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**RACP Submission:
NZ End of Life Choice Bill 2017**

February 2018

Introduction

The Royal Australasian College of Physicians (RACP) welcomes the opportunity to submit feedback on the End of Life Choice Bill 2017 (“the Bill”). **Our submission should not be taken to mean that the RACP supports the intention of the Bill.**

The RACP works across more than 40 medical specialties to educate, innovate and advocate for excellence in health and medical care. Working with our senior members, the RACP trains the next generation of specialists, while playing a lead role in developing world best practice models of care. We also draw on the skills of our members, to develop policies that promote a healthier society. By working together, our members advance the interest of our profession, our patients and the broader community.

There is diverse opinion within the RACP membership on medical assistance in dying. The RACP is currently developing a cross-College position statement on the provision of medical assistance in dying. While this policy work is underway, the New Zealand RACP has consulted with Members and College bodies to inform this submission. We anticipate the publication of the RACP’s position statement on medical assistance in dying in 2018.

The purpose of our submission is to:

1. Provide feedback on the concerning aspects of the Bill,
2. Highlight the impact that the introduction of the scheme would have on physician practise in New Zealand, and
3. Highlight the impact on the person, bereaved whānau, carers, and other health professionals.

Key issues observed in this Bill are that:

- The RACP has a concern about the lack of detail contained in the Bill.
- The RACP has a concern about the role of the medical practitioner
- The RACP are concerned about the potential impacts on vulnerable patients and populations, which will be difficult to adequately safeguard against.

Terminology

Medical Assistance in Dying

In this submission, the term “medical assistance in dying” refers to the following treatment provided at the request of a patient by a medical practitioner or those with appropriate prescribing rights, and includes:

- The prescription or supply of a lethal drug which a competent patient self-administers without further assistance; or
- The administration of a lethal drug to a competent patient requesting assistance to die.

The following are not considered to be medical assistance in dying and are well-established end of life practices:

- Refusing life-sustaining treatments: Patients with capacity have the right to refuse treatment including the provision of medically assisted nutrition and/or hydration.
- Withholding or withdrawing treatments that are not benefiting the patient: physicians have a duty to consider the benefits and harms of any treatments including the provision of medically assisted nutrition and/or hydration before instituting them. The benefits and harms of ongoing treatment should also be regularly reviewed.
- Providing appropriate palliative sedation to manage refractory symptoms.
- Titrating medical treatment to relieve symptoms even if it may have the perceived potential to hasten death.

Whilst treatment intended to relieve symptoms could foreseeably hasten death (although this may not be an inevitable consequence), this is not the prescriber’s intent but a secondary consequence. The

primary intention is to relieve distress, not to end life. This situation is also called the “principle of double effect”¹.

Lethal Drug

The Bill defines “assisted dying” as the “administration by a medical practitioner of a lethal dose of medication to a person to relieve his or her suffering by hastening death”. The phrasing of “lethal dose of medication” could be interpreted as inconsistent with the Medicines Act 1981, which defines a medicine as any substance or article “administered to one or more human beings for a therapeutic purpose”². The use of the phrase “lethal drug” within a definition of medical assistance in dying reduces any perceived ambiguity.

Background

The legalisation of medical assistance in dying is a highly contentious and divisive issue. It raises ethical, social, legal, and religious concerns. Arguments for and against legislation are well-articulated in the medical literature and public discourse in New Zealand and internationally.

Individual patient situations at the end of life are often not straightforward. Assessment of quality of life, capacity and prognosis can be contested. If the law were changed to allow medical assistance in dying in certain circumstances, physicians would be required to assess many complex issues. Our experience tells us that there would be many patients who would not fit neatly into particular rules or situations, and working through these issues would push existing boundaries.

RACP Position

The RACP is in the process of establishing a position paper on medical assistance in dying, in consultation with its membership.

While this policy work is in progress, the RACP has drawn on consultations with key College bodies as well as our broader membership to inform this submission.

The RACP holds that physicians and society have a duty to provide high quality end of life care to patients and their families and carers. This is set out in the RACP position statement ‘Improving Care at the End of Life: Our Roles and Responsibilities’ (May 2016)³.

The RACP advocates for:

- High quality end of life care for patients and the duty of all physicians to provide this,
- Open and honest communication with patients about impending death,
- A doctor-patient relationship based on openness, trust, and good communication,
- The positive contribution a physician can make to end of life care,
- Acknowledging and respecting different cultural preferences and approaches to death and dying, and providing culturally safe end of life care.

The RACP recognises that medical assistance in dying, as defined above, is distinct from the practice of palliative care. It should be noted that the Australian and New Zealand Society of Palliative Medicine

¹ Where the administration of treatment or other action intended to relieve symptoms of suffering may have a secondary consequence of hastening death. Boyle J. Who is entitled to double effect? *J Med Philos* 1991; 16(5): 475-94.

² Medicines Act 1981, s3.

³ The Royal Australasian College of Physicians. Improving Care at the End of Life: Our Roles and Responsibilities. May 2016. Available from: <https://www.racp.edu.au/docs/default-source/advocacy-library/pa-pos-end-of-life-position-statement.pdf>. Accessed 24 January 2018.

has strongly stated that the provision of medical assistance in dying is not part of the Palliative Medicine discipline⁴.

RACP comments on the Bill

Palliative care referral

The RACP recognises that medical assistance in dying is not part of palliative care practice.

Specialist physicians trained in palliative care are commonly part of a multidisciplinary team caring for and monitoring patients at the end of their lives. This involvement is often essential to ensure that patients are well managed. Every patient should receive timely, equitable, good quality end-of-life care, including access to specialist palliative care where appropriate.

Referral to specialist palliative care should be strongly recommended for patients considering medical assistance in dying. However, the RACP would not recommend mandatory palliative care referral or consultation after a request has been made, for the following reasons:

- The provision of medically assisted dying must not be seen as part of palliative care. As already stated, these are distinct practices
- Referral or consultation is not mandated for any patients under existing arrangements
- Legalisation of medical assistance in dying in any form will create significant challenges for palliative medicine specialists and palliative care organisations
- The risk that involvement of palliative care referral and/or consultation is simply seen as, and becomes, a procedural step or 'tick the box' exercise

At the very least, patients must be made aware of the benefits that palliative care can offer at the end of life.

To this end, information on palliative care should be available for patients and their whānau through a neutral and centralised information service. Such a service could assist with informed consent and offer additional support by (amongst other methods):

- Providing patients with consistent information
- Providing information in accessible formats
- Supporting practitioners and healthcare institutions in answering questions from patients, whānau, carers and other members of the health care team

Regarding accessible formats, information should be provided in writing in the patient's preferred language (with oral provision of information if the patient cannot read their primary language of communication). The form of the patient's response should correspond to that of the advice provided. If oral advice and response are provided, there should be a third person present to provide witness for the whole process.

Discretionary participation

Physicians wish to uphold their right to choose whether they wish to be involved in medical assistance in dying and the extent of their involvement, if any.

Many physicians consider that providing medical assistance in dying is not within the professional boundaries or authority of physicians. In addition, the system is an opt-out process. This means that instead of choosing to participate, doctors who object by conscience or ethics will need to voluntarily opt out of the system and provide the patient with information about SCENZ. This is a considerable

⁴ The Australian & New Zealand Society of Palliative Medicine Inc. ANZSPM Position Statement on The Practice of Euthanasia & Assisted Suicide (Updated 31 March 2017). Available from <http://www.anzspm.org.au/c/anzspm?a=da&did=1005077>. Accessed 8 February 2018.

burden for medical practitioners to bear. This is particularly the case in relation to the relatively severe repercussions under section 27 of the Bill if the practitioner does not comply with the Bill.

In general, where practitioners object on conscience in New Zealand, they must refer patients to another practitioner or clinic⁵. However, for some physicians the moral impact of referring a request for medical assistance in dying to a willing practitioner may be felt deeply. The RACP holds that physicians should not be forced to refer, but neither should they hinder patients from accessing such services.

It must be acknowledged that the provision of medical assistance in dying would affect not only the medical practitioner but the multi-disciplinary team treating the patient. Conscientious objection may also occur for individuals within multidisciplinary teams or at an institutional level.

The matter of conscientious objection may present issues in certain settings, for example inpatients who may be within an objecting hospital or hospice or who are unable to go to another clinic; practitioners who would perform medical assistance in dying but are not accredited at that site; and patients living in rural areas serviced by the objecting practitioner(s).

The Justice Select Committee should consider establishing in legislation a neutral intermediary body to maintain an opt-in, confidential list of participating practitioners and to create links with providers where appropriate. As part of this arrangement consideration should be given to involving others such as patients themselves, whānau members, and other health professionals in linking patients with an intermediary body. Requirements for participating practitioners should still apply, in that they must have:

- developed an adequate (preferably long-term) professional relationship with the patient,
- a sufficient understanding of the patient's preferences and values in relation to end of life care, and
- an informed understanding of the patient's medical condition.

Having a centralised body such as this managing conscientious objection may also go some way to alleviate very difficult conversations between patients and treating physicians. However, this must be on a voluntary basis.

Protections should be available for participating or objecting practitioners who do not wish to be identified. Some practitioners might encounter stigma, victimisation, harassment and other issues relating to perception by patients, whānau, colleagues and the broader community, if a public register of practitioners is mandated. A practitioner may not want to be identified because they are concerned that patients will not come to see them if they are known to be participating in medical assistance in dying. Conversely, a patient may refuse to see a doctor if they choose not to participate which may compromise timely assessment and care in a geographical area where there are limited doctors to see.

It should also be recognised that some practitioners may be potentially willing to participate in medical assistance in dying for eligible patients in limited ways e.g. in a limited range of cases, or in only providing a second opinion.

Suitable medical practitioner

As stated above, if the Bill is enacted then the RACP uphold the right for a practitioner to choose whether they wish to be involved in medical assistance in dying.

The Bill does not provide sufficient details about the 'attending medical practitioner' or the 'independent medical practitioner', for example how long they must have known the patient, their qualifications, and expertise.

If medical assistance in dying is legalised, the RACP would support safeguards proposed by AMA Victoria that relate to participating medical practitioners having:

⁵ In New Zealand in relation to accessing reproductive health services health practitioners who object as a matter of conscience must refer the requesting person to a practitioner or clinic where they can obtain the service. Health Practitioners Competence Assurance Act 2003, s174.

- Developed an adequate (preferably long-term) professional relationship with the patient,
- A sufficient understanding of the patient's preferences and values in relation to end of life care, and
- An informed understanding of the patient's medical condition⁶.

Participating practitioners would also have to be properly skilled in several domains and would have to be qualified in the diagnosis and prognosis of the specific medical condition. The Justice Select Committee could consider setting out the domains of expertise required to provide medical assistance in dying, rather than circumscribing it to a particular profession or qualification level, which could create restrictions to access, or lead to an inexperienced medical practitioner confirming a request. For example, a neurologist who specialises in stroke care, and holds qualifications in neurology, may still not have sufficient experience of motor neurone disease management to be able to discuss prognosis in detail, or answer questions about the role of artificial ventilation. This would need to be balanced against the equitable access issues that arise in the remote areas when patients are too sick to travel. These situations would require more detailed consideration around how equitable access to assessment by someone suitably skilled could be achieved.

Clause 4 – “Meaning of person who is eligible for assisted dying”

“Likely to end his or her life”

The section which states that a person who qualifies for medically assisted dying must be “likely to end his or her life within 6 months”. This implies that, if legislated, medical assistance in dying would be eligible only for those who are determined to arrange to end their lives within the next 6 months. The section should instead read “who has a terminal illness whose life is likely to end within 6 months”.

6-month time period

Being confident of a 6-month time span on an individual basis is very difficult⁷. Prognostication is generally a variable skill not only affected by patient factors but also level of clinician experience, duration of relationship with the patient, and whether it is done by an individual or a multidisciplinary team. It is based on statistical data which will only apply on average. Therefore, if a certain group of patients have a 6-month expectation of life, a significant proportion will die before this time and a significant proportion afterwards. Studies are also heterogeneous. Most studies have been in the cancer population and there are studies in the non-cancer population where forecasting is even more inaccurate.

Clause 12 - Capacity assessment by a “specialist”

Clause 12 requires a “specialist” (as defined in the Bill as a psychiatrist or psychologist) to assess competence of the person, if either the attending and/or independent medical practitioners are uncertain about whether the person is competent.

A psychologist is unlikely to provide the same opinion as a psychiatrist. Some medical conditions, which a psychologist is not trained to diagnose or assess, may affect the decision-making capacity of the person. The RACP strongly recommends that the Committee seeks the advice of the Royal Australasian and New Zealand College of Psychiatrists on these issues.

⁶ AMA Victoria. Physician Assisted Dying Position Statement. Available from <https://membership.amavic.com.au/files/DAM/Policy%20and%20Advocacy/2016/AMA%20Victoria%207s%20position%20statement%20on%20physician%20assisted%20dying.pdf>. Accessed 25 January 2018.

⁷ White N, Reid F, Harris A, Harries P, Stone P A Systematic Review of Predictions of Survival in Palliative Care: How Accurate Are Clinicians and Who Are the Experts? PLOS ONE 2016; 11 (8): e0161407.

Protection of vulnerable people

The RACP has concerns about under diagnosis of people with depression. The many groups who experience poor access to good end of life care, and risks to individuals who do not fit the criteria or who do not want medical assistance in dying. There is also the risk of coercion of vulnerable patients to end their lives, which will be difficult to completely safeguard against.

Grievous and irremediable medical condition

The ambit of who is eligible under section 4 of the Bill is too wide. The wording “grievous and irremediable medical condition” is of particular concern, due to the lack of definition and potential for wide ambit of application. It is unclear whether this could include mental illness, chronic disease or even general frailty.

The wide definition also risks capturing vulnerable people including the elderly, those with mental illness, or those with a disability. The Bill may place pressure on vulnerable elderly people, who may feel that they are a ‘burden’ on others. These feelings may be due to depression, financial problems, or whānau dynamics.

This is a potential risk particularly with elderly people who are more susceptible to depression and suicide⁸. Growing evidence shows that people who develop dementia under the age of 70 are at increased risk of suicide, especially if there are symptoms of depression and anxiety. This means that people in these age groups might consider medical assistance in dying in some circumstances. The RACP are concerned about the impact that the medical assistance in dying debate may have on older persons. We recommend that elderly people who are experiencing depression are not given the option of medical assistance in dying instead of proper diagnosis and treatment of mental health issues; and that suicide prevention programs also need to include older persons. We also acknowledge the Royal Australia and New Zealand College of Psychiatrist’s recommendation that good quality assessment, care, and support is provided for those with dementia⁹.

Groups with poor access to good end of life care and palliative care

Individuals with poor access to good end of life care may choose medical assistance in dying even though symptom relief and a peaceful death could have been provided if they had had appropriate access to end of life care.

It is important to highlight that inequitable access to consistent, good quality end-of-life care persists for some groups of people in New Zealand. This includes people from culturally and linguistically diverse backgrounds and low-income groups^{10 11}.

The quality of healthcare that patients receive towards and at the end of life also significantly affects the patient and their whānau, friends, and carers.

⁸ The Royal Australia and New Zealand College of Psychiatrists. Submission to the Ministerial Advisory Panel’s discussion paper on a Voluntary Assisted Dying Bill. April 2017. Available from <https://www.ranzcp.org/Files/Resources/Submissions/06780-President-and-Chair-to-Prof-Owler-re-VIC-Vol.aspx>. Accessed 23 January 2018.

⁹ The Royal Australia and New Zealand College of Psychiatrists. Position Statement 67: Physician assisted suicide. February 2016. Available from https://www.ranzcp.org/Files/Resources/College_Statements/Position_Statements/PS-67-Physician-Assisted-Suicide-Feb-2016.aspx. Accessed 23 January 2018.

¹⁰ Gott M, R Allen, T Moeke-Maxwell, C Gardiner, and J Robinson. No matter what the cost: A qualitative study of the financial costs faced by family and whānau caregivers within a palliative care context. *Palliat Med* 2015; 29(6): 518-28. Available from <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4441882/>. Accessed 25 January 2018.

¹¹ Frey R, Gott M, Raphael D, Black S, Teleo-Hope L, Lee H, Wang Z. Where do I go from here? A cultural perspective on challenges to the use of hospice services. *Health Soc Care Community* [Internet] 2013; 21(5):519-29. Available from <https://www.ncbi.nlm.nih.gov/pubmed/23638970>. Accessed 25 January 2018.

Individuals who do not fit the criteria or who do not want a medically assisted death

There is a risk that the bill would compromise the treatment or palliative options available for people who do not fit the criteria or who do fit the criteria but do not want a medically assisted death. If medical assistance in dying is legalised, a contemporaneous legal provision clarifying double effect must be introduced to avoid any implicit assumption that those experiencing severe suffering who do not fit the criteria or who do not want a medically assisted death cannot receive treatments which might, as an unintended secondary consequence, hasten their deaths.

Financial advantage

The Bill does not address or provide protection against any financial advantage potentially gained by any relative or close associate of the patient, including any advantage gained by a person nominated to assist with the end of life process.

Role of SCENZ

The Bill states that a group will be established called the Support and Consultation for End of Life in New Zealand group ("SCENZ"). SCENZ will be established by the Director-General of Health and serviced by the Ministry of Health. SCENZ will maintain a list of medical practitioners, specialists in mental health, and independent medical practitioners. They will write standards of care, provide advice on medical and legal procedures, and provide practitioners with practical assistance if requested.

The exact role and ambit of SCENZ have not been discussed in sufficient detail. More clarification is needed. Practitioners participating in SCENZ will need current registration with the regulatory authority (the NZ Medical Council) and any other appropriate qualifications required for the role. For further detail, see the above section on suitable medical practitioners.

Māori perspective

The Bill fails to acknowledge the existence of a mātauranga Māori (Māori worldview) approach to death and dying, which can vary within whānau, hapū, and iwi. It is important to note that some of the assumptions underpinning the Bill, including ideas of "choice" and "dignity" as used in the Bill, are not in fact universal but are based on cultural assumptions.

Dying and sickness from a mātauranga Māori perspective do not happen solely to the individual. This is reflected for example in the practice of kirimate and whānau pani (bereaved whānau). In these practices (which vary from rohe to rohe) the close family of the deceased effectively enter into the world of the dead during the tangihanga and become highly tapu, and are returned to the world of the living through their participation in the hakari and other rituals¹².

The body is important in the traditional Māori funeral custom. The wairua (spirit) of the deceased is considered to stay by its body at first, and needs encouragement to start on the journey to the next world. This underscores the importance of the body as a focus for Māori funeral custom (tangihanga). When a Māori patient dies it is critical that the whānau has prompt access to the tūpapaku. If a post-mortem is required this must be done as soon as feasible¹³.

The New Zealand Committee of the RACP 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

¹² Higgins R and Moorfield JC. Tangihanga: Death customs. in Ka'ai TM, Moorfield JC, Reilly MJP, Moseley S (eds). Ki te Whaiao: An introduction to Māori culture and society. Auckland: Pearson Education; 2004.

¹³ Māori Health Committee and New Zealand CPD Committee. Guideline commentary on care and support of Māori and their whānau around the time of death. Sydney and Wellington: Royal Australasian College of Physicians; 2011.

poor health their continuing presence is seen as enhancing the mana of their Marae and people”.

The assumption that death is therefore about individual choice is a faulty one. This also problematizes the processes as outlined in the Bill, especially the lack of whānau involvement in key decision-making points.

The Bill also fails to acknowledge the problematic relationship between Māori and social policy and legislation. While it makes claims as to the efficacy of the legislative safeguards for the vulnerable in other jurisdictions, it does not allow for the historical and social context that is unique to New Zealand. In this context, seemingly universal legislation often has a disproportionately negative impact on Māori. This is noticeable in many spheres of New Zealand life including education, justice, and health. Factors such as “unconscious bias” can influence how policy is implemented in such areas, is not accounted for in legislation, and ends with outcome disparities in many areas for Māori.

Role of the medical practitioner

Communicating a negative decision

Section 13 requires the practitioner to communicate the reasons for a negative decision. These are complex conversations that require context, skill and nuance and the RACP would recommend that this step be recommended in relevant guidelines rather than prescribed as a legislative requirement.

Administering a lethal drug

There is a lack of definition of the role of the medical practitioner in relation to administering the lethal drug. It is unclear whether the lethal drug is administered by the medical practitioner or by the person (in this context “the person” meaning the patient, which is the terminology used in the Bill).

Under section 3 of the interpretation section of the Bill, “assisted dying” is defined as “the administration by a medical practitioner of a lethal dose of medication to a person to relieve his or her suffering by hastening death”. Under s 16(4) the medical practitioner “must administer” the medication. S16(4) also states that the medical practitioner must administer the medication by “providing” it to the person using the methods described in section 15 (3)(a) (i) – (iv). Sections 15 (3)(a) (i) and (ii) discuss ingestion and intravenous delivery of the medication “triggered” by the person, but does not provide a definition of “triggered”.

Definitions of “providing” or “administer/administration” or “triggered” are not included. This makes the role of the medical practitioner unclear. Clarification is required as to whether the medical practitioner is expected to inject or otherwise administer the lethal drug themselves, to give the medication to the person to administer, or if someone else will administer the lethal drug.

Some practitioners may wish to only be involved in the prescription stage and not the administration stage of the lethal drug. Alternatively, SCENZ participants could be the only practitioners to administer the lethal drug to the person.

Attendance by a healthcare worker or practitioner at the time the person self-administers the lethal drug, including role and obligations

The role and obligations of an attending practitioner are important considerations that require further examination. If medical assistance in dying is legalised, attendance may put treating physicians in a difficult situation – opening up the risk of a physician refusing care to a patient at a time of significant vulnerability and of major physical and existential need.

The RACP suggests that there be no statutory prohibition to attendance by a health practitioner, and that the patient and the health practitioner should both be freely able to request or decline the health practitioner being present.

If a health practitioner is present, comprehensive guidance should be available covering what to do in a range of scenarios e.g. management of side effects, if the patient does not die in the expected time period, failure of self-administration or if the lethal drug is not effective.

Lethal drug not effective - the obligations of a health practitioner be to treat a person who has chosen to ingest the lethal drug

The obligations of a practitioner in scenarios where a lethal drug is not effective requires examination. These issues will also be different depending on the type of health practitioner. Documentation indicating that a person has chosen to take a lethal drug would have to be readily available to ensure any treatment provided accords with the patient's wishes. There are serious risks that outcomes may not always be certain and may be the opposite to what was intended.

Possible scenarios include:

- A medical practitioner in attendance when the patient ingests a dose of the lethal drug and it has not been effective
- A medical practitioner in the Emergency Department receiving a patient who has ingested the lethal drug but it has not resulted in the death of the patient – moreover, if there is uncertainty as to whether the patient intended to die, and so health professionals would be obliged to provide life-saving interventions
- A medical practitioner in the Emergency Department receiving a patient who has ingested the lethal drug and the family request treatment because they do not agree with the patient's decision to end their life
- A paramedic called to a patient who has ingested a dose of the lethal drug but it has not been effective
- A paramedic called by the family to a patient who has ingested a dose of the lethal drug because the family do not agree with the patient's decision to end their life

Clear guidelines would have to be developed to assist and protect all individuals involved in the above scenarios before, during, and afterwards. These must be developed in consultation with the medical profession and other relevant health professions.

Support services for conflict, bereavement, and distress

The RACP recommends that adequate whānau support should be provided, counselling and conflict mediation services as part of this process. There is no mention in the proposal about what support systems will be provided for individuals, whānau, and health professionals who may be involved, regardless of whether the patient ultimately proceeds with a medically assisted death or not.

This must be dealt with in any proposed framework, perhaps via SCENZ. The impact of conflict and bereavement can be considerable, as can the stress on individual practitioners receiving requests on a regular basis, and at varying levels of involvement. Practitioners may, for example, face pressure from patients who are deemed not to meet the criteria for access. Patients may also face pressure or coercion from whānau or carers.

Medically assisted deaths may also lead to enduring conflict and complex grief for remaining whānau, carers, and health professionals. Physicians may be placed in very difficult situations when an individual wants medical assistance in dying but whānau disagree with their decision. The whānau may then blame the physician if it goes ahead. Evidence shows that many doctors who have participated in medical assistance in dying experience emotional distress¹⁴¹⁵. Adequate support including counselling services should be provided for practitioners who are involved in the process.

¹⁴ Emanuel EJ, Onwuteaka-Philipsen BD, Urwin JW, Cohen J. Attitudes and Practices of Euthanasia and Physician-Assisted Suicide in the United States, Canada, and Europe. *Journal of the American Medical Association*. 2016;316(1):79-90.

¹⁵ Stevens KR, Jr. Emotional and psychological effects of physician-assisted suicide and euthanasia on participating physicians. *Issues in Law & Medicine*. 2006;21(3):187-200.

If a proposal is legalised in New Zealand, there is a clear need for education, support, and guidance for bereaved whānau members and health professionals.

Patient-doctor relationships

The doctor's potential role in assisted dying may have an impact on doctor-patient relationships. Participation in assisting people to end their lives may also impact trust in the medical profession particularly amongst vulnerable groups who may be more reluctant to seek treatment.

Certification as to death

It is acknowledged there may be some stigma in listing medically-assisted in dying as the cause of death on the death certificate. However, there is significant public interest in having this information available in a de-identified manner. Cause of death data must remain accurate for future planning of medical care. The cause of death must not only include the terminal illness that made the patient eligible, but also that a substance was taken to provide active assistance to the patient in dying. Listing both the immediate and underlying causes of death (as is currently the case) could be considered.

Medical records to be kept

It is imperative that robust and accurate records are kept both at the micro and macro levels and as part of the medical record. Reporting must be undertaken directly to a monitoring body to track trends, the reasons for patient requests, and other important information to monitor the process. For example, there could be a specific reportable form filled out and sent to a monitoring body for review.

Data collection

A system for the careful and thorough collection of data is essential for monitoring the effects of legalisation. This system must be part of any proposed legislation. Monitoring should cover a range of areas including reasons for requests, conscientious objection, disposal of unused lethal drug, and impact on suicide rates.

Data sovereignty and retaining authority over one's own medical information (including samples and genetic material) is an important issue for Māori and indigenous peoples globally. Any data collection protocols developed as a result of legislation should be co-designed with Māori.

Privacy issues

Although the RACP acknowledges the importance of thorough data collection, there are privacy concerns in relation to the names held by SCENZ of practitioners involved in end of life practises. Strong safeguards should be put in place to keep practitioner names and practice names private (Unless they choose to be on a public register) and to protect the medical professionals involved.

Evidence-based review period

The RACP agrees that a review period is appropriate to include in the Bill. As a minimum, a parliamentary committee should scrutinise the data collected and the operation of the legislation. This might lead to amendment or further public consultation. If the introduction of medical assistance in dying is found to have negative or unintended effects, there must be a mechanism to review or withdraw the legislation and to examine and manage problems arising in practice, unforeseen or otherwise.

Public health message

Some members have raised concerns about conflicting health messages whereby suicide becomes acceptable in certain circumstances, and the impact this may have on impressionable groups such as youth.

Summary

- The RACP recognises that strong and opposing views are held within the medical profession and in the community on the issues of medical assistance in dying. The feedback provided is not exhaustive and the RACP may have more comments, concerns, and questions as we continue to examine the issues.
- The RACP is concerned about the lack of detail contained in the bill.
- The RACP is concerned about the potential impacts on vulnerable patients and populations, which will be difficult to adequately safeguard against.
- The RACP supports the provision of high quality, accessible, and equitable palliative care as a priority in New Zealand

The RACP thanks the Justice Select Committee for the opportunity to provide feedback on this Bill. The RACP would like to present in person to the Justice Select Committee. To discuss this submission further, please contact the NZ Policy and Advocacy Unit at policy@racp.org.nz.

Yours sincerely

A handwritten signature in black ink, appearing to read 'J. Christiansen', with a large loop at the start and a horizontal stroke at the end.

Dr Jonathan Christiansen
New Zealand President
The Royal Australasian College of Physicians