

# Key Issues with the End of Life Choice Bill

## The Bill is about deadly drugs.

The Bill proposes 'assisted dying', a euphemism for euthanasia and assisted suicide.

A new Curia Market Research Poll found that New Zealanders are confused about what 'assisted dying' means. This ground-breaking poll challenges the validity of other public polls on the issue.

The Bill doesn't mention the words 'euthanasia' and 'assisted suicide', but four methods are proposed: ingestion or intravenous delivery triggered by the person (assisted suicide); and ingestion through a tube or injection (euthanasia). – *Clause 15 (3) (a)*

It is assisted suicide when the person who dies takes the final action that ends their life, e.g. swallowing deadly drugs. It is euthanasia when someone else takes the final action that ends the person's life, e.g. giving the person a lethal injection. Euthanasia causes a person to die not from their underlying medical condition, but from being poisoned.

This Bill is NOT about turning off life support, 'do-not-resuscitate' requests or stopping unwanted or futile medical tests and treatment. In these situations a person dies of natural causes – from their underlying medical condition.

## The Bill proposes to remove a core principle of law.

This Bill has been referred to the Justice Select Committee, not the Health Committee, which is appropriate because what it proposes is not part of health care.

The Bill proposes a profound change to the Crimes Act: that some people should be allowed to intentionally end the lives of other people. The ultimate choice and control will be with the system and its agents, not with the person who dies.

*"[The Bill] removes a principle at the core of the law written to protect everybody, and particularly the most vulnerable, and that is the blanket prohibition against taking the life of another. That is at the core of our criminal law that protects everybody, particularly the most vulnerable. In removing that prohibition, which has been in our law for as long as this country has existed, this Parliament is taking a huge step."*

– Rt Hon Bill English during the First Reading debate on this bill

## The Bill is about doctors.

The bill proposes immunity from prosecution for medical practitioners who facilitate assisted suicide or euthanasia using lethal drugs. – *Clause 26*

Why doctors? Why not vets, social workers, lawyers, pharmacists, counsellors, or a new profession? Doctors should not be required to intentionally end the lives of their patients. Doctors should only be required to make a medical diagnosis and prognosis (an estimation of how quickly a disease will progress).

*"Doctors are not necessary in the regulation or practice of assisted suicide. They are included only to provide a cloak of medical legitimacy. Leave doctors to focus on saving lives and providing real care to the dying."*

If you are a doctor, please consider adding your name to this open letter at [doctorssayno.nz](http://doctorssayno.nz)

## **No euthanasia law can protect people against pressure and coercion.**

How could a doctor, or any other person, ever be certain that a person's request for assisted suicide is truly voluntary and free?

At the point of expressing a wish for assisted suicide a person may own their decision, but may have come to that decision as a result of subtle or overt abuse, pressure or coercion that had already occurred. A skilled manipulator may even cause the victim to believe that the request for death is their decision. Abuse can be subtle and hidden, even from health practitioners. The victim may be the only person who has witnessed the perpetrator's abusive behaviour. The abuser may put pressure on the victim to deny that abuse has occurred.

Abuse is common. Elderly and disabled people are particularly at risk. Disabled women are about twice as likely to be victims of violence or abuse compared to other women [1] Age Concern reports that 3-10% of elderly people experience abuse or neglect every year and that only 16% of abuse incidents come to the attention of support agencies. They report a variety of reasons why a victim may be reluctant to report abuse. [2]

## **Assisted Suicide is not the solution**

After carefully examining this complex issue we are convinced that legal assisted suicide in any form would put vulnerable Kiwis at risk: People who are elderly, disabled, mentally ill, dependent on others, in abusive relationships, depressed, grieving or otherwise emotionally vulnerable.

No 'assisted dying' law could adequately protect vulnerable people from abuse, coercion or pressure. Pressure can be subtle and remain hidden, like other forms of emotional abuse. Pressure could be external (for example from relatives or cost-cutting bureaucrats). Pressure could also come from an internalised obligation to "do the right thing" – to choose death because it would be cheaper than care and treatment.

The answer to suffering, illness or disability is NOT to legalise assisted suicide. All that would do is place vulnerable people in our families and neighbourhoods at risk. It would also undermine suicide prevention strategies in New Zealand.

The truly humane and dignified response is to ensure that everyone has access to the best physical, emotional, social and spiritual care they need, when they need it.

### References:

1. Ministry of Social Development (2018). *Family violence is not OK: Statistics*. Retrieved from <http://areyouok.org.nz/family-violence/statistics/>
2. Age Concern New Zealand. *Elder abuse and neglect prevention*. Retrieved from [https://www.ageconcern.org.nz/ACNZPublic/Services/EANP/ACNZ\\_Public/Elder\\_Abuse\\_and\\_Neglect.aspx](https://www.ageconcern.org.nz/ACNZPublic/Services/EANP/ACNZ_Public/Elder_Abuse_and_Neglect.aspx)

## The End of Life Choice Bill's limits are artificial.

**4 (a)** The proposed 18-or-older age limit will be open to challenge because it discriminates on the basis of age (according to the Attorney-General's report on the Bill). The Bill is inconsistent with other legislation such as under 18s being allowed to marry.

**4 (c)** Words such as "grievous", "irremediable", "advanced", "decline in capability", "unbearable suffering" and "tolerable" are subjective and open to wide interpretation. The eligibility criteria could be interpreted to include any chronic (longstanding) physical or psychological condition or disability.

Medical diagnosis and prognosis are often wrong. Do you know of someone who lived longer than their doctor expected? Under this Bill some people will die based on incorrect information.

**4 (e)** "Unbearable suffering" is self-defined by the patient, and cannot be objectively assessed by any health professional.

If unbearable suffering is proposed as a ground for assisted suicide, any criteria limiting eligibility would be artificial and discriminating against other people who may also feel they are suffering unbearably. There would always be someone just on the other side of such an arbitrary line asking, "But what about me?" Do people who are expected to live for six months suffer more than people who are expected to live for 7 months? Do people with a terminal illness necessarily suffer more than people who have a chronic physical or mental illness or an ageing-related condition? Do people with an illness necessarily suffer more than people who are lonely, grieving, poor or homeless?

Once euthanasia is legal for one group, there will be no logical reason to stop it from being extended to more groups who also feel they are suffering.

Psychological suffering could include loneliness, fear of becoming disabled, financial concerns or the worry of being a burden. It could be resolvable issues such as fear, loneliness or financial concerns that tip the scale and cause the person to feel that their suffering has become unbearable.

### Clause 4 Meaning of person who is eligible for assisted dying

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—

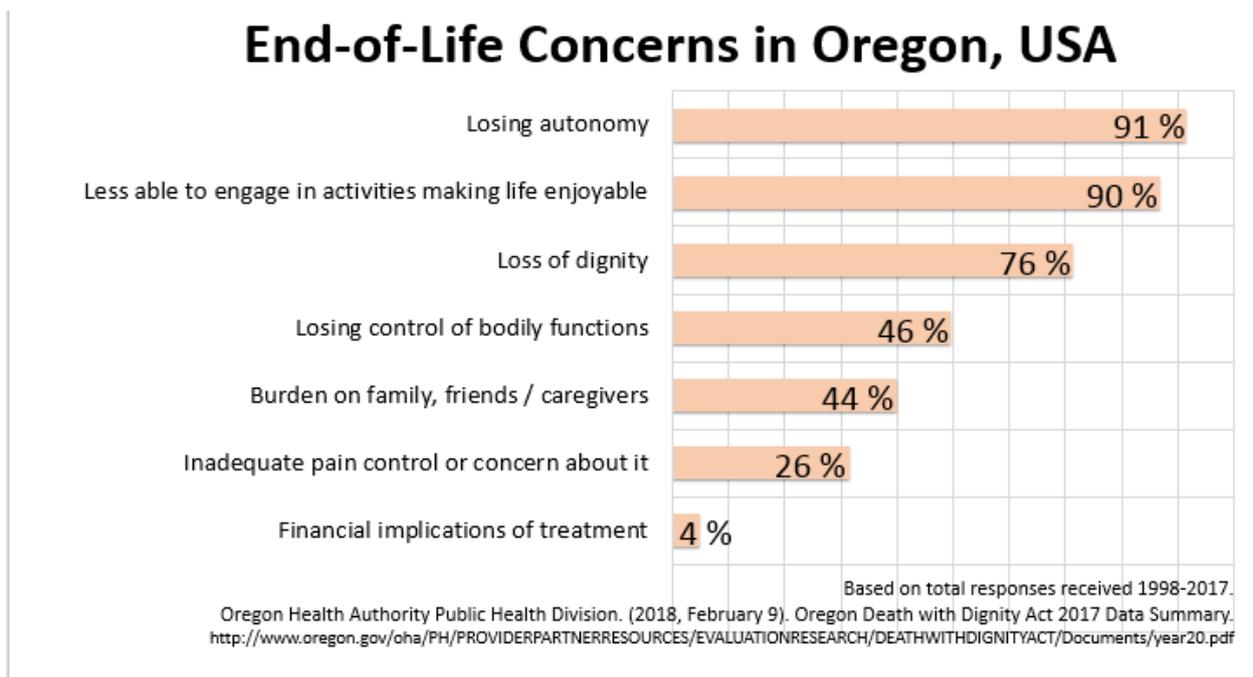
(i) the nature of assisted dying; and

(ii) the consequences for him or her of assisted dying.

**The complete Bill is on Parliament's website. See [tiny.cc/Seymourbill](http://tiny.cc/Seymourbill)**

## People request assisted suicide mainly for emotional and existential reasons, not pain.

In Oregon people who died by lethal drugs were asked about the reasons they requested assisted suicide. The top five reasons are existential reasons, related to feelings of meaninglessness and concerns about being dependent on others.



The most common reason given is concern about losing autonomy (91%), followed by concern about being 'less able to engage in activities making life enjoyable' (90%). 'Inadequate pain control or concern about it' featured for only 26% of people. It's worth noting that these responses reflect people's feelings, and not necessarily their circumstances at the time. A person may have been concerned about the possibility of such issues in the future.

In 2017 the most common reason was concern about being 'less able to engage in activities making life enjoyable' (88.1%), followed by concern about 'losing autonomy' (87.4%) and concern about 'loss of dignity' (67.1%).

Concern about 'being a burden to family, friends and caregivers' rose to 55.2% and was followed by concern about 'losing control of bodily functions' (37.1%). 'Inadequate pain control or concern about it' fell to 21.0% and concern about 'financial implications of treatment' rose to 5.6%.

Reference:

Oregon Health Authority Public Health Division (2018, February 9). Oregon Death with Dignity Act 2017 Data Summary. p.10.

## **Safeguards are unenforceable because they are based on self-reporting.**

In Oregon, USA, it is legal to receive lethal drugs from a doctor to take later (called assisted suicide) - if the person has been diagnosed with a terminal illness that will lead to death within six months.[1]

However, during 2017 people took the drugs up to 20 months (603 days) after receiving them, with a record of three years and nine months (1009 days) in previous years.[2]

According to the Oregon Health Authority, 7.6% of people who received lethal drugs had conditions that are usually considered chronic rather than terminal conditions,[3] including diabetes, hepatitis, “benign and uncertain neoplasms” and HIV/AIDS which is no longer a terminal illness.[4] The 2018 report mentions that “arthritis, arteritis, sclerosis, stenosis, kidney failure, and musculoskeletal systems disorders” would also be eligible.[5]

The law requires that a doctor waits at least 15 days before issuing a prescription, but, some patients who knew their prescribing physician for one week or less.[6]

Of those who received lethal drugs since the law was passed, only 64.8% are known to have ingested it. That means that it’s possible that 692 lethal doses were left in the community like loaded guns.[7]

In all cases it is unknown whether the person was pressured leading up the request and the moment of ingestion.

In meetings with a British House of Lords Committee, Oregon officials conceded that “there’s no way to know if additional deaths went unreported” because the Oregon Health Authority “has no regulatory authority or resources to ensure compliance with the law”.[8]

They rely on the word of doctors prescribing the drugs. The officials admitted: “For that matter the entire account [received from a prescribing doctor] could have been a cock-and-bull story.”[9]

## **A quick and dignified death is not guaranteed**

During 2017 two people had seizures, one had difficulty ingesting or regurgitated the drugs, one person regained consciousness and another person had an unidentified complication. Whether there were complications is unknown in 70.6% of cases during 2017.[10]

During 2017 people it took people up to 240 minutes (10 hours) to become unconscious and up to 21 hours to die after ingesting the drugs. The time up to death is unknown in 73% of cases during 2017.[11]

### **References**

1. Oregon Health Authority. About the Death With Dignity Act.
2. Oregon Health Authority Public Health Division (2018, February 9). Oregon Death with Dignity Act 2017 Data Summary. p.11.
3. Oregon Health Authority Public Health Division (2017, February 21). Oregon Death with Dignity Act Data Summary 2016. p.9,11.
4. Whitfield, R.G. in Bronner, A. (2007, July 12). The Doc is in: Is HIV a terminal illness?
5. Oregon Health Authority Public Health Division (2018, February 9). Oregon Death with Dignity Act 2017 Data Summary. p.11.
6. Ibid. p.11.
7. Ibid. p.5.
8. Linda Prager, “Details emerge on Oregon’s first assisted suicides, ” *American Medical News*, Sept. 7, 1998. in Patients Rights Council. Ten Years of Assisted Suicide in Oregon.
9. Oregon Health Division, CD Summary, vol. 48, no. 6 (March 16, 1999), p. 2. in Patients Rights Council. Ten Years of Assisted Suicide in Oregon.
10. Oregon Health Authority Public Health Division (2018, February 9). Oregon Death with Dignity Act 2017 Data Summary. p.10.
11. Ibid. p.11.