



End of Life Choice Bill

New Zealand Medical Association

Submission to the Justice Select Committee

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Statement of Position / Summary

The New Zealand Medical Association (NZMA) is opposed to euthanasia and doctor-assisted suicide. We regard these practices to be unethical and harmful to individuals, especially vulnerable people, and society. Accordingly, we do not support the proposed End of Life Choice Bill.

Furthermore, we believe the Bill itself has a number of serious shortcomings and technical flaws. These reflect the impossibility of drafting euthanasia and doctor-assisted suicide legislation that is completely effective in terms of defining those eligible, ensuring a free choice, protecting the vulnerable, and ensuring competency.

In conclusion, euthanasia in any form conflicts with the ethical principles of medical practice and would change the fundamental role of the doctor and the doctor-patient relationship.

These are serious matters for the medical profession and we ask they be accorded due consideration.

We also ask the Select Committee to acknowledge that the immutable risk in enacting legislation permitting euthanasia, is an individual's wrongful death.

About the NZMA

1. The NZMA is New Zealand's largest medical organisation, with more than 5,000 members from all areas of medicine. The NZMA's mission is to provide leadership of the medical profession, and to promote professional unity and values, and the health of all New Zealanders. An integral part of the NZMA's leadership role is our Code of Ethics,¹ which sets out principles of ethical behaviour for the medical profession and recommendations for ethical practice. The NZMA is a constituent member of the World Medical Association www.wma.net.

2. Our commitment to the health of all New Zealanders reflects the social contract the medical profession has with the community, which is underpinned by ethical commitments, trust as the basis of the doctor-patient relationship, and altruism. Our position on euthanasia is primarily about the longstanding ethical practice of medicine and the protection of vulnerable people, and our submission will therefore reflect both professional and societal considerations.

Previous work on euthanasia / doctor-assisted suicide

3. In February 2016, the NZMA made a submission to the Health Select Committee on the Investigation into ending one's life in New Zealand.² The key considerations in that submission remain relevant to the current Bill under scrutiny and will be discussed below.

¹ NZMA Code of Ethics, 2014. Available from <https://www.nzma.org.nz/publications/code-of-ethics>

² Available from http://www.nzma.org.nz/data/assets/pdf_file/0015/47022/sub_Investigation-into-ending-ones-life.pdf

Subsequent to our 2016 submission, the NZMA commissioned Grant Gillett, Professor of Medical Ethics at the University of Otago, to write an independent report on the debate about euthanasia as it affects the medical profession in New Zealand.³ Having considered this report, the NZMA Board and Ethics Committee have agreed that the report does not change the NZMA's longstanding position on euthanasia.

4. To help inform our submission on the current Bill, we have sought feedback from our members as well as our Board and Advisory Councils, including our Ethics Committee. While we acknowledge that there is a range of opinions within the medical community, it remains the NZMA's view that euthanasia and doctor-assisted suicide are contrary to the ethics of the profession. The 2005 NZMA position statement on euthanasia,⁴ reaffirmed in 2017, and reproduced in full below, remains our position on this issue.

The NZMA is opposed to both the concept and practice of euthanasia and doctor-assisted suicide.

Euthanasia, that is the act of deliberately ending the life of a patient, even at the patient's request or at the request of close relatives, is unethical. Doctor-assisted suicide, like euthanasia, is unethical.

The NZMA, however, encourages the concept of death with dignity and comfort, and strongly supports the right of patients to decline treatment, or to request pain relief, and supports the right of access to appropriate palliative care.

In supporting patients' right to request pain relief, the NZMA accepts that the proper provision of such relief, even when it may hasten the death of the patient, is not unethical.

This NZMA position is not dependent on euthanasia and doctor-assisted suicide remaining unlawful. Even if they were to become legal, or decriminalised, the NZMA would continue to regard them as unethical.

Patient autonomy and end-of-life decisions

5. The medical profession respects and supports patient autonomy, and the NZMA welcomes the discussion on choice in end-of-life decisions. Patients already have the explicit statutory right to refuse medical treatment.⁵ The Code of Patient Rights also states that every consumer has the right to refuse services and may use an advance directive in accordance with common law.⁶

6. Relying on the principle of autonomy of the patient to choose to end one's life can, however, ignore real uncertainties and vulnerabilities that influence people to make certain

³ Gillett G. A report on euthanasia for the NZMA, 2017. Available from http://www.nzma.org.nz/_data/assets/pdf_file/0006/77766/NZMA-euthanasia-Gillett-report-Final.pdf

⁴ NZMA Position Statement on Euthanasia, 2005. Available from http://www.nzma.org.nz/_data/assets/pdf_file/0004/16996/Euthanasia-2005.pdf

⁵ Section 11 of the New Zealand Bill of Rights Act 1990 "everyone has the right to refuse to undergo any medical treatment."

⁶ <http://www.hdc.org.nz/the-act--code/the-code-of-rights>

decisions about their lives. Fear of future pain, incapacity, or the desire not to become a burden to others, are examples of uncertainties and concerns that might drive a decision to end one's life without taking the opportunity to test those assumptions.

7. Patient autonomy is an important value but is not without limits. Democratic societies have many laws that—to protect the larger community—limit individual autonomy and choice. For the medical profession, other key ethical considerations that must be balanced with patient autonomy include non-maleficence, beneficence and justice.

The doctor-patient relationship and ethical obligations

8. The NZMA's Code of Ethics⁷ requires that doctors always bear in mind the obligation to preserve life wherever possible and justifiable, while allowing death to occur with dignity and comfort when it appears inevitable. Allowing death to occur is fundamentally different from a deliberate act that has the primary intent of terminating life. We are of the view that permitting individuals to end their lives with the assistance of a doctor—even when that assistance is limited to assessment, verification or prescribing—is contrary to the ethics of medical practice and would profoundly alter the ethos within which medical care is provided. If doctors are authorised to purposefully terminate a person's life, or help terminate a person's life, however carefully circumscribed the situation, they acquire an additional role that is contrary to the nature of the doctor-patient relationship.

9. The obligation of preserving life does not mean, however, that doctors must attempt, or patients accept, burdensome or futile treatments, or treatments that do not offer a reasonable hope of benefit. Similarly, allowing death to occur in comfort encompasses situations where treatment is provided to relieve pain and distress, even when it may have the secondary effect of hastening death.

The role of palliative care

10. Modern palliative care is aimed at improving the quality of life of patients facing terminal illness, where care focuses on the prevention and relief of pain, nausea, shortness of breath and other symptoms, alleviation of psychological and spiritual suffering, and support of the patient and their family in the final stage of life. It affirms life and regards dying as a normal process, and intends neither to hasten nor postpone death.

11. We believe that euthanasia or doctor-assisted suicide has the potential to diminish our focus on comprehensive and compassionate end of life care provided by palliative care clinicians and facilities. The quality of New Zealand's palliative care, where available and resourced,⁸ is considered world leading,⁹ and we should continue to strive to ensure that all New Zealanders in need have excellent and timely access to this care.

⁷ <http://www.nzma.org.nz/publications/code-of-ethics>

⁸ Palliative Care Council of New Zealand. National Health Needs Assessment for Palliative Care Phase 2 Report: palliative care capacity and capability in New Zealand. Wellington: Cancer Control New Zealand, 2013. <https://www.health.govt.nz/system/files/documents/publications/national-health-needs-assessment-for-palliative-care-jun13.pdf>

⁹ <http://www.economistinsights.com/healthcare/analysis/quality-death-index-2015>

12. The experience of palliative care experts and providers as they support patients and their families through the end stages of life must be acknowledged and listened to when considering factors that contribute to the desire to end one's life when faced with terminal illness. They are witnesses to what can be achieved for the person in palliative care, both in terms of physical and emotional care. They have also experienced first-hand how attitudes and desires can evolve and change during care.

13. Euthanasia or doctor-assisted suicide is antithetical to the role of palliative care and the commitment to address suffering and provide care until the very end of life. Further, it is our view that a contributing factor to public support for euthanasia is that the assistance which good palliative care can provide is not well understood. Addressing this, and meeting the need for good access to well-resourced palliative care,⁸ are essential measures that we urge all parliamentarians to support.

14. To ensure that New Zealanders have access to quality, personalised and compassionate palliative care, a greater investment in palliative care services is required. We therefore strongly recommend that the Government increase funding to ensure access for everyone who needs palliative care—whether provided by hospitals, rest homes, primary care teams or hospices.⁸

Clinical considerations

15. Decisions to end one's life when there is the prospect of disease-related death or grievous and irremediable illness are premised on the assumption of an accurate diagnosis and prognosis.

16. While advances in diagnostic tools and improvements in knowledge regarding the progression of disease continue, it is still an inexact science. Errors occur and individuals can still prove all of the experts wrong. According to *The American Journal of Medicine*¹⁰ and *BMJ Quality and Safety*,¹¹ published studies indicate misdiagnoses occur anywhere from 10–15% of the time.

17. Likewise, while a large number of papers are published in the medical literature on attempts to find prognostic markers in advanced disease, they in fact confirm that a high level of accuracy is not attainable. While averages can be determined across populations, it is impossible to predict where an individual's life expectancy lies within the range, and there are always exceptional cases where a person lives much longer happily than the population data would suggest.

18. The administration of euthanasia or doctor-assisted suicide also gives rise to potential complications. A Dutch study¹² reported difficulties in administering the lethal drugs in 10% of assisted suicides and 5% of euthanasia cases; complications such as vomiting and muscle spasms in 7% of assisted suicides and 3% of euthanasia cases; and cases where death took an

¹⁰ Berner ES, Graber ML. Overconfidence as a cause of diagnostic error in medicine. *Am J Med*. 2008 May;121(5 Suppl):S2-23. doi:10.1016/j.amjmed.2008.01.001.

¹¹ Graber ML. The incidence of diagnostic error in medicine. *BMJ Qual Saf* 2013;22 Suppl2:ii21-ii27. doi:10.1136/bmjqs-2012-001615. http://qualitysafety.bmj.com/content/22/Suppl_2/ii21.long

¹² Groenewoud JH, van der Heide A, Onwuteaka-Philipsen BD, et al. Clinical problems with the performance of euthanasia and physician-assisted Suicide in The Netherlands. *N Engl J Med* 2000;342:551-6. <http://www.nejm.org/doi/full/10.1056/NEJM200002243420805>

unexpectedly long time (up to 7 days) in 15% of assisted suicides and 5% of euthanasia cases. Reports from Oregon¹³ also highlight long intervals between ingestion and death—up to 104 hours with a median of 25 minutes—and also report that six patients woke up post ingestion. It is of interest that none of these six people requested re-attempts at assisted suicide following its failure to achieve death.

19. The requirement to determine mental capacity in the context of euthanasia or assisted suicide decision making is also complex and challenging. There is no absolute test for mental capacity, and patients that appear completely mentally competent may not in fact be so. For example, evidence given to the UK Select Committee on physician assisted dying showed that 30% of people with motor neurone disease were, after careful neuropsychological testing, found to be cognitively impaired.¹⁴ Furthermore, an individual's capacity may vary over time from total to partial to absent. Capacity can also be influenced by external factors such as receiving disturbing information about their condition, hearing family members discussing financial pressures, or politicians talking about the expense of caring for an aging population.

20. The links between capacity, cognition and underlying conditions are complex. While cognitive incapacity may result from dementia or delirium, cognitive impairment may occur in people with (frequently remediable or time-limited) feelings of hopelessness or depressed mood. The determination of capacity is not wholly clinical; it involves two components, an ethical component and a clinical component. In addition, there is ongoing debate on whether to use a fixed or sliding standard when determining capacity, and what clinical factors should be given the greatest weight if a sliding standard is adopted.¹⁵

Challenges with any proposed legal framework

21. It is our view that it is impossible for any law designed to protect the voluntary nature of euthanasia or assisted suicide to be completely effective in ensuring that individuals make decisions free from any pressure to do so. Once voluntary euthanasia or doctor-assisted suicide is legal, terminally ill patients will be left wondering what is expected of them in terms of requesting euthanasia. Subtle emotional coercion from relatives might be present but not identified, and self-imposed pressure may also be a factor if the individual feels euthanasia is something they ought to consider rather than becoming a burden on family and others. Elderly people may be particularly vulnerable to suggestions they are a burden. The 2014 annual report on Oregon's Death with Dignity Act 17 years post enactment reports that 40% of patients choosing to use the law cite concerns about being a burden as part of the reason they want to end their life.¹⁶

22. A legislative safeguard that is often proposed is the requirement to have two doctors provide sign off before a euthanasia or assisted suicide. We do not, however, believe that this

¹³<http://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Documents/year17.pdf>

¹⁴ Assisted Dying for the Terminally Ill Bill – First Report, 2005. House of Lords. Report HL 86-II; <http://www.publications.parliament.uk/pa/ld200405/ldselect/ldasdy/86/8607.htm#a30> para 125; full report <http://www.publications.parliament.uk/pa/ld200405/ldselect/ldasdy/86/8602.htm> .

¹⁵ Howe E. Ethical aspects of evaluating a patient's mental capacity. *Psychiatry* (Edgemont) 2008;9(7):15-23. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2728941/>

¹⁶ Oregon Public Health Division Dept Human Sciences. Oregon's Death with Dignity Act: Annual Report 2014 <https://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Documents/year17.pdf>

would provide any real protection, as it is likely that only small numbers of doctors would consider active involvement in euthanasia. The small number of doctors that might make this part of their medical practice are likely to refer to those who will support their recommendations. This would inevitably lead to ‘doctor shopping’. It would also mean that the prescribing doctor may only have been involved with the patient for a short period of time, and therefore have no in-depth knowledge of the patient’s emotional state and personal or family circumstances. The Oregon experience demonstrates these points, with one doctor writing 12 prescriptions (8% of the total lethal drug prescriptions issued in 2014) and duration of the patient-physician relationship recorded as short as one week.

23. Given that even the most carefully crafted legislation will be unable to ensure infallible safeguards, the gravity of the risk in question—a wrongful death—is of sufficient magnitude to override many of the arguments for the legalisation of euthanasia, including patient choice.

24. For the medical profession, being involved in a wrongful death of this nature has serious implications for the doctor who could conceivably be subject to criminal charges. The social contract between the medical profession and the community is also at stake if wrongful deaths arising from the practice of euthanasia and doctor-assisted suicide ultimately damage society’s confidence in the profession’s commitment to integrity, morality and altruism.

25. As we predicted, the current Bill before the Committee has many deeply problematic provisions. For example, there are major deficiencies with the definitions of those eligible for assisted dying; erroneous assumptions about prognosis; serious deficits relating to the determination of competence; and a failure to recognise the magnitude of what the Bill could facilitate, namely, a wrongful death. We elaborate on these issues in the paragraphs below.

26. The Bill proposes that a person who is eligible for assisted dying needs to suffer from either i) a terminal illness that is likely to end his or her life within 6 months; or ii) a grievous and irremediable medical condition. These criteria are problematic for a number of reasons. The term ‘grievous and irremediable medical condition’ is vague, subjective and open to interpretation and misinterpretation. It is unclear what conditions this term would encompass. For example, would it include all psychiatric conditions and chronic illnesses such as diabetes, arthritis or chronic pain syndrome, regardless of severity?

27. Given that only doctors who are supportive of euthanasia / doctor-assisted suicide would be considering patient requests to die, the clause ‘grievous and irremediable medical condition’ would open up euthanasia / doctor-assisted suicide for patients with a whole range of conditions. It is also unclear what ‘irremediable’ actually means. For example, does this mean there are no currently available funded treatments that are effective and suitable? What about near-future treatments, or current treatments that exist and are effective and suitable, but are rejected by the patient without good grounds? The criterion ‘experiences unbearable suffering that cannot be relieved in a manner that he or she considers tolerable’ is also deeply problematic given its highly subjective nature.

28. The assumption that it will be possible to reliably predict that a patient’s terminal illness is ‘likely’ to end their life within 6 months is flawed. It is often impossible to provide an accurate estimate of prognosis for an individual patient (see paragraphs 16-18). It is therefore possible that some patients will base their wish for assisted dying on the basis of an incorrect prognosis. The term ‘likely’ is also vague as it is open to interpretation. How likely

does this estimate have to be? For example, does it mean a probability greater than 50%, greater than 75% or greater than 90%?

29. In order to confirm that a person is eligible for assisted dying, a medical practitioner, independent practitioner and, when necessary, a specialist (defined in the Bill as a psychiatrist or psychologist) must reach the opinion that a person is competent. The Bill defines competence as ‘the ability to understand the nature of assisted dying; and the consequences for him or her of assisted dying.’ This definition is overly simplistic and weak. Determining competency and mental capacity in the context of euthanasia or assisted suicide decision making is complex and challenging (see paragraphs 19-20). Capacity is time specific and can vary from complete to partial to absent. It is also influenced by external factors and a person’s underlying emotional and psychiatric state, sense of being a burden, and underlying medical conditions. The Bill fails to recognise these challenges and therefore fails to sufficiently protect persons who are partially or temporarily impaired. It also fails to address the required standard of confidence in the assessment outcome / tools to determine competence, let alone the practitioner making this assessment. There is an increasing tendency, even in the psychiatric workforce, to see the assessment of capacity as something that requires additional training and skills.

30. The provisions in the Bill will not ensure that a decision to seek assisted dying will always be made freely and without subtle coercion. While it requires medical practitioners to ‘do their best’ to ensure that the person expresses their wish free from pressure from any other person, there is no way legislation can ensure this will always be so. Furthermore, an attending medical practitioner may have only a very limited understanding of the patient’s family and social history.

31. The Bill is overly prescriptive, stipulating a number of steps that are required by an attending medical practitioner but completely failing to include any requirement to provide counselling / further psychiatric evaluation for a patient requesting to die. This is at odds with the approach to a suicidal patient and would appear to conflict with the duties of a practitioner to provide good clinical care for each individual patient. Very careful psychological assessment from an appropriately qualified practitioner during several interactions would be required to reveal the many subtle pressures affecting a person’s decision for euthanasia and evaluate the permanence of a person’s decision.

32. While the Bill identifies wilfully failing to comply with requirements in this Act as offences, it fails to recognise the enormity of the consequences of such a failure, namely, a wrongful death. The proposed penalties of either or both a term of imprisonment not exceeding 3 months and a fine not exceeding \$10,000 appear incongruent with the consequences of an offence which could include a wrongful death.

33. The background to the Bill in the Explanatory note makes a number of unsubstantiated assurances and statements. For example, it states that “there was broad consensus that palliative care cannot alleviate all suffering, including suffering that is unbearable for a person”. This statement is misleading as it implies that palliative care is not good enough for a large group of patients. We strongly disagree with this statement and suggest the Committee listen to the view of Palliative care specialists. The main failing in palliative care in New Zealand is the lack of access⁸ and insufficient funding, as well as poor understanding from the general public as to what palliative services can do. We believe that these issues must be addressed as a priority rather than diverting funding into euthanasia / assisted suicide.

34. The Bill suggests that the situation in jurisdictions where euthanasia and / or physician assisted suicide is legal is working well. Yet the Gillet report and others¹⁷ suggest there are a number of concerns relating to the slippery slope and the inadequacy of protections for vulnerable people in jurisdictions where legislation has been introduced. The Bill also suggests that public opinion is in favour of assisted dying, yet ignores the challenges associated with reliably ascertaining public opinion on this complex issue. For example, opinion polls often tend to be simple, direct questions without proper explanatory context. They also often suggest a binary choice between intolerable suffering and an ending of a patient's life, whereas the clinical reality, for example, with good palliative care, is often far more subtle.

35. The Bill is silent on resourcing and funding requirements, yet these are likely to be substantial. As we have already pointed out, palliative care services in New Zealand are already underfunded and geographically variable. Mental health services are also under resourced and underfunded (as evidenced by the Mental Health Service review currently underway). The health system is already not meeting current mental health needs let alone possessing the capacity to properly evaluate people requesting euthanasia / physician-assisted suicide.

Implications for society

36. Laws are more than just regulatory instruments. They also convey important societal messages. Legalising euthanasia or assisted suicide, even in limited circumstances, would contribute to normalising suicide across society, including among youth. They would send the message that suicide is sometimes an appropriate response to coping with suffering. This would be of major concern given New Zealand's high rates of suicide and the efforts underway towards preventing youth suicide.

37. We also believe that legalisation of euthanasia or doctor-assisted suicide would change the way we regard death and the care of the dying for everybody, not just those who would choose euthanasia. Many patients implicitly trust in their doctor. If we allow doctors to be life takers as well as life savers, then the characteristics we produce in doctors, and other health professionals, will fundamentally change. They will not necessarily presume in favour of life and a patient may not be able to trust in this presumption, and the option of choosing to end life will be ever present in medical care.

38. The 'routinisation' of assisted dying in clinical practice is evident in the escalating numbers in the countries that allow it. In Belgium, deaths under their 2002 Euthanasia Act almost doubled in four years (an increase of 89%), from 953 reported in 2010 to 1,807 in 2013. Euthanasia now represents 1.7% of all deaths in Belgium.¹⁸ Similar incremental rises have been reported in the Netherlands, with around one death in 25 (4%) now the result of doctor-assisted suicide.¹⁹

¹⁷ Lerner BH, Caplan AL1. Euthanasia in Belgium and the Netherlands: On a Slippery Slope? JAMA Intern Med. 2015 Oct;175(10):1640-1.

¹⁸ Commission Fédérale de Contrôle et D'évaluation de L'euthanasie Sixieme Rapport aux Chambres Législatives (Années 2012-2013)

¹⁹ Regional Euthanasia Review Committees 2016 Annual Report. Available from <https://www.euthanasiecommissie.nl/binaries/euthanasiecommissie/documenten/jaarverslagen/2013/nl-en-du-fr/nl-en-du-fr/jaarverslag-2013/annual-report-2013-tcm52-48.pdf>

39. Of most concern, however, is the lack of protection for vulnerable people, including disabled people and the elderly. It is of note that the High Court of Ireland determined that a relaxation of the ban on assisted suicide would be inimical to the public interest in protecting the most vulnerable members of society, stating that “The evidence from other countries shows that the risks of abuse are all too real and cannot be dismissed as speculative or distant”.²⁰ A relatively recent paper²¹ has challenged the assertion by proponents of euthanasia that there is no evidence vulnerable people are euthanised disproportionately more; vulnerability to euthanasia cannot be categorised simply by reference to ethnicity, sex or socioeconomic status. Other characteristics, such as emotional state, reaction to loss, personality type, and the sense of being a burden are also important.

40. The debate on euthanasia / physician-assisted suicide rarely considers non-dominant cultural perspectives that differ from Western individualistic modes of thought with their emphases on personal choice. For example, in many traditional ways of thinking, individual human life and choice is relativised to a wider context of relatedness and connection to others. Another challenging issue is that for certain cultures, when a person is sick, it is expected that the family will take decisions for them. This makes it extremely difficult to ensure that decisions about end of life are a true reflection of the wishes of the person.

Particular considerations for the medical profession

41. In debating issues relating to euthanasia / physician assisted suicide, the medical profession faces additional questions beyond those raised for debate in the general public. As outlined in the Gillett report, these include:

- i. Should we as healthcare professionals go beyond what is currently acceptable in terms of withdrawing unhelpful and burdensome treatment and embrace the further (very big and irreversible) step of ending, or assisting a patient, to end their own life, at their request?
- ii. Will that further step, with the dire responsibilities it places on doctors and nurses dealing with end-of-life care, significantly benefit our patients?
- iii. Should our profession, which has always acted out of utter respect for life and our duty to care for patients in life-affirming ways, embrace a different ethos in one area of our practice?

Conclusion

42. The NZMA acknowledges that the issues at the core of the debate that has given rise to this Bill are complex and challenging. The rights of patients to personal autonomy in their health care is an underpinning principle of our health services in New Zealand, and is universally acknowledged and supported by doctors and other health professionals. There are, nevertheless, some matters where ethics and other societal considerations must necessarily place limitations on that autonomy.

²⁰ <http://www.bailii.org/ie/cases/IEHC/2013/H2.html>

²¹ Finlay IG, George R. Legal physician-assisted suicide in Oregon and The Netherlands: evidence concerning the impact on patients in vulnerable groups--another perspective on Oregon's data. *J Med Ethics*. 2011 Mar;37(3):171-4

43. Our analysis of both the ethical and practical issues raised by euthanasia and doctor-assisted suicide confirms our view that these practices would be harmful to individuals, especially vulnerable people, and society. A change in the law to allow euthanasia or doctor-assisted suicide, no matter how circumscribed, would also profoundly alter the role and responsibilities of the medical profession and the doctor-patient relationship. We believe that acting with the primary intention to bring about death cannot be reconciled with the core medical ethical principles of beneficence and non-maleficence, and is therefore not supported by the NZMA.

44. The End of Life Choice Bill has a number of serious flaws, many of which we believe are inherent in any legislative attempt to legalise euthanasia or doctor-assisted suicide. We do not believe that the Bill is, or could be amended to be, completely effective in terms of defining those eligible, ensuring this is a free choice, and that persons making it are competent to do so. We recommend the Government urgently increase funding to ensure access for everyone who needs palliative care—whether provided by hospitals, rest homes, primary care teams or hospices. We also recommend measures to enable a better public understanding of the assistance which good palliative care can provide.

We hope this submission is of assistance to the Select Committee. We would like to have the opportunity for an oral hearing to speak to our submission and answer any questions the Committee may have.

Yours sincerely



Dr Kate Baddock
NZMA Chair

Appendix: Common questions

What is euthanasia?

Euthanasia, or voluntary euthanasia more specifically, is where lethal drugs are administered to a patient at the patient's request.

What is doctor-(physician)assisted suicide?

Doctor- or physician-assisted suicide is where a patient self-administers lethal drugs supplied by a doctor. The doctor or other member of the health care team may or may not be present when the patient takes the drugs. For it to be considered assisted suicide rather than euthanasia, the patient must take the action of self-administration.

Is withdrawal or withholding treatment euthanasia?

Withdrawal of treatment, with the knowledge that death will follow, differs from the administration of a lethal medical intervention with the objective of causing death prior to the natural dying process.

What is palliative sedation?

In medicine, palliative sedation (also sometimes referred to as terminal sedation) is the practice of relieving distress in a terminally ill person in the last hours or days of a dying patient's life, by means of a continuous intravenous or subcutaneous infusion of a sedative drug.

Palliative sedation is considered when the patient is clearly distressed, all other symptom-relieving measures have failed, and the ongoing symptoms are therefore determined to be refractory. The level of sedation is titrated to achieve removal of distress and this intervention involves interdisciplinary collaboration in conjunction with the patient and carer and/or family members.

Sedation of this type may be subject to the principle of 'double effect', which is the dual effect of intentional relief of suffering and increased risk of hastening death. In clinical practice, however, palliative sedation does not usually alter the timing or mechanism of a patient's death, as refractory symptoms (those that cannot be controlled by tolerable therapy) are most often associated with very advanced terminal illness.

How is palliative sedation different from euthanasia?

The primary intent of palliative sedation is to sedate the dying patient so that they do not experience distress and do not suffer due to specific refractory and intractable symptoms. The intent is NOT to deliberately hasten the dying process. Palliative sedation is also guided by the principle of proportionality, ie, the benefits of any intervention should outweigh the burdens of that intervention. In particular, this requires that interventions with any risk of harm be administered only to the degree necessary to confer the desired amount of therapeutic benefit.

Palliative sedation is therefore clearly demarcated from euthanasia. The intention is sedative in nature and is aimed at, and designed to, reduce the patient's consciousness of severe symptoms. The sedative intention is related to, and evidenced by, adherence to various ethical parameters. The sedatives are administered only when the symptoms have become intractable, in accordance with the principle of proportionality, and when the patient is terminal, such that the expected loss of life duration is nil or minimal.

Is the NZMA's position consistent with medical associations in other countries?

Yes—the world's professional medical associations overwhelmingly oppose voluntary euthanasia and assisted suicide.²²

The World Medical Association: euthanasia, that is the act of deliberately ending the life of a patient, even at the patient's own request or at the request of close relatives, is unethical. Physician-assisted suicide, like euthanasia, is unethical and must be condemned by the medical profession.

²² The World Medical Association (WMA) has 114 National (or territorial) Medical Associations (NMAs) as members. Of these, 109 NMAs have backed the WMA policy, four have a neutral position (Belgium, Luxemburg, Switzerland, Canada) and one (Royal Dutch Medical Association) actively advocates for euthanasia and physician-assisted suicide.

The World Medical Association reaffirms its strong belief that euthanasia is in conflict with basic ethical principles of medical practice, and

The World Medical Association strongly encourages all National Medical Associations and physicians to refrain from participating in euthanasia, even if national law allows it or decriminalises it under certain conditions.

The Australian Medical Association: medical practitioners should not be involved in interventions that have as their primary intention the ending of a person's life.

The American Medical Association: strongly opposes any bill to legalise physician-assisted suicide or euthanasia, as these practices are fundamentally inconsistent with the physician's role as healer.

The British Medical Association: opposes assisted dying in all its forms.

Are there alternative pathways that do not involve doctor participation?

An alternative professional group with appropriate training could be authorised to undertake euthanasia and related activities including assessment and prescribing. While this would protect the doctor-patient relationship and ensure that the role of the doctor is not changed or undermined, the societal questions and challenges outlined in this submission would still remain and perhaps be intensified by separating the act of assisted dying from more comprehensive health care skills.

What do people mean by 'the slippery slope'?

The 'slippery slope' argument contends that the acceptance of certain practices, such as doctor-assisted suicide and voluntary euthanasia, will invariably lead to the acceptance or practice of concepts that are currently deemed unacceptable, such as non-voluntary euthanasia.

While the idea of New Zealanders ever accepting non-voluntary euthanasia seems highly improbable, the experience of the few overseas jurisdictions that have legalised euthanasia and/or doctor-assisted suicide demonstrates that initial limitations are ultimately loosened and eligibility extended. Examples include extending rights to those with mental illnesses, those with chronic but not terminal disease, those with disabilities, and children. In 2006 the Netherlands agreed that "being over the age of 70 and tired of living" was an acceptable reason for requesting euthanasia, and in 2014 Belgium amended its euthanasia laws to remove all age restrictions. Neither of these developments were envisioned by the parliaments and the people of those countries when euthanasia laws were passed in 2002.