

ASSISTED SUICIDE



Stop the bill that could stop you

SPEAK UP NOW on David Seymour's Euthanasia Bill

Another push to legalise euthanasia and assisted suicide is currently underway in New Zealand. The NZ Parliament has just voted the *'End of Life Choice Bill'* through its 1st Reading and it is now being considered by the Justice Select Committee.

Even if you made a submission to the Inquiry last year, [we need your help again](#) to protect vulnerable lives.

THE SELECT COMMITTEE CONSIDERING THIS SPECIFIC BILL NEEDS TO HEAR YOUR VOICE. Please make a submission opposing this bill and any changes to how New Zealand approaches this subject. To help you make a submission, we have prepared the following:

- 1. THE PROBLEM WITH EUTHANASIA / ASSISTED SUICIDE:** This pamphlet contains the key reasons why the current laws on suicide / assisted suicide / euthanasia should be maintained. The information in this document can help form the basis of your own submission.
- 2. THE PROBLEMS WITH THIS BILL:** The centre page of this pamphlet contains a critique of the proposed law change that the politicians are considering.
- 3. HOW TO MAKE A SUBMISSION:** Don't know where to start? On the back page, we've outlined the key information you need to include, the ways you can send your submission in, and other relevant information.

The final date for submissions is **20 February 2018**, but the Select Committee is now receiving submissions. **Please do it as soon as possible.**

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The Problems With Euthanasia / Assisted Suicide

Euthanasia defined

In the euthanasia debate there are a number of terms used more or less interchangeably - euthanasia, mercy killing, physician-assisted suicide, assisted dying, withdrawal of life-prolonging treatment - but the concepts are not identical and are often not well-understood.

Voluntary Euthanasia is the act of intentionally, knowingly, and directly causing the death of a patient, at the request of the patient. If someone other than the person who dies performs the last act, euthanasia has occurred.

Involuntary Euthanasia is where the person is able to give consent but has not done so, or where a person was euthanised against their will.

Non-voluntary Euthanasia is where the person lacks capacity to give consent or request to end his or her life.

Assisted Suicide is the act of intentionally and knowingly providing the means of death to another person at that person's request in order to facilitate his/her suicide. If the person who dies performs the last act, assisted suicide has occurred.

Physician-assisted suicide is where the person providing the means (e.g. lethal drugs) is a medical practitioner.



What is not euthanasia

The administration of pain relief

Everyone has a right to effective pain relief. The administration of drugs in doses sufficient to alleviate pain and suffering rarely causes death. It is permitted, and it is ethical. From time to time, a patient may die while receiving such drugs. That is not euthanasia, since the death of the patient was not the intended outcome of the medication. The Australian and New Zealand Society of Palliative Medicine (ANZSPM 2013) states: *“Treatment that is appropriately titrated to relieve symptoms and has a secondary and unintended consequence of hastening death, is not euthanasia.”* (our emphasis added) (‘Titrated’ means *measured and adjusted*)

The withdrawal of burdensome and futile life-prolonging treatment

The common practice of withdrawing futile medical assistance from a patient for whom it is not accomplishing anything useful, despite this action being associated potentially with the person's death, is lawful. There is no legal or ethical requirement that a diseased or injured person must be kept alive ‘at all costs’. The law has drawn a clear and consistent line between withdrawing medical support, thereby allowing the patient to die of his or her own medical condition, and intentionally bringing about the patient's death by a positive act.



IS NOT EUTHANASIA / ASSISTED SUICIDE	IS EUTHANASIA / ASSISTED SUICIDE
turning off life support	receiving a deadly dose of drugs to swallow later
stopping futile medical tests, treatment and surgeries	receiving a deadly dose of drugs by injection
making a ‘Do Not Resuscitate’ (no CPR) request	
stopping food and/or fluids if they become too burdensome for the patient	
receiving as much medication as needed to treat pain and other symptoms	

‘Safe’ euthanasia is an illusion.

What does the law currently say about suicide

Section 179 of the Crimes Act 1961 (NZ) states that “Everyone is liable to imprisonment for a term not exceeding 14 years who—(a) incites, counsels, or procures any person to commit suicide, if that person commits or attempts to commit suicide in consequence thereof; or (b) aids or abets any person in the commission of suicide.” Furthermore, under Section 151 there is a duty to provide the “necessaries” of life to those who have the care or charge of a “vulnerable adult” who is unable to provide himself or herself with these essentials.

What about my ‘choice’

It is important to note that a person may refuse medical treatment and may do so even if it results in his or her death. Section 11 of the New Zealand Bill of Rights Act 1990 reinforces this common law right by providing that “everyone has the right to refuse to undergo any medical treatment.” The Australian and New Zealand Society of Palliative Medicine (ANZSPM 2013) states: “Patients have the right to refuse life sustaining treatments including the provision of medically assisted nutrition and/or hydration. Refusing such treatment does not constitute euthanasia.” Complying with such a refusal does not constitute euthanasia.

Abuse – even with ‘safeguards’

The potential for abuse and flouting of procedural safeguards is a strong argument against legalisation. An overseas study found that 32 percent of all euthanasia deaths in the Flemish region of Belgium are done without explicit request. The legal requirement to report euthanasia has not been fully complied with in countries that allow euthanasia either. The terminally ill are often vulnerable. And not all families, whose interests are at stake, are wholly unselfish and loving. There is a risk that euthanasia / assisted suicide may be abused in the sense that vulnerable people may be persuaded that they want to die or that they ought to want to die. We need to apply the precautionary principle: the higher the risk – the higher the burden of proof on those proposing legislation. The risk of abuse cannot be eliminated. **‘Safe’ euthanasia is an illusion.**

What if the diagnosis is wrong

A diverse range of research into this issue over the past several decades suggests that the diagnosis is wrong 10–15% of the time. And a 2012 paper published in the British Medical Journal noted that 28% of autopsies report at least one misdiagnosis. A study of doctors’ prognoses (the medical prediction of the course of a disease over time) for terminally ill patients found that only 20% of predictions were within 33% of the actual survival time.

Victoria Reggie Kennedy, widow of the late Democratic Senator Edward Kennedy, campaigned against a bill that would have legalised physician-assisted suicide in Massachusetts. She said:

“When my husband was first diagnosed with cancer, he was told that he had only two to four months to live, that he’d never go back to the U.S. Senate, that he should get his affairs in order, kiss his wife, love his family and get ready to die. But that prognosis was wrong. Teddy lived 15 more productive months.... Because that first dire prediction of life expectancy was wrong, I have 15 months of cherished memories - memories of family dinners and songfests with our children and grandchildren; memories of laughter and, yes, tears; memories of life that neither I nor my husband would have traded for anything in the world. When the end finally did come – natural death with dignity – my husband was home, attended by his doctor, surrounded by family and our priest.”

Mission creep

Many critics emphasise the inevitable extension of euthanasia over time - the so-called ‘mission creep’ or ‘slippery slope’ phenomenon. There is concrete evidence from those countries which have authorised euthanasia that the availability and application of euthanasia expands to situations never initially envisaged.

Euthanasia became legal in the Netherlands in 2002. It allows euthanasia for those aged at least 12 years of age. Children aged from 12 – 15 years require parental consent. More recently, some Dutch doctors are urging lawmakers to extend the euthanasia law to include children aged 1 to 12.¹³ Belgium, which introduced euthanasia for those at least 18 years of age in 2002, voted to extend the practice to children in 2014.

Based on overseas experience, it is extremely likely that if legalised in New Zealand, euthanasia will become a mechanism to terminate the lives of those who do not consent to it as well as those who do consent. It will be available to, and thus come to be utilised by, minors and those with mental illnesses. It may be applied to new-born infants with disabilities. Once society accepts one form of euthanasia restricted to a precise set of conditions, it will be difficult or impossible to confine euthanasia to those conditions. For instance, if the law allows euthanasia for adults with a terminal disease, what prevents minors, those with chronic conditions, and those simply tired of living, from demanding this ‘treatment’?

When a newly-permitted activity is characterised as a ‘human right’ there is often a constituency who will lobby to extend such a right to a greater number of persons. If some citizens are currently deprived of enjoying this newly-minted right, then ‘equality’ and non-discrimination demands that they be granted it too.

Professor Theo Boer was a member of the Dutch Regional Euthanasia Commission for nine years, during which he was involved in reviewing 4,000 cases. He was a strong supporter of euthanasia and argued originally that there was no ‘slippery slope’. However, by 2014 he had had a complete change of mind. He testified to UK politicians considering the issue:

“Whereas in the first years after 2002 hardly any patients with psychiatric illnesses or dementia appear in reports, these numbers are now sharply on the rise. Cases have been reported in which a large part of the suffering of those given euthanasia or assisted suicide consisted in being aged, lonely or bereaved. Some of these patients could have lived for years or decades.”

‘Right to die’ or ‘duty to die’

Procedural safeguards which require the patient’s consent look convincing in theory. In practice, such safeguards can only go so far. Coercion is subtle. The everyday reality is that terminally ill persons and those afflicted with non-terminal, but irreversible and unbearable physical or mental conditions, are vulnerable to direct and indirect pressure from family, caregivers, and medical professionals, as well as self-imposed pressure. They may come to feel euthanasia would be ‘the right thing to do’; they have ‘had a good innings’; they do not want to be a ‘burden’ to their nearest and dearest.

Annual reports by Oregon Public Health contain data on the numbers of patients who reported that part of their motivation to request euthanasia was because they felt themselves to be a ‘burden on family and friends’. 49 percent of patients who requested assisted suicide in 2016 did so out of concern for being a burden on their family; only 13% did so in 1998.

Burden placed on patients

Even simply offering the possibility of euthanasia or assisted suicide shifts the burden of proof, so that patients must ask themselves why they are not availing themselves of it. Society’s offer of death communicates the message to certain patients who are struggling that they may continue to live if they wish, but the rest of us have no strong interest in their survival. Indeed, once the option of a quick and seemingly easy death is officially available, resistance to this choice may be seen as being stubborn, eccentric or even selfish.

Elder abuse

Older New Zealanders are not a problem to be rid of – they are a generation to be honoured and cared for. Elder abuse has become a significant problem in New Zealand. We cannot ignore the possibility that dependent elderly people may be coerced into assisted suicide / euthanasia. We cannot put older New Zealanders at risk by creating



Safeguards can only go so far. Coercion is subtle.

new paths to elder abuse, potentially resulting in a 'duty to die'. Assisted suicide / euthanasia poses a threat to the equality of persons.

Emeritus Professor David Richmond contends:

"It is older people (and those with disabilities, of whom older people form a large percentage) who actually have the most to fear from legalising these practices.... Older people are, by and large, very sensitive to being thought to be a burden, and more likely than a young person to accede to more or less subtle suggestions that they have 'had a good innings'... That is why most District Health Boards in the country have an Elder Abuse team. Hence subtle and not so subtle pressure on older people to request euthanasia where it is available as an option for medical 'care' is not always because the family has the best interests of their ageing relative at heart."

Elderly and ailing patients are all too aware that their increasingly expensive rest home and geriatric care is steadily dissipating the inheritance that awaits their children. Sadly, the more unscrupulous and callous offspring would not be slow in pointing this out either.

'Rational' suicide

The design of a euthanasia or assisted suicide regime is heavily premised on the assumption that people are clear-minded, rational and free of coercion. But how 'rational' a decision can one make when facing a devastating life event? Research on human decision-making suggests that when a person is suffering, decision-making becomes less rational. Most of the demands for legalising euthanasia and assisted suicide come from strong-minded individuals who are intelligent, articulate and who clearly comprehend their predicament. But many people are not like that. Yet a euthanasia law would have to protect everyone – the inarticulate as well as the articulate; the impaired, gullible or naïve, as well as the intelligent and alert.

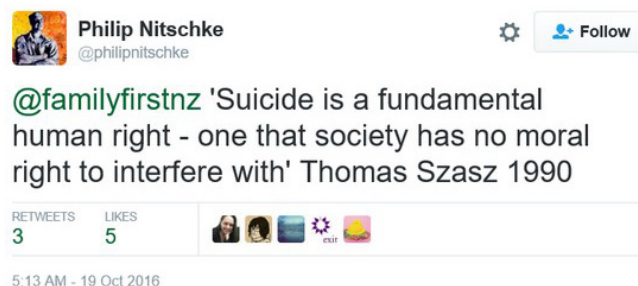


Philip Nitschke: EXIT INTERNATIONAL

The recent government report on euthanasia (2017) said:

"Many submitters were concerned that if assisted dying was legalized, people would see death as an acceptable response to suffering. It would be difficult to say that some situations warranted ending one's life while others do not. These submitters were concerned that while terminal illnesses would initially be the only scenario in which ending one's life would be considered acceptable, this would quickly widen to include any degree of physical pain, then to include mental pain, and then in response to many other situations that arise throughout life..."

"...Several submitters suggested that, during their worst periods of depression, they would have opted for euthanasia had it been available in New Zealand."



Advocates of assisted suicide tried to suggest that suicide can be categorised as either 'rational' or 'irrational'. But the government report also said:

"This distinction was not supported by any submitters working in the field of suicide prevention or grief counselling. On the contrary, we heard from youth counsellors and youth suicide prevention organisations that suicide is always undertaken in response to some form of suffering, whether that is physical, emotional, or mental."

Conflicting messages about suicide prevention

There will always be concerns about conflicting messages being sent regarding suicide if assisted suicide becomes lawful. On the one hand society will offer some individuals assistance to commit suicide, yet on the other hand seek to prevent individual suicides. The arguments put forward for allowing assisted death can also be reasons given for

any suicide. Legalising euthanasia could potentially institutionalise suicide as a method of coping with personal problems. The risk of ‘suicide contagion’ associated with a media campaign around promoting euthanasia is also a real concern.

The World Health Organisation notes the scholarly research on the imitative nature of suicide:

“Systematic reviews of these (50) studies have consistently drawn the same conclusion: media reporting of suicide can lead to imitative suicidal behaviours.... Particular subgroups in the population (e.g., young people, people suffering from depression) may be especially vulnerable to engaging in imitative suicidal behaviours.”



The Scottish Parliament Report on Assisted Suicide (2015) concluded:

“There appears to be a contradiction between a policy objective of preventing suicide on the one hand, and on the other, legislation which would provide for some suicides to be assisted and facilitated.... [T]his has the potential not only to undermine the general suicide prevention message by softening cultural perceptions of suicide at the perimeters, but also to communicate an offensive message to certain members of our community ... that society would regard it as ‘reasonable’, rather than ‘tragic’, if they wished to end their lives”.

Commenting on Brittany Maynard’s suicide which has been a *cause celebre* for euthanasia advocates, social scientist Dr. Aaron Kheriaty from the University of California argues that, “*given what we know about suicide’s social effects, and given the media portrayal around her death, we can anticipate that her decision will influence other vulnerable individuals.*”

A 2012 New Zealand Medical Journal report by New Zealand suicide researchers Annette Beautrais and David Ferguson says reporting on suicide in any way puts vulnerable people at risk.

Promotion of assisted suicide is a message that will be heard not just by those with a terminal illness but also by anyone tempted to think he or she can no longer cope with their suffering – whatever the nature of that suffering. **You don’t discourage suicide by assisting suicide. There is a ‘social contagion’ aspect to suicide – assisted or non-assisted. Suicide is already a public health crisis. We need more discussion about suicide prevention.**

Depression

Many people with depression who request euthanasia revoke that request if their depression and pain are satisfactorily treated. Even very mild depression – of the kind that would not render a person legally incompetent – can have a marked effect on one’s predisposition to live or die. **Virtually all patients who are facing death or battling an irreversible, debilitating disease are depressed at some point.** If euthanasia or assisted suicide is allowed, many patients who would have otherwise traversed this dark, difficult phase and gone on to find meaning in continued living may not get that chance and will die prematurely.

Assisted suicide devalues the disabled

Advocates for the rights of people with disabilities are correct to be concerned. Disability rights group *Not Dead Yet Aotearoa* said, “*There are endless ways of telling disabled people time and time again that their life has no value.*”

The international disability-rights group *Not Dead Yet* says:

“[I]t cannot be seriously maintained that assisted suicide laws can or do limit assisted suicide to people who are imminently dying, and voluntarily request and consume a lethal dose, free of inappropriate pressures from family or society. Rather, assisted suicide laws ensure legal immunity for physicians who already devalue the lives of older and disabled people and have significant economic incentives to at least agree with their suicides, if not encourage them, or worse.”

New Zealander Dr John Fox, who is trustee of Elevate Christian Disability Trust, notes:

“We already know as disabled people that we have to fight to have a job, fight to be born, fight structural prejudice,

“There are endless ways of telling disabled people time and time again that their life has no value.”

patronising assumptions, and cultural realities which call us less than, and worth less. Those challenges are likely not equal for you and me, and the impact of David Seymour's bill would not be equal either."

Baroness Campbell of Surbiton (shown right), former Commissioner of the Equality and Human Rights Commission and of the Disability Rights Commission, who has spinal muscular dystrophy has argued in the UK House of Lords:

"The Bill offers no comfort to me. It frightens me because, in periods of greatest difficulty, I know that I might be tempted to use it. It only adds to the burdens and challenges which life holds for me."



The 'elephant in the room'

In Canada, it has been estimated that euthanasia and assisted suicide will reduce annual health care spending by between \$34.7 million and \$138.8 million (CA\$). The very existence of this report highlights the frightening prospect that money and markets are likely to influence the scope and reach of euthanasia and assisted suicide in the event that it was ever legalised in New Zealand. In 2008, two patients from Oregon who were on Medicaid – 'the state's health insurance plan for the poor' – were denied state-sponsored treatment but told the state would pay for assisted suicide.

A large amount of the public purse is spent on healthcare for the dying, those with dementia and the elderly. Euthanasia is cheap; good palliative care and hospice services are expensive. Bureaucrats are always looking for the cheapest ways to spend health care budgets. This harsh argument from economics is seldom, if ever, heard issuing from the lips of advocates for euthanasia, but it is arguably the 'elephant in the room' in the debate. The cold fiscal reality is that, "end of life care is expensive and having citizens opt for an earlier death is associated with substantial government savings".



What do the medical professionals think

The majority of the medical profession and national medical associations around the world remain resolutely opposed to the introduction of euthanasia or assisted suicide.

The New Zealand Medical Association Position Statement on Euthanasia states: *"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. Doctor-assisted suicide, like euthanasia, is unethical ... 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."*

The World Medical Association Resolution on Euthanasia, *"strongly encourages all National Medical Associations and physicians to refrain from participating in euthanasia, even if national law allows it or decriminalizes it under certain conditions."*

The Australia and New Zealand Society of Palliative Medicine (ANZSPM) Position Statement on Euthanasia (2017) states: *"In accordance with best practice guidelines internationally, the discipline of Palliative Medicine does not include the practices of euthanasia or physician assisted suicide."*

However, the NZ Medical Association's Position Statement on Euthanasia (approved 2005) also says:

"...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. 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."

In September 2017, the American College of Physicians, which claims more than 150,000 members spread throughout 145 countries, reaffirmed their opposition to physician-assisted suicide, saying, *"It is problematic given the nature of the patient-physician relationship, affects trust in the relationship and in the profession, and fundamentally alters the medical profession's role in society."* They called *"for efforts to address suffering and the needs of patients and families, including improving access to effective hospice and palliative care."*

For an online version of this pamphlet (including references & additional information), go to protect.org.nz

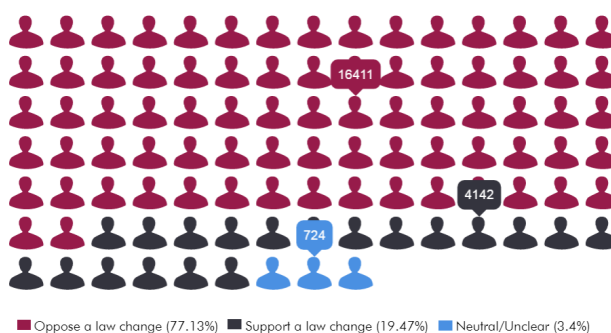
Polls have confused the issue

Opinion polls in New Zealand suggest the majority supports the legalisation of euthanasia and/or assisted suicide. But as we showed earlier, **many people simply want to ensure that the administration of pain relief and the withdrawal of burdensome treatment are not treated as illegal.** The questions used in polls are often misleading in that they conflate actions that are perfectly legal and moral with those that are unlawful. They consistently ask about a patient in 'insufferable' pain thus playing on people's fears, while failing to acknowledge that the most common reasons for requesting euthanasia are existential suffering, not physical pain. In the 10 years that assisted suicide has been legal in Oregon State, it is doubtful if there has been a single request for it from a person suffering from uncontrolled pain. The continued emphasis on pain suggests a degree of cynicism on the part of those who compile such questions.

It is also significant to note that the recent Parliamentary Inquiry on this issue – surely the most accurate and definitive poll – had more than 20,000 submissions with almost 80% of submissions OPPOSING assisted suicide.



77% of submissions are OPPOSED to changing the law



<http://carealliance.org.nz/health-select-committee-77-of-submissions-oppose-euthanasia/>

Is it only 'religious' people that oppose euthanasia

No, far from it. A full analysis of submissions made to the recent Inquiry on assisted suicide revealed almost 80% opposition to any change in the law, but also conclusively rebutted the claims made by ACT MP David Seymour and other supporters of assisted suicide that opposition to euthanasia is driven by 'religious' people only. Some 13,539 (82%) of the 16,411 submissions opposed to euthanasia contained no reference to religious arguments. Ironically, 208 submissions referred to religious reasoning in supporting euthanasia.

Opposition came from those in the **disability sector, senior citizens, human rights advocates, health sector** and concerns were raised that the **economically disadvantaged** who don't have access to better healthcare could feel pressured to end their lives.

What has the overseas experience shown us

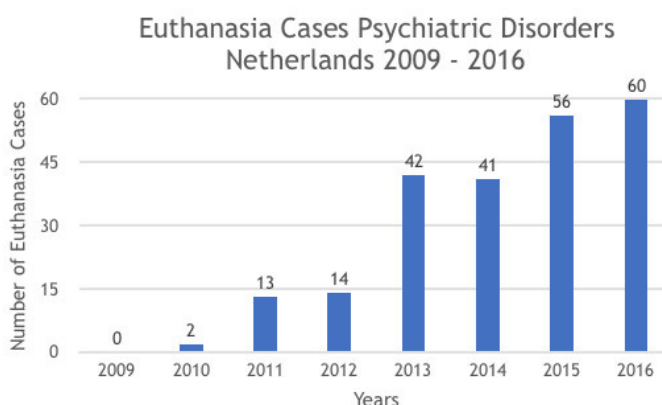
OREGON

- 1 in 6 people prescribed lethal drugs under the state's Death with Dignity Act suffer from clinical depression
- Though Oregon doesn't know the circumstances surrounding the deaths of 543 people who have ingested lethal drugs (about 50% of those who have died under the Death with Dignity Act), in the deaths they do know about, there have been complications in 36 assisted suicide deaths:
 - At least 30 people have regurgitated the drugs
 - At least 6 have regained consciousness after ingesting the drugs
- In 2016, 48.9% of those who died under the Death with Dignity Act cited "burden on family, friends/caregivers" as a reason for accessing assisted suicide
- Doctors have prescribed lethal drugs to patients that they have known less than a week. The median length of doctor/patient relations is 13 weeks

Opposition came from those in the disability sector, senior citizens, human rights advocates, health sector...

NETHERLANDS

- Legal euthanasia deaths in the Netherlands:
 - 54-year-old with personality and eating disorders
 - 47-year-old with tinnitus
 - A woman in her 70s who had dementia, was secretly drugged and held down by her family while a doctor euthanised her despite her protests that she did not want to die
- At least 23% of euthanasia deaths are not reported each year, despite reporting being required by law
- When last studied, complications were recorded in 16% of assisted suicide deaths and 6% of euthanasia deaths in the Netherlands
- The Netherlands' *Termination of Life on Request and Assisted Suicide Act* was passed in 2002:
 - By 2005, newborns could be euthanised under the Groningen Protocol, a list of requirements laid out by the Dutch Society for Paediatrics without recourse to a change in the law by Parliament
 - By 2010, reports began coming in of people being euthanised for mental illness in the absence of a physical disease; two such deaths were reported in 2010, rising to 60 deaths by 2016; again, without recourse to Parliament for a change in the law
 - In 2012, mobile euthanasia clinics (Leven-seindekliniek) began providing euthanasia to patients whose doctors had refused; by 2014, there were 39 of these clinics, again without recourse to Parliament for a change in the law
- As of 2016, euthanasia and assisted suicide account for 4.1% of all deaths in the Netherlands – 5,875 euthanasia deaths, and 216 assisted suicide deaths



BELGIUM

- Legal euthanasia deaths in Belgium:
 - 44-year-old woman with chronic anorexia nervosa
 - 45-year-old twins who were going blind
 - 24-year-old with depression (cleared for euthanasia, but decided not to go through with it at the last minute)
- In the region of Flanders, roughly 30% of all euthanasia deaths are non-voluntary; that's roughly 1.8% of all deaths in the region
- In the Flanders region, approximately 50% of euthanasia deaths are not reported, despite reporting being required by law

WASHINGTON (US STATE)

- As of August 2017, one person prescribed lethal drugs in 2009 under the state's Death with Dignity Act – which requires that those receiving prescriptions have 6 months or less to live – has not died yet. Twenty-two people prescribed lethal drugs in Washington between 2009 and 2017 have not died yet.

CANADA

- Between June 2016 and June 2017, 1,982 people died under Canada's Medical Aid in Dying (MAID) Law– 1,977 were euthanised, and 5 people committed assisted suicide
- After just one year, paediatricians are already “increasingly” being asked by parents to euthanise disabled or dying children and infants, according to a survey by the Canadian Paediatric Society

(References available at Protect.org.nz)

Some disturbing cases in the media recently

Go to protect.org.nz to find links to these news items.

Canadian Mother says doctor brought up assisted suicide option as sick daughter was within earshot

July 2017

“I’m dying of brain cancer. I prepared to end my life. Then I kept living.”

Sept 2017

Terminal cancer patient told hospital would rather spend money on others

*(New Zealand)
Mar 2017*

Netherlands considers euthanasia for healthy people over 75.

July 2017

Dutch gov’t panel: Doctor who forcibly euthanized elderly woman ‘acted in good faith’

Jan 2017

Sex abuse victim in her 20s allowed to choose euthanasia (Holland)

Dec 2016

Belgium man seeks euthanasia to end his sexuality struggle

June 2016

Netherlands offers euthanasia for alcoholics

Dec 2016

Belgium study finds euthanasia targets women and people with depression or autism

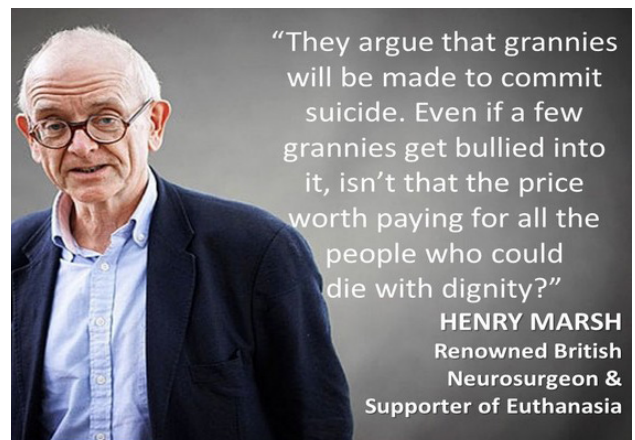
July 2015

Netherlands sees sharp increase in people choosing euthanasia due to ‘mental health problems’

May 2016

Man with same brain cancer as Brittany Maynard (US) has lived 13 years after being given just 6 months

Nov 2014



April 2017

How ‘rational’ a decision can one make when one is suffering from a devastating life event?

The way forward from here

As you can now see, this bill currently before Parliament is flawed and dangerous. Here's the real solution to the genuine concerns of supporters of euthanasia.

New Zealand has a well-developed network of hospices, and palliative medicine is widely practiced. Research on the actual experience of those nearing the end of life indicates that fears of dying tend to dissipate when terminally-ill patients receive good hospice or palliative care. In a study of 200 terminally ill cancer patients, the prevalence of depressive syndromes among patients who expressed a desire for death was 59 percent. Among those who did not desire death, only 8 percent demonstrated depressive syndromes.

“Researchers have found hopelessness, which is strongly correlated with depression, to be the factor that most significantly predicts the wish for death.”

According to researchers in Oregon, when patients who ask for a physician's assistance in suicide “are treated by a physician who can hear their desperation, understand the ambivalence that most feel about their request, treat their depression, and relieve their suffering, their wish to die usually disappears.”

The key priority must be to improve the provision of high quality palliative care and practical support. This should be available in all areas of New Zealand.

Family First NZ is calling for the highest quality of pain control and palliative medicine to be given priority in funding and in medical training so that every New Zealander can benefit.

Patients facing death have a fundamental human right – a right to receive the very best palliative care, love and support that we can give to alleviate the ‘intolerable suffering’ that they fear. This is real death with dignity – surrounded and supported by loved ones – rather than a right to try and preempt the uncertainty and timing of the end.

Safe euthanasia is a myth. Safeguards, while sounding good, would not guarantee the protection required for vulnerable people including the disabled, elderly, depressed or anxious, and those who feel themselves to be a burden or who are under financial pressure. The international evidence backs up these concerns, and explains why so few countries have made any changes to the law around this issue.

We should reject assisted suicide. We should reject David Seymour's bill.



Would you like more copies of this pamphlet? To order FREE copies for your group, email admin@familyfirst.org.nz

Questions for David Seymour

- * Are people with mental illness in or out?
- * What is the error rate of medical diagnosis?
- * How do you prevent subtle coercion of older people?
- * How much money will this save in healthcare spending?
- * How does this not undermine suicide prevention efforts?
- * Why is assisted suicide seen as a compassionate act for young disabled people when suicide is seen as a tragedy for other young people?
- * Would a person with chronic arthritis be eligible?

Read the full list of questions, as well as the 'answers':

www.10questionsfordavidseymour.nz/

Other websites we recommend you read

Care Alliance: carealliance.org.nz

The Nathaniel Centre: nathaniel.org.nz

Euthanasia-Free NZ: euthanasiadebate.org.nz

Every Life Research Unit: everylife.nz

Not Dead Yet Aotearoa: facebook.com/NDYAotearoa

Family First NZ: rejectassistedsuicide.nz

How many euthanasia 'mistakes' are we willing to accept?

ANALYSIS: The problems with David Seymour's Bill

SECTION 4 (OF SEYMOUR'S BILL)

4 Meaning of person who is eligible for assisted dying. In this Act, person who is eligible for assisted dying means a person who –

(a) is aged 18 years or over; and

(b) is –

- (i) a person who has New Zealand citizenship as provided in the Citizenship Act 1977; or
- (ii) a permanent resident as defined in section 4 of the Immigration Act 2009; and

(c) suffers from –

(i) a terminal illness that is likely to end his or her life within 6 months; **or**

(ii) a grievous and irremediable medical condition; and

(d) is in an advanced state of irreversible decline in capability; and

(e) experiences unbearable suffering that cannot be relieved in a manner that he or she considers tolerable; and

(f) has the ability to understand –

(i) the nature of assisted dying; and

(ii) the consequences for him or her of assisted dying.”

SECTION 4 (a) AGE LIMIT

- Given the restriction to persons aged at least 18y/o, this Bill is **discriminatory on the basis of age**. This opinion was backed up by the Attorney-General who said the age restriction could not be justified!
- As such, it could be subject to challenge on basis of inconsistency with human rights legislation (eg Human Rights Act 1993), allowing euthanasia for children.

SECTION 4 (c) (i) PROGNOSIS / DIAGNOSIS

- **“likely” is not defined.** How “likely”? Beyond reasonable doubt? 50/50 probability?
- **Both diagnosis and prognosis are matters of probability, subject to error.** If this bill becomes law, some people will be euthanised on account of a disease they thought they had, but did not. Prognosis is an even more uncertain procedure. Many people know or have heard of a person who, having been given a pessimistic prognosis, has lived for many years to tell the tale. There will be those who decide for euthanasia on the basis of an unduly pessimistic prognosis. The drafters of the bill have ignored these issues.

SECTION 4 (c) (ii) GRIEVOUS AND IRREMIABLE MEDICAL CONDITION

- There is **no requirement that the condition have any terminal effect to qualify**.
- This is similar to the terminology in both the Belgian and the Dutch law that has led to **interpretations including the qualification of those ‘tired of life’ and euthanasia for psychiatric reasons**.
- This means that the requirement that an applicant should have a **“terminal illness” is redundant**. All terminal illnesses could be described as *“grievous and irremediable medical conditions in an advanced state of irreversible decline.”* **If it is meant to be a ‘safeguard’ against abuse it fails utterly** given that the other indications are so broad. The backers of this bill should admit that its real intention is to allow legal euthanasia on demand.
- Is the “grievous” nature assessed by the person or the medical professional(s)? If the opinion of the person concerned determines whether a condition is grievous, this provision is ineffective. Any person wishing to be assisted to die – for any reason – could simply claim that their condition is sufficiently grievous to justify that wish.
- **The term “medical condition” is not defined in the Bill**, meaning that in addition to physical conditions, any mental, psychological and psychiatric condition would qualify a person to have assistance in dying.

ANALYSIS: The problems with David Seymour's Bill

- Does “irremediable” only mean that the current treatment of choice is no longer effective? Does it include a situation where treatment is available but there are financial or practical limitations to accessing it? What if treatments exist but the patient refuses them in favour of requesting euthanasia? For example, would sex-change operations that go wrong come within the definition as has been the case in Belgium? Would **Asperger’s Syndrome** and **autism** come within the definition as has been the case in Belgium? Would **depressed** people and those with **bipolar disorder** come within the definition as has been the case in the Netherlands?

SECTION 4 (d) IRREVERSIBLE DECLINE IN CAPABILITY

- Is the “irreversible” decline in capability to be assessed by the person or the medical professional(s)? What if the patient genuinely believes that their condition and quality of life is worsening?
- Logically speaking **it is impossible to be certain whether any condition is irreversible, given the possibility of medical breakthroughs** between the relevant time and what would be the time of natural death.
- The **possibility of misdiagnosis appears not to have been considered**. The stakes are raised considerably for medical professionals, as a misdiagnosis (for example, a false positive result on a test for cancer) could facilitate an entirely unjustifiable / ill-founded decision by a person to end his/her life.

SECTION 4 (e) UNBEARABLE SUFFERING

- This provision adds no meaningful safeguard and is particularly lacking in merit so far as mental ill-health is concerned:
- The lack of safeguard can be seen by the fact that **any person wishing to be assisted to die – for any reason – could simply claim that they do not regard any efforts to relieve their suffering as being ‘tolerable’**.
- Regarding a situation of mental ill-health, including and especially depression, people inevitably have (even if only temporarily) a reduced ability to make decisions in a reasonably balanced way. It is **dangerous that under this Bill a mental health patient’s own depressed – and hence impaired – judgement can solely determine the prospects of ‘tolerable’ relief**.
- The specific issue of depression is mentioned nowhere in this bill, despite the fact that depression is well recognised as a huge problem for legalising euthanasia. It is established that depression causes those suffering from it to contemplate death. It is also recognised that **diagnosing depression is difficult even for experts in the field**.
- **‘Unbearable’ suffering is not a measurable concept**. Does this bill refer to physical suffering or psycho-social suffering or both? Realistically, no-one other than the applicant can determine when their suffering becomes “unbearable.”
- **This bill may include not only the terminally ill but also the disabled and the mentally ill.**

SECTION 4 (e) UNDERSTANDING

- Who determines this level of understanding?
- **If the person’s ability to understand cannot be determined either way, is there a presumption in favour of understanding (competence)?**
- How ‘rational’ a decision can one make when one is facing a devastating life event? Research on human decision-making suggests that when a person is suffering physically or mentally, decision-making becomes less rational. The recent government report on euthanasia (2017) said “...*Several submitters suggested that, during their worst periods of depression, they would have opted for euthanasia had it been available in New Zealand.*” Many people with depression who request euthanasia revoke that request if their depression and pain are satisfactorily treated.

MAKE A SUBMISSION

Even if you made a submission to the Inquiry last year, this is a separate consideration of a proposed law change.

When preparing your submission, there are some things to remember

- **At all times, be positive, respectful and constructive.** Highlight what you are FOR, and why you are opposed to the *End Of Life Choice Bill*. We are for maintaining the current law opposing assisted suicide / euthanasia. Avoid personal attacks, negative labels or angry words.
- If appropriate, **include a personal story** of how suicide or a terminal illness has affected your family, and how assisted suicide laws would affect vulnerable people. Highlight any examples of palliative care that have made the difference and helped families cope.
- **We would strongly encourage you to say YES to appearing before the Select Committee.** Making an oral submission provides you with the opportunity to reinforce what you have said in your written submission. We can send helpful guidelines to help you prepare for this. Submitters can also be heard via phone.
- When you send your submission in, please consider also **emailing or posting a copy to your local MP.** You can find out who your local MP is (and their email address) at our website www.haveyoursay.nz
- **Share your submission** with friends and family. It may inspire them to make a submission also. Please note: **SUBMISSIONS ARE DUE BY 20 February 2018.** (*The Committee will not accept late submissions.*) However, we would encourage you to make your submission as soon as possible. Please note that submissions are made public unless you specifically request anonymity at the time of putting in your submission.



There are three options you can choose to send in your submission:

POST

Post **two** copies to:
Committee Secretariat
Justice Committee
Parliament Buildings
Wellington 6160

ONLINE

A link to the online submission form is on our website: protect.org.nz

EMAIL

ju@parliament.govt.nz
For further info
Phone: 04 817 9520

Mandatory details for your submission via email or post

ADDRESS: Committee Secretariat, Justice Committee, Parliament Buildings, Wellington 6160

HEADING: SUBMISSION – End of Life Choice Bill

YOUR DETAILS: Name of Individual / Family / Organisation, Address, Phone, Signature

VERBAL SUBMISSION: I/We wish to appear before the Committee to speak to my/our Submission YES / NO

VIEWS: Include reasons for these views. Use your own words.

Remember to **send two copies** if posting your submission. Online submissions have their own format for you to complete.

This pamphlet is produced by Family First NZ

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For an online version of this pamphlet (including references & additional information), go to protect.org.nz

