society** such as the elderly, the lonely, the disabled. It puts "my right to choose" as more important than "assisted suicide was never an option for me before, now I have it as an option and I am feeling like burden and undervalued by my society so perhaps I should choose it."

I am concerned about the **message sent to our youth about the validity of suicide-** we are telling youth that suicide is not the answer and yet, saying to our disabled and terminally ill that it is. Those youth that have talked to me about the issue have mentioned the double standard.

I am concerned that this Bill fundamentally **alters the relationship of doctor and patient** from one of trust and power given by the patient to the doctor to strengthen, extend and improve that patient's health/life, to one where the power to end life becomes part of the package. I want to remain totally committed to the LIFE of my patients, not having to then work with them as they decide if they want me to refer them for termination of that life. That gives us as doctors, too much power and we are fallible human beings too. We did away with the death penalty because the law is not robust enough and humanity not trustworthy enough to ensure that no innocent person is not killed. Likewise, **I do not believe that our law** or the humans that would be

involved in its execution are trustworthy or **robust enough** to ensure that only those who truly have intractable, non-treatable pain or extreme disability and can fully consent, will be the ones to be assisted to die.

I am not of the "life at all costs" view but I do believe that the process of dying, when well supported, can be as important in an individual's life as living. Experience overseas shows that **most people do not request assisted termination of life because of intractable pain, rather out of fear of that dying process and of loss of autonomy.**

I work in a South Auckland low decile practice with mostly Maori, Pacifica and Indian patients. I have not encountered the desire to end life or this intense need for control and autonomy that was present in the previous white middle class practice that I worked in. There seems to be great faith that family can be trusted to be there for them in their dying days, that they will be well cared for. They don't seem to see themselves as a burden to the family. This makes me wonder how much of David Seymour's bill is about his and other proponents' world view/culture and less about the actual reality of suffering. It is interesting that by far the majority of those actively supportive of euthanasia are wealthy, well educated European New Zealanders. I have concerns that this is yet another situation of **unconscious cultural imperialism at work on a populace that is no longer predominantly aligned with a Western world view.** We are trying to learn from our relationship with Maori how to partner with, not colonise, through our law. I am concerned that euthanasia voice is strongly coming from the colonial voice rather than **other cultural voices** and I think we need to seek out these other voices as I suspect they are **telling us a different story around euthanasia.**

Recommendations

My recommendation is that the members of parliament DO NOT support the End of Life Choice Bill