



Committee Secretariat
Justice Committee
Parliament Buildings
Wellington 6160

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SUBMISSION

End of Life Choice Bill

Family First New Zealand

Address: P.O.Box 276-133, Manukau City 2241

Phone: 09 261 2426

Email: admin@familyfirst.org.nz

Website: www.familyfirst.nz

- 1.1 This submission is being made by **Family First NZ**, a charitable organisation that researches and advocates on family issues in the public domain.
- 1.2 **Family First opposes the Bill. No amendments to the Bill will make it acceptable, and it should be rejected by Parliament.**
- 1.3 **We wish to appear before the Committee to speak to our Submission**

EXECUTIVE SUMMARY

- 1.4 Voluntary euthanasia and physician-assisted suicide is a complex and challenging subject. Both the advocates and opponents of euthanasia are sincere and committed to what they see as the most humane and prudent policy for society.
- 1.5 **To legalise assisted suicide (euthanasia) would place large numbers of vulnerable people at risk** – in particular those who are depressed, elderly, sick, disabled, those experiencing chronic illness, limited access to good medical care, and those who feel themselves to be under emotional or financial pressure to request early death.

- 1.6 Furthermore, any law change would undermine the well-established legal, medical and social principles that people should not be helped to kill themselves and that doctors should not intentionally end life. Maintaining the current laws protects all New Zealanders equally.
- 1.7 **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.** Legalising assisted suicide / euthanasia is a recipe for abuse. So-called ‘safeguards’ are an illusion because they are unable to prevent the potential for coercion and abuse.
- 1.8 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. The highest quality of pain control and palliative medicine should be given priority in medical training so that every New Zealander can benefit.
- 1.9 **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.
- 1.10 **How many euthanasia ‘mistakes’ are we willing to accept?**

SUBMISSION

WHAT IS EUTHANASIA

- 1.11 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.
- 1.12 **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. Euthanasia is **involuntary** where the person is able to give consent but has not done so, or where a person was euthanised against their will, and **non-voluntary** where the person lacks capacity to give consent or request to end his or her life.
- 1.13 **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 their suicide. Assisted suicide occurs where a person self-administers the lethal substance that has been obtained with the assistance of a third party. **Physician-assisted suicide** is where the person providing the means (e.g. lethal drugs) is a doctor.

WHAT IS NOT EUTHANASIA

1.14 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 and it is permitted and it is ethical. From time to time, a patient may die whilst 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.”*¹

1.15 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.²

1.16 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 s 151 there is a duty to provide *“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.

1.17 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.³ 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.

1.18 As a NZ Herald editorial put it - *“devising a robust euthanasia regime, complete with adequate safeguards, seems hardly feasible.”*⁴ The potential for abuse and flouting of procedural safeguards is a strong argument against legalisation. An overseas study found that 32 percent of all assisted deaths in the Flemish region of Belgium are done without explicit request.⁵ The legal requirement to report euthanasia has not been fully complied with in those nations either. In the Netherlands, several official, government-sponsored surveys have disclosed both that in

¹ Australian and New Zealand Society of Palliative Medicine (ANZSPM 2013). The Double Effect principle was endorsed by the NZ High Court in *Seales v Attorney-General* [2015] NZHC 1239 at [101]-[106]

² *Nicklinson v A Primary Care Trust* [2013] EWCA Civ 961 at [25] and [26]

³ Skegg et al 2006: 230, 534

⁴ New Zealand Herald (2004) “Legal mercy killing just not feasible”, 2 April 2004

⁵ Chambaere, Kenneth, Johan Bilsen, Joachim Cohen, et al (2010) “Physician-assisted deaths under the euthanasia law in Belgium: a population-based survey” *Canadian Medical Association Journal* 182(9): 895-901

thousands of cases, doctors have intentionally administered lethal injections to patients without a request and that in thousands of cases, they have failed to report cases to the authorities.

- 1.19 The terminally ill and those suffering great pain from incurable illnesses are often vulnerable. And not all families, whose interests are at stake, are wholly unselfish and loving. There is a risk that 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.⁶
- 1.20 Many critics emphasise the inevitable extension of euthanasia over time - the so-called 'mission creep' or 'slippery slope' phenomenon. There is empirical evidence from those countries that have authorised euthanasia that the availability and application of euthanasia expands to situations never initially envisaged as indications for it. So, for example, euthanasia has been extended to enable minors to avail themselves of it (albeit with parental consent) in the Netherlands and Belgium.
- 1.21 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. It will 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 one allows euthanasia for adults suffering from incurable terminal diseases, then what prevents those with curable diseases from demanding this "treatment"?
- 1.22 Dr. Paul McHugh, University Distinguished Service Professor of Psychiatry at Johns Hopkins University School of Medicine and Psychiatrist-in-Chief at Johns Hopkins Hospital from 1975 to 2001, highlights that "*with physician-assisted suicide, many people—some not terminally ill, but instead demoralized, depressed and bewildered—die before their time.*"⁷
- 1.23 "*Researchers have found hopelessness, which is strongly correlated with depression, to be the factor that most significantly predicts the wish for death,*" write Dr. Herbert Hendin, Professor of Psychiatry and Behavioral Science at New York Medical College and Chief Executive Officer and Medical Director of Suicide Prevention Initiatives, and Dr. Kathleen Foley, Professor of Neurology at Cornell University's medical school and attending neurologist, pain and palliative care services, at Sloan-Kettering Cancer Center.⁸ As Dr. Hendin says:

Mental illness raises the suicide risk even more than physical illness. Nearly 95 percent of those who kill themselves have been shown to have a diagnosable psychiatric illness in the months preceding suicide. The majority suffer from depression that can be treated. This is particularly true of those over fifty, who are more prone than younger victims to

⁶ *Pretty v DPP* [2001] UKHL 61 at [54]

⁷ Paul McHugh, "Dr. Death Makes a Comeback," *The Wall Street Journal*, January 22, 2015, <http://www.wsj.com/articles/paul-mchugh-dr-death-makes-a-comeback-1421970736>

⁸ Herbert Hendin and Kathleen Foley, "Physician-Assisted Suicide in Oregon: A Medical Perspective," *Michigan Law Review*, Vol. 106, No. 8 (June 2008), p. 1622. 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. See H. M. Chochinov et al., "Desire for Death in the Terminally Ill," *The American Journal of Psychiatry*, Vol. 152, No. 8 (August 1995), pp. 1185–1191.

*take their lives during the type of acute depressive episode that responds most effectively to treatment.*⁹

1.24 Drs. Hendin and Foley report that 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."*¹⁰

1.25 Dr. Aaron Kheriaty, Associate Professor of Psychiatry at U.C. Irvine School of Medicine says;

*"To abandon suicidal individuals in the midst of a crisis - under the guise of respecting their autonomy - is socially irresponsible: It undermines sound medical ethics and erodes social solidarity."*¹¹

1.26 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.

1.27 The Netherlands are simply following the trend in Belgium. A Belgium Senator admitted that during the debate on the passing of child euthanasia laws, euthanasia supporters talked about children with anorexia, mental illnesses, and children who were simply tired of life. Belgium is unable to control or prevent the abuse of the existing law. Now they have expanded it to impact children. A recent documentary in Belgium featured a doctor killing a healthy young woman who was struggling with mental illness.¹²

1.28 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."*¹³

1.29 The New South Wales upper house recently voted down a bill on assisted suicide.¹⁴ The defeat in NSW follows a trend worldwide. An analysis of attempts in the USA to allow assisted suicide

⁹ Herbert Hendin, *Seduced by Death: Doctors, Patients, and Assisted Suicide* (New York: W.W. Norton, 1998), pp. 34–35.

¹⁰ Hendin and Foley, "Physician-Assisted Suicide in Oregon," pp. 1625–1626.

¹¹ Aaron Kheriaty, "Apostolate of Death," *First Things*, April 2015, p. 19.

¹² <https://www.youtube.com/watch?v=eo8Hn0DEcpw>

¹³ <http://www.dailymail.co.uk/news/article-2686711/Dont-make-mistake-As-assisted-suicide-bill-goes-Lords-Dutch-regulator-backed-euthanasia-warns-Britain-leads-mass-killing.html>

¹⁴ <http://www.abc.net.au/news/2017-11-16/nsw-parliament-votes-on-euthanasia-bill/9158384>

reveal an overwhelming failure rate associated with such legislation: fewer than 1% of all assisted suicide bills become law. Just this year, 46 bills to legalise assisted suicide in 27 states have been defeated, despite proponents of assisted suicide spending heavily. Between 2015-2017, legislation was also defeated in Scotland, United Kingdom, South Australia¹⁵, New South Wales and Tasmania¹⁶, with the only successes coming in Canada, the three US states of California, Colorado and Washington, DC., and the recent decision in Victoria.¹⁷

1.30 New South Wales Labour health spokesman Walt Secord said, during their recent debate;

*"I have not yet seen it possible to develop adequate legislative safeguards to protect people from the misuse of these laws. I have not yet seen a legislative model in this area that cannot be exploited or manipulated. And I cannot support any gaps for exploitation when the consequences are so final."*¹⁸

1.31 Procedural safeguards that 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 self-imposed pressure. They will come to feel euthanasia would be 'the right thing to do', they have 'had a good innings', they do not want to be 'burden' to their nearest and dearest.

1.32 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". 40% of patients who requested assisted suicide in 2014 did so out of concern for being a burden on their family¹⁹; only 12% did so in 1998²⁰.

1.33 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.

1.34 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 an easy 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 choice of a quick and painless death is officially accepted, resistance to this choice may be seen as being stubborn, eccentric or even selfish.²¹

¹⁵ <http://www.abc.net.au/news/2016-11-16/voluntary-euthanasia-debate-in-south-australia-goes-to-committee/8031776>

¹⁶ <http://www.abc.net.au/news/2017-05-24/tasmania-votes-down-euthanasia-bill/8555882>

¹⁷ https://www.washingtonpost.com/news/powerpost/paloma/the-health-202/2017/10/24/the-health-202-legalizing-assisted-suicide-has-stalled-at-every-level/59ee109330fb045cba000973/?utm_term=.a7e4175a98aa

¹⁸ <http://www.smh.com.au/nsw/voluntary-assisted-dying-bill-defeated-in-nsw-upper-house-20171116-gzn25g.html>

¹⁹ Oregon Public Health Division, Oregon's Death with Dignity Act—2014 [Annual Report-Year 17] (Salem: Oregon Public Health, 2015)

²⁰ Department of Human Resources, Oregon Health Division, Center for Disease Prevention and Epidemiology, Oregon's Death with Dignity Act: The First Year's Experience (Portland: Oregon Health Division, 1999)

²¹ Recommended Reading: "Do You Call This A Life?: Blurred Boundaries in The Netherlands' Right-To-Die Laws" by Gerbert van Loenen (available on [Amazon](#))

- 1.35 Elder abuse is a major concern with any changes to euthanasia laws. As 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."*²²

- 1.36 Renowned British neurosurgeon Henry Marsh, CBE, FRCS, in an interview with the *Sunday Times* that accompanied an extract from his new book, made a disturbing statement: "***They argue that grannies will be made to commit suicide. Even if a few grannies get bullied into it, isn't that the price worth paying for all the people who could die with dignity?***"²³

- 1.37 The design of a euthanasia or assisted suicide regime is heavily premised on the assumption that persons are clear-minded, rational and free of coercion. But how 'rational' a decision can one make when one is suffering from a devastating life event? Research on human decision-making suggests that when a person is suffering, decision-making becomes less rational.²⁴ Most of the demands for legalising euthanasia and assisted suicide come from exceptional individuals who are intelligent, articulate and who clearly comprehend their predicament. Yet a euthanasia law will have to protect everyone - the inarticulate as well as the articulate, the impaired, gullible or naïve, as well as the intelligent and alert.

- 1.38 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."*²⁵

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

²² Richmond, David (2013) "Why elderly should fear euthanasia and assisted suicide" Euthanasia-Free NZ, 16 June 2013: <http://euthanasiadebate.org.nz/84/>

²³ <https://www.medscape.com/viewarticle/879187>

²⁴ Apkarian, A Vania, Yamaya Sosa et al (2004) "Chronic pain patients are impaired on an emotional decision-making task" *Pain* 108: 129-136

²⁵ https://www.parliament.nz/resource/en-NZ/SCR_74759/4d68a2f2e98ef91d75c1a179fe6dd1ec1b66cd24

“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.”

1.40 The 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.”²⁶

1.41 Baroness Campbell of Surbiton, 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”.²⁷

1.42 Ryan T Anderson, author of *Always Care, Never Kill: How Physician-Assisted Suicide Endangers the Weak, Corrupts Medicine, Compromises the Family, and Violates Human Dignity and Equality*²⁸ summarises recent cases where diagnoses of disability are now considered sufficient grounds for death.

“In December 2012, Marc and Eddy Verbesssem, 45-year-old deaf twins, were euthanized in a Belgian hospital after they discovered they were going blind.²⁹ Nancy Verhelst, a 44-year-old transsexual Belgian whose doctors made mistakes in three sex change operations, was left feeling as though she was a “monster.” She then requested—and was granted—euthanasia by lethal injection.³⁰ In the Netherlands, the euthanized include Ann G., a 44-year-old woman whose only ailment was chronic anorexia.³¹ In the beginning of 2013, Dutch doctors administered a lethal injection to a 70-year-old blind

²⁶ Diane Coleman, “Assisted Suicide Laws Create Discriminatory Double Standard for Who Gets Suicide Prevention and Who Gets Suicide Assistance: Not Dead Yet Responds to Autonomy, Inc.,” *Disability and Health Journal*, Vol. 3, No. 1 (January 2010), p. 48, [http://www.disabilityandhealthjnl.com/article/S1936-6574\(09\)00089-2/fulltext](http://www.disabilityandhealthjnl.com/article/S1936-6574(09)00089-2/fulltext)

²⁷ United Kingdom Parliament, “Assisted Dying Bill (HL),” House of Lords Hansard, 755, 2014, [https://hansard.parliament.uk/Lords/201407-18/debates/14071854000545/AssistedDyingBill\(HL\)](https://hansard.parliament.uk/Lords/201407-18/debates/14071854000545/AssistedDyingBill(HL)).

²⁸<http://www.heritage.org/research/reports/2015/03/always-care-never-kill-how-physician-assisted-suicide-endangers-the-weak-corrupts-medicine-compromises-the-family-and-violates-human-dignity-and-equality>

²⁹ Naftali Bendavid, “For Belgium’s Tormented Souls, Euthanasia-Made-Easy Beckons,” *The Wall Street Journal*, June 14, 2013, <http://www.wsj.com/articles/SB10001424127887323463704578495102975991248>

³⁰Editorial, “Belgian Helped to Die After Three Sex Change Operations,” BBC News, October 2, 2013, <http://www.bbc.com/news/world-europe-24373107>

³¹ Graeme Hamilton, “Death by Doctor: Controversial Physician Has Made His Name Delivering Euthanasia When No One Else Will,” *National Post*, November 22, 2013, <http://news.nationalpost.com/2013/11/22/death-by-doctor-controversial-physician-has-made-his-name-delivering-euthanasia-when-no-one-else-will/>

woman because she said the loss of sight constituted "unbearable suffering."³² In early 2015, a 47-year-old divorced mother of two suffering from tinnitus, a loud ringing in the ears, was granted physician-assisted suicide in the Netherlands.³³ She left behind a 13-year-old son and a 15-year-old daughter.³⁴ Gerty Casteelen was a 54-year-old psychiatric patient with molysomophobia, a fear of dirt or contamination. Her doctors decided that she would not be able to control her fear and agreed to administer a lethal injection.³⁵

- 1.43 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. A recent article from Australia highlights the concern that deaths among younger people were an "unintended consequence" of the voluntary euthanasia movement putting out information online on suicide methods.³⁶ (further discussed at 1.66 onwards)
- 1.44 Many people with depression who request euthanasia revoke that request if their depression and pain are satisfactorily treated.³⁷ 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 difficult dark phase (and found meaning in continued living) may not get that chance and will die prematurely.
- 1.45 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 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.³⁸ Another smaller-sized 'elephant' is the increasing demand for human organs suitable for transplants.³⁹

³²DutchNews.nl, "Woman, 70, Is Given Euthanasia After Going Blind," October 7, 2013, http://www.dutchnews.nl/news/archives/2013/10/women_70_gets_euthanasia_after/

³³DutchNews.nl, "Euthanasia Clinic Criticized for Helping Woman with Severe Tinnitus to Die," January 19, 2015, <http://www.dutchnews.nl/news/archives/2015/01/euthanasia-clinic-criticised-for-helping-woman-with-severe-tinnitus-to-die.php/>

³⁴Sue Reid, "The Country Where Death Is Now Just a Lifestyle Choice: A Mum with Ringing Ears. Babies Whose Parents Don't Want Them to Suffer. They've All Been Allowed to Die by Assisted Suicide in Holland," *Daily Mail*, January 1, 2015, <http://www.dailymail.co.uk/news/article-2893778/As-debate-assisted-suicide-dispatch-Holland-thousands-choose-die-year.html>

³⁵Joke Mat, "In the Netherlands, Nine Psychiatric Patients Received Euthanasia," *NRC Handelsblad* (Amsterdam), January 2, 2014, <http://www.nrc.nl/nieuws/2014/01/02/in-the-netherlands-nine-psychiatric-patients-received-euthanasia/>

³⁶<http://www.smh.com.au/national/health/deaths-among-young-an-unintended-consequence-of-euthenasia-movement-mother-20150711-gia7e5>

³⁷Mishara, Brian L and David N Weistubb (2013) "Premises and evidence in the rhetoric of assisted suicide and euthanasia" *International Journal of Law and Psychiatry* 26: 427-435

³⁸Mishara and Wiesstubb 2013: 434

³⁹Graham and Prichard 2013: 20

1.46 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\$).⁴⁰ 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.⁴¹

1.47 The majority of the medical profession and national medical associations around the world remain resolutely opposed to the introduction of euthanasia or assisted suicide.⁴² The role of the doctor would be irrevocably changed from healer to sometime killer, from caring professional who saves lives to one who takes them. “Therapeutic killing” would have arrived. Inevitably, patient trust would be eroded.

1.48 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.”⁴³

1.49 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.”⁴⁴ The World Medical Association reiterated their strong opposition to physician assisted suicide in October 2017.⁴⁵

1.50 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.”⁴⁶

⁴⁰ Aaron J. Trachtenberg and Braden Manns, “Cost analysis of medical assistance in dying in Canada,” CMAJ 23, 189 (2017):E101-5, <http://www.cmaj.ca/content/189/3/E101.full.pdf+html>.

⁴¹ Susan Donaldson James, “Death Drugs Cause Uproar on Oregon,” ABC News, 2008, <http://abcnews.go.com/Health/story?id=5517492&page=1>

⁴² See Seales v Attorney-General [2015] NZHC 1239 at [56]-[57]

⁴³ New Zealand Medical Association, “Position Statement: Euthanasia,” 2015, https://www.nzma.org.nz/_data/assets/pdf_file/0004/16996/Euthanasia-2005.pdf.

⁴⁴ World Medical Association, “WMA Resolution on Euthanasia,” 2013, <https://www.wma.net/policies-post/wma-resolution-on-euthanasia/>.

⁴⁵ <https://www.wma.net/news-post/world-medical-association-reiterates-strong-opposition-to-physician-assisted-suicide-and-to-australian-bill/>

⁴⁶ ANZSPM, “Position Statement: The Practice of Euthanasia and Physician Assisted Suicide,” 2017, <http://10questionsfordavidseymour.nz/wp-content/uploads/2017/07/ANZSPM-Position-Statement-2013-on-The-Practice-of-EuthanasiaAssisted-Suicide.pdf>.

- 1.51 However, *“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.”*
 NZ Medical Association: Position on Euthanasia⁴⁷
- 1.52 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.”*⁴⁸
- 1.53 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 have sometimes been 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 peoples’ fears, while failing to acknowledge that the most common reasons for requesting euthanasia are existential suffering, not physical pain.⁴⁹ 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.
- 1.54 A full analysis of submissions made to the recent Inquiry on assisted suicide revealed 77% 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.⁵⁰ 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.
- 1.55 A 2017 University of Auckland survey on attitudes to euthanasia *Demographic and psychological correlates of New Zealanders support for euthanasia*⁵¹ admits, the *“findings do not represent peoples’ support for the concept of euthanasia per se. Those relying on it cannot do so with confidence.”*

⁴⁷ http://www.nzma.org.nz/_data/assets/pdf_file/0004/16996/Euthanasia-2005.pdf

⁴⁸ <http://annals.org/aim/fullarticle/2654458/ethics-legalization-physician-assisted-suicide-american-college-physicians-position-paper>

⁴⁹ https://www.washingtonpost.com/news/to-your-health/wp/2017/05/24/its-not-pain-but-existential-distress-that-leads-people-to-assisted-suicide-study-suggests/?utm_term=.46976648c3cb

⁵⁰ <http://carealliance.org.nz/wp-content/uploads/2017/05/HSC-submissions-analysis.pdf>

⁵¹ <https://www.stuff.co.nz/national/health/euthanasia-debate/88349694/most-kiwis-support-euthanasia-for-those-with-painful-incurable-diseases>

1.56 It said:

“..we measured support for euthanasia using the single item “Suppose a person has a painful incurable disease. Do you think that doctors should be allowed by law to end the patient’s life if the patient requests it?” This item has been used previously in the British Social Attitudes Survey and assesses levels of support versus opposition to euthanasia as a general concept only. As such, our results do not provide information about potentially more nuanced differences in support for euthanasia in different contexts and for different types of illnesses. For example, previous studies using vignettes have found that people tend to exhibit differing levels of support depending on the subject, type of illness and voluntariness of euthanasia.” (our emphasis added)

And

“It is also important to note that, due to the improvement in palliative care and pain-management in Western countries, most patients today should die without physical pain. As a result of effective palliative care, the avoidance of physical pain may no longer be the central motivation for desiring euthanasia. Moreover, patients’ definition of ‘unbearable suffering’ and reasons for requesting euthanasia now revolve around psycho-emotional and existential factors such as feelings of meaninglessness, loss of self and being a burden on others. The question used in our study included the term ‘painful’ but did not mention any psychological factors associated with desires for euthanasia. This raises the possibility that our findings do not represent peoples’ support for the concept of euthanasia per se, but instead, support for assisted death in the face of severe physical pain.” (our emphasis added)

THE OVERSEAS EXPERIENCE

1.57 **Oregon**

- 1 in 6 people prescribed lethal drugs under the state’s Death with Dignity Act suffer from clinical depression⁵²
- 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 drugs⁵³
- 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 suicide⁵⁴
- Doctors have prescribed lethal drugs to patients that they have known less than a week. The median length of doctor/patient relations is 13 weeks⁵⁵

⁵² BMJ (2008); Journal of Medical Ethics (2011)

⁵³ Oregon Public Health Division, Oregon’s Death with Dignity Act: 2016 data summary (2017).

⁵⁴ Oregon Public Health Division, Oregon’s Death with Dignity Act (2017).

⁵⁵ Oregon Public Health Division, Oregon’s Death with Dignity Act (2017).

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 die⁵⁶
- At least 23% of euthanasia deaths are not reported each year, despite reporting being required by law⁵⁷
- When last studied, complications were recorded in 16% of assisted suicide deaths and 6% of euthanasia deaths in the Netherlands⁵⁸
- 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 law⁵⁹
 - In 2012, mobile euthanasia clinics (Levenseindekliniek) 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 law⁶⁰
- 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 deaths⁶¹

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 region⁶²
- In the Flanders region, approximately 50% of euthanasia deaths are not reported, despite reporting being required by law⁶³

⁵⁶ Dutch News, "Doctor reprimanded for 'overstepping mark' during euthanasia on dementia patient," (29 January 2017), available at: <http://www.dutchnews.nl/news/archives/2017/01/doctor-reprimanded-for-overstepping-mark-during-euthanasia-on-dementia-patient/>.

⁵⁷ B D Onwuteaka-Philipsen et al., "Trends in end-of-life practices before and after the enactment of the euthanasia law in the Netherlands from 1990 to 2010: a repeated cross-sectional survey," in *Lancet* (2012) 380(9845): 908-915.

⁵⁸ JH Groenewoud, et al., "Clinical problems with the performance of euthanasia and physician-assisted suicide in the Netherlands," in *New England Journal of Medicine* (2000) 342(8): 551-6.

⁵⁹ S Boztas, "Netherlands sees sharp increase in people choosing euthanasia due to 'mental health problems'," in *The Telegraph* (11 May 2016); SYH Kim, RG De Vries, J Peteet, "Euthanasia and assisted suicide of patients with psychiatric disorders in the Netherlands 2011 to 2014," in *JAMA Psychiatry* (2016) 73(4): 362-368.

⁶⁰ M C Snijdewind, D L Willema, L Deliens, et al, "A study of the first year of the End-of-Life Clinic for physician-assisted dying in the Netherlands," in *JAMA Internal Medicine* (2015) 175:10, 1633-1640.

⁶¹ European Institute of Bioethics, "Netherlands 2016 euthanasia deaths increase by another 10%," (18 April 2017), available at: <https://www.ieb-cib.org/fr/pdf/report-2016-euthanasia-in-netherlands.pdf>.

⁶² Canadian Medical Association Journal (2010)

- As of 2014, there is no age limit on who may access euthanasia and assisted suicide
- Among those euthanised in the past few years: deaf 45-year-old twins who were going blind; a 44-year-old woman with chronic anorexia nervosa; a 64-year-old woman with chronic depression without informing her family
- A *British Medical Journal* paper by Dr Thiespont – a psychiatrist personally involved in euthanasia – revealed that 74 percent of Belgian patients euthanised for mental suffering were women.⁶⁴

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.⁶⁵

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 suicide⁶⁶
- After just one year, pediatricians are already “increasingly” being asked by parents to euthanise disabled or dying children and infants, according to a survey by the Canadian Paediatric Society⁶⁷. UNICEF Canada is pushing for assisted suicide and euthanasia for children — or “mature minors” — arguing that this conforms with the Charter, Canadian legal precedent and the UN Convention on the Rights of the Child. That would include euthanasia or assisted suicide for mature minors who suffer from a non-terminal illness or disability, according to UNICEF Canada’s policy director Marvin Bernstein.^{68 69}

SOME DISTURBING CASES IN THE MEDIA RECENTLY

- I’m dying of brain cancer. I prepared to end my life. Then I kept living⁷⁰ *Sep 2017*
- Canadian Mother says doctor brought up assisted suicide option as sick daughter was within earshot⁷¹ *July 2017*
- Netherlands considers euthanasia for healthy people over 75⁷² *July 2017*
- Terminal cancer patient told hospital would rather spend money on others⁷³ (*New Zealand*) *Mar 2017*
- Woman comes out of coma after doctors tell her mother to turn off life support⁷⁴ (*New Zealand*) *Mar 2017*

⁶³ BMJ (2010)

⁶⁴ <http://www.scoop.co.nz/stories/GE1608/S00133/74-of-belgian-mental-suffering-euthanised-were-women.htm>

⁶⁵ Washington State Department of Health, “2016 Death with Dignity Act Report” (2017), available at: <https://www.doh.wa.gov/Portals/1/Documents/Pubs/422-109-DeathWithDignityAct2016.PDF>.

⁶⁶ Health Canada, “2nd Interim Report on Medical Assistance in Dying in Canada,” (2017), available at: <https://www.canada.ca/en/health-canada/services/publications/health-system-services/medical-assistance-dying-interim-report-sep-2017.html>.

⁶⁷ <https://www.cps.ca/en/documents/position/medical-assistance-in-dying#ref22>

⁶⁸ <https://www.lifesitenews.com/news/unicef-lobbies-canadian-parliament-to-allow-euthanasia-for-children>

⁶⁹ <https://sencanada.ca/en/Content/Sen/Committee/421/LCJC/09ev-52593-e>

⁷⁰ https://www.washingtonpost.com/outlook/im-dying-of-brain-cancer-i-prepared-to-end-my-life-then-i-kept-living/2017/09/29/ef88f0fc-8ce7-11e7-84c0-02cc069f2c37_story.html?utm_term=.8c99c9920358

⁷¹ <https://rejectassistedsuicide.org.nz/mother-says-doctor-brought-up-assisted-suicide-option-as-sick-daughter-was-within-earshot/>

⁷² <https://rejectassistedsuicide.org.nz/netherlands-considers-euthanasia-for-healthy-people-over-75/>

⁷³ <https://www.stuff.co.nz/national/health/90267348/cancer-patient-told-hospital-would-rather-spend-money-on-others>

- Hospitals slap do-not-resuscitate orders on patients without consent⁷⁵ (*New Zealand*) Feb 2017
- Dutch doctor drugged patient's coffee and got family to hold her down⁷⁶ Jan 2017
- Sex abuse victim in her 20s allowed to choose euthanasia (*Holland*)⁷⁷ Dec 2016
- Netherlands offers euthanasia for alcoholics⁷⁸ Dec 2016
- Assisted-suicide law prompts insurance company to deny coverage to terminally ill California woman⁷⁹ Oct 2016
- Belgium man seeks euthanasia to end his sexuality struggle⁸⁰ June 2016
- Growing number of mentally ill Dutch choosing to be killed at euthanasia clinic⁸¹ Aug 2015
- Belgium study Finds Euthanasia Targets Women and People With Depression or Autism⁸² July 2015
- Deaths among young an unintended consequence of euthanasia movement: Australian mother⁸³ July 2015
- A healthy, 24-year-old woman to be euthanised in Belgium for psychological reasons⁸⁴ June 2015
- Euthanasia wanted for man in constant pain after having a tumour despite not being terminally ill⁸⁵ May 2015
- Woman given two months to live survived for nine years⁸⁶ Sep 2016
- Doctors Killed His Belgian Mom Because She Was Depressed. Now He Speaks Out Against Euthanasia⁸⁷ Jan 2015
- Elderly Scottish cousins undergo joint euthanasia for fear of being put in separate care homes⁸⁸ Feb 2015
- Documentary shows Belgian doctor euthanizing a depressed, suicidal woman⁸⁹ Jan 2015
- Mentally ill patients killed by euthanasia in Holland trebles in a year⁹⁰ Oct 2014
- Man with same brain cancer as Brittany Maynard (US) has lived 13 years after being given just 6 months⁹¹ Nov 2014

⁷⁴ <https://www.stuff.co.nz/national/health/90705063/Woman-comes-out-of-coma-after-doctors-tell-her-mother-to-turn-off-life-support?cid=app-iPhone>

⁷⁵ <http://www.stuff.co.nz/national/health/89655156/hospitals-slap-donotresuscitate-orders-on-patients-without-consent>

⁷⁶ <https://rejectassistedsuicide.org.nz/female-dutch-doctor-drugged-a-patients-coffee/>

⁷⁷ <http://www.dailymail.co.uk/news/article-3583783/Sex-abuse-victim-20s-allowed-choose-euthanasia-Holland-doctors-decided-post-traumatic-stress-conditions-uncurable.html>

⁷⁸ <https://www.mercatornet.com/careful/view/netherlands-offers-euthanasia-for-alcoholics/19066>

⁷⁹ <http://www.washingtontimes.com/news/2016/oct/20/assisted-suicide-law-prompts-insurance-company-den/>

⁸⁰ <https://rejectassistedsuicide.org.nz/man-seeks-euthanasia-to-end-his-sexuality-struggle/>

⁸¹ <https://www.lifesitenews.com/news/growing-number-of-mentally-ill-dutch-choosing-to-be-killed-at-euthanasia-cl>

⁸² <http://www.lifenews.com/2015/07/26/study-finds-euthanasia-targets-women-and-people-with-depression-or-autism/>

⁸³ <http://www.smh.com.au/national/health/deaths-among-young-an-unintended-consequence-of-euthenasia-movement-mother-20150713-gia7e5>

⁸⁴ http://alexschadenberg.blogspot.ca/2015/06/healthy-24-year-old-woman-to-be.html?utm_source=Euthanasia+Prevention+Coalition+Newsletter&utm_campaign=73a94a1493-EPC_Newsletter_Update6_22_2015&utm_medium=email&utm_term=0_105a5cdd2d-73a94a1493-157142057&m=1

⁸⁵ <http://www.dailymail.co.uk/news/article-3100838/Father-two-constant-pain-nerve-damage-launches-crowd-funding-appeal-end-life-Dignitas-despite-not-terminally-ill.html>

⁸⁶ <http://www.dailymail.co.uk/news/article-2990255/Study-Tetanus-shot-aid-treatment-deadly-brain-cancer.html>

⁸⁷ <http://dailysignal.com/2015/01/02/doctors-killed-mom-depressed-now-speaks-euthanasia/>

⁸⁸ <http://www.telegraph.co.uk/news/11382849/Elderly-cousins-undergo-joint-euthanasia-for-fear-of-being-separated.html>

⁸⁹ <https://liveactionnews.org/documentary-shows-belgian-doctor-euthanizing-a-depressed-suicidal-woman/>

⁹⁰ <http://www.dailymail.co.uk/news/article-2779624/Number-mentally-ill-patients-killed-euthanasia-Holland-trebles-year-doctors-warn-assisted-suicide-control.html>

⁹¹ <https://www.lifesitenews.com/news/man-with-same-brain-cancer-as-brittany-maynard-has-lived-13-years-after-bei>

- Euthanasia for ‘depressed’ alleged murderer by campaigner Philip Nitschke (Aust)⁹² July 2014
- Swiss – assisted dying for elderly who are not terminally ill⁹³ May 2014

1.58 The High Court of Ireland voiced their concern:

“[T]he incidence of legally assisted death without explicit request in the Netherlands, Belgium and Switzerland is strikingly high.”⁹⁴

1.59 California woman **Brittany Maynard** had a brain tumour and went to Oregon for her assisted suicide last year. She became a *cause célèbre* for pro-euthanasia advocates. But one must also consider the cases of **Stephanie Lipscomb**, **Fritz Anderson** and **Nancy Justice**. They all had the same kind of brain tumour as Brittany Maynard, but they went for the cure and are alive today, their tumours eliminated or dramatically reduced in size.

WHAT IF THE DIAGNOSIS IS WRONG

1.60 A diverse range of research into this issue over the past several decades suggests that the diagnosis is wrong 10–15% of the time.⁹⁵ A 2012 paper published in the British Medical Journal noted that 28% of autopsies report at least one misdiagnosis⁹⁶. 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 time⁹⁷.

1.61 College student Stephanie Lipscomb had Stage IV glioblastoma which gave her a large cancerous tumour in her brain. In May 2012, Stephanie received experimental treatment using a re-engineered polio virus. Over the next year, her tumour dramatically shrank, and then disappeared. Nearly 3½ years later, Stephanie is cancer-free and living life to the full. There are other glioblastoma survivors whose brain tumours have been eliminated without harming surrounding tissue -- in addition to Stephanie, *60 Minutes* in March 2015 covered the success stories of patients Dr. Fritz Anderson and Nancy Justice. Stage IV glioblastoma multiforme was the same condition of Californian Brittany Maynard, who tragically committed suicide in November 2014.⁹⁸

⁹²<http://mobile.news.com.au/national/western-australia/philip-nitschke-denies-he-went-too-far-helping-depressed-nigel-brayley-die/story-fnii5thn-1226978024808>

⁹³ <http://www.theguardian.com/society/2014/may/26/swiss-exit-assisted-suicide-elderly-not-terminally-ill>

⁹⁴ *Fleming v. Ireland & Ors*, IEHC 2 (2013), para. 102, <http://www.bailii.org/ie/cases/IEHC/2013/H2.htm>

⁹⁵ Mark L Graber, “The incidences of diagnostic error in medicine,” *BMJ Quality and Safety*, 0 (2013): p. 1, <http://qualitysafety.bmj.com/content/qhc/early/2013/08/07/bmjqs-2012-001615.full.pdf>.

⁹⁶ B Winters, J Custer, SM Galvagno, et al., “Diagnostic errors in the intensive care unit: a systematic review of autopsy studies,” *BMJ Quality and Safety* 21 (2012): p. 894, <http://qualitysafety.bmj.com/content/21/11/894>.

⁹⁷ Nicholas A Christakis and Elizabeth B Lamont, “Extent and determinants of error in doctors’ prognoses in terminally ill patients:

⁹⁸ <http://abcnews.go.com/Health/polio-shrinks-womans-brain-tumor/story?id=19688955>

- 1.62 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.”⁹⁹

- 1.63 The NZ Herald reported one such case in November 2017:

“A groom who had been told he had just weeks to live used his wedding to tell guests that he wasn’t dying and had actually been misdiagnosed. Jack Kane, 23, proposed to his girlfriend Emma Clarke, 23, after being told that he had a cancerous tumour on his spine. He had been struggling with severe back pain and hypersensitivity in his legs, eventually finding that he could not move at all. He was later told he just weeks to live, according to The Telegraph UK.

Their wedding was arranged to take place in a ceremony at the James Cook Hospital in Middlesbrough eight days after his emotional proposal. But in that time doctors discovered that the “terminal” cancer was actually a rare neurological condition called neuromyelitis optica, also known as Devic’s disease. The couple told their immediate family but decided to keep it a secret from the rest of their 130 guests. Mr Kane eventually told them during his speech. The moment was caught on video and shows Mr Kane sitting in his wheelchair. He begins to sob as he says: “The doctors have done some further tests and they came back positive – I am not terminal.”¹⁰⁰

- 1.64 New Zealand has a well-developed network of hospices, and palliative medicine is widely practiced. There is research on the actual experience of those nearing the end of life indicating that fears of dying tend to dissipate when terminally-ill patients receive good hospice or palliative care.¹⁰¹ 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. The highest quality of pain control and palliative medicine should be given priority 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

⁹⁹Victoria Reggie Kennedy, “Question 2 Insults Kennedy’s Memory,” *Cape Cod Times*, November 3, 2012, <http://www.capecodtimes.com/article/20121027/OPINION/210270347>

¹⁰⁰ <http://www.nzherald.co.nz/index.cfm?objectid=11943130&ref=twitter>

¹⁰¹ Kastenbaum, Robert (2006) *The Psychology of Death*, 3rd ed. New York: Springer; Mishara and Weisstub 2013: 433

by loved ones, rather than a right to try and preempt the ‘uncertainty’ and timing of the end. Assisting suicide is not the answer.

- 1.65 Dr Catherine Byrne, who is a Tauranga GP who has worked at Waipuna Hospice for 15 years, wrote in an op-ed for the NZ Herald:

“Death, even from cancer or other frightening diseases, does not have to be “lonely, violent and concealed from family”, nor does it have to be “excruciatingly painful”, as [Californian] Governor Jerry Brown fears. The whole point of the hospice movement is to prevent those very things, by excellent medical care and by warm, compassionate psychological and social support. There is no need to legislate for euthanasia to initiate “frank and honest conversations about death” – we have these conversations every day with people at the hospice.... [H]aving those conversations brings comfort and relief to people previously afraid to articulate their fears.

There is no need for anyone who receives good palliative care to die in excruciating pain; nor to die with loss of autonomy or dignity. Palliative care practitioners, from nurses and doctors to cooks and cleaners, spend their whole working lives doing everything they can to prevent any suffering at the end of life, and most people who have had contact with a hospice would support that statement. The way forward with difficult deaths should be to encourage the Government to ensure every single New Zealander who needs it has access to ever-better palliative care services.”¹⁰²

- 1.66 Voluntary euthanasia has the allure of being an enlightened and compassionate response to the plight of the suffering. But its practical operation is fraught with risks and there are slippery slopes that are indeed very slippery. Perhaps the most ominous change is one that cannot be proved. There will be an irreversible alteration to the way society and the medical professional view the demise of the elderly, the disabled, the incurably afflicted and the terminally ill. Death will be planned, coordinated and state-sanctioned in a manner hitherto unknown.
- 1.67 We should increase care, support, and funding for the best palliative care regime in the world. But we should not allow euthanasia and assisted suicide.

YOU DON'T DISCOURAGE SUICIDE BY ASSISTING SUICIDE

- 1.68 *'Suicide is a fundamental human right - one that society has no moral right to interfere with'.* This is what we would classify as an objectionable and dangerous idea – a tweet from euthanasia advocate Dr Philip Nitschke to Family First in 2016.

¹⁰² <http://www.nzherald.co.nz/index.cfm?objectid=11880452&ref=twitter>



Philip Nitschke
@philipnitschke



Follow

@familyfirstnz 'Suicide is a fundamental human right - one that society has no moral right to interfere with' Thomas Szasz 1990

RETWEETS
3

LIKES
5



5:13 AM - 19 Oct 2016

- 1.69 In 2014 Nitschke came under fire from two Australian suicide prevention organisations, *Beyond Blue* and the *Black Dog Institute*, after his involvement in the suicide of a physically healthy 45-year-old Australian man¹⁰³, a 39-year-old mother suffering from post-natal depression who died an agonizing death from euthanasia drugs; a 26-year-old suffering from hidden depression; and a Wellington woman who ended her life with Nembutal, after receiving advice on how to obtain it from Dr Nitschke.¹⁰⁴ She was a life-member of EXIT and was suffering from depression, but was physically fit and not suffering a terminal illness. As a result, the Medical Board of Australia has imposed 25 strict conditions on Philip Nitschke, known as Doctor Death. The board believes he “presents a serious risk to public health and safety.”¹⁰⁵
- 1.70 Dr Wesley Smith, the author of *Forced Exit: Euthanasia, Assisted Suicide* and *The New Duty to Die and Culture of Death: The Assault on Medical Ethics in America* says about Dr Nitschke;

“In 2001, [Nitschke] told Kathryn Jean Lopez¹⁰⁶ he would like to make suicide pills available in supermarkets, including to ‘troubled teens’: “So all people qualify, not just those with the training, knowledge, or resources to find out how to “give away” their life. And someone needs to provide this knowledge, training, or recourse necessary to anyone who wants it, including the depressed, the elderly bereaved, [and] the troubled teen. If we are to remain consistent and we believe that the individual has the right to dispose of their life, we should not erect artificial barriers in the way of sub-groups who don’t meet our criteria.

“Nitschke is not a euthanasia outlaw disdained by his fellow travelers. Indeed, he enjoys something of a cult status among euthanasia camp followers. Nitschke has often been a featured speaker at international pro-euthanasia symposia, His only sin, in the eyes of movement leaders, is excess candor. For political reasons, they want to pretend that euthanasia will remain a limited option rather than the wide-open death agenda we see developing already.”¹⁰⁷

¹⁰³ <http://www.abc.net.au/news/2014-07-10/voluntary-euthanasia-advocate-dr-philip-nitschke-investigated/5588062>

¹⁰⁴ <http://www.stuff.co.nz/national/health/250448/Outrage-as-healthy-woman-helped-to-die>

¹⁰⁵ <http://www.newshub.co.nz/world/medical-board-suspends-dr-death-2014072412>

¹⁰⁶ <http://www.nationalreview.com/article/420133/euthanasia-sets-sail-kathryn-jean-lopez>

¹⁰⁷ <http://www.nationalreview.com/corner/442766/death-demand-true-euthanasia-movement-goal>

- 1.71 **This Bill and the public debate presents a serious risk to public health and safety.**
- 1.72 In 2016, Chief Coroner Judge Deborah Marshall referred to NZ’s unacceptable and stubbornly high suicide rate and said that there needs to be more discussion.¹⁰⁸ We’re having more discussion here – which is a good thing – but Judge Marshall said we needed more discussion about suicide *prevention*. This Bill is being driven by a desire to promote assisted suicide.
- 1.73 **You don’t discourage suicide by assisting suicide.**
- 1.74 Laws permitting physician-assisted suicide send a message that, under especially difficult circumstances, some lives are not worth living — and that suicide is a reasonable or appropriate way out. **But suicide is already a public health crisis.** Do we want to worsen this crisis?
- 1.75 Many of us are concerned with the impact on elder suicide and youth suicide as a result of ‘normalising’ the concept of so-called ‘rational suicide’. But this creates a problem. There is a ‘social contagion’ aspect to suicide – assisted or non-assisted.
- 1.76 The World Health Organization notes the scholarly research on the imitative nature of suicide:
- “Over 50 investigations into imitative suicides have been conducted. Systematic reviews of these 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. Finally, and probably most importantly, overt description of suicide by a particular method may lead to increases in suicidal behaviour employing that method.”¹⁰⁹*
- 1.77 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”.¹¹⁰*
- 1.78 Commenting on Brittany Maynard’s suicide which has been a *cause de celebre* for euthanasia advocates, social scientist Dr. Aaron Kheriaty from the University of California argues that “*given*

¹⁰⁸ http://www.nzherald.co.nz/nz/news/article.cfm?c_id=1&objectid=11731076

¹⁰⁹ http://www.who.int/mental_health/prevention/suicide/resource_media.pdf

¹¹⁰ Health and Sport Committee, “Stage 1 Report on Assisted Suicide (Scotland) Bill,” The Scottish Parliament, SP Paper 712, 2015, Sections 277-280, http://www.parliament.scot/S4_HealthandSportCommittee/Reports/her15-06w-rev.pdf.

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."¹¹¹

1.79 In his article published in the *Southern Medical Journal* last year, he goes on to say:

"[The Werther Effect] has been replicated many times since in rigorous epidemiological studies, including research demonstrating this effect following cases of doctor-assisted suicide... Because this phenomenon is well-validated, the U.S. Centers for Disease Control and Prevention, the World Health Organization and the U.S. surgeon general have published strict journalistic guidelines for reporting on suicides to minimize this effect. It is demoralizing to note that these guidelines were widely ignored in the reporting of recent instances of assisted suicide, with the subject's decision to end his or her life frequently presented in the media as inspiring and even heroic... A related phenomenon influences suicide trends in the opposite direction, however; the so-called Papageno effect suggests that coverage of people with suicidal ideation who do not attempt suicide but instead find strategies that help them to cope with adversity is associated with decreased suicide rates.

1.80 We know this to be the case – for example – the Chilean 14-year-old Valentina Maureira. She made a YouTube video¹¹² begging her government for assisted suicide, and her case illustrates the Werther and Papageno effects. Maureira admitted that the idea to end her life began after she heard about the case of Brittany Maynard¹¹³. But Maureira changed her mind after meeting another young person also suffering from the same disease, cystic fibrosis, who conveyed a message of hope and encouraged her to persevere in the face of adversity.

1.81 **With our laws, we can encourage vulnerable individuals in one of these two directions:** the path of Werther or the path of Papageno.

1.82 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 cannot go on any longer.

1.83 As you may be aware, the Stuff website recently did a feature on the issue entitled *Public reports of suicides linked to copycat deaths*¹¹⁴ and said that a contagion effect can occur when an already vulnerable person emulates the suicide of another person following reports or public discussion of the suicide. This is sometimes referred to as a "copycat suicide".

1.84 The Mental Health Foundation's Moira Clunie said that restrictions on reporting are in place to protect those who are already vulnerable. She says that reports of suicide can give vulnerable people "*triggers or pictures*" around potential methods.

¹¹¹ https://www.washingtonpost.com/opinions/the-dangerously-contagious-effect-of-assisted-suicide-laws/2015/11/20/6e53b7c0-83fb-11e5-a7ca-6ab6ec20f839_story.html?utm_term=.c4e9a71afe38

¹¹² <https://www.youtube.com/watch?v=HG1zsTzshVU>

¹¹³ <http://thebrittanyfund.org/>

¹¹⁴ <http://www.stuff.co.nz/national/80198760/Public-reports-of-suicides-linked-to-copycat-deaths>

1.85 The Human Rights Commission recently released a paper on “*prioritisation of vulnerable customers*”¹¹⁵ to help insurers, and potentially other businesses and social sector agencies, to prioritise vulnerable customers. Under the definition of vulnerability, they say that;

“It changes over time and depending on people’s circumstances, meaning that people can move in and out of vulnerability and between different kinds of vulnerability.”

1.86 Examples include:

- *Customer has been diagnosed with a chronic illness or terminal illness*
- *Customer has a serious physical health condition or serious mental health condition which requires continuous monitoring*

1.87 They say that Vulnerability is about “*valuing customers (patients) and better managing risk.*”

1.88 A 2010 New Zealand Medical Journal report by New Zealand suicide researchers Annette Beautrais and David Fergusson says reporting on suicide in any way puts vulnerable people at risk.¹¹⁶

1.89 The joint World Health Organization (WHO) and International Association for Suicide Prevention (IASP) guidelines on suicide and media reporting (2000) conclude:

*“Overall, there is enough evidence to suggest that some forms of non-fictional newspaper and television coverage of suicide are associated with a statistically significant excess of suicide; the impact appears to be strongest among young people.”*¹¹⁷

1.90 A 2010 study examined both the positive and negative effects of media reporting using Austrian data.¹¹⁸ This study found that the **repetitive** reporting of completed suicide or suicide attempts, had harmful effects and led to increases in suicidal behaviour.

1.91 **This is exactly the risk to young and to vulnerable people and elderly people as a result of the current obsession in New Zealand with promoting assisted suicide.**

1.92 The *New Zealand Suicide Prevention Action Plan 2013–2016*¹¹⁹ released in May 2013 has a number of action areas in order to achieve the objectives of reducing our suicide rates. One action area (#5) is to “*Support communities to respond following suicides, especially where there are concerns of suicide clusters and suicide contagion.*” But protracted discussion and the promotion of assisted suicide / euthanasia and related cases will undermine the suicide prevention message and goals in the following ways:

¹¹⁵ https://www.hrc.co.nz/files/5114/7426/1153/HRC_Vulnerability_Guidelines.pdf

¹¹⁶ <https://www.nzma.org.nz/journal/read-the-journal/all-issues/2010-2019/2012/vol-125-no-1362/editorial-beautrais>

¹¹⁷ http://www.who.int/mental_health/media/en/426.pdf

¹¹⁸ *Role of media reports in completed and prevented suicide: Werther v. Papageno effects*, Thomas Niederkrotenthaler et al; The British Journal of Psychiatry Sep 2010, 197 (3) 234-243;

¹¹⁹ <http://www.health.govt.nz/system/files/documents/publications/new-zealand-suicide-prevention-action-plan-2013-2016-v2.pdf>

- legalised assisted suicide can imply that the promotion of mental health and wellbeing for people in pain is futile or counter productive
- it can imply that people in pain do not need care when they feel suicidal and instead asserts that suicide is their best outcome
- it can increase the means to suicide especially for those who are vulnerable because of pain or illness
- it would normalise positive portrayals of suicide in the public domain. People contemplating suicide may justify doing it based on positive stories and arguments they have heard about assisted suicide
- it would ignore the possible harmful effects on families / whanau

1.93 In 2014, the Law Commission released a Report entitled *“Suicide Reporting”*¹²⁰. It said that the aspects of normalising suicide, glorifying the suicide, sensational coverage and/or the prominence of the coverage were significant. The Law Commission said:

*“While most readers will not be affected, a minority of already vulnerable people may be affected. The research shows young people and those with mental health problems may be particularly vulnerable to suicide reports.”*¹²¹

And:

*“Reports of suicides contribute to other suicidal behaviour if they create more positive definitions of suicide (advertising the method of suicide, glorifying the suicide, providing sensational coverage, normalising the suicide) than negative definitions (focusing on the pain of suicide, promoting alternatives to suicide).”*¹²²

And:

“A normalising effect may occur when suicide is represented (often inadvertently) as a reasonable or common response to problems or a crisis. By being presented as relatively common, a person may feel that it is more acceptable.”

1.94 Last October, an important study was published by British scholars David Jones and David Paton demonstrating that legalizing assisted suicide in other states has led to a rise in overall suicide rates — assisted and unassisted — in those states.¹²³ The paper says: *“It may be that legalising PAS also provides positive role models who help normalise suicide more generally.”*

1.95 **You don’t discourage suicide by assisting suicide.**

¹²⁰ <http://www.lawcom.govt.nz/sites/default/files/projectAvailableFormats/NZLC%20R131.pdf>

¹²¹ DP Phillips and LL Carstensen “Clustering of teenage suicides after television news stories about suicide” (1986) 315 N Engl J Med 685.

¹²² Steven Stack “Suicide in the Media: A Quantitative Review of Studies Based on Nonfictional Stories” (2005) 35 Suicide and Life Threatening Behavior 121.

¹²³ <http://www.medscape.com/viewarticle/852658>

- 1.96 It noted that Oregon's rate of 'unassisted' suicide in the general population is 41% higher than the national average,¹²⁴ the Netherland's official statistics agency reported in 2013 that the suicide rate in the general population has "grown dramatically" over the past five years, with a 30% increase from 2008 to 2012.¹²⁵
- 1.97 It's time for this debate to be ended, and for the discussion to focus on providing the very best palliative care and support for vulnerable people – whether they are at the end of their life, or wishing they were at the end of their life.
- 1.98 Terminally ill Australian Julie Morgan, in her article published in the *Sydney Morning Herald* in January 2017, said:

"The doctors have told me I have a few months to live. The cancer that began in my breast four years ago has spread to my spine, ribs, hips and, more significantly, to my lungs. The surgeries, extensive chemotherapy, and radiation that I went through back then, plus the on-going hormone therapy, didn't do the trick. And so now, in my mid 50's, I'm terminally ill. It often doesn't seem real, yet it is. But there's so much more that I want to do – I am not ready to go!..."

The debate worries and scares me on several levels. Fortunately we just don't go around killing each other anymore, so the notion that it's a person's "free choice" to die just doesn't make sense. Recognising the full scope of human dignity, we stopped capital punishment a long time ago. Now bringing in legislation that allows a group of experts to determine who can "legally" die, seems a retrograde move. Intellectually, that worries me. And once the legislation has been approved, experience tells us that it is likely to grow exponentially. I can imagine a time when particularly frail and vulnerable people will succumb to the thought that it might be best for their families and for society in general for them to let go and die – they will agree to something because they think they ought to. That scares me...

I have always been an extremely private person, so the thought that my increasingly frail body will need intimate help does not thrill me. But just as I cared for and loved my friend in all her messiness and fragility, I will have to let others care for and love me in the same way. There is nothing undignified about that. So my experience of being a primary carer tells me that as I'm dying, the presence of people who have the emotional capacity to sit with me during long hours, who have the strength to continually stroke my arm, to bring me cups of water in the night, to tell me that they love me and to stay with me even if it seems that I am no longer present to them is of beyond measure. I'm sure that I will know their voices, and that I will know their touch. So as the doctors relieve my physical pain, I trust that my family and friends will abide with me so that just as I have lived, so will I die, with integrity and grace."¹²⁶

¹²⁴ Oregon Public Health Division "Suicides in Oregon: Trends and risk factors – 2012 report"

<http://public.health.oregon.gov/DiseasesConditions/InjuryFatalityData/Documents/NVDRS/Suicide-in-Oregonreport.pdf>.

¹²⁵ www.cbs.nl/en-GB/menu/themas/dossiers/allochtonen/publicaties/artikelen/archief/2013/2013-3995-wm.htm.

¹²⁶ <http://www.smh.com.au/comment/im-terminally-ill-and-the-debate-on-euthanasia-scares-me-20170117-gtt0kn.html>

1.99 Zachary Schmoll is a PhD student in humanities in the US. He writes:

“As a man with a physical disability, I need a lot of help to perform many basic daily activities. I still consider myself to be an independent thinker, but my physical independence is substantially limited by my severely reduced muscle strength. I need help to drive my van, get dressed, prepare my meals, and complete other daily tasks. For me, this is life. For many others, this level of dependence is motivation to consider bringing life to an end.... The legalization of physician-assisted suicide sends the message that it is better to be dead than disabled. Do I lack dignity because I lack physical independence?”

Better Dead Than Disabled

Legally, the government has two choices. Laws that prohibit physician-assisted suicide encourage a worldview that says there is value to life and it ought not to be thrown away based on an individual’s subjective perception of his or her situation. Such laws teach us that our lives are objectively valuable, even if we do not recognize our own value. And they teach everyone else to help us in finding value and enjoyment in our lives.

But by legalizing physician-assisted suicide, we make a different statement. Such laws communicate the idea that suicide can be a reasonable, moral, and socially acceptable choice, because some lives are no longer valuable. Suicide is prohibited in all other circumstances, sending the message that most lives have value that ought to be protected by law, even when the person in question does not see that value. In certain circumstances, however—specifically, when an individual is losing his or her own independence—such protections need not apply. Society is affirming, by legalizing physician-assisted suicide, that it is better to be dead than disabled. It is better to be in the grave than to live with reduced independence. This message is sent both to people with disabilities like me and everyone else who interacts with us.

Naturally, this is a terrifying step for people like me. By legalizing physician-assisted suicide, our political leaders are saying that if they ever have to live life like mine, they want the opportunity to end it all. They want the ability to “die with dignity.” This raises serious questions as to how they perceive my life. Am I not living with dignity because I lack some physical independence? Is there an inevitable link between dignity and physical strength? Advocates of physician-assisted suicide seem to think so.”¹²⁷

1.100 Robert Salamanca wanted to commit suicide after being diagnosed with Lou Gehrig’s disease. This was when Jack Kevorkian was—to much media acclaim—helping people with disabilities and terminal conditions kill themselves. Eventually, he admitted, “*I came out of the fog*” so happy to be alive. Bob spent his final years watching his children grow, investing successfully online to help his family financially, and collecting art. Before he died peacefully in his sleep in 1997, Bob wrote an op-ed column for the *San Francisco Chronicle* titled *I Don’t Want a Choice to Die*:

¹²⁷ http://www.thepublicdiscourse.com/2017/05/19163/?utm_source=The+Witherspoon+Institute&utm_campaign=9db6b266f0-RSS_EMAIL_CAMPAIGN&utm_medium=email&utm_term=0_15ce6af37b-9db6b266f0-84094405

“[R]eporting in the media too often makes us feel like token presences, burdens who are better off dead . . . Many pro-euthanasia groups “showcase” people with ALS. They portray us as feeble, unintelligible and dying by slow suffocation. This is absolutely false, and I protest their efforts vehemently. By receiving proper medical care, a terminally ill person can pass away peacefully, pain-free and with dignity. We are not people just waiting for someone to help us end our misery, but to the contrary, we are people reaching out to love . . . to be loved . . . wanting to feel life at its best. Too many people have accepted the presumption that an extermination of some human lives can be just... Where has our sense of community gone? True, terminal illness is frightening, but the majority of us overpower the symptoms and are great contributors to life.

“The hopelessly ill may be subtly pressured to get their dying over with — not only by cost-counting providers but by family members concerned about burdensome bills, impatient for an inheritance, exhausted by care-giving or just anxious to spare a loved one further suffering. In my view, the pro-euthanasia followers’ posture is a great threat to the foundation upon which all life is based, and that is hope. I exhort everyone: Life is worth living, and life is worth receiving. I know. I live it every day.”

SPECIFIC CRITIQUE OF DAVID SEYMOUR’S BILL

1.101 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.¹²⁸
- 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.

1.102 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.

¹²⁸ https://www.parliament.nz/resource/en-NZ/PAP_74858/f9d96acc7a874d8f2709a40bb20cdb2c8d5548b5

1.103 Section 4(c)(ii): GRIEVOUS AND IRREDEMIABLE MEDICAL CONDITION

- There is no requirement that the person have a terminal illness 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.
- 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?

1.104 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.

1.105 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 entity. 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 the disabled and the mentally ill. It starts further down the slope than anywhere else with the exception of the Canadian Courts.

1.106 Section 4(f): 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 suffering from a devastating life event? Research on human decision-making suggests that when a person is suffering, 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.*¹²⁹ Many people with depression who request euthanasia revoke that request if their depression and pain are satisfactorily treated.

CONCLUSION

- 1.107 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.¹³⁰ 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.¹³¹
- 1.108 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."*¹³²
- 1.109 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.
- 1.110 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 pre-empt the 'uncertainty' and timing of the end.
- 1.111 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.
- 1.112 We should reject euthanasia / assisted suicide. We should reject David Seymour's bill.



Bob McCoskrie
National Director – Family First NZ

¹²⁹ https://www.parliament.nz/resource/en-NZ/SCR_74759/4d68a2f2e98ef91d75c1a179fe6dd1ec1b66cd24

¹³⁰ Kastenbaum, Robert (2006) *The Psychology of Death*, 3rd ed. New York: Springer; Mishara and Weisstub 2013: 433

¹³¹ H. M. Chochinov et al., "Desire for Death in the Terminally Ill," *The American Journal of Psychiatry*, Vol. 152, No. 8 (August 1995), pp. 1185–1191

¹³² Hendin and Foley, "Physician-Assisted Suicide in Oregon," pp. 1625–1626