



Protect Caring. Not Killing.

The investigation into ending one's life in New Zealand

Another push to legalise euthanasia and assisted suicide is currently underway in New Zealand. We need your help to protect vulnerable lives, preserve human dignity, and show care and compassion. A petition is before the Health Select Committee asking for a full investigation of public attitudes towards euthanasia and assisted suicide. The committee will investigate this topic, but it will be doing so within the wider framework of ending one's life in general. This way it can examine all forms of suicide in New Zealand, including euthanasia and assisted suicide.

The committee needs to hear your voice in this investigation. It needs to know why you oppose the promotion of euthanasia, or any other form of suicide. Please make a submission to the committee opposing any changes to how New Zealand approaches this subject. To help you make a submission, we have prepared the following:

- 1. Briefing Paper: "A Call for Care, Not Killing"** – This document contains the key reasons why the current laws on suicide / assisted suicide / euthanasia should be maintained. The information in this document can help form the basis of your own submission.
- 2. How to make a submission** – Don't know where to start? We've listed the key information you need to include, the ways you can send your submission in, and other relevant information.

The final date for submissions is February 1 2016, but the Select Committee is already receiving submissions. Why not do yours this week!

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

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Abuse – even with ‘safeguards’

As a NZ Herald editorial put it – “*devising a robust euthanasia regime, complete with adequate safeguards, seems hardly feasible.*” 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. The legal requirement to report euthanasia has not been fully complied with in countries that allow euthanasia either. 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.

Mission creep

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.



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”?

(Maryan Street’s proposed euthanasia Bill – subsequently withdrawn – *already* had this extended availability.)

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

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

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

‘Right to die’ or ‘Duty to die’



Procedural safeguards 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 a ‘burden’ to their nearest and dearest.

Annual reports by Oregon Public Health contain data on the numbers of patients who reported that part of their motivation to request euthanasia was because they felt themselves to be a “burden on family and friends”. Forty percent of patients who requested assisted suicide in 2014 did so out of concern for being a burden on their family; only 13% did so in 1998.

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.

Burden placed on patients

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.

Elder abuse



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."*

Rational suicide?



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. 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.

Conflicting messages about suicide prevention

There will always be concerns about conflicting messages being sent regarding suicide if assisted suicide becomes lawful. On the one hand society will offer some individuals assistance to commit suicide, yet on the other hand seek to take a zero-tolerance approach to 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.

Depression



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

The 'elephant in the room'

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. Another smaller-sized 'elephant' is the increasing demand for human organs suitable for transplants.

What do the medical professionals think?

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

“...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 Statement on Euthanasia (approved 2005)

Polls have confused the issue

Opinion polls in New Zealand suggest the majority supports the legalisation of euthanasia and/or assisted suicide. But as we showed earlier, many people simply want to ensure that the administration of pain relief and the withdrawal of burdensome treatment are not treated as illegal. The questions 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, whilst failing to acknowledge that pain is no longer a good reason for requesting euthanasia. 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. Support typically drops for euthanasia or assisted suicide when state-funded palliative care is on the table.

What has the overseas experience shown us?

Oregon

- From 1998 to 2014, the number of deaths from assisted suicide has increased from 16 to 105 per year – a 656% rise over 16 years
- Studies have found that 1 in 6 patients who receive a prescription for lethal drugs have clinical depression
- Forty percent of patients who requested assisted suicide in 2014 did so out of concern for being a burden on their family; only 13% did so in 1998

Netherlands

- At least 23% of euthanasia deaths are not reported each year as is required by law
- The Dutch have practiced euthanasia on infants since 2005, under guidelines laid out in the Groningen Protocol. One of the authors of the Groningen Protocol, Professor John Griffiths, believes that the legalisation of euthanasia “assuredly changed” the cultural norms in the Netherlands “in the direction of open acceptance of the legitimacy of termination of life of severely defective newborn babies”

Belgium

- Roughly 30% of euthanasia deaths in the Flanders region are performed without patient request or consent (1.8% of all deaths in the region) – those most often euthanised without their request or consent are the elderly, the incompetent, and those dying in hospitals
- Euthanasia deaths increased by over 5000% between legalisation in 2002 and 2011; between 2011 and 2012, the rate of euthanasia deaths increased by a further 25%
- Only about 50% of euthanasia deaths in the Flanders region are reported to the Federal Control and Evaluation Committee as is required by law
- 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

Source: Maxim Institute (References available at protect.org.nz)

Some disturbing cases in the media recently

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

**Growing number of mentally ill
Dutch choosing to be killed at
euthanasia clinic**
Aug 2015

**Belgium study Finds Euthanasia
Targets Women and People With
Depression or Autism**
July 2015

**Deaths among young an
unintended consequence of
euthanasia movement**
(Aust) July 2015

**A healthy, 24-year-old woman
to be euthanised in Belgium for
psychological reasons**
June 2015

**Euthanasia wanted for man in
constant pain after having a tumour
despite not being terminally ill**
(UK) May 2015

**Doctors Killed His Belgian Mom
Because She Was Depressed. Now
He Speaks Out Against Euthanasia**
Jan 2015

**Elderly Scottish cousins undergo
joint euthanasia for fear of being
put in separate care homes**
Feb 2015

**Documentary shows Belgian
doctor euthanizing a depressed,
suicidal woman**
Jan 2015

**Mentally ill patients killed by
euthanasia in Holland trebles in a year**
Oct 2014

**Man with same brain cancer as
Brittany Maynard (US) has lived 13
years after being given just 6 months**
Nov 2014

**Euthanasia for 'depressed'
alleged murderer by
campaigner Philip Nitschke**
(Aust) July 2014

**Swiss – assisted dying for elderly
who are not terminally ill**
May 2014

The way forward from here



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

Summary

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.

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 medical professionals 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.

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.



This information was primarily sourced from the research paper “Killing Me Softly: Should Euthanasia Be Legalised?” by Professor Rex Ahdar (2014). The full paper (including the Executive Summary) can be downloaded for free from our website www.protect.org.nz

This pamphlet is produced by Family First NZ

Find out more about the work of Family First NZ and become a supporter at familyfirst.org.nz



MAKE A SUBMISSION

Details of the Inquiry

The Health Select Committee will undertake an investigation into ending one's life in New Zealand. In order to fully understand public attitudes the committee will consider all the various aspects of the issue, including the social, legal, medical, cultural, financial, ethical, and philosophical implications.

The Committee will investigate:

1. The factors that contribute to the desire to end one's life.
2. The effectiveness of services and support available to those who desire to end their own lives.
3. The attitudes of New Zealanders towards the ending of one's life and the current legal situation.
4. International experiences.

When preparing your submission, there are some things to remember

- **At all times, be positive, respectful and constructive.** Highlight what you are FOR - maintaining the current law opposing assisted suicide / euthanasia. Avoid personal attacks, negative labels or angry words.
- If appropriate, **include a personal story** of how suicide or a terminal illness has affected your family, and how assisted suicide laws would affect vulnerable people. Highlight any examples of palliative care that have made the difference and helped families cope.
- **We would strongly encourage you to say YES to appearing before the Select Committee.** Making an oral submission provides you with the opportunity to reinforce what you have said in your written submission. We can send helpful guidelines to help you prepare for this. The Committee is likely to travel to different parts of the country. Submitters can also be heard via phone.
- When you send your submission in, please consider also **emailing or posting a copy to your local MP.** You can find out who your local MP is (and their email address) at our website www.haveyoursay.org.nz (also available as a smartphone app).
- **Share your submission** with friends and family. It may inspire them to make a submission also.

Please note: **SUBMISSIONS ARE DUE BY 1 February 2016.** (*The Committee will not accept late submissions.*)

However, we would encourage you to make your submission as soon as possible as the Committee has already started to hear submissions. Please note that submissions are made public unless you specifically request anonymity.

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

POST

Post **2** copies to:
Committee Secretariat
Health Committee
Parliament Buildings
Wellington 6160

ONLINE

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

EMAIL

select.committees@parliament.govt.nz

For further info

Phone: 04 817 9541

Fax: 04 499 0486

Mandatory details for your submission via email or post

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

HEADING: SUBMISSION – Investigation into ending one's life in New Zealand

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

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

VIEWS: Include reasons for these views (Try to cover some of the issues listed above under 'Details of the Inquiry')

Remember to **send 2 copies** if posting your submission. Online submissions have their own format for you to complete.

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copies for your group, email admin@familyfirst.org.nz

