

WE ALREADY HAD 'CHOICE'

A person may refuse medical treatment, even if it will result in his or her death. Section 11 of the New Zealand Bill of Rights Act 1990 says, "Everyone has the right to refuse to undergo any medical treatment." This can include 'Do Not Resuscitate' orders. Refusing medical treatment is not euthanasia.



It's really important to understand the terminology in this debate. Most people simply want to ensure that the administration of pain relief and the withdrawal of burdensome treatment

are not treated as illegal. That's already the case. There is no legal or ethical requirement that a diseased or injured person must be kept alive 'at all costs'. The law has drawn a clear and consistent line between withdrawing medical support thereby *allowing* the patient to die of his or her own medical condition, versus *intentionally* bringing about the patient's death.

EUTHANASIA / ASSISTED SUICIDE IS NOT

turning off life support

stopping futile medical tests, treatment and surgeries

making a 'Do Not Resuscitate' (no CPR) request

stopping food and/or fluids if they become too burdensome for the patient

receiving as much medication as needed to treat pain and other symptoms

EUTHANASIA / ASSISTED SUICIDE IS

injecting a deadly dose of drugs

receiving a deadly dose of drugs to swallow later

ABUSE WILL HAPPEN

The terminally ill and those living with life-limiting illnesses are often vulnerable. And not all families, whose interests are at stake, are wholly unselfish and loving. They could coerce a patient into requesting euthanasia, perhaps to get an inheritance sooner or to save themselves the 'burden' of caring for the patient. An overseas study found that a third of all euthanasia deaths in the Flemish region of Belgium are done without explicit request, and the legal requirement to report euthanasia has not been fully complied with in other countries that allow euthanasia either. The risk of abuse cannot be eliminated.

TERMINOLOGY

EUTHANASIA is the act of intentionally, knowingly, and directly causing the death of a patient, at the request of the patient. If someone other than the person who dies performs the last act, euthanasia has occurred.



ASSISTED SUICIDE occurs if the person who dies performs the last act.

PHYSICIAN (DOCTOR) ASSISTED SUICIDE is where the person providing the means (e.g. lethal drugs) is a medical practitioner.

ASSISTED DYING is a term that is also used for both euthanasia and assisted suicides.

[The End of Life Choice Act 2019 allows both euthanasia and assisted suicide. It allows doctors and nurse practitioners to provide or administer a lethal dose of drugs.]

PALLIATIVE CARE is "active total care... for people whose illness is no longer curable, the goal is around providing quality of life, managing pain and symptoms to enable people to live every moment in whatever way is important to them." (Hospice NZ)

The End of Life Choice Act is seriously deficient in so far as it only requires doctors to "do their best" to ensure that the person is free from pressure - an extremely low legal threshold. Moreover, it fails to outline any process for ensuring patients are free from coercion. As the NZMA stated in their submission to the Justice Select Committee: "The provisions in the Bill will not ensure that a decision to seek assisted dying will always be made freely and without subtle coercion." In addition, a euthanasia request could be signed on a person's behalf by someone who stands to benefit from that person's death. [The majority of MPs voted against strengthening the safeguards in this area].

DIAGNOSIS AND PROGNOSIS

CAN BE WRONG

Diagnosis and prognosis are based on probability, not certainty. Some people will be euthanised on account of a disease they *thought* they had but did not. The Act relies on a diagnosis that a person suffers from a terminal illness which is "likely" to end his or her life within six months.

[cont. over]

There are many examples of individuals who have outlived their prognoses – sometimes by months, even years. A study of doctors’ prognoses for terminally ill patients found only 20% of predictions were within 33% of the actual survival time. A 2012 paper published in the *British Medical Journal* noted that 28% of autopsies report at least one misdiagnosis.

A SLIPPERY SLOPE

There is concrete evidence from the countries which have introduced euthanasia that the availability and application of euthanasia expands to situations not initially envisaged. When a newly-permitted activity is characterised as a ‘human right’, the overseas experience is that there is an inevitable push to extend such a ‘right’ to a greater number of people, such as those with chronic conditions, disabilities, mental illness, those simply ‘tired of life’, or even children.



‘RIGHT TO DIE’ WILL BECOME

A ‘DUTY TO DIE’



The reality is that terminally ill people are vulnerable to direct and indirect pressure from family, caregivers and medical professionals, as well as self-imposed pressure. They may come to feel euthanasia would be ‘the right thing to do’; they’ve ‘had a good innings’ and do not want to be a ‘burden’ to their nearest and dearest. It is virtually impossible to detect subtle emotional coercion, let alone overt coercion, at the best of times.

DID YOU KNOW? Of the 39,159 submissions made to the Select Committee considering the new law, almost 92% were opposed to the bill, including 93.5% of submissions received from doctors, nurses and other health care staff.

“One person’s right to die becomes another person’s feeling that it’s a duty to die ... you can say it to me, but nobody’s gonna be dragged there. ... It’s not as straightforward as that, ... once it exists it exists. Some of the worst coercion is choosing it yourself, because you feel you’ve got no option.”

Liz Carr UK TV Star &
Disability Rights Activist



HOPE
Preventing Euthanasia & Assisted Suicide

www.no euthanasia.org.au

THE INCREASED RISK OF

ELDER ABUSE

Elder abuse is already a significant problem in New Zealand. About 80% of it remains hidden and unreported. We cannot ignore the possibility that dependent elderly people may be coerced into assisted suicide/euthanasia. Elderly and ailing patients are also all too aware that their increasingly expensive rest home and geriatric care is steadily dissipating the inheritance that awaits their children. Sadly, some unscrupulous and callous offspring might not be slow in pointing this out.

‘ASSISTING’ SUICIDE MAY

PROMOTE SUICIDE

As 21 New Zealand mental health practitioners and academics argued, there is mounting statistical evidence from Oregon, Belgium and the Netherlands that as the numbers using assisted dying rise, so too do suicide rates in the general population. It may be that promoting suicide as a response to suffering is a message that cannot be contained to just those with a terminal illness. Proponents of assisted suicide have been asked to prove that legalising assisted suicide won’t raise the general suicide rate, but they won’t because they can’t. On the one hand society will offer some individuals *assistance* to commit suicide, i.e. euthanasia, yet on the other hand seek to *prevent* individual suicides. Given our suicide epidemic, sensible and caring thinking says it is too risky to proceed.

DEPRESSION MAY BE INFLUENCING

THE DECISION

Virtually all patients who are facing death or battling an irreversible, debilitating disease are depressed at some point. However, many people with depression who request euthanasia overseas revoke that request if their depression and pain are satisfactorily treated. If euthanasia or assisted suicide is allowed, many patients who would have otherwise traversed this dark, difficult phase and gone on to find meaning in life will die prematurely.

How many euthanasia ‘mistakes’ are we willing to accept?

FAMILY
FIRST
WHANAU TAHI AOTEAROA
NEW ZEALAND

ASSISTED SUICIDE DEVALUES

DISABLED PEOPLE

Advocates for the rights of people with disabilities are correct to be concerned. New Zealander Dr John Fox, a sufferer of spastic hemiplegia who is in daily pain, says: “Don’t drop us. Don’t make it harder for us. Don’t tempt us to end our lives. When we have our darkest moments, we need our country to reflect back to us that we are loved, necessary, valued and equal. Even though they say they’ve fixed [the Act], we know that a law like this broadens, that we can’t control it, that loopholes come back to haunt us.” As disability rights group *Not Dead Yet* put it, “There are endless ways of telling disabled people time and time again that their life has no value.”



WIDESPREAD OPPOSITION

Opposition to the new law has come from those in the **disability sector, senior citizens, human rights advocates, lawyers, doctors** and others in the **health sector**.

COST MAY DRIVE DECISIONS

The End of Life Choice Act only provides a ‘right’ to one choice – premature death. **There is no corresponding right to palliative care.** Good palliative care and hospice services are resource intensive; euthanasia would be cheaper. A law change will introduce a new element of ‘financial calculation’ into decisions about end-of-life care. This harsh reality is arguably the ‘elephant in the room’ in the debate. At an individual level, the economically disadvantaged who don’t have access to better healthcare could feel pressured to end their lives because of the cost factor or because other better choices are not available to them.

MEDICAL BODIES OPPOSE IT

Almost all medical associations around the world have position statements *opposing* euthanasia, including the World Medical Association representing more than 10 million physicians worldwide. The New Zealand Medical Association (NZMA) has clearly stated its opposition to euthanasia and doctor-assisted suicide, and regard these practices to be “unethical and harmful to individuals, especially vulnerable people, and society.”

SPECIFIC PROBLEMS WITH THE END OF LIFE CHOICE ACT

The new euthanasia law contains significant flaws which will place vulnerable and elderly people at risk.

NO INDEPENDENT WITNESSES

No independent witnesses are required at any stage of the process, including at the death. In contrast, two people need to witness the signing of the written request in Oregon, one of whom must be totally independent (not a relative or someone able to benefit from the estate, or an employee of a health care facility or the attending medical practitioner). Canada and Victoria (Aus) require two independent witnesses as well as the co-ordinating medical practitioner. *[The majority of MPs voted against an amendment requiring an independent witness at the death].*

NO REQUIREMENT FOR MENTAL COMPETENCE AT DEATH

Unlike in Victoria or Canada, there is no safeguard in the proposed law whereby the person’s mental competence should be assessed at the time the lethal dose is administered. This increases the risk of wrongful death.

NO COOLING-OFF PERIOD

There is no mandatory cooling-off period before the administration of the lethal dose, such as the minimum of 15 days in Oregon (with a limited exception), 9 in Victoria or 10 in Canada. The only timeframe specified in the End of Life Choice Bill 2019 is a minimum of 48 hours between the writing of the prescription and the chosen time of death. **That means the whole process from request to death could be completed in just a few days.** *[The majority of MPs voted against a one-week cooling-off period].*

DID YOU KNOW?

MPs proposed 114 amendments to make the new euthanasia law less flawed. Of those 114, just 3 were approved, including the decision to allow the referendum. Many of the proposed amendments weren’t even debated. This was after members of the Select Committee, given 16 months to study the bill and hear submissions, were unable to agree that it be passed.



*“[W]e 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.”

NZMA Submission to Justice Select Committee

*appropriate protections in this area]. **Medical practitioners with a conscientious objection** would still be obliged to inform their patient about the government body which would be set up to help administer euthanasia, even if this would be against their professional judgment and personal ethics. [The majority of MPs voted against full freedom of conscience provisions].*

WEAK ACCOUNTABILITY

Under-reporting is a major issue overseas. In the new law, the registrar doesn't need to follow up missing death reports or check for anomalies. The review system does not allow for the examination of the patient's background health records, unlike in the Netherlands. And even there, up to a quarter of Dutch euthanasia deaths are not being officially reported. New Zealand could end up with an even less robust system of accountability.

NO REQUIREMENT FOR EXISTING DOCTOR/PATIENT RELATIONSHIP



The first medical practitioner (in the proposed two-practitioner process) need not have met the patient previously. Further, they can also determine a person is eligible for assisted dying without having talked to the person face-to-face. A

medical practitioner with concerns could be blocked by the patient from talking to the family to check for coercion. This is especially problematic where a doctor has no former knowledge of the patient. There is no requirement that the person discuss his or her assisted suicide or euthanasia wishes with any other person. These are serious flaws in the Act. Appropriate protections in relation to coercion are sadly lacking. [The majority of MPs voted not to fix this problem].

NO CLEAR LINE BETWEEN TERMINAL & CHRONIC/DISABLED

Supporters of the proposed law claim that it doesn't threaten people with disabilities. However, **many disabilities are life-limiting and involve complications that can become life-threatening.** In Oregon, “death within six months” has been interpreted by the health authorities to include “death within six months if not receiving medical treatment.” [An appropriate safeguard was proposed, but MPs didn't even debate or vote on it].

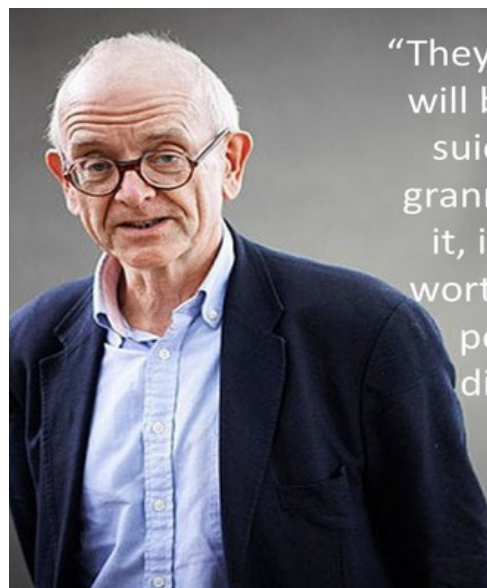
NO REQUIREMENT TO SEEK AVAILABLE TREATMENTS

There is no requirement that a person tries palliative care or other treatments first. That means that for some people, euthanasia will not be a last resort. [The majority of MPs voted against putting appropriate safeguards in this area].

Euthanasia and assisted suicide put many of us in danger. Nothing in new law guarantees the protection required for vulnerable people, including the disabled, elderly, depressed or anxious, and those who feel themselves to be a burden or who are under financial pressure. The international evidence backs up these concerns, and explains why so few countries have made any changes to the law around this issue.

WEAK FREEDOM OF CONSCIENCE RIGHTS

The Act offers **no explicit protection for organisations such as rest homes and hospices** whose philosophical, ethical or religious traditions may preclude offering euthanasia or assisted suicide. In the future they may be forced to offer euthanasia on their premises to avoid losing government funding, as has happened in Canada. [The majority of MPs voted against putting in



“They argue that grannies will be made to commit suicide. Even if a few grannies get bullied into it, isn't that the price worth paying for all the people who could die with dignity?”

HENRY MARSH
Renowned British Neurosurgeon & Supporter of Euthanasia