

Committee Secretariat
Health Select Committee
Parliament Buildings
Wellington 6160

25/11/2015

**Submission on the Investigation into Ending One's Life
in New Zealand**

To the Health Select Committee

Personal details:

This submission is from Christian Medical Fellowship of New Zealand
(CMF NZ).

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We wish to appear before the committee to speak to our submission.

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We oppose any change to the existing law that might permit euthanasia or assisted suicide in New Zealand.

We recognise that this is a very complex issue and we appreciate the time taken by this committee to comprehensively review the situation in New Zealand.

Regarding the terms of reference, we wish to elaborate on the following areas of concern relating to terms 1-3.

1) The factors that contribute to the desire to end one's life and the effect a law change might have on caring for those with suicidal ideation.

2) The effectiveness of services and support available to those who desire to end their own lives and the likely detrimental impact of a law change on the patient-doctor relationship and the practice of medicine.

3) The attitudes of New Zealanders towards the ending of one's life and the likely effects on vulnerable populations should there be any change to the existing law.

Regarding terms of reference point 4, CMF NZ is an organisation of New Zealand doctors and medical students. As our fellowship and experience is in a New Zealand context, we therefore will not address international experiences.

1) Factors that contribute to an individual desiring to end their life are diverse and complex. While this desire may relate to a terminal illness or an irreversible physical condition, more commonly suicidal ideation relates to mental illness such as depression and/or unresolved existential issues such as hopelessness or loneliness. The Chief Coroner has expressed concerns about the high frequency of suicide in New Zealand and that it represents a significant loss to our society (Message from the Chief Coroner, 2015). Furthermore, depression often goes undiagnosed in the elderly and those with long-term illness (Birrer RB, 2004).

Studies have been conducted looking at the desire for hastened death in cancer patients admitted to hospital for palliative care. This desire is strongly associated with a clinical diagnosis of depression, severity of depressive symptoms, and hopelessness (Breitbart W, 2000). The strength of this desire has also been demonstrated to show significant individual fluctuation over time (Chochinov, 1995). Rather than providing these patients with the means to end their lives, compassionate palliative care aims to relieve physical, emotional, mental and spiritual suffering.

Regarding consideration of a law change to allow euthanasia or assisted suicide, the language of the petition request raises a number of concerns. Firstly, 'terminal illness' is difficult to medically define. Predicting the timing of death is inherently inaccurate and even

the certainty of a terminal diagnosis may not always be assured (Poulson J, 2005). While a physician may guide a patient as to possible life-expectancy in order that they may prepare their affairs or access palliative care services, even 'expert' estimation of life span is imprecise and highly variable between 'experts' (Forster LE, 1988).

Secondly, the term 'irreversible condition' is even less well-defined, encompassing a range of chronic illnesses from diabetes, to colour-blindness, to bipolar disorder. Any of these conditions could be considered, at certain times in the life of an individual, to 'make life unbearable'.

2) Regarding the effectiveness of services and support available to those who desire to end their own lives, we are wary of the conflicting responsibilities 'medically-assisted' suicide or euthanasia would place on medical practitioners in New Zealand. As doctors we provide day-to-day care for those with depression, chronic illness and those needing palliative care. When a patient confides that they have suicidal ideation, or makes a suicide attempt, it is seen as a cry for help. Our role is to identify the physical, psychological and social factors which have led to such thoughts. We aim to provide comfort for physical symptoms, facilitate access to or provide mental health services and encourage the person to seek the support of family and friends. Current guidelines for management of depression include immediate referral to acute mental health services for those expressing serious suicidal intent (New Zealand Guidelines Group, 2008). To make doctors responsible for 'assisting' death in addition to our current provision of care would create an ambiguous and unsafe situation because of the inherent conflicts of interest that would arise.

The basis of the patient-doctor relationship is trust. Making doctors the 'gatekeepers' for euthanasia or assisted suicide would strain the integrity of this relationship. In some circumstances, doctors would be promoting the life and well-being of their patients. In others, the doctor would be asked to end the life of patients with very similar, perhaps identical conditions. Inevitably doctors would be expected to guide patients as to their suitability for euthanasia or assisted suicide, as well as making that assessment and invoking it. Patients could no longer trust their doctor to always care for them and promote their well-being. Doctors would find themselves forced into the role of judging that some of their patients' lives are no longer worth living- this is arguably the ultimate act of medical paternalism.

Involving doctors in euthanasia or assisted suicide would change the character of the medical profession in New Zealand forever. It would have wide-reaching effects in the areas of palliative care, internal medicine, general practice, psychiatry and oncology. Patients' expectation of doctors to provide and facilitate death could deeply impact the nature of how medicine is practiced and the psyche of those involved. Further impacts on workforce recruitment and retention, practitioners' mental health, and the perceived value of patient life would be difficult to predict.

New Zealand already has an effective, world-leading model of palliative care. Doctors are vigilant in discussing Not For Resuscitation (NFR) orders, Advance Directives and Enduring Power Of Attorney (EPOA). Furthermore, patients already have the right to refuse medical intervention, and are often counselled as to the appropriateness of comfort cares in palliative situations. Hospice services and palliative care teams provide in-home care for the majority of patients, with in-patient Hospice admissions available when needed. We advocate improving access and provision of this service, through ongoing funding and training.

3) Regarding the attitudes of New Zealanders towards ending one's life we are concerned that any change in the law to allow euthanasia or assisted suicide would have detrimental effects on vulnerable populations.

For some, chronic illness is a part of life, yet they adjust and enjoy life, in many cases more than those who are healthy. For others, any change from full physical health is poorly tolerated and greatly affects their enjoyment of life. To try and determine the value of one's life based on their current physical health is one factor in something much more complex.

We are particularly concerned that those most likely to suffer, should euthanasia or assisted suicide be legalised, are those with long-term health impairments. This includes the elderly, those with mental illness and those with disabilities. All are already vulnerable groups in our society.

There is readily identifiable bias in New Zealand society towards those who are young, physically fit and economically contributing to society. Over half of older New Zealanders report being lonely and many experience everyday discrimination (Waldegrave, 2012). Those with mental illness can feel alienated and misunderstood, while often struggling with depression and suicidal thoughts. Those with disabilities are impacted by negative societal attitudes and report greater unmet healthcare needs (World Health Organisation, 2014). Should euthanasia or assisted suicide become legalised, social and societal pressure to consider it would be highest on these already vulnerable groups.

In this context, the difficulty to detect coercion becomes a paramount consideration. Family members, caregivers or associates may have a vested interest in a person undergoing euthanasia or assisted suicide. At the time of considering euthanasia or assisted suicide a person would be in a vulnerable situation and the potential for coercion would be high. Detecting coercion is not part of medical training, and would be difficult in the complex situation of a person expressing their wish to die.

Further complicating this are the issues of determining competence and informed consent. Determining competence in general medical practice is based on an informal assessment of a patient's ability to understand a proposed treatment and provide informed consent. This is appropriate in the situation where a proposed treatment is expected to be of definite

benefit to the patient. In the case of euthanasia or assisted suicide, it would be difficult to determine competence in those with depression, mild cognitive impairment or other conditions affecting a patient's judgement. As euthanasia and assisted suicide constitute irreversible interventions, standard methods for determining competence would pose a significant risk of premature death- the ultimate 'harm'.

In summary, as medical practitioners in New Zealand, we are very concerned on a number of levels, at any attempt to legalise euthanasia or assisted suicide. Suicide is already of high frequency and represents a significant loss to New Zealand society. In patients receiving palliative care for cancer, the desire for hastened death fluctuates significantly over time. The terms 'terminal illness' and 'irreversible condition' are difficult to define and any attempted justification through these terms would be open to abuse.

We are concerned about the wider implications for the medical profession including the quality of care for those with suicidal ideation, trust in the patient-doctor relationship and impacts on the nature of how medicine is practiced. These factors constitute why doctors should never be directly involved as the gate-keepers or agents of euthanasia or assisted suicide. We already have a world-leading palliative care service and advocate for further improving access and provision of this service.

Finally we live in a society where prejudice already exists towards groups that would be most vulnerable to societal pressure and/or coercion should euthanasia or assisted suicide be legalised. This includes the elderly, those with mental illness and those with long-term disabilities. We are particularly concerned about the high potential for abuse in these groups under any system of euthanasia or assisted suicide.

We therefore strongly oppose any introduction of legislation which would allow medically assisted euthanasia or suicide in New Zealand, as well as opposing any introduction of legislation that would make euthanasia or assisted suicide available by any other means.

"To cure sometimes, to relieve often, to comfort always."

Bibliography

Birrer RB, V. S. (2004, May 15). Depression in later life: a diagnostic and therapeutic challenge. *American Family Physician* , 69(10):2375-82.

Breitbart W, R. B.-E. (2000, Dec 13). Depression, hopelessness, and desire for hastened death in terminally ill patients with cancer. *JAMA* , 284(22):2907-11.

Chochinov, H. e. (1995). Desire for death in the Terminally Ill. *American Journal of Psychiatry* , 152 1185-1191.

Forster LE, L. J. (1988). Predicting Life Span for Applicants to Inpatient Hospice. *Arch Intern Med* , 148(12):2540-2543.

Message from the Chief Coroner. (2015). Retrieved November 25, 2015, from Coronial Services of New Zealand: <http://www.justice.govt.nz/courts/coroners-court/suicide-in-new-zealand/message-from-the-coroner>

New Zealand Guidelines Group. (2008, July 01). *Ministry of Health*. Retrieved November 25, 2015, from Identification of Common Mental Disorders and Management of Depression in Primary Care. An Evidence-based Best Practice Guideline.: <http://www.health.govt.nz/publication/identification-common-mental-disorders-and-management-depression-primary-care>

Poulson J, B. E. (2005). Discrepancy between clinical and autopsy diagnosis and the value of post mortem histology. *Histopathology* , 47: 551 – 559.

Waldegrave, C. K. (2012). *Aucklanders 50 and over: A health, social, economic and demographic summary analysis of the life experiences of older Aucklanders*. Auckland: Auckland Council.

World Health Organisation. (2014, December). *Disability and Health*. Retrieved November 25, 2015, from WHO Media Centre Fact Sheet: <http://www.who.int/mediacentre/factsheets/fs352/en/>