

End of Life Choice Bill

Justice Select Committee

Submission from the Anglican Bishops of Dunedin, Christchurch, Te Waipounamu, Nelson, Wellington, Waiapu, Waikato & Taranaki, and Auckland

19 February 2018

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We would like to make an oral submission.

The submitters As bishops of the Anglican Church in Aotearoa New Zealand, we speak out of our extensive experience in the pastoral care of the dying and their families over many years. We recognise the deep personal stress of those involved with end of life events, and seek to blend compassion with the well-being of the community, of individual rights with the common good.

Bicultural Perspective We are concerned that the Bill as currently drafted does not take account of the cultural, spiritual or tikanga concerns of Maori and Pasifica peoples and would wish to be heard on these matters as part of an oral presentation to the select committee.

Summary While recognising the great distress of patients, families and friends in the case of some intractable and prolonged terminal illnesses, it is our view that legalising medically-assisted dying will open the gateway to many foreseen and unforeseen consequences which will be damaging to individuals and the social fabric. **We recommend** that no change be made in the existing law, but that resources to enhance palliative care and counselling support for both patients and their whanau be increased.

Comment on Preamble to the Bill We believe the Preamble to the Bill makes at least two incorrect claims:

1. “Strong public support” for a law change is claimed on p2 of the Preamble. While it is true that public polls consistently show that a majority of the public support a law change, the quality and usefulness of these polls may be legitimately questioned. The issue is a very complex one, as noted by Justice David Collins in his ruling on the high profile Lecretia Seales’ case. Polls generally ask one very simple question that fails to capture such complexity.

A recent Curia Market Research public poll indicates confusion about the meaning of 'assisted dying', with respondents thinking it included turning off life support (85%) and 'do not resuscitate' instructions (79%).¹

Of the 21,000 submissions to the Health Select Committee following the 2015 Maryan Street petition, almost 80% of the submitters opposed any change in the law, and the Select Committee was unable to make a recommendation. One needs to distinguish between a popular reaction to a high profile case and the more considered submissions of experts and relevant associations who made submissions.

2. "Analysis of overseas jurisdictions where assisted dying is permitted demonstrates that concerns, including concerns about abuse of the vulnerable, have not materialised and that risks can be properly managed through appropriate legislative safeguards" (p2). This is a contestable claim and official evidence from Belgium, the Netherlands and Switzerland show that there is slippage in the criteria, the addition of new criteria, and an oversight of cases that is by no means robust.

Moral Principle In our view the protection of human life is a fundamental cornerstone of society, and one that is affirmed universally whether as a result of religious conviction or from other code of ethics. Every person and every life is of worth, and to legalise medically assisted dying is to undermine this moral cornerstone and open the way to damaging outcomes (*see The Dangers, p2*).

In particular there would be a significant shift in an individual's trust in the positive support of official, professional, social and family networks. Trust in the life-supporting intentions of one's human environment is replaced by a fear that systems and individuals may be planning to terminate one's life. Trust would be destroyed, and insecurity and anxiety would set in. This could happen even with members of one's own family.

Morality pertains not just to the stated criteria but also to the reality of slippage, extension of the accepted criteria and in the oversight of cases. The reality of doctor-shopping to find someone willing to sign the forms would be an obvious consequence.

Hard Cases Over many years of pastoral care we have experienced how distressing and prolonged a terminal illness can be. We have experienced it with our own family members. Pain, dementia, and the indignities of failing bodily functions can be extremely distressing. We do not in any way subscribe to rigid moral principles that override human compassion and care.

We are not clinicians, but colleagues in the medical profession, and especially in palliative care, advise that new technologies and drugs can do much to alleviate most pain. An Australian doctor, Karen Hitchcock, who has worked for 12 years in large public hospitals,

¹ <https://www.euthanasiadebate.org.nz/poll-widespread-confusion-about-assisted-dying//>

caring for hundreds of dying patients, says she has often had patients say they want to die, but... “it is rarely because of pain, but often because of despair, loneliness, grief, the feeling of worthlessness, meaninglessness or being a burden. I have never seen a patient whose physical suffering was untreatable”.

Not Prolonging Life We accept the wide-spread practice accepted in the medical profession of withdrawing life support systems in cases where a patient has slipped into a coma or long-term unconsciousness, there is no future prospect of recovery and the person would die naturally without the support of mechanical devices. Artificial prolongation of life in such circumstances is contrary to the natural order of dying, and not necessary. Such a step would be a decision reached by doctors and family, and may be in line with the expressed advance intention of the patient through a Living Will.

Likewise we accept that the provision of morphine or other drug for the purpose of pain relief is both acceptable and desirable, even although one of the side effects may be the shortening of a person’s life. The latter is not the intention and hence this widely established form of medical care to relieve pain is an important part of palliative treatment.

The Dangers of Legislative Change We believe the legalising of medically-assisted dying, while intending to assist in hard cases, could open the way for many unfortunate outcomes:

1. The creating of a legal option establishes medically assisted dying as an acceptable and socially approved form of ending life which could encourage its use.
2. Instead of being restricted to intractable cases of terminal illness, categories might extend to include other forms of treatable illness, depression, loneliness, the handicapped or babies born with severe deformities. Many suffering such conditions, or their parents or guardians, might take advantage of a new way out of the situation. Evidence from Belgium, the Netherlands and Switzerland indicate such realities.
3. Official committees set up to approve applications might in time adopt a de facto “death on demand” ethos, turning down only a few applications. Again, evidence from European nations suggests a lack of robust oversight.
4. Elder abuse is a well-established reality of our society and increasing year on year. Family members and care providers might bring subtle, or not so subtle, pressure to bear on an ageing family member to “do the decent thing” and exit this life. We have known situations of such pressure driven by family members alarmed to see their inheritance evaporating with the costs of caring for an ageing parent.
5. Ageing family members themselves may feel the guilt of being a burden on their families, or they may see long-term friends taking the step and feel pressured to do the same.
6. In times of budget constraints, governments or health boards may see medically-assisted dying as a way of saving on the health budget and reduce funds for aged care.

7. This could lead to a restriction of resources for palliative care, quality aged care, or providing social support for the lonely or depressed.
8. Bicultural issues and the Treaty of Waitangi come into play insofar as the concept of whanau for many Maori makes caring for the extended family in all circumstances a priority. We need to take care that a majority of public opinion does not over-ride the culture of a Treaty partner.
9. Suicide: It is ironic that in a country plagued by the most disturbing increases in suicides, especially among impressionable youth, we are contemplating assisting people to die. The pain of a teenager, young adult or, for that matter, a person of any age who seeks suicide as a way to die, is viewed as tragic. Frequently it is said that the family and loved ones never fully recover. Yet the pain of a terminally ill cancer patient is viewed as worthy of consideration as a candidate for assisted dying. On what basis do we understand the difference? It is worth noting in Belgium a depressed patient is a candidate for medically assisted dying. This is not because this depression is terminal but because it is viewed as incurable, (and this appears to be a development or extension of the original legislation). This seems so at odds with the virtue of hope and the value we place on life. Followers of Jesus Christ and members of other world religions hold to the teaching of the sanctity of life. Life is a gift to be treasured and thus to assist death is misdirected action and a devaluing of death.

To assist dying is not the same as increasing pain medication which may or may not eventually shorten the life of the patient. One seeks death. The other seeks quality of life. There is a significant difference. The difference in intention is very marked. In our own pastoral experience we know how families and loved ones may be painfully divided as a result of disagreements over assisted dying.

10. Coercion of the Medical Team and Family: To place a cost on medical care and social care and then evaluate the reasonableness of assisting dying places a price tag on human life. Human persons are relational and devaluing any one human being's life affects the larger community. To say that one human life is expendable is actually to state the quality of community is insufficient to support people in their last months. Indeed, in Belgium there are instances of medically assisted dying when there is every reason to expect longevity without such intervention. Yet medically assisted dying is permitted.

We live in a society that insists and encourages ramps and assistance for those who have physical disabilities because we recognise them as members of the community and we want to offer inclusion. In return we find we benefit from their participation and inclusion. How odd therefore that we are moving towards saying we have neither the will nor the means to keep other people alive, comfortable and included. There is a time honoured question among people about how does a government, a community or a family define and assure free choice among the members of the population? One also might ask when in history has hastening death, even by choice and with great consideration, ever improved community well-being?

11. Palliative Care and Hospice Care: It is frequently commented that Palliative Care units and Hospice Care ministries are places of extraordinary hope. However these

remarkable places and ministries are already underfunded and at present there are inadequate research funds supporting their progress. Why would we ignore or overlook such effective services and seek instead to fund medically assisted dying?

Emotions and fear will always fuel and drive this argument from every side and we want to acknowledge there are people of good will on every side of the debate and recognise the importance and validity of emotion in the decision-making process.

We are conscious of how Megan's Law in the USA (and similar legislation in the UK) was seen to be hurried into practice on the wave of a huge emotional reaction to the abuse and death of a child. Without denying the horror of the circumstances, it has been said that a more dispassionate response may have generated a better piece of legislation.

When the balance is examined, we believe the prospect of this practice, of medically assisted suicide, passing into law, carries far more risk for harm for individuals and community life, than does the improvement and support of palliative and hospice care. Human beings are not disposable. In the words of Dame Cecily Saunders: *"You matter because you are you, and you matter to the end of your life. We will do all we can not only to help you die peacefully, but also to live until you die."*

Our experience is that there are individuals who believe their worth has always been in being useful to others. When they are no longer useful and helpful for the common good, they may feel it is time to get out of the way. But this person is still to be valued and cherished. They still make a contribution by allowing another person to sit with them, keep watch and hold their hand. The person remains valuable and valued in the sight of God; their loved ones and the larger community. Please do not write them off.

Looking more closely at the opinion polls suggesting a big majority in New Zealand in favour of an Assisted Dying Bill, it is difficult to know what it is that New Zealanders are wanting to change. Is it wanting to reduce the incidence and extent of pain, nausea, vomiting, breathlessness – or any of the symptoms that can be controlled medically; or is there really a call to allow the intentional ending of a life? And would a measure that allowed one individual to end the life of another – even with safeguards – actually fulfil the sincerely held views aspiring to a peaceful death?

Conclusion We acknowledge the tensions in this very difficult debate on how to maintain the principle of the worth of each individual along with adequate care for those in stressful situations. Our view is of an "on balance" nature weighing up the pros and cons of the options. We therefore believe:

1. New Zealand should not enact legislation that would establish medically-assisted dying as an authorised form of terminating life, thus undermining a fundamental ethical principle.
2. We should take steps to increase resources for palliative care, and the provision of social support for the lonely, ageing and depressed.

3. We should enhance support for families caring for those with terminal illnesses to assist them in understanding what is happening and likely to happen, how to manage stress and grief, and how to build positive relationships with the dying, remembering that dying can be an important last phase of life in resolving conflicts of the past and establishing new relationships of love and care. *(ends)*