

ANZSPM

Aotearoa Executive

04 November 2015

Committee Secretariat
Health Committee
Parliament Buildings
Wellington 6160

<p style="text-align: center;">SUBMISSION: Investigation into Ending One's Life in New Zealand</p>
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1.1 This submission is being made by ANZSPM, The Australian and New Zealand Society of Palliative Medicine which is a not-for-profit specialty medical society for medical practitioners who provide care for people with a life-limiting illness in both Australia and New Zealand.

1.2 We wish to appear before the Committee to speak to our Submission.

EXECUTIVE SUMMARY

1.3 We acknowledge that this subject is extremely challenging for all New Zealanders and appreciate the opportunity to address the Health Select Committee.

1.4 As a Society we oppose any attempt to legalise assisted suicide and/or euthanasia in New Zealand under any conditions.

1.5 Palliative Medicine exists to improve the quality of care of patients with life-limiting illnesses and their families. It encompasses not just the physical but emotional, social, spiritual and cultural needs of the individual and family unit.

1.6 ANZSPM has a Position Statement opposed to euthanasia and doctor-assisted suicide in line with the New Zealand Medical Association and the World Medical Association.

1.7 The withdrawal of treatment in any form is not euthanasia and results in the disease progressing on its natural course.

1.8 It is our belief that most doctors in New Zealand are not deliberately ending the lives of their patients. Medication with the intent of symptom control is not euthanasia but rather good medical practice.

SUBMISSION

ANZSPM AOTEAROA

- 1.9 ANZSPM has approximately 103 members in New Zealand. It promotes the discipline and practice of Palliative Medicine in order to improve the quality of care of patients with palliative diagnoses, and support their families.
- 1.10 ANZSPM members are medical practitioners. They include Palliative Medicine Specialists, doctors training in the Palliative Medicine discipline, General Practitioners and doctors who are specialists in other disciplines such as Oncology.
- 1.11 ANZSPM's objectives are to:
- a) Provide a forum for Registered Medical Practitioners engaged in the practice of Palliative Medicine or related disciplines to facilitate their professional development and to provide mutual support.
 - b) Advance the discipline of Palliative Medicine.
 - c) Provide a voice on policies relating to Palliative Medicine.
 - d) Promote undergraduate and postgraduate education and training in Palliative Medicine and to support Palliative Medicine Trainees.
 - e) Promote research in and evaluation of medical and related issues in Palliative Medicine.
 - f) Liaise with other relevant bodies.
- 1.12 ANZSPM embraces the definition of Palliative Medicine adopted in Great Britain in 1987: 'Palliative Medicine is the study and management of patients with active, progressive, far-advanced disease for whom the prognosis is limited and the focus of care is the quality of life.'
- 1.13 It is a fundamental tenet of Palliative Medicine that it neither hastens nor prolongs life.
- 1.14 The Australian and New Zealand Society of Palliative Medicine is opposed to physician-assisted suicide and euthanasia under any condition. In 2013 the ANZSPM membership of approximately 420 doctors across Australia and New Zealand were surveyed directly about their views on the practice of euthanasia and physician-assisted suicide. ANZSPM members in both Australia and New Zealand voted with a decisive majority in favour of adopting the Position on The Practice of Euthanasia and Assisted Suicide.¹
- 1.15 The ANZSPM Council endorsed that Position Statement as follows:
- a) The discipline of Palliative Medicine does not include the practice of euthanasia or assisted suicide.
 - b) ANZSPM endorses the World Medical Association Resolution on Euthanasia adopted by the 53rd WMA General Assembly, Washington DC, USA in October 2002.²
 - c) ANZSPM opposes the legalisation of both euthanasia and assisted suicide.¹
- 1.16 ANZSPM confirms the strong belief that euthanasia and assisted suicide is in conflict with the basic ethical principles of medical practice.
- 1.17 Legalising physician-assisted suicide or euthanasia under any conditions would also compromise the effective delivery of Palliative Care and place at risk the frailest and vulnerable patients the medical profession has the privilege to care for.

¹ <http://www.anzspm.org.au/c/anzspm?a=da&did=1000948&pid=1383782594>

² <http://www.wma.net/en/30publications/10policies/e13b/>

- 1.18 Palliative Care affirms life and regards dying as a normal process. It improves the quality of life of patients and their families facing the problems associated with life-limiting illness. It aims to prevent and relieve suffering by means of early identification, and assessment and treatment of pain and other problems – physical, psychosocial and spiritual. It is about life, not death.
- 1.19 Those advocating for law change to legalise euthanasia believe it will not affect medical ethics because doctors will not be forced to engage in physician-assisted suicide if they choose not to participate. This misses the point. Our opposition to physician-assisted suicide and euthanasia is not based on personal values. Our Position Statement reflects the strong belief that physician-assisted suicide and euthanasia are contrary to the fundamental tenets of medical practice and inherently harmful.
- 1.20 ANZSPM’s position is consistent with the New Zealand Medical Association’s opposition to euthanasia and doctor-assisted suicide.³ The New Zealand Medical Association Position Statement approved in 2005 states:
- a) The NZMA is opposed to both the concept and practice of euthanasia and doctor-assisted suicide.
 - b) Euthanasia, that is the act of deliberately ending the life of a patient, even at the patient’s request or at the request of close relatives, is unethical.
 - c) Doctor-assisted suicide, like euthanasia, is unethical.
 - d) The NZMA, however, encourages the concept of death with dignity and comfort, and strongly supports the right of patients to decline treatment, or to request pain relief, and supports the right of access to appropriate Palliative Care.
 - e) In supporting patients’ right to request pain relief, the NZMA accepts that the proper provision of such relief, even when it may hasten the death of the patient, is not unethical.
 - f) This NZMA position is not dependent on euthanasia and doctor-assisted suicide remaining unlawful. Even if they were to become legal, or decriminalised, the NZMA would continue to regard them as unethical.

WORLD MEDICAL ASSOCIATION POSITION STATEMENT

- 1.21 The World Medical Association (WMA) is an international organization representing physicians. As it records on its website, it was founded in 1947 when physicians from 27 different countries met at the First General Assembly of the WMA in Paris.
- 1.22 The organization was created to ensure the independence of physicians and to work for the highest possible standards of ethical behaviour and care by physicians at all times. This was particularly important to physicians after the Second World War and therefore the WMA has always been an independent confederation of free professional associations. Membership of the WMA currently stands at 111 National Medical Associations.
- 1.23 The WMA provides ethical guidance to physicians through its Declarations, Resolutions and Statements. These also help to guide National Medical Associations, governments and international organizations throughout the world.
- 1.24 The World Medical Association's Declaration on Euthanasia⁴ was adopted by the 53rd WMA General Assembly held in Washington DC, United States of America, in October 2002 and reaffirmed with minor revision by the 194th WMA Council Session in Bali, Indonesia in April

³ https://www.nzma.org.nz/_data/assets/pdf_file/0004/16996/Euthanasia-2005.pdf

⁴ <http://www.wma.net/en/30publications/10policies/e13/>

2013. It states: '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.'

1.25 The WMA Position Statement on Physician-Assisted Suicide, adopted by the 44th World Medical Assembly in Marbella, Spain, in September 1992 and editorially revised by the 170th WMA Council Session in Divonne-les-Bains, France, in May 2005 likewise states: 'Physician-assisted suicide, like euthanasia, is unethical and must be condemned by the medical profession. Where the assistance of the physician is intentionally and deliberately directed at enabling an individual to end his or her own life, the physician acts unethically. However, the right to decline medical treatment is a basic right of the patient and the physician does not act unethically, even if respecting such a wish results in the death of the patient.'⁵

1.26 These Position Statements strongly urge physicians to refrain from participating in euthanasia even if national law allows it or decriminalises it under certain condition.

WITHDRAWAL OF TREATMENT

1.27 The basic ethical principles that govern medicine include patient autonomy, beneficence or simply do good, non-maleficence (do no harm), justice and futility. A competent patient is able to decide to stop treatment of any form. Equally, a medical practitioner is able to withdraw a treatment that is deemed to be futile. This results in the disease progressing on its natural course.

1.28 It is helpful to remember that for many conditions, patients would not ever have survived without modern medicine 'artificially' keeping them alive. Therefore stopping a treatment is not a decision to actively cause death. Rather, it is a decision to allow a natural death.

1.29 In stark contrast, euthanasia and assisted suicide always and actively seeks death and is an irreversible decision. While some members of the public and some advocates for euthanasia may not understand the distinction, as highlighted by the WMA Position Statements above, medical professionals and ethicists are clear that the distinction is absolute.

DOCTORS IN NEW ZEALAND ARE NOT 'KILLING PATIENTS ANYWAY'

1.30 A doctor in New Zealand who acted deliberately to end the life of his or her patient would be acting unethically and committing a serious criminal offence.

1.31 There is a perception in some groups that euthanasia or physician-assisted suicide is happening in New Zealand anyway. This is usually linked with opioid use, particularly Morphine. Morphine is an excellent medication for pain but is also used first-line for breathlessness.⁶ Very few people are aware of this and some colleagues are also not up to date with this practice. Doses should be increased with the intent of ameliorating a symptom and when this is done correctly is well-tolerated.

⁵ <http://www.wma.net/en/30publications/10policies/p13/>

⁶ Abernethy, A. P., Currow, D. C., Frith, P., Fazekas, B. S., McHugh, A., & Bui, C. (2003). Randomised, double blind, placebo controlled crossover trial of sustained release morphine for the management of refractory dyspnoea. *Bmj*, 327(7414), 523-528.

- 1.32 Opioids are an enabler; they enable patients to live better. When titrated correctly the amount is not really important. It may be that a patient requires 100s of milligrams of opioids, such as Morphine, but if this allows good symptom management it is acceptable.
- 1.33 The doses of opioids may increase, generally over days, weeks or months as needed by the patient. In these situations it is actually very hard to cause a terminal event with the opioid itself. Unfortunately, sometimes doctors who are not specialists in Palliative Care believe the doses and increases in opioids are what are causing the deterioration where for the vast majority of cases it is actually the disease.
- 1.34 An inadvertent overdose of opioid will generally cause sedation and will be reversed by withholding further medication and allowing sleep. For the rare occasion when it suppresses the breathing it is given for a genuine symptom as someone is dying and this is allowed for both in law and medicine. When the intent is to relieve a symptom and one of the outcomes is to hasten death it is called the principle of 'double effect.'⁷ The intent is comfort and not death.
- 1.35 While some members of the public and some advocates for euthanasia may not understand the distinction between providing symptom relief and causing death, that does not mean that the distinction does not exist. Medical practitioners, and especially those of us practising in the Palliative Care Specialities, are very clear on the difference between the two.
- 1.36 Various surveys and opinion polls have entered the public arena recently (Malpas⁸) which suggest doctors are practicing euthanasia and believe it is part of their practice. ANZSPM Aotearoa believes this particular survey and most of the opinion polls are fundamentally flawed in design and bias.
- 1.37 The Malpas survey⁸ in particular leads the participant with unclear terminology and mixed questions to conclusions which do not actually make sense, eg: Medical decisions at the end of life (MDEL) comprised any act or omission at the end of life, including that which may hasten death. Such acts include withholding or withdrawing treatment, as well as intensifying the alleviation of pain and/or symptoms using Morphine or a comparable drug.
- 1.38 This implies MDEL (which is not an acronym used by health professionals) is euthanasia which is not the case at all. Euthanasia is the administration of a lethal drug with the intent of ending someone's life. What is described above is legally, ethically and clinically allowed currently in New Zealand law.
- 1.39 It is important to be clear about the definitions and the New Zealand public struggles with mixed messages.

CONCLUSION

In a recent independent review of quality of death across 80 countries, New Zealand was ranked third. This reflects our high quality of end of life care for all. Palliative Care is not a treatment, a place or a group of individuals, but a way of hearing a person's voice and helping achieve the best quality of life until the last breath.

Palliative Care Specialists have the privileged position of spending our working life listening to, supporting and advising families and patients at the most vulnerable time of their lives.

⁷ The Double Effect principle was endorsed by the NZ High Court in *Seales v Attorney-General* (2015) NZHC 1239 at (101)-(106)

⁸ http://m.marketpulseinternational.com/s/AD_survey/

ANZSPM Aotearoa would not support any changes to the current law. Existing legislation safeguards these vulnerable members of our society and the medical professionals who are trained to provide medically ethical care.

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The Driving Force In Palliative Medicine in New Zealand And Australia