Euthanasia and Physician-Assisted Suicide

A Position Statement by the New Zealand Committee of the Royal Australasian College of Physicians

February 2014

Introduction

The Royal Australasian College of Physicians (the College) has developed the following position statement in the context of the proposed End of Life Choice Member's Bill. This Bill could significantly affect physicians' daily practice and its potential consequences sit alongside the increased political and social debate on euthanasia and physician-assisted suicide in New Zealand. It is recognised there are diverse views within the College and the broader community on the question of euthanasia and physician assisted suicide.

Position

The College *acknowledges* the wide range of perspectives and ethical views in New Zealand on euthanasia and physician-assisted suicide.

The College *maintains* that:

•Euthanasia and physician-assisted suicide are not part of palliative care practice (in accordance with the Australia and New Zealand Society of Palliative Medicine's position statement and Hospice New Zealand's statement).

•The practice of euthanasia and physician-assisted suicide is not within the professional boundaries, nor the authority of the physician.

The College *supports* the World Medical Association Declaration on Euthanasia that 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."*

The College *acknowledges* there is a general misunderstanding and misinterpretation of euthanasia and physician- assisted suicide in New Zealand. Euthanasia and/or physician assisted suicide is *not* the withdrawal or discontinuation of treatment. As such, The College *supports*:

•Patients' rights to refuse or discontinue treatment, allow natural death, and patients' advanced directives (including do not resuscitate orders).

•The concept of death with dignity.

•The current end of life care initiatives in place in New Zealand including: Te Wa Aroha/Allow Natural Death, the National Advanced Care Planning Cooperative and the Liverpool Care Pathway for the dying patient (National Liverpool Care Pathway for the Dying Patient [LCP]Office New Zealand).

The College is *committed* to:

• Quality of life and quality of end of life care for patients.

• Open and honest communication with patients about impending death.

• A doctor-patient relationship based on openness, trust and good communication; therefore would not support any policy decision that may erode this trust.

• The positive contribution a physician can make to end of life care.

• Acknowledging and respecting different cultures' preferences and approaches to death and dying and providing culturally sensitive end of life care.

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 College *believes*:

• That every New Zealander should have timely and equitable access to high quality Palliative Care and end of life care.

• That end of life decisions should be made with consideration of the concepts of non-maleficence, advocacy of best interest, and appreciation of the philosophical approach of palliative care, along with the appreciation of the autonomy and competence of the patient3.

Unintended consequences

The College is *concerned* about the potential unintended consequences and associated complexities of legalising euthanasia and physician-assisted suicide in New Zealand including:

• Portraying a conflicting public health message, wherein suicide is acceptable in certain circumstances, and the impact this may have on impressionable groups, such as youth.

• Placing undue pressures on vulnerable patient groups, such as the frail and the elderly,

• The difficulty in determining what decision is in the patient's best interests, particularly when they are in a compromised cognitive state.

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

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

• Changing the concept of doctors being 'treaters', 'life savers' and 'healers' to being potential agents of death, and the impact this may have on doctors' professionalism and patient-doctor relationships.

• Increasing justifications for euthanasia and potential for abuse, for example cost savings for the health system

• Devaluing the morality of death and dying.

Many doctors may choose not to be involved in the process. Who is involved and how euthanasia or physician-assisted suicide are to be completed without doctors must be adequately addressed in the proposed End of Life Choice Bill.