

Committee Secretariat

Justice Committee

Parliament Buildings

Wellington 6160

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Submission regarding End of Life Choice Bill

I am making this submission as a General Practitioner who opposes the End of Life Choice Bill. I have grave concerns regarding both the nature and the specific details of this bill. Below I outline some of the many concerning issues raised by this proposed bill.

The bill states that its purpose is to allow people to “end lives in peace and dignity”. As a doctor, and as a member of society, I fully support this motive. However, it is misleading to believe that euthanasia is an important means to achieve this end. The aim of good palliative care (which is unfortunately under resourced in New Zealand) is to achieve this. To propose that assisted dying would provide a more peaceful and dignified death is a contentious point. The act of taking somebody’s life through an active process is not a peaceful action. One of the cornerstones of medical ethics is non-maleficence, to do no harm, and it is difficult for me to reconcile this with the participation in the active taking of a patient’s life.

Dying is an often difficult but inevitable part of our life’s journey. It is common and normal for people to hold a lot of fear about dying, and what it will be like. It seems to me that many of those who are proponents of assisted dying do so as they see this as a way, as the bill states, “to die without unbearable suffering and pain” and to preserve their autonomy. It is of course desirable that people should be able to die without unbearable suffering and pain. With good palliative care (which is not always resourced or available), this goal can be achieved for most people. From a physical perspective (for example, control of pain and breathlessness), we have access to a wide range of medicines and comfort interventions to alleviate this kind of suffering. Not all members of the general public would be aware of the range of treatments and interventions available. Suffering in dying is not however a purely physical phenomenon. Many other issues are raised including emotional, mental and spiritual issues. These issues can also be addressed as part of holistic palliative care, and in my opinion would not be better addressed (or well addressed) by euthanasia.

Also, in my experience as a doctor and as a family member, people’s wishes and feelings regarding death can be very fluid. In terminally ill people, it is not uncommon on a day of more severe symptoms for a wish to “die soon” to be pronounced, followed by a desire on a more comfortable day to undertake positive activities such as visits with family members or a desire to go to a place they love. This fluidity of expressed wants, hopes and fears on a day to day, or week to week basis runs counter to any imposed notion of an achievable informed decision regarding “assisted dying” for a patient, who if they had lived longer, might yet have enjoyed a better quality of life than they anticipated at the time of committing to an “assisted death”.

The bill specifies in extremely broad terms that those eligible for the bill would have “a terminal illness likely to end their life within 6 months” or those with “a grievous and irremediable medical condition”. Firstly, medical prognosis is an extremely inaccurate art. To be able to say with reasonable certainty that somebody is likely to end their life within 6 months is much more difficult than it may seem. Secondly, the term “grievous and irremediable medical condition” is incredibly

unclear and open to vast interpretation. For example, some patients with complications of diabetes mellitus (for example nephropathy (kidney disease) and neuropathy (involvement of the nerves)) may be said to fit this category, yet actually have many years of potentially productive and fulfilling life ahead of them. Furthermore, mental health conditions such as “treatment resistant depression” (that which has not responded to a range of different medical treatments) might be seen to fall into this category. This does not mean that there are no further social, medical and community supports that could be put into place to improve the quality of life of these people. It is known that people with chronic medical conditions are more likely to suffer from mental health conditions such as depression, which could impact on their assisted dying seeking behaviour. It is not a counterargument to state that this would be addressed in a competence assessment by a mental health practitioner, as having a mental health condition such as depression does not on its own deem somebody to be incompetent (even though it may have an impact on their current views and decisions).

Another major concern I have is the issue of coercion. The bill states that the medical practitioner should “ensure this is a free choice, made without coercion”. This is an almost impossible task. Coercion can consist of a broad range of practices, from overt threats through to much more subtle behaviour and influences. As the nature of coercion can be subversive, it will often be concealed and therefore not apparent to the medical practitioner. Elder abuse is known to be a scourge upon our society. Furthermore, patients may feel under pressure to “take the burden off” their family by choosing assisted dying, even if the family do not actually have any desire for the patient to access this. If assisted dying were to become legal, this could make some vulnerable people feel obliged to consider this as an option (to relieve family, the health care system, etc.), when they would not have actively sought this otherwise.

The bill acknowledges the benefit of patients having the opportunity to liaise with friends, family and counsellors. I believe this is an important part of any major decision making, and support patients to engage with their whanau, friends and support people when facing important medical decisions. However, the bill also states that the doctor must “ensure that the person knows that he or she is not obliged to talk to anyone”. This could discourage patients from engaging with their support network, which could leave them less supported and with possible misconceptions (for example, thinking family will feel relieved of a burden when they are gone). Furthermore, if patients enter into assisted dying without the involvement or understanding of family members and friends, this can have grievous flow on effects. It is well known that a risk factor for suicide is the suicide of a loved one. I am concerned that assisted dying of a patient, whether discussed with family/friends or not, could have serious flow on effects for the mental health of those other parties (and in fact, of involved medical practitioners, who are known to suffer from worse mental health and suicide rates than the general population). Likewise, it is possible that interested parties may present after the fact and state that the decision to support assisted dying has been a miscarriage of justice, for example because they have some evidence that the person may have been coerced or had not been competent to make that decision.

The bill requires that on the death certificate the stated cause of death is the underlying condition for which assisted dying was sought, rather than assisted dying itself. This is essentially falsification of a medical document, which is counter to the transparency, honesty and accountability that the medical profession stands for.

Finally, I am concerned that the bill states that “medical practitioners who conscientiously object must refer people to the SCENZ group”. This means that doctors who object to active involvement in taking a patient’s life are still required to refer them to a doctor that is willing to engage in this. Yet, the bill states “nothing in this Act affects a medical practitioner’s duty to alleviate suffering in accordance with standard medical practice”. For me these two clauses cannot exist alongside each other. For example, if I had a patient who was requesting assisted dying through fear of suffering in

death, but had not seen a palliative care specialist to discuss what that speciality had to offer, I believe that standard medical practice would expect that I would arrange this review for them (and explain the benefits of this). However, it seems that under the bill I would automatically be obliged to refer them to the SCENZ group, which does not guarantee them seeing a palliative care specialist. I also have concerns that in legalising euthanasia, this could provide an “easy option” for doctors who do not have the energy or expertise to provide more compassionate and holistic medical and palliative care. This could have dangerous consequences.

Above are just some of the issues that I see raised by this bill. I am strongly opposed to the bill and hope for the sake of our people that the bill does not proceed.

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