

Dr Wendy Pattemore

Submission for the Justice Select Committee

Re: End of Life Choice Bill

I would also like to make a verbal submission.

I am making this submission as an individual who has a vocation working in Palliative Care with people who have severe life limiting disease. I am a Specialist Palliative Care doctor employed by the CDHB, working in the community in Christchurch with a Multidisciplinary Team.

I fear the fabric of our society will be torn apart if this Bill proceeds -

The Bill provides no protection for the weak, old, disabled or vulnerable.

The Bill favours the Individual over the greater good of society.

The Bill undermines the message that suicide amongst our population is not OK and problems should be faced in another way.

The Bill introduces a procedure that is considered unethical by the majority of Medical Associations and Societies.

The Bill introduces the possibility of monetary gain for ending life.

The Bill suggests doctors should lie about the cause of death on official papers, with subsequent falsification of statistics and predictions that flow from these.

I would like to comment on some specific aspects of the Bill that I am concerned about.

End of Life Choices Bill

Part 1 :3 Interpretation

"attending medical practitioner" The definition of this person is unclear. Is there some quality of relationship that needs to be held by the practitioner, or at least the practice? Or is it acceptable that the "attending medical practitioner" knows little of the wholistic background of the person and their environment?

I know from my experience as a doctor who deals almost exclusively with "suffering" that there is no single element to suffering. Often it is attributed, quite wrongly, to a physical symptom when in reality suffering flows from a lifetime of interactions. Hence

palliative care medicine talks of "Total Pain" or "Existential Suffering". Allowing euthanasia or assisted suicide will remove the need for the attending practitioner to address or even care about the multitude of interacting strands of suffering for the individual. Those strands will remain in the community - hurting a far wider group of people.

Part 1:4 Meaning of Person who is eligible for assisted dying

- (a) "Is aged 18 years or over" - this can immediately be challenged as a contravention of a right by limiting the age range - this has been challenged overseas - hence this safeguard will not be adequate.
- (c) 1 - Establishing that a person is likely to die within 6 months is fraught with error. It is the pastime of many patients to "beat the doctor" as far as a prediction of life expectancy goes.
Further this does not take into account the small but significant number of people misdiagnosed as having a life-limiting disease.
I tell my patients that I am pretty good at telling when death will come when they only have a couple of hours left but other than that there is no watertight method of determining prognosis.
- (c)2 What is a "grievous and irremediable medical condition"? It could be anything that an individual does not like. Does it include osteoarthritis (for which there is overseas precedent), low back pain, or urinary urgency?
- (d) Every elderly person would be covered under this clause. It is our natural state to decline from our youthful peak. Our bodies wear out. They are only good for just over 100 years at best currently and it is a normal thing for them to break down and be no more. This is part of life and maybe we should be asking why our society does not value the lessons from a normal completion of life rather than hurrying it and pretending it does not exist. Why do we not put as much resource into nurturing people in their dying as we do in their birthing?
- (e) The definition here is so loose as to be unenforceable. One person may consider the pain of a splinter "unbearable" but finds it "intolerable" to have a needle lift the splinter out. Obviously I exaggerate, but the principle stands. One of our patients recently believed his life was not worth living. He had some unaddressed pain and needed more support than could be offered at home. He thought he would prefer to die rather than move into Aged Residential Care, which was the only option offered him. When he did go into care he became the life and soul of the party, supporting other residents.
- (f) Nowhere are the consequences of assisted dying addressed. This section specifies the consequences for the patient - but what about the social, emotional and behavioural consequences for the family, the wider whanau, the community and the country?

Part 2- Assisted Dying

6 I am gratified that there is a clause permitting conscientious objection. However there will still be issues with this if euthanasia is carried out in public hospitals. The unspoken coercion by senior colleagues on doctors and nurses could be considerable. With the admission to training programmes or jobs considered at risk if a "junior" stands up to a "boss".

7.2(b) A replacement medical practitioner will not know patient and family background. History can be gleaned from notes but there is so much knowledge that a good family practitioner holds in their head about people that can never adequately be expressed in a document.

8.2.(a) 1 As previously stated prognosis is not an exact science - even for the specialists in each individual field. It becomes fraught in chronic diseases such as neurological, cardiac and lung diseases. It is misguided to expect that every practitioner can give accurate information to this point.

(f) The person is not obliged to talk to anyone about their decision - but encouraged to do so. This is in contradiction to the person understanding the effects his/her action will have on those around them. It contradicts all tenets of good relationship and therapy.

(h) This clause itself admits that there is no guarantee that this act will be free from coercion, A practitioner only has to "do his or her best" (what does that mean?).

I see coercion everyday. It is hidden under the veil of "safety" or "what is best for you". This currently is with respect to the elderly, frail and ill leaving their own home. They do not want to - ever. But with enough talking they quietly say "If I must, yes" then it all happens like a whirlwind. All out of the "best intentions" of course. But in reality it is coercion, because of a lack of money and time and commitment to maintain folks in their own homes - by family and by society and the health service as a whole.

How can we possibly ensure that this does not happen to the most vulnerable in our society with respect to euthanasia? We cannot.

This clause suggests talking to members of the person's family - is this in contradiction to the previous section if the person does not want to talk to anyone about it and may in fact want to keep his/her actions secret?

Again I work every day with people of the type that may be considered for this act. Often the families are harder work than the patient. It can be the family that causes suffering, the family that prevents adequate symptom control, the family that wants it all over sooner.

We see the worst of families and their interactions. And we see the best of families where a loved one is ushered through the portal of death with love, dignity and compassion. And it is not a matter of drugs or symptoms.

9:4,4 - There is no definition of mental disability. Does a Personality Disorder count? Does a past history of mental illness count? Does current mild depression count? Does someone on an anxiolytic with no formal diagnosis count?

It all seems to fall on the decisions of the 2 medical practitioners (or 3). This already contravenes the right of autonomy of the Individual - if this is what is held as the ethical priority.

15

This section makes no distinction between the active and deliberate taking of a life - euthanasia and providing the method for a person to take their own life - physician assisted suicide.

These are two very different scenarios and having them lumped together would be ethically challenging for most practitioners. The problems of policing the two methods would multiply exponentially. It is my understanding that other places that have considered this form of death choose one or the other.

Despite the intention of the bill on the surface to give autonomy to people in regards to the timing of their death, in fact their autonomy is still limited in this Bill. A person must take the death dose whilst being supervised by a medical practitioner. They have to preset a date to die - and then do it. Or not - and go through it all again at a later stage if they feel hopeless again. The practitioner must remain in the same room with them or in close proximity -this needs to be defined.

I fear the emergence of "Death Houses". Because Hospices certainly are not these places. We are about Life and Living to the Full with whatever condition assaults one. The BMJ recently related the history of a person with motor neurone disease who was suicidal, but given appropriate palliative care regained hope and made significant artistic and humanistic achievements despite their severe disability.

15,4 It appears that the only "stand down" period - to allow personal reflection and others who are involved with the person to discuss with them their decision - is the 48 Hrs (2 days) described in this paragraph where the registrar co-signs the prescription and it is forwarded to the pharmacist for dispensing.

This means that a person could decide they have had enough and be dead in 49 hours. Think a one-stop-shop. It will happen because it is efficient and cost effective. It does not guarantee a considered decision.

This is not adequate time to allow treatments to be instituted, or to work, or to get over a complication or bump on the journey. Or for changes in the natural progression of disease. For example there have been cases where metastatic melanoma has disappeared - without treatment. One of the more horrible cancers. Yes it is rare. But we don't understand it. One person whose life is lost unnecessarily is too much. That was why capital punishment was removed.

Part 3. Accountability

20:1 (b) -Assisted dying in any form is not a part of Palliative Care. This is emphasised by the statements made by Hospice NZ, ANZSPM Aotearoa, RACP (bodies directly related to end of life care in NZ).

There is general agreement from professional bodies that it should not be part of medical practice. It is a misconception that euthanasia happens behind doors all the time in hospitals and hospices. It does not. It is acknowledged that there are a variety of opinions held by individual members.

Part 4 - Related Matters

25. This is pure deception and looks like data-laundering. Euthanasia or assisted suicide is predictable, arranged, and enacted, very unlike dying from natural causes. Lying on an official document will subsequently skew statistics on causes of death and lead to poor decisions on the allocation of care and resources.

It will change our knowledge of the natural progression of disease and therefore how to ameliorate or cure it. It will give false evidence about ages of death - prognosis is inexact.

I also want to ask "Who will pay for this?"

There is no mention of payment or cost or where the money will come from. And it will cost. Maybe not as much as caring for people in love and dignity in Care Facilities or Hospitals but it will cost.

I would be loathe to see the money come from the health budget - diverted from the core business of health, when that is already under pressure. Certainly not taken from palliative care where we are already struggling and believe Assisted Dying has no place.

Why should it come under the medical aegis at all? It does not in Switzerland.

I believe that there are other ways to deal in compassion with suffering people. I do not believe that changing the Law of the Land is right or needful. On the other hand, it will change our society over the next generations, ethically, relationally, and in medical interactions. I don't believe this has been adequately considered by either the elected representatives who voted for the Bill or by the population as a whole who are afraid of death, the unknown that surrounds it, and do not understand the options already available to manage suffering.

I am hoping that the committee reviews with an open mind these concerns about the Bill. In particular the inadequacies of this Bill for making any such legislation safe for New Zealand as a whole.