The End of Life Choice Bill

(Member's Bill 269-1)

Submission by South West Baptist church

1. **Introduction**

In this submission we articulate, on behalf of South West Baptist Church, our opposition to the End of Life Choice Bill. This statement, reflecting our research, engagement with our communities and the life experience of many people in the medical profession, and those supporting youth and vulnerable groups as well as personal experiences, explains our objections to the Bill. These objections are formed from several perspectives including - medical, psychiatric, community well-being, as well as the experience of voluntary euthanasia within other societies where similar bills have been legalised. We strongly believe that New Zealand society is immeasurably better off without Physician Assisted Suicide being legalised.

2. **Our Perspective**

As a Christian church, we place great significance on all life, particularly human life, and believe society should tread very carefully in issues of life and death. While this strongly held value is under pinned by our Christian beliefs it is also drawn from our experience of being alongside dying people and grieving families. We understand the societal mood for choice and individualism that elevates personal choice to be the primary arbiter in personal decisions of comfort and suffering. However there is an opposing societal value of

protection of the weak, the poor, and the mentally unwell that is equally, if not more, compelling than that of personal choice.

We believe that this bill unreasonably places the desires of a few over the needs of the many, and in doing so, diminishes the fundamental value of life.

We acknowledge there are genuine concerns held by the terminally ill and their families and those who look ahead fearful of the dying process, but in our experience these concerns can be more positively met by:

1. Improving and investing in palliative care so that quality palliative care is available to all in need of it. Knowing that from medical research and the experience of those we have cared for in the final stages of life, good palliative care can allow people to die comfortably and end their lives well.
2. Providing the Police and court systems with greater clarity around what actions of individuals and families to support dying people need to be investigated or tested in the courts.

3. **'End of Life Choice' Bill.**

As this Bill rightly states there are undoubted situations of incredible suffering in our world, and end of life physical, emotional, social and spiritual fears can be overwhelming; both for the individual directly suffering and their families. We acknowledge that the Bill seeks to address this for the small group of people "*suffering unbearably at the end of their lives*" and also seeks to ensure safeguards from the Bill's misuse. Under the proposed Bill to qualify for Medically Assisted Suicide individuals must be over 18 years of age, of sound mind, persistent in their wishes, expected to die of a terminal illness within 6 months or

have a 'grievous and irremediable medical condition', are in an advanced state of irreversible decline, are experiencing intolerable suffering despite options for palliation offered, and are aware of their options and have ability to understand the implications of their choice.

4**. Primary Concerns with the Bill**

Changing the law to allow Medically Assisted Suicide is a major change to a fundamental societal norm which respects life with the highest of regard. Our primary concerns are:

- This change in law would send a strong societal statement that, for those who perceive their circumstances to be grievous and with unbearable suffering, suicide, (albeit Medically Assisted Suicide), is a valid option. It is noteworthy that the 2016 Oregon 'Death with Dignity Act Report'[1] states that the majority of reasons for wishing life to be terminated are <u>not</u> usually physical pain or fears of the same (35%) but those commonly associated with depression and existential anguish (around 90%), and suicide. This change in law and societal norms will have the inevitable consequence of increasing our already high suicide rates because it justifies suicide as a viable reasonable solution. We believe this is irresponsible at worst and unhelpful at best. South West Baptist is particularly effective in youth work, founding the Spreydon Youth Community (SYC) and the 24-7 Youth Work. The latter has placed part-time youth workers in more than 80 schools across the country. From our day-to-day and face-to-face work with New Zealand youth we are both acutely aware of our present youth suicide rate and the impact that legalising 'physician-assisted suicide' will have in increasing this in the

[1] Oregon Death with Dignity Act Summary 2016, accessed at http://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Documents/year19.pdf

future. Tragically, we already have the world's highest youth suicide rate. It is inconceivable that we could enact a law with a flow-on effect of increasing our youth suicide numbers.

- This change in law provides for increased freedom for self-determination with the cost of reduced respect for life.
- The argument that this change in law would be open to incremental expansion, beyond those originally intended in its articulation. In Belgium, the numbers of people undergoing euthanasia has increased exponentially since its legal introduction and now represent around 2% of all deaths.[2] The proposed Bill includes not only terminal illnesses but also 'grievous and irremediable medical conditions' as grounds for euthanasia, and every health professional knows that there are vast numbers of physical and psychiatric conditions that this could encompass.
- Though proposed as fundamentally about 'choice', the argument that this law puts in jeopardy the lives of those with diminished voice or no voice is compelling. It is exceedingly difficult, indeed impossible, to ensure a non-coerced choice to end one's life. South West Baptist has for decades been involved in supporting mental health initiatives including establishing Stepping Stone Trust (the largest provider of mental health support outside the DHB in Christchurch), Sarona residential care, providing a weekly church service for people with dual physical and mental disabilities that regularly has 180 plus attendees, and running programmes and caring pastorally for many elderly people. We regularly encounter people who, in the face of terminal and/or severe physical and mental illness, at one time expressed a will to die, but later regret that. We

[2] Dierickx S, Deliens L, Cohen J, Chambaere K. Euthanasia in Belgium: trends in reported cases between 2003 and 2013. *Canadian Medical Association Journal*, 188:16: E407-414

are aware of the subtle pressure that can be placed on vulnerable people from family, carers, those around them, and that which they can impose on themselves, often from perceived societal expectations. A recent study in Australia noted how poorly oncology patients and their caregivers concurred about end-of-life issues.[3] Nevertheless these subtle pressures could lead these vulnerable people to see themselves as a 'potential burden to others' or to believe that others would somehow be better off if they were to end their lives. In the future, decisions could be made for them under the banner of 'quality of life' but open to subtle and not-so-subtle pressure, abuse, financial and political expediency. It is noteworthy that nearly 50% of those dying under the 'Death with Dignity Act' in Oregon in 2016, stated a concern of 'being a burden on family, friends or caregivers'.

- The Netherlands has practiced medically assisted suicide over the last 35 years based on a convention of not prosecuting doctors who had committed euthanasia in very specific circumstances. Herbert Hendin, Psychiatrist and former Professor of Psychiatry, New York Medical College, argues that their situation demonstrates a slippery-slope in practice, changing attitudes of doctors over time and moving them from tightly regulated voluntary euthanasia for the terminally ill to the acceptance of euthanasia for people suffering from psychological distress, and from voluntary euthanasia to the acceptance of non-voluntary and potentially involuntary euthanasia. (Herbert Hendin: The Slippery Slope: the Dutch example[1]).
- Another commentator, Dr Boudewijn Chabot, a prominent supporter of medically assisted suicide and euthanasia in the Netherlands, has recently expressed horror in a

[3] Waller et al... Do medical oncology patients and their support persons agree about end-of-life issues? Internal Medicine Journal. 48 (2018) 60–66.

leading Dutch newspaper[2] in 2017, that the legal safeguards for euthanasia are slowly eroding away and that the law no longer protects those with psychiatric conditions and dementia.

- This change of law creates a conflict of duties within the medical profession. A cornerstone of medical practice is "First, do no harm" – this principle underlies the trust between the physician and patient based on healing, and where this is not possible or appropriate, the provision of high quality palliative care. A change to the nature of the relationship between physician and patient is significant and is one that the doctors we have spoken with view negatively for their profession and personally.

5. Suggested alternative actions for government

The Bill appears to have two key motivations. Firstly, to alleviate the pain of a small number of people "*who suffer unendurably during the terminal days or weeks of a difficult illness, despite the best palliative care can offer*." And secondly, to alleviate the legal vulnerability of family members and/or carers who support a loved one to die in the final stages of a terminal illness. These are both complex and exceptionally painful situations for anyone to face. However, we would strongly argue that the positive gain from the proposed Bill is significantly outweighed by the societal cost, change to a pivotal societal norm, the fundamental shift in the role of medical doctors that it would introduce, and the opportunities for misuse of the provisions, lapses in the procedure outlined in the bill and the inevitable slippery-slope that once begun would be very hard to amend.

Government would significantly, and without incurring other unintended and dangerous consequences, address the two motivations for the proposed Bill by further investing in and

providing quality palliative care to those in need and by clarifying the law, Police investigation guidelines and penalties around the very real but also very rare cases of family or carer support for a terminally ill loved one to die.

6. **Conclusion**

The End of Life Choice Bill has the very real potential to reduce society's view of life to simple terms of pain and comfort, the useful and burdensome. To view our fellow, suffering citizens as somehow less valuable is to act in a profoundly inhuman way.

For these reasons, **South West Baptist Church strongly opposes the End of Life Choice Bill and requests that it be rejected**.

References:

1. Herbert Hendiin: The Slippery Slope: the Dutch example, Duquesne Law Review, 35:1. P 427 https://www.ncbi.nlm.nih.gov/pubmed?db=pubmed&cmd=Link&LinkName=PubMed_PubMed&from_uid=19655662
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