

“Leave doctors out of it”

Euthanasia and assisted suicide (EAS) are not medical treatment, are not compatible with medical ethics, and undermine good medical practice.

- In the 2015 *Report on Assisted Suicide (Scotland) Bill*, both supporters and opponents of the Assisted Suicide Bill acknowledged that “the involvement of healthcare professionals in assisted suicide, even if it were legal, would not amount to ‘medical treatment’”.¹
 - Medical associations, within New Zealand and internationally, hold that a doctor’s duty of care does not include deliberately ending a patient’s life.
 - The *World Medical Association* and the *New Zealand Medical Association* both state that **EAS would remain unethical even if it was legalised**. Other key NZ professional medical groups, including the *Australia & New Zealand Society of Palliative Medicine*, *Australian and New Zealand Society for Geriatric Medicine*, *Hospice New Zealand*, and *Palliative Care Nurses New Zealand*, are also opposed.
- “Even if our wider society were to make this practice lawful it would remain essential that the Medical Profession stand apart from any participation in it.”
- It is argued that doctors who do not wish to participate will be able to exercise conscientious objection. However, overseas experience shows doctors and health institutions become subject to various forms of coercion, raising serious doubts as to whether, in the long-term, they would be adequately protected by conscientious objection, even when this is enshrined in law.
 - A physician “processing a request for euthanasia, is working in the opposite direction to a physician who is working to improve the quality of the patient’s life ... the underlying assumption in processing a request for euthanasia is that this is a life that’s no longer worth living, whereas the premise underlying a desire to improve quality of life is that the patient has a life worth living.”² If the doctor explores and processes a request for EAS, the doctor affirms the patient’s outlook that their life is not worth living.
 - Euthanasia regimes are predicated on the subjective notion that some lives are no longer worth living. Conversely, ethical medical practice is predicated on the idea that doctors eschew their subjective judgements about persons they are treating, which is why, for example, doctors do not refuse to treat the ‘enemy’ in times of war. Thus, EAS introduces an *inherent and unacceptable contradiction* into medical care.
 - It is readily accepted that ‘coercion’ presents the most significant risk for an EAS regime. “Detecting coercion is extremely difficult. Doctors are not in a position to do this.”³ There are others, such as lawyers or psychologists who, because of their training and experience, are in a better position to detect coercion and assess capacity.

¹ Health and Sport Committee, “Stage 1 Report on Assisted Suicide (Scotland) Bill,” (2015), n. 207, www.parliament.scot/S4_HealthandSportCommittee/Reports/her15-06w-rev.pdf.

² Affidavit of Baroness Ilora Finlay on Behalf of the Defendant, (2015), n. 99, p. 26, http://carealliance.org.nz/wp-content/uploads/2015/11/crown_finlay.pdf.

³ Ibid. n. 20, p. 6.

- The most common argument “that patients have a right to control when and how they die – in fact points to the involvement not of doctors but of legal agencies as decision makers, plus technicians as agents.”⁴
- Doctors are not necessary for the regulation or practice of EAS. “Even if our wider society were to make this practice lawful it would remain essential that the Medical Profession stand apart from any participation in it.”⁵
- “... the majority [of doctors], for moral, ethical, legal and professional reasons, do not wish to become involved in killing their patients ... **Doctors are not a necessary step in the process** ... they are a **very convenient tool for legislators to abrogate their responsibility** and pass it to a caring profession.”⁶

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Conclusion: It is commonly and uncritically assumed that doctors need to be at the centre of euthanasia and assisted suicide. This is an erroneous view. The key ethical question is not whether ‘physician-assisted suicide’ or ‘euthanasia by doctors’ should be legalised, as these are not treatments or healthcare interventions, but whether euthanasia or assisted suicide as part of the justice system, should be legalised.⁷ “Doctors are not necessary in the regulation or practice of assisted suicide. They are included only to provide a cloak of medical legitimacy” (See: Doctors want no part in assisted suicide - www.doctorssayno.nz).

⁴ F. Randall, and R. Dowie, “Assisted suicide and voluntary euthanasia: role contradictions for physicians,” *Clinical Medicine* 10.4, (2010), p. 323.

⁵ New Zealand Health Professionals Alliance, “Viewpoint: Why the Royal New Zealand College of General Practitioners needs to have a Position Statement on Euthanasia,” (2017), <http://www.nzhpa.org/general-practitioners-professionals-royal-new-zealand-college-general-practitioners-needs-position-statement-euthanasia/>.

⁶ Dr Ron Jones, “Leave doctors out of ‘assisted dying’ discussion,” *The New Zealand Herald*, (2017), http://www.nzherald.co.nz/nz/news/article.cfm?c_id=1&objectid=11823577.

⁷ F. Randall, and R. Dowie.

Euthanasia and assisted suicide (EAS) place our elders at risk of a premature death.

- Our society, with its overt emphasis on individuality, independence and productivity, has taken on a strongly 'functionalist' flavour – dignity is identified with being strong, self-reliant, fit, healthy and useful. This mind-set has fostered an increasingly 'ableist' and 'ageist' culture in which it is a weakness to become a 'burden' to others. *This context puts our elders at risk of EAS coercion as a result of social prejudices.*
- Those of our elders who are subject to a loss of physical and mental function, and consequently a loss of autonomy, become exceptionally vulnerable to internalising the (negative) messages from a functionalist societal narrative that advantages and promotes the strong and independent. *This context puts our elders at risk of EAS coercion as a result of their own internalised feelings of loss of worth.*
- The number of older persons requiring support is rising as the 'baby boomers' generation reach retirement age. In a context in which there are growing pressures on our health system,¹ growing pressures on providing sufficient places and carers for our elders,² and growing economic pressures on families, families and the State find themselves less able to provide care at the very time the needs are greatest. *This context puts our elders at risk of EAS coercion from families and caregivers.*
- The levels of **elder abuse in New Zealand continue to rise in spite of tough laws and policies.** Age Concern reports that it receives more than 1500 confirmed referrals for older people facing elder abuse or neglect each year. It has been estimated that only 16% of actual elder abuse cases come to the attention of service agencies such as Age Concern, which makes the total number around 9,300. Age Concern reports that 75 percent of cases seen involve psychological abuse. 75 percent of alleged abusers are family members.³
- While Seymour's bill purportedly provides protection against abuse or coercion by requiring verification from a medical practitioner that the person making the request is free from coercion,⁴ **"there is no way to guarantee the absence of coercion** in the context of assisted suicide" or euthanasia.⁵ The different forms of coercion are not only hard to detect, but doctors are not trained to detect such coercion.
- A wish to die prematurely is recognised by professionals as arising from underlying depression, financial concerns or family dynamics.⁶

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¹ Lyndon Keene, Philip Bagshaw, et al. "Funding New Zealand's public healthcare system: time for an honest appraisal and public debate," *The New Zealand Medical Journal* 129, 1435 (2016), <https://www.nzma.org.nz/journal/read-the-journal/all-issues/2010-2019/2016/vol-129-no-1435-27-may-2016/6891>.

² Helen King, "Aged-care sector warns of workforce crisis", *Stuff*, (2017), <https://www.stuff.co.nz/business/99454652/agedcare-worker-fears-for-future>.

³ Age Concern, "Elder Abuse and Neglect," https://www.ageconcern.org.nz/ACNZPublic/Services/EANP/ACNZ_Public/Elder_Abuse_and_Neglect.aspx

⁴ New Zealand Health Select Committee, "Ending One's Life in New Zealand," (2017), p.2, https://www.parliament.nz/resource/en-NZ/SCR_74759/4d68a2f2e98ef91d75c1a179fe6dd1ec1b66cd24.

⁵ Health and Sport Committee, "Stage 1 Report on Assisted Suicide (Scotland) Bill," (2015), n. 194, www.parliament.scot/S4_HealthandSportCommittee/Reports/her15-06w-rev.pdf.

⁶ Australia & New Zealand Society for Geriatric Medicine, "Points for reference with regard to ANZSGM and Euthanasia," <http://www.anzsgm.org/documents/PointsforreferencewithregardtoANZSGMandEuthanasia11817.pdf>.

- Evidence from Oregon indicates that **the most common end of life concerns are not about pain control** but relate to existential questions; ‘being less able to engage in enjoyable activities’, ‘loss of autonomy’, ‘loss of dignity’, and ‘being a burden on family and friends’.⁷
- There is a **growing sense of social isolation amongst our elders in New Zealand**. In the New Zealand Longitudinal Study of Aging, 41.2 percent of participants were categorised as ‘moderately lonely’, 7 percent as ‘severely lonely’ and 3 percent as ‘very severely lonely’. Less than half (48.8 percent) of the participants were categorised as ‘not lonely’.⁸ Loneliness is related to poorer health outcomes, depression and the loss of a will to live.
- There is also evidence that **certain groups of older persons suffer high rates of depression**. The New Zealand LiLACS longitudinal study found the prevalence of depression ranged from 15 percent for Māori men and women and from 10-12 percent for non-Māori men and women.⁹
- When the symptom driving requests for assisted suicide is psychological distress “the standard of care for depression and demoralization is not a lethal dose of barbiturates.”¹⁰

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Conclusion: There has never been a more dangerous time, as far as our elders are concerned, to contemplate legalising euthanasia or assisted suicide. Our elders will find themselves having to increasingly justify their right to life, and the so-called ‘right to die’ will be increasingly perceived as a ‘duty to die’. *This is not real choice*. EAS will place many of our elders at risk of a premature death under the *guise* of ‘personal choice’. This is unacceptable, particularly because it is well known that *persistent requests for euthanasia are extremely rare when patients have access to quality palliative care*.

⁷ Oregon Public Health Division. Oregon Death With Dignity Act: Annual Reports, <http://www.oregon.gov/OHA/PH/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/pages/index.aspx>.

⁸ Jack Noone and Christine Stephens, “The New Zealand Longitudinal Study of Ageing: Summary Report - Social Integration, Health and Quality of Life,” *Massey University*, (2014), http://www.massey.ac.nz/massey/learning/departments/school-of-psychology/research/hart/publications/project-reports_nzlsa.cfm.

⁹ Teh, R., Kerse, N., Kepa, M., Doughty, R. N., Moyes, S., Wiles, J., ... & Mace, C. (2014). Self-rated health, health-related behaviours and medical conditions of Maori and non-Maori in advanced age: LiLACS NZ. *The New Zealand Medical Journal (Online)*, 127(1397).

¹⁰ HR. Greene, “Letter to the council on ethical affairs,” *California Medical Association*, (2006), Available at http://dredf.org/assisted_suicide/greene.shtml.