The Royal Australasian College of Physicians
New Zealand

4 November 2015

Mr Simon O'Connor
Chair, Health Select Committee
C/- Committee Secretariat
Health
Parliament Buildings
Wellington

Via email: select.committees@parliament.govt.nz

Dear Mr O'Connor

Health Select Committee Inquiry to "fully investigate public attitudes towards the introduction of legislation which would permit medically-assisted dying in the event of a terminal illness or an irreversible condition which makes life unbearable".

The Royal Australasian College of Physicians (RACP) welcomes the opportunity to contribute to the Parliamentary Inquiry to "fully investigate public attitudes towards the introduction of legislation which would permit medically assisted dying in the event of a terminal illness or an irreversible condition which makes life unbearable".

The RACP trains, educates and advocates on behalf of more than 15,000 physicians – often referred to as medical specialists – and 6,500 trainees, across Australia and New Zealand. It represents more than 32 medical specialities including paediatrics and child health, cardiology, respiratory medicine, neurology, oncology and public health medicine, occupational and environmental medicine, palliative medicine, sexual health medicine, rehabilitation medicine, geriatric medicine and addiction medicine. Beyond the drive for medical excellence the RACP is committed to developing health and social policies which bring vital improvements to the wellbeing of patients[1].

There are diverse views within the College on these issues and the RACP is currently developing a cross-College position statement on euthanasia and physician assisted dying. This will address the substantive ethical issues related to euthanasia and to physician assisted dying, including the ethically relevant distinctions between the two issues. While this policy work is underway, the New Zealand RACP has consulted with key Fellows and College bodies to inform this submission, which reflects the views of the New Zealand Committee. As our members' expertise is medical rather than legal, the RACP has focused on highlighting 'medical' implications. The RACP is aware that variable terminology is used to discuss these issues, which may have subtly different implications. This submission intends to address the New Zealand RACP's broad ethical concerns, and has favoured the term 'assisted dying', as it is becoming a generally accepted term in the literature.

[1] The Royal Australasian College of Physicians www.racp.edu.au.

The New Zealand RACP Committee's main concern about the political and social debate on euthanasia and physician assisted dying in New Zealand, is that any change to existing law that permits 'medically-assisted dying' will implicate its members, and would significantly impact on and affect physicians' daily practice. Also, there are diverse and divergent views within the College and the broader community on the question of euthanasia and physician assisted dying. In this context, RACP supports the Health Select Committee's role in undertaking "a full investigation into ending one's life in New Zealand, in order to fully understand public attitudes, and give consideration of all the various aspects of the issue, including the social, legal, medical, cultural, financial, ethical, and philosophical implications".

The RACP is pleased that the breadth of investigation will include consideration of the context that leads to making a decision to end life: "1.The factors that contribute to the desire to end one's life. 2. The effectiveness of services and support available to those who desire to end their own lives. 3. The attitudes of New Zealanders towards the ending of one's life and the current legal situation. 4. International experiences".

Main Concerns

Euthanasia and assisted dying each raise a number of ethical, social, legal and religious concerns, and there are various ethical arguments for and against the legalisation of euthanasia and assisted dying in medical practice which are well-articulated in medical literature, public discourse, and proposed legislation[2].

The New Zealand Committee of the College is concerned about potential and unintended consequences and associated complexities of legalising euthanasia and/or physician assisted dying in New Zealand and wishes to draw these matters to the attention of the Health Select Committee, including:

1. The presumption that legalised assisted dying is necessarily an activity for doctors to consider, when it might reasonably fall within the expertise of other occupational groups.

2. Removing the emphasis on, and support for, high quality palliative care and advance care planning.

3. Conflicting public health messages, where suicide is acceptable in certain circumstances, and the impact this may have on impressionable groups, such as youth.

4. Placing undue pressures on vulnerable patient groups, such as the frail, elderly, neonates and children, the socially marginalised, people with impaired intellectual capacity and those with reduced educational capacity.

5. The difficulty in determining what decision is in the patient's best interests, particularly when they are in a compromised cognitive state or in the case of neonates when such a decision could be based on the prediction of future disability, rather than current health status.

6. The enhanced possibility of making an irreversible mistake (i.e. ending the life of someone who didn't want to die but whose intentions were misinterpreted).

7. Rationalising the decision to end a life, because the patient feels s/he is 'a burden' and determining whether this is due to underlying depression, influenced by family, or a reality for the patient.

8. The impact that doctors' potential role in assisted dying may have on doctors' professionalism and patient-doctor relationships. A doctor's role is not just to heal or cure, more importantly it is to reduce human suffering.

[2] The Australia Institute. Survey results: Attitudes to voluntary euthanasia. 2011. [cited 2015 October 15] Available at http://www.tai.org.au/node/1316

9. Undermining public trust in the institutions of health care, if one of the possible outcomes is that the institution might deliberately end the life of a patient.

10. Increasing justification for euthanasia and potential for abuse, for example cost savings for the health system[3].

11. Devaluing the experience of dying.

12. Conflation of ethically distinct activities of symptom control at the end of life with the deliberate intention to terminate life.

13. Conflation of ethically distinct scenarios of the terminal phase with earlier phases of incurable illness.

These concerns are reflected in the World Medical Association's Declaration on Euthanasia which states that deliberately ending the life of a patient is unethical:

> *"Euthanasia, that is the act of deliberately ending the life of a patient, even at the patient's own request or at the request of close relatives, is unethical. This does not prevent the physician from respecting the desire of a patient to allow the natural process of death to follow its course in the terminal phase of sickness[4].*

Issues in end of life care

High quality planning and effective palliative care are ethical and produce the best care for patients at the end of their lives, wherever they are in the life course. Good end–of-life care is associated with a number of positive outcomes for patients, whānau/family and carers, contributes to better quality of life, and reduces psychological burden. This is the care that doctors are vocationally trained to provide. The New Zealand RACP Committee holds that providing good end-of-life care to all patients negates the need for euthanasia.

Physicians should ensure that every effort is made to provide high quality end-of-life care, and champion this throughout the health system. All physicians have a role in providing good end-of-life care, and physicians have a key role in promoting Advance Care Planning, ensuring that the wishes of patients and loved ones are known and respected, and that care is personalised.

Challenges in providing good end-of-life care include uncertainties around diagnosing dying, particularly in non-malignant diseases, taboos around discussing death and dying, and fragmentation of care.

The RACP has identified five key elements of end-of-life care:
1. Diagnosing dying or the risk of dying
2. Respecting patient autonomy and providing personalised care
3. Ensuring that medical treatment decisions respect the patient's best interests
4. Managing symptoms
5. Supporting carers and family

Care must involve the fundamental components of diagnosis, investigation, prescribing/deprescribing and management, and be founded in rational assessment and careful consideration of all aspects of health care that people receive towards and at the end of life. Health care teams and services must also consider the significant impact on a patient's whānau/family and carers. Good end-of-life care requires clear communication and commitment from a range of health care providers and others, e.g.

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[3] Vogel L. Line between acts and omissions blurred, euthanasia critics argue. CMAJ 2012 [cited 2015 October 9];184(1):e19-e20. Available at http://www.cmaj.ca/content/184/1/E19

[4] Dean J, Mahar P, Loh E, Ludlow K. Duty of care or a matter of conduct. Can a doctor refuse a person in need of urgent medical attention? Aust Fam Physician 2013 October; 42(10):746-748 [cited 2015 October 8] http://www.racgp.org.au/afp/2013/october/duty-of-care/

social workers, pastoral carers, as well as the whānau/family having a central role (Whānau/family-centred care).

Good end-of-life care enables patients to live as well as possible and ensures that a patient's whānau/family and carers get the support they need. Care is characterised by providing high quality palliative care that is patient-centred and integrated. A better death is likely to result from a reduction in the use of unwanted, inappropriate and ineffective treatment, resulting in less suffering and pain, and a lessened psychological burden on the patient as well as their whānau/family, carers and health professionals involved in their care.

The New Zealand Committee of the RACP also upholds a Māori perspective on death and dying:

> *"An important cultural consideration in Te Ao Māori is that the mauri of a person is independent from their brain, in this context spiritual presence is still respected during physical and psychological deterioration. Furthermore, the mana of an iwi and whānau is often relative to the number of kaumātua (elders) present. As such, independent of whether Māori elderly are in poor health their continuing presence is seen as enhancing the mana of their Marae and people".*

The RACP believes quality end-of-life care is becoming a critical aspect of medicine as more people are dying from terminal illness or chronic diseases due to the significant gains in life expectancy and advances being made in medicine[5]. However not all patients have equitable access to consistent, good quality end-of-life care, such as socioeconomically disadvantaged populations, non-cancer patients, older people living in residential aged care facilities, and people in rural or remote communities[6]. Guidance and programmes are also needed to help physicians comply with regulatory requirements, and demonstrate their performance and commitment to providing high quality end-of-life care that supports patients, whānau/family and carers to access where needed[7].

Summary points

1. This submission of the New Zealand RACP Committee, rather than the RACP, recognises that strong and opposing views are held within the medical profession and in the community on the issues of euthanasia and physician assisted dying.

2. The New Zealand RACP Committee notes that many doctors are against euthanasia and physician assisted dying and will not choose to be involved. We urge the Inquiry to adequately address alternative arrangements not requiring the input of doctors in the proposed Bill.

3. The New Zealand RACP Committee supports the provision of high quality accessible and equitable palliative care as a priority in New Zealand.

4. The New Zealand RACP Committee upholds Māori perspectives on death and dying, and the statement on the World Medical Association's Declaration on Euthanasia.

5. The New Zealand RACP Committee is concerned about potential unintended consequences and associated complexities of legalising euthanasia and physician assisted dying in New Zealand .

6. The New Zealand RACP Committee wishes to draw the Health Select Committee attention to points raised in the main concerns section of this submission as those to be addressed during the Inquiry on euthanasia and physician assisted dying.

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[5] Australian Institute of Health and Welfare. Australia's Health 2014: How healthy are we? 2015 [cited 2015 October 16]. Available at http://www.aihw.gov.au/australias-health/2014/how-healthy/

[6] Queensland Health: Statewide strategy for end-of-life care. May 2015 [cited 2015 October 6]. Available at http://www.health.qld.gov.au/system-governance-strategic-direction/plans/health-service/

[7] For further information about quality end of life care, please refer to the Australian and New Zealand Society of Palliative Medicine (ANZSPM) Position Statement: Quality End-of-Life care – Part 1 – Essential elements for quality, safety and appropriate clinical care at the end of life. 2014 [cited 2015 October 5]. Available at http://www.anzspm.org.au/c/anzspm?a=da&did=1005077

The RACP thanks the Health Select Committee for the opportunity to comment on the Bill, and wishes to register its interest in presenting in person to the Committee during the oral submissions process. Please contact the Royal Australasian College of Physicians' NZ Policy and Advocacy Unit at: policy@racp.org.nz.

Yours sincerely

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New Zealand President
The Royal Australasian College of Physicians