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Committee Secretariat
Justice Committee
Parliament Buildings
Wellington

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To the Justice Committee

End of Life Choice Bill

Thank you for giving The Royal New Zealand College of General Practitioners the opportunity to comment on the End of Life Choice Bill.

Introduction to general practice and the College

General practice is the medical specialty that treats patients: with the widest variety of conditions; with the greatest range of severity (from minor to terminal); from the earliest presentation to the end; and with the most inseparable intertwining of the biomedical and the psychosocial. General practitioners (GPs) treat patients of all ages, from neonates to elderly, across the course of their lives.

GPs comprise almost 40 percent of New Zealand's specialist workforce and their professional body, The Royal New Zealand College of General Practitioners (the College), is the largest medical college in the country. The College provides training and ongoing professional development for GPs and rural hospital generalists, and sets standards for general practice. The College has a commitment to embed the three principles (participation, partnership and protection) of Te Tiriti o Waitangi (Treaty of Waitangi) across its work, and to achieving health equity in New Zealand.

Health equity is the absence of avoidable or remediable differences in health outcomes and access to health services among groups of people, whether those groups are defined socially, economically, demographically, or geographically (World Health Organisation). To achieve health equity, we advocate for:

- A greater focus on the social determinants of health (including labour, welfare, education, housing, and the environment).
- Funding and support to sustain the development of a GP workforce of sufficient capacity to meet population need for access to quality primary medical care, particularly in rural and high need areas.
- Sustained focus on measures to reduce smoking and to increase healthy food options for low-income families.
- Improved integration of primary, community, and secondary care health and social services which ensures the provision of high quality services.
- Universally accessible free primary health care for children and low-income families, because health inequities begin early and compound over the life course.

- A review of the funding model for primary care to ensure that resourcing is allocated equitably across diverse populations with differing needs.

Submission

The College's position

The College's submission **should not** be taken as endorsement of euthanasia and/or physician-assisted suicide.

As our members hold a wide range of views on euthanasia and physician-assisted suicide, we have decided not to comment on whether or not euthanasia and/or physician-assisted suicide are ethically or morally right. Instead, we consider this to be a matter for individual members' own consciences, within the framework of the law.

This submission reflects our members' and the College's own analysis of the End of Life Choice Bill. We have collated member feedback on specific aspects of the draft Bill that we feel would need further consideration by the Justice Select Committee. We have noted the numerous challenges euthanasia and physician-assisted suicide presents to general practice and believe that, in its current form, the Bill does not adequately address these challenges.

The Bill's introduction states: 'The motivation of this Bill is compassion.'

It is important to note that all of the College members who provided feedback, whether for or against euthanasia, are motivated by compassion for their patients and their families. Doctors are trained and motivated to provide compassionate care. This is a fundamental tenet of our profession.

The College would like to call the Select Committee's attention to the New Zealand Medical Association (NZMA) and World Medical Association (WMA), both of which set the code of ethics for the medical professional. Both of these organisations oppose euthanasia. As such, it is our hope the Select Committee takes into consideration that should euthanasia and physician-assisted suicide become legal in New Zealand, our members could find themselves in conflict between international and national medical ethical standards and the law.

Several of our members stated they supported the NZMA and WMA's opposition to euthanasia and physician-assisted suicide, and even if euthanasia were to become legal in New Zealand, they would be unwilling to support it. As one member wrote, "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".

Executive summary of recommendations

The first five recommendations refer to end of life care, and steps the Government should take to make sure all New Zealanders have knowledge and access of end of life care.

- 1. The Government improves and strengthens palliative care services for all New Zealanders.**
- 2. The Government provides more financial support for families caring for a family member at the end of their life.**
- 3. The Government invests in ensuring Māori have access to culturally appropriate palliative care.**

4. **The Government implements a public information campaign to ensure New Zealanders understand what euthanasia and physician-assisted suicide are, who would be eligible for it, and the wider implications of any legalisation before the Bill progresses further through Parliament. This would be of particular importance if the Government holds a referendum on this issue.**
5. **The Government invests more money in mental health services.**

The following recommendations apply if the law is changed.

6. **The Bill specifically prevents people with mental health conditions from qualifying for euthanasia or physician-assisted suicide.**
7. **The Select Committee carefully considers the scope of medical practitioners and minimum practice experience of the practitioners who would offer euthanasia or physician-assisted suicide services.**
8. **The Bill requires that medical practitioners receive appropriate training and support to enable them to provide quality advice and care to patients and their families.**
9. **The minimum age of eligibility for euthanasia be set at 25 years.**
10. **The Bill's eligibility criteria are reconsidered to tighten the definition of who is eligible for euthanasia and for physician-assisted suicide.**
11. **The Bill's introduction be amended to remove the requirement for medical practitioners who do not wish to participate in euthanasia to refer patients to the SCENZ Group.**
12. **Patients seeking euthanasia or physician-assisted suicide be obliged to self-refer to the SCENZ register in the first instance to consult with a registered medical professional who is trained and willing to provide physician-assisted suicide and euthanasia services.**
13. **Clause 8 be amended to recognise the difficulties of making accurate prognoses and to clarify whether medical practitioners' advice to patients is limited to medical impacts.**
14. **The Select Committee considers how to deal with situations where a patient with reduced decision-making capacity wishes to forgo the Advanced Care Plan made when they were mentally competent.**
15. **Clause 15 be amended to make it explicitly clear if the Bill refers to euthanasia or physician-assisted suicide, and if both, when the legislation applies to either option.**
16. **The Select Committee considers the complexities of euthanasia and/or physician-assisted suicide if something goes wrong.**
17. **Clause 19 be amended to ensure the privacy and confidentiality of the medical professionals who elect to perform euthanasia or provide physician-assisted suicide.**

Terminology

The terminology surrounding euthanasia is emotive and generally reflects a person's ethical position on the subject. Our members used a range of terms to describe euthanasia including 'assisted suicide,' 'medical assisted dying' and 'killing patients'.

The College has chosen to use the terminology 'euthanasia' and 'physician-assisted suicide' to describe the options in the End of Life Choice Bill, as these terms are widely used in the literature. These terms are defined below:

Euthanasia: a medical practitioner actively and intentionally ends a patient's life by some medical means such as an injection. For the purposes of this submission, euthanasia only refers to voluntary euthanasia, in which the patient has requested to be euthanised.¹

Physician-assisted suicide (PAS): a patient is prescribed lethal drugs at their request and the patient self-administers the drugs with the aim of ending his or her life.²

The College would like to acknowledge current legal practice in New Zealand with regard to end of life care. Under New Zealand law, medical practitioners are able to increase dosages of opiates to relieve patients' suffering, and this can sometimes hasten a person's death.

As such, we would like to reiterate the point made in the Maryann Street petition, which is that 'there is an important distinction between giving pain relief that may shorten a person's life and deliberating causing death.'³

Structure of submission

The College's submission is split into two sections. The first section analyses some of the challenges arising from euthanasia and physician-assisted suicide generally. This section covers:

- the state of palliative care in New Zealand
- the effect any legalisation may have on vulnerable people
- the effect euthanasia or physician-assisted suicide has on the doctor/patient relationship
- funding and workforce issues.

¹ Emanuel EJ, Onwuteaka-Philipsen BD, Urwin JW, Cohen J. Attitudes and practices of euthanasia and physician-assisted suicide in the United States, Canada, and Europe. *Jama*. 2016 Jul 5;316(1):79-90.

² Ibid.

³ Health Select Committee. Petition 2014/18 of Hon Maryann Street and 8,974 others. Report to the Health Committee [internet]. 2017 [cited 2018 January 31]. Available from https://www.parliament.nz/resource/en-NZ/SCR_74759/4d68a2f2e98ef91d75c1a179fe6dd1ec1b66cd24.

The second part of the College's submission covers specific challenges with the End of Life Choice Bill. This section covers:

- the broad definition of a medical practitioner
- the criteria for assisted dying
- conscientious objection
- the role of the medical practitioner
- whether or not the Bill refers to euthanasia or physician-assisted suicide
- the need to cover what to do if something goes wrong
- medical professionals having the right to remove their name from the euthanasia register.

For ease of understanding, following each subheading we have included the clause in the Bill to which the subheading applies.

Challenges of euthanasia and physician-assisted suicide

The need for accessible, good, quality palliative care in New Zealand

Any discussion on euthanasia and/or physician-assisted suicide needs to be part of a wider analysis of palliative care services.

Current estimates suggest New Zealand's hospice services cost more than \$100 million per annum.⁴ Although the Government does contribute to this cost, there is a \$45 million shortfall, which is met by community fundraising efforts.

This reliance on fundraising and donations creates uncertainty and financial pressure, and is neither satisfactory nor sustainable for patients, communities or health professionals. In considering New Zealanders' end of life experiences, the College would encourage the Government to consider adjusting its financial support to this valuable and much-needed service.

Palliative care also needs to be accessible for all communities. Of concern is a Gott *et al.* study, which found that families were often not aware of their palliative care entitlements and did not know how to find out what these were. Access to good palliative care in New Zealand is hindered by the lack of easily accessible information.⁵ This is further compounded by some District Health Boards not funding consultations on advanced care planning or end of life care.

Cost can also be a barrier to accessing these services. Although hospice care is free for most New Zealanders, the cost of looking after a family member at the end of their life can be significant. The Gott *et*

⁴ Hospice New Zealand. Facts and Figures [cited 2018 February 2]. Available from <http://www.hospice.org.nz/hospice-care/facts-amp-figures>

⁵ Gott M, Allen R, Moeke-Maxwell T, Gardiner C, Robinson J. 'No matter what the cost': A qualitative study of the financial costs faced by family and whānau caregivers within a palliative care context. *Palliative medicine*. 2015 Jun;29(6):518-28.

al. study reports home visits by the GP, transport to and from medical appointments, and indirect costs such as time off work all put a lot of financial pressure on family members.⁶

In addition, access to palliative care can also be hindered by geographical location. In the 2017 Ministry of Health review of adult palliative care services, the Ministry noted a shortage of palliative care specialists, particularly in rural areas.⁷ One of our members commented on this issue:

“I think the discussion highlights the need for palliative care services to be strengthened and access to them increased. The services that exist in [my rural area] are very good, but at times there can be delays getting access to assessments or input due to the number of staff available.”

Access to culturally appropriate care is important too, especially for Māori. The 2014 report *Māori Health Literacy and Communication in Palliative Care* noted there are significant barriers to Māori accessing palliative care. The report highlighted the need for better communication, culturally competent staff and a greater number of Māori palliative care specialists as a way to address these barriers.⁸

The majority of our members agree that improving access, funding and the quality of palliative care is of paramount importance. By addressing these issues, the Government will be able to help a significant number of New Zealanders experience a dignified, comfortable death, which appears to be a primary motivator for those who support euthanasia and physician-assisted suicide.

The College’s recommendations

- 1. The Government improves and strengthens palliative care services for all New Zealanders.**
- 2. The Government provides more financial support for families caring for a family member at the end of their life.**
- 3. The Government invests in ensuring Māori have access to culturally appropriate palliative care.**

Need for a better understanding of palliative care

Debate surrounding euthanasia has revealed a lack of understanding on the dying process and palliative care.

The Maryan Street petition report pointed out, ‘Members of the public spoke of relatives dying in extreme pain because the pain relief was not working, while many medical professionals stated that such tragedies almost never occur. We found it difficult to reconcile these perspectives and suspect that greater

⁶ Ibid.

⁷ Ministry of Health. Review of Palliative Care Services in New Zealand [internet]. 2017 [cited 2018 February 2]. Available from <https://www.health.govt.nz/publication/review-adult-palliative-care-services-new-zealand>.

⁸ Rauawaawa Kaumātua Charitable Trust Research Project Team. Māori health literacy and communication in palliative care: Kaumātua-led models [internet]. 2014 [cited 2018 February 2]. Available from <https://www.health.govt.nz/system/files/documents/publications/maori-health-literacy-communication-in-palliative-care-kaumatua-led-models-aug14.pdf>.

communication between health professionals and the general public is required to explain the dying process and to alleviate patients' and whānau/families' fear.⁹

College members have commented on the lack of knowledge about palliative care and the dying process. As one member wrote:

"I worry that the public assume people are suffering from terrible pain and suffering etc in their last days when this is in fact rarely the case nowadays. In patients I have been involved with there has never been a scenario where assisted death would have been beneficial...I also think that in today's world, people's expectations of death and dying can become unrealistic or not based on reality, due to media etc."

Not only did members say the general public lacked a good understanding of palliative care, but they feel there is also a lack of knowledge about what constitutes euthanasia. The confusion surrounding the definition (and general understanding) of euthanasia and physician-assisted suicide makes analysing public opinion surveys on this subject difficult.

For example, a TV3 News/Reid Research poll asked "Should the law be changed to allow 'assisted dying' or euthanasia?". Seventy one percent of respondents said yes to this question, yet it is unclear to what they were saying yes. The survey did not provide a clear definition of what constitutes euthanasia or 'assisted dying'. Furthermore, the survey did not ask participants the circumstances in which euthanasia could be performed.

College members also pointed out that patients often referenced neurological conditions, such as dementia, as a rationale for legalising euthanasia. However, under this Bill, a person suffering from dementia would not meet the criteria required for legally assisted dying.

The public's understanding of the differences between euthanasia and physician-assisted suicide, the circumstances when these options could be used, and the details of this Bill, is limited.

The College's recommendation

- 4. The Government implements a public information campaign to ensure New Zealanders understand what euthanasia and physician-assisted suicide are, who would be eligible for it, and the wider implications of any legalisation before the Bill progresses further through Parliament. This would be of particular importance if the Government holds a referendum on this issue.**

Protecting vulnerable people

The College is concerned about the effect any law change would have on vulnerable people, particularly the elderly and those with mental health conditions.

In their feedback to us, College members frequently pointed out that elder abuse is a problem in New Zealand (according to Age Concern, 1 in 10 elderly people are victims of abuse).¹⁰ Members expressed

⁹ Petition 2014/18 of Hon Maryan Street and 8,974 others.

¹⁰ Age Concern. How prevalent is elder abuse. [Cited 2018 February 2]. Available from https://www.ageconcern.org.nz/ACNZPublic/Services/EANP/ACNZ_Public/Elder_Abuse_and_Neglect.aspx

concern that legalised euthanasia could become an additional risk for people already in vulnerable positions. Our members' anecdotal evidence illustrates this concern.

"The family dynamics surrounding the care of the elderly, the infirm or terminally ill patients can on occasion be extremely toxic. Any provision for technically assisted suicide (homicide) will only make that toxicity of human relationships surrounding a substantial number of cases of terminally ill patients even more extreme and dysfunctional."

"Every week our practice has a patient who is encouraged to move into a rest home by an absent relative to relieve their worry... We also have less savoury evidence of elder abuse with financial pressure, requests to change wills or power of attorney, relatives will ring us requesting confidential information in an exchange for an account payment or saying they have power of attorney when further detective work reveals that are not."

Members also frequently mentioned that elderly patients often say they feel they are a burden. This is concerning, particularly as research shows one of the key reasons for considering or requesting euthanasia is the feeling of being a burden.¹¹

The College also notes the contradiction between allowing euthanasia and efforts to reduce New Zealand's high suicide rate. The College is concerned that legalisation of euthanasia will send mixed messages to vulnerable members of society. As our members explain:

"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."

"I also don't think my elderly patients will understand why youth suicide is considered terrible, but that it is ok for them (most dying people being elderly) – again this is borne out that the number one reason for seeking euthanasia in Holland is 'fear of being a burden' not pain or physical symptoms."

"Saying it is OK to end your life in some situations totally undermines any suicide prevention programme or counselling that is done. NZ already has one of the highest suicide rates in the world, especially amongst our precious rangatahi/youth."

"A minority's right to personal autonomy or choice enshrined in law legalising assisted suicide (euthanasia) is a slippery slope that will herald a time for some of our most vulnerable in our communities to the self-imposed pressure with regard to duty to die."

"I certainly can think of many cases where it has been appropriate to withdraw treatment, because it was not prolonging life, but rather prolonging dying, however I cannot think of any situations with [sic] actively assisting dying would have seemed the best option... especially as I think of different depressed and lonely people who later expressed gratitude for the support and healing that they were given during a dark hour when they would willingly have chosen a way out."

Our members frequently mentioned the 'slippery slope' argument.

¹¹ Ganzini L, Goy ER, Dobscha SK. Oregonians' reasons for requesting physician aid in dying. Archives of Internal Medicine. 2009 Mar 9;169(5):489-92.[internet]. Available from <https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/414824>.

They referred to the Netherlands and Belgium where the euthanasia law has been extended to allow people suffering mental distress, and those under 18 years of age, to request euthanasia. Parliament cannot guarantee that a similar process would not occur in New Zealand.

The College's recommendation

- 5. The Government invests more money in mental health services.**
- 6. The Bill specifically prevents people with mental health conditions from qualifying for euthanasia or physician-assisted suicide.**

Change to the doctor–patient relationship

The effects of euthanasia and physician-assisted suicide are not limited only to patients who request it, but will also affect the whole New Zealand community.

College members not only viewed euthanasia as a threat to vulnerable people, but also to the doctor–patient relationship. Members wrote about how the doctor–patient relationship is built on trust, and how some patients turn to their general practitioner to voice their concerns about wanting to die, and want to receive reassurance:

“I believe that crossing the line to intentionally assist a person to die would fundamentally weaken the doctor–patient relationship which is based on trust and respect... I am especially concerned with protecting vulnerable people who can feel they have become a burden to others, and I am committed to supporting those who find their own life situations a heavy burden.”

“If we deviate from this tradition, the profession will be weakened and therapeutic relationships will be harmed.”

“I believe introducing euthanasia will forever change the doctor–patient relationship. Our role is to care for patients and to be their advocate and instil hope in a difficult situation. I want my patients to be able to trust that my intension is to ‘above all, first do no harm’.”

Some members were also worried about the potential pressures that might be applied to the medical professions that decide to practice euthanasia.

“As a [rural practitioner] I could see situations arising in which a GP could be pressured to prescribe or assist in the process against their conscience, or face angry patients/family members for refusing.”

Another member reflected on their own experience of being a general practitioner in a country where euthanasia is legal:

“I have worked in [a country] when euthanasia had become legal and have seen the negative effects this has on patients and doctors...the patients were less open for pain relief and good palliative care and they have become more demanding towards the doctor to perform euthanasia.”

There is also potential that legalising euthanasia or physician-assisted suicide would fracture the medical workforce. One member asked if being willing to perform euthanasia would affect their relationship with their colleagues. This question raises a good point. Few people are neutral about this topic, so it is not difficult to see how such a change would lead to tension between colleagues.

Funding and the workforce

If euthanasia is legalised, it will need to be adequately funded.

New Zealand is a country of growing health inequity and, as such, there is a need to prioritise spending into services that will ensure good quality health care is available to all New Zealanders. The resources required for euthanasia or physician-assisted suicide would be immense (these include doctor training, patient counselling, appropriate facilities, medication, family support services, and new legal processes and advice).

In the College's view, the potential spending on the implementation of euthanasia and physician-assisted suicide and the necessary safeguards needs to be weighed carefully against other health priorities. Our members were concerned that introducing euthanasia would further compound GP workforce shortages:

"More effort is required to ensure that general practitioners are supported in providing this [palliative care] indispensable service to their patients, but the introduction of voluntary euthanasia would undoubtedly drain already stretched resources in primary care making this even less likely."

The question of funding and the effect euthanasia would have on the workforce should not be taken lightly. Even if only a few New Zealanders request euthanasia, the community as a whole will be affected as funding would be diverted away from services for the whole population.

Specific concerns with the End of Life Choice Bill

Broad definition of the medical practitioner

Part 1 clause 3

This Bill defines a medical practitioner as a health practitioner who –

- (a) is registered with the Medical Council of New Zealand as a practitioner of the profession of medicine or is deemed to be registered; and
- (b) holds a current practising certificate

While this definition is correct, the College considers it too broad for a Bill concerned with euthanasia.

There is no mention of how long a medical practitioner must have practised medicine before being considered 'suitably experienced' to perform euthanasia, or what branch of medicine would be most appropriate to perform euthanasia.

It should not be assumed general practitioners would take on this role.

Some members who submitted to the College stated that euthanasia should remain outside of the scope of general practice, although others argued it was outside of the scope of medicine and should remain so.

The Bill does not appear to reference any necessary guidance, training or support for medical practitioners. The legalisation should specify that training would be available to make sure medical practitioners are able to appropriately deal with all the complexities that go with euthanasia. In particular, the complex conversations involved with, not just the patient, but also family members, and assessing their competency to make such a significant decision. There would also need to be support systems put in place for medical practitioners' own well-being.

The College's recommendations

- 7. The Select Committee carefully considers the scope of medical practitioners and minimum practice experience of the practitioners who would offer euthanasia or physician-assisted suicide services.**
- 8. The Bill requires medical practitioners receive appropriate training and support to enable them to provide quality advice and care to patients and their families.**

The criteria for assisted dying are too broad

Part 1. Clause 4

In this Act, *person who is eligible for assisted dying* means a person who—

- (a) is aged 18 years or over; and
- (b) is—
 - (i) a person who has New Zealand citizenship as provided in the Citizenship Act 1977; or
 - (ii) a permanent resident as defined in section 4 of the Immigration Act 2009; and
- (c) suffers from—
 - (i) a terminal illness that is likely to end his or her life within 6 months; or
 - (ii) a grievous and irremediable medical condition; and
- (d) is in an advanced state of irreversible decline in capability; and
- (e) experiences unbearable suffering that cannot be relieved in a manner that he or she considers tolerable; and
- (f) has the ability to understand—
 - (i) the nature of assisted dying; and
 - (ii) the consequences for him or her of assisted dying.

The College has several concerns with this section.

First, the College considers 18 years old is too young for euthanasia. As our members note, the brain is not fully developed until 25 years of age.

Second, the eligibility criteria have several flaws. Members pointed out that diagnosis is often difficult and that sometimes doctors can get a diagnosis wrong. As one of our members explained:

“Doctors also get things wrong. Even in the best system in the world (and I believe we have a very good system), wrong diagnoses are made. Medicine is inherently complex and sometimes we read the shades of grey wrong and reach an incorrect conclusion. Even the majority of the time when we get the disease right we are generally poor at predicting what the course of that disease will be.”

The College considers the wording ‘a grievous and irremediable medical condition’ too broad. It is unclear from the Bill if this will be limited to physical conditions or also extend to include mental illness. One member commented:

“It is hard to imagine what conditions it wouldn't cover under the ‘grievous and irremediable medical condition’ provision. Even if mechanisms are created to restrict this, if assisted suicide becomes legal for certain conditions it is difficult to see how it will not be extended to other groups over time, such as those under 18 (as has happened in Belgium).”

As stated previously, the College recommends the Bill make it explicitly clear that mental illness is not a criterion for physician-assisted suicide or euthanasia (recommendation 6).

In the College's view, the current eligibility criteria are ambiguous and open to misinterpretation. As they the most important part of the Bill, they need substantial work to define in which cases euthanasia and physician-assisted suicide could be legal in New Zealand.

The College also finds the competency clause very problematic. Assessing a patient's competency to make a rational decision, especially during end of life care can be incredibly difficult. As one member wrote:

"It is well known that an illness can trigger depression, and that the elderly are also vulnerable to low mood. It seems silly not to allow people the 6 months (or possibly 6 years) left to them to be treated for depression and leave this life accepting rather than seeking death. The difference can be profound for both patients and their families. The need in the Bill to be assessed for mental health competence seems a real challenge for the psychiatrist involved."

The College acknowledges that under other legislation (such as the Protection of Personal and Property Rights Act 1988), GPs are required to assess competency. However, this is known to be a complicated and difficult process.¹²

The literature confirms that the difficulty of assessing competency is compounded during end of life, as there are numerous factors that affect how a person may feel on a day-to-day basis.¹³ Furthermore, the College is concerned this process will be made more difficult as there is no requirement for the medical practitioner to have an established relationship with the patient involved.

The College's recommendations

9. The minimum age of eligibility for euthanasia be set at 25 years.

10. The Bill's eligibility criteria are reconsidered to tighten the definition of who is eligible for euthanasia and for physician-assisted suicide.

Medical practitioners should not be required to refer patients to the SCENZ Group

Part 2 Assisted Dying clause 7. Effect of conscientious objection

(1) This section applies when—

- (a) a person tells the attending medical practitioner under section 8(1) that the person wishes to have the option of receiving assisted dying; and
- (b) the attending medical practitioner has a conscientious objection.

¹² Woo JA, Maytal G, Stern TA. Clinical challenges to the delivery of end-of-life care. Primary care companion to the journal of clinical psychiatry. 2006;8(6):367. [Internet]. Available from <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1764519/>. Howe E. Ethical aspects of evaluating a patient's mental capacity. Psychiatry (Edgmont). 2009 Jul;6(7):15-23. Available from <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2728941/>.

¹³ Assisted Dying for the Terminally Ill Bill – First Report, 2005. House of Lords. Report HL 86-II. [Internet] [Cited 2018 February 9]. Available from <https://publications.parliament.uk/pa/ld200405/ldselect/ldasdy/86/8602.htm>.

- (2) The attending medical practitioner must tell the person that—
 - (a) the medical practitioner has a conscientious objection; and
 - (b) the person may ask the SCENZ Group for the name and contact details of a replacement medical practitioner.

Part 4 Related matters 27 Offences

- (1) A person commits an offence who—
 - (a) wilfully fails to comply with a requirement in this Act; or
 - (b) completes or partially completes a prescribed form for a person without the person's consent; or
 - (c) alters or destroys a completed or partially completed prescribed form without the consent of the person who completed or partially completed it.
- (2) The person is liable on conviction to either of both of—
 - (a) a term of imprisonment not exceeding 3 months
 - (b) a fine not exceeding \$10,000.

The wording of this section tends to imply that a medical practitioner would not be required to make a referral to SCENZ if they have an ethical objection. However, the introduction to the Bill states 'No person is obligated to take a role under this Bill, although medical practitioners who conscientiously object must refer people to the SCENZ Group.'

The College firmly disagrees with any requirement to refer.

By referring a patient, a medical practitioner may feel complicit in an act to which they are strongly ethically opposed. This may put undue strain on the medical practitioner. The College argues it is paramount that this wording is amended so medical practitioners cannot be obliged to take part in euthanasia or physician-assisted suicide.

We submit that the Bill should be worded in such a way that it protects other health professionals from being involved in euthanasia too. For example, if a medical practitioner decides to perform euthanasia, any other health practitioner in their team must also have the option to participate or conscientiously object.

Due to the Bill's requirement for a medical practitioner to make a referral, any medical practitioner who objects due to conscientious objection may face a term of imprisonment not exceeding 3 months and a fine not exceeding \$10,000. This in and of itself seems a coercive way to get medical practitioners to be explicitly involved in euthanasia.

As stated above, the College strongly recommends the conscientious objection clause be changed to not require a referral. This is not unprecedented. In the United Kingdom, a Parliamentary report recommended a similar change to draft legislation.¹⁴ In Victoria, Australia, the Ministerial Advisory Panel on euthanasia recommended referrals not be a requirement for euthanasia. In the United States, several jurisdictions do not require a referral.¹⁵

¹⁴ *ibid.*

¹⁵ Department of Health and Human Services. Ministerial Advisory Panel on Voluntary Assisted Dying. [Internet]. 2017 [cited 2018 February 2]. Available from

The College's recommendations

- 11. The Bill's introduction be amended to remove the requirement for medical practitioners who do not wish to participate in euthanasia to refer patients to the SCENZ Group.**
- 12. Patients seeking euthanasia or physician-assisted suicide be obliged to self-refer to the SCENZ register in the first instance to consult with a registered medical professional who is trained and willing to provide physician-assisted suicide and euthanasia services.**

Clarity needed about when a request is made and the role of the medical practitioner

Part 2 Assisted Dying Clause 8

- (1) A person who wishes to have the option of receiving assisted dying must tell the attending medical practitioner of his or her wish.
- (2) The attending medical practitioner must—
 - (a) give the person the following information:
 - (i) the prognosis for the terminal illness or grievous and irremediable medical condition; and
 - (ii) the irreversible nature of assisted dying; and
 - (iii) the anticipated impacts of assisted dying; and
 - (b) talk with the person about his or her wish at intervals determined by the progress of his or her terminal illness or medical condition; and
 - (c) ensure that the person understands his or her options for end of life care; and
 - (d) ensure that the person knows that he or she can change his or her mind at any time; and
 - (e) encourage the person to talk about his or her wish with others such as family, friends, and counsellors; and
 - (f) ensure that the person knows that he or she is not obliged to talk to anyone; and
 - (g) ensure that the person has had the opportunity to talk about his or her wish with those whom he or she chooses; and
 - (h) do his or her best to ensure that the person expresses his or her wish free from pressure from any other person by—
 - (i) talking with other health practitioners who are in regular contact with the person; and
 - (ii) talking with members of the person's family approved by the person; and
 - (iii) complete the first part of the prescribed form requesting the option of assisted dying by recording the actions he or she took to comply with paragraphs (a) to (b).

<https://www2.health.vic.gov.au/about/publications/researchandreports/ministerial-advisory-panel-on-voluntary-assisted-dying-final-report>

This section could be made clearer. As stated earlier, it is difficult to give a prognosis for some conditions. Second, it is unclear what is meant by 'the anticipated impacts of assisted dying'. It is unclear if this is limited to medical impacts, or whether it would also cover the social, financial or legal impacts of euthanasia.

If the expectation were that the patient should receive advice about this broad range of impacts, the Bill would need to be amended to reflect the fact that medical practitioners do not have the expertise to cover the legal or financial impacts of euthanasia or physician-assisted suicide. As it is currently worded, this places an unfair requirement on medical practitioners.

The College also considers clause (h) where the medical practitioner is required to 'do his or her best to ensure that the person expresses his or her wish free from pressure' is problematic. As one member wrote:

"It will prove impossible to determine if a patient is 'free from coercion'. What criteria will doctors use to determine whether or not coercion exists? If patients request assisted death, there is no provision in the Bill as to what a doctor should do if she or he thinks that coercion is actually present. Coercion of patients will be impossible to discern in every request for assisted death. Doctors will not be 100% correct in their assessments of coercion. Wrongful deaths will be the result of this proposed new law."

Again, we question the practicalities of medical practitioners being able to consult with other health practitioners. In cases where some medical professionals and health professionals have a conscientious objection to euthanasia, in sharing their medical opinion they may feel complicit in the process of enabling euthanasia.

The College is also curious how Advanced Care Plans would work with euthanasia services. We are concerned about situations where a patient may make a decision to be euthanised when are considered mentally competent but, as their disease progresses, their decision-making capability may become compromised and they may decide they no longer want euthanasia.

The Select Committee needs to consider how legislation will protect both the patient and doctor in circumstances like this, when the current Bill does not appear to provide an opt-out clause for patients, or the role of family/whānau in these circumstances.

The College's recommendations

- 13. Clause 8 be amended to recognise the difficulties of making accurate prognoses and to clarify whether medical practitioners' advice to patients is limited to medical impacts.**
- 14. The Select Committee considers how to deal with situations where a patient with reduced decision-making capacity wishes to forgo the Advanced Care Plan made when they were mentally competent.**

Whether or not the Bill refers to physician-assisted suicide and/or euthanasia

Part 2 Assisted Dying clause 15 Medication chosen

- (3) The attending medical practitioner must –
 - (a) tell the person about the following methods for the administration of a lethal dose of medication;
 - (i) ingestion, triggered by the person

- (ii) intravenous delivery, triggered by the person
- (iii) ingestion through a tube
- (iv) injection, and
- (b) ask the person to choose one of the methods.
- (c) ask the person to choose the time at which he or she wishes the medication to be administered; and
- (d) ensure that the person knows that he or she can change his mind at any time.

The College is concerned this section is unclear whether it is referring to physician-assisted suicide or euthanasia. In the above section, it says 'triggered by the person,' yet clause 16 states:

'If the person chooses to receive the medication, the attending medical practitioner must administer by

- (a) providing it to the person, for the methods described in section 15(3)(a)(i) and (ii) or
- (b) providing it, for the methods described in section 15(3)(a)(iii) and (iv).

Some of our members stated they agree with physician-assisted suicide, but not euthanasia. This distinction is important. The degree to which a medical practitioner would participate in physician-assisted suicide and/or euthanasia needs to be clarified and may need to be explored further by Parliament.

The College's recommendation

- 15. Clause 15 be amended to make it explicitly clear if the Bill refers to euthanasia or physician-assisted suicide, and if both, when the legislation applies to either option.**

The need to cover what to do if something goes wrong

The Bill does not cover what to do if something goes wrong. For example, if a patient has an adverse reaction to a euthanasia-inducing drug, what does the medical practitioner do next? Should the patient be transported to hospital for secondary euthanasia services, or should there be no intervention?

There needs to be clear guidance for all medical and health practitioners who may be involved in euthanasia and physician-assisted suicide. This is particularly important if the Select Committee decides to only legalise physician-assisted suicide. In some jurisdictions, if the drug does not work or a patient has a reaction to it, there is limited or no guidance as to what the role of the medical practitioner is at intervening.¹⁶ Although this only has occurred in a minority of cases, there is a need to produce guidelines if such an event did occur.

¹⁶ Ibid.

The College's recommendation

- 16. The Select Committee considers the complexities of euthanasia and/or physician-assisted suicide if something goes wrong.**

Medical professionals should be allowed to remove their name from the SCENZ Group list and their name should be kept confidential

Part 3 Accountability clause 19 SCENZ Group

- (1) The Director-General must establish the SCENZ Group by appointing to it the number of medical practitioners that the Director-General considers appropriate.
- (2) The functions of the SCENZ Group are—
 - (a) to make and maintain a list of medical practitioners who are willing to act for the purposes of this Act as—
 - (i) replacement medical practitioners
 - (ii) independent medical practitioners
 - (b) to provide a name and contact details from the list, when this Act requires the use of a replacement medical practitioner or independent medical practitioner, in such a way as to ensure that the attending medical practitioner does not choose the replacement medical practitioner or independent medical practitioner
 - (c) to make and maintain a list of health practitioners who are willing to act for the purposes of this Act as specialists
 - (d) to provide a name and contact details from the list, when this Act requires the use of a specialist, in such a way as to ensure that neither the attending medical practitioner nor the independent medical practitioner chooses the specialist
 - (e) to make and maintain a list of pharmacists who are willing to dispense medication for the purposes of section 16
 - (f) to provide a name and contact details from the list when section 16 is to be applied
 - (g) in relation to the administration of medication under section 16,—
 - (i) to prepare standards of care; and
 - (ii) to advise on the required medical and legal procedures; and
 - (iii) to provide practical assistance, if assistance is requested.
- (3) The Ministry must service the SCENZ Group.

The College recommends adding a clause that medical professionals can remove their name from this list at any time without needing to a reason for doing so.

Furthermore, although it would be difficult to keep the names of doctors performing euthanasia anonymous, this list should be confidential to the SCENZ Group, and names should only be distributed to certain organisations and patients who request euthanasia. This is to protect medical professionals from undue pressure to perform or not to perform euthanasia.

The College's recommendation

- 17. Clause 19 be amended to ensure the privacy and confidentiality of the medical professionals elect to perform euthanasia or provide physician-assisted suicide.**

Conclusion

From our own analysis of the Bill and our members' feedback, it is clear there is strong apprehension about legalising physician-assisted suicide and euthanasia.

As stated at the beginning of this submission, the College recommends the Government's primary focus in this area should be improving health care for all New Zealanders, so they have appropriate access to good quality palliative care and mental health services.

The College is concerned about the lack of clarity in the Bill and we would recommend Parliament address the points the College has raised. It is clear more work needs to be done to strengthen this Bill to avoid ambiguity, confusion and unintended consequences.

We hope you find our submission helpful. We will be available through the oral submission process if the committee has any questions.

Yours sincerely



Dr Tim Malloy
President