The Royal Australian & New Zealand College of Psychiatrists
Tu Te Akaaka Roa
New Zealand National Office

Your Health in Mind

15 February 2018

Hon. Raymond Huo
The Chairperson
Justice Select Committee
Parliament Buildings
Private Bag 18041
Wellington 6180

By email: select.committees@parliament.govt.nz

Dear Chairperson

End of Life Choice Bill

Thank you for the opportunity to respond to the proposed 'End of Life Choice Bill'.

The Royal Australian and New Zealand College of Psychiatrists (RANZCP) is a membership organisation that prepares doctors to be medical specialists in the field of psychiatry, supports and enhances clinical practice, advocates for people affected by mental illness and advises government on mental health care.

This submission has been prepared by the New Zealand National Committee – Tu Te Akaaka Roa – in consultation with other New Zealand based Committees. The RANZCP neither supports nor opposes the proposed Bill but seeks to provide commentary on potential omissions we have identified. Nothing in this submission should be taken as explicit or implied support by the RANZCP regarding the legalisation to end one's life.

The purpose of our submission is to highlight the issues around the complexities associated with the psychology of dying and the impact this has on a person's decision-making. We have noted our general views on the proposed legislation and analysed the Bill by section.

In our view the proposed Bill requires significant revision and strengthening to ensure processes are robust and there are safeguards in place for both the individual who wishes to end their life and the medical practitioners who are necessarily involved. We would anticipate that once feedback is received from the sector, a revised Bill is reconsidered by the Justice Select Committee.

The RANZCP would appreciate an opportunity to appear before the Justice Select Committee to speak to our submission.

If you require further information regarding this submission, please contact the RANZCP's New Zealand Manager, Rosemary Matthews, on 04 472 7265 or by email Rosemary.Matthews@ranzcp.org.

Box 10669, Wellington 6143 New Zealand
T +64 4 472 7247 F +64 4 472 7246
ranzcp.nz@ranzcp.org www.ranzcp.org

Nāku nā

Dr Mark Lawrence FRANZCP
Chair, New Zealand National Committee – Tu Te Akaaka Roa

The Royal Australian & New Zealand College of Psychiatrists

Tu Te Akaaka Roa
New Zealand National Office

Justice Select Committee – End of Life Choice Bill

February 2018

Develop and promote best practice standards

Royal Australian and New Zealand College of Psychiatrists
New Zealand National Committee
Submission to the Justice Select Committee on End of Life Choice Bill

About the Royal Australian and New Zealand College of Psychiatrists

The Royal Australian and New Zealand College of Psychiatrists (RANZCP) is a membership organisation that prepares doctors to be medical specialists in the field of psychiatry, supports and enhances clinical practice, advocates for people affected by mental illness and advises government on mental health care. The RANZCP is the peak body representing psychiatrists in Australia and New Zealand, and as a binational college has strong ties with associations in the Asia-Pacific region.

The RANZCP has more than 6000 members, including around 4000 fully qualified psychiatrists and almost 2000 members who are training to qualify as psychiatrists. Psychiatrists are clinical leaders in the provision of mental health care in the community and use a range of evidence-based treatments to support a person in their journey to recovery. The RANZCP is guided on policy issues by a range of expert committees whose membership is made up of leading psychiatrists with relevant expertise, and consumer, carer and community representatives.

Recommendations

Nothing in this submission should be taken as explicit or implied support by the RANZCP of the legalisation to end one's life.

General Recommendations on the Bill

1. The RANZCP submits the proposed legislation requires reflection and revision. We call to have the Bill significantly revised and strengthened to ensure processes are robust and there are safeguards in place for both the individual who wishes to end their life and the medical practitioners who are necessarily involved.
2. We strongly advocate that it is explicit in this Bill that a 'medical condition' does not include a mental illness and experiencing mental illness is not a basis for ending one's life.
3. We respect the concept of an individual having autonomy and patient choice in regards to wishing to end their life. However, the determination about who can die by euthanasia remains with medical practitioners, as they have responsibility in assessing an individual's eligibility and then delivering the lethal dose to end the person's life. This may be a burden that some medical practitioners are not keen to assume.
4. Cultural perspectives may include the person's spiritual and religious beliefs and these may also influence their decisions around wishing to end their life. We do not see how these perspectives have been incorporated into the Bill, or if other ethnic groups have been consulted on the Bill.
5. If the Bill is enacted, there will be workforce implications for medical practitioners. Doctors would need to familiarise themselves with the practical medical knowledge associated with euthanasia and also understand the legal implications of ending a person's life.
6. The current provisions are silent on Advanced Care Directives (ACD). ACDs enable people to plan for their future medical treatment and care at a time when they are not competent to make, or unable to communicate, these decisions for themselves. The RANZCP strongly advocates that ACD are excluded from the Bill. Enacting an ACD can be difficult as no-one can accurately forecast how they would really feel in a particular situation, so what may seem clear in theory, may look very different when it actually happens.
7. We argue that children do not have the capacity or competence to make decisions to end their lives. Some thought needs to be given to individuals with a moderate intellectual disability and how they might be assessed regarding capacity.

Recommendations on Specific Sections and Clauses in the Bill

We make the following recommendations regarding these clauses in the proposed Bill:

Section 8 Request made

- When the person first makes a request to die, some initial assessment should be made regarding the person's competence when there is a clear mental disorder e.g. psychoses or dementia.
- The Bill should include a clause encouraging the person to seek guidance from a psychiatrist or psychologist to have a conversation about death and dying.
- A clause should be added that a medical practitioner cannot initiate discussions with an individual about wishing to die.

S 8 (2) (a) (i)

- We do not believe that *"grievous and irremediable medical condition*" is sufficiently defined. While we note overseas legislation uses similar terminology, we contend the proposed legislation must specifically exclude mental illness such as depression, schizophrenia and psychosis as a basis for seeking euthanasia.

S 8 (2) C

- We argue this clause should include '*and a suitability qualified health professional is consulted regarding the options available'*. The clause should now read '*ensure the person understands his or her options for end of life care and a suitability qualified health professional is consulted regarding the options available'*.

Section 9 Request Confirmed

S 9 (d) (iv)

- The term '*mental disability*' is not defined and we are unable to see this term listed in the Interpretation section of the Bill. We contend this term needs to be defined within the context of the proposed Bill.
- It is not clearly articulated in the Bill what the options are for an individual who can no longer write or verbalise their wishes around ending his/her life.

Section 11 Second opinion reached

Once the first medical practitioner has deemed that the person is competent and can end his/her life, a second independent medical opinion is sought. We suggest that some thought is given to who might be the second medical practitioner.

- The medical practitioner should hold general or vocational registration with the Medical Council of New Zealand for a specified number of years. This is not a role for trainee doctors.
- The medical practitioner should hold a vocational registration in the field of medicine that relates to the individual's presenting condition. To make a prognosis that the person has a terminal or 'grievous and irremediable medical condition' that is irreversible or will cause their death, a specialist should be consulted to provide an opinion based on the most recent research and treatments relating to the person's condition.

Section 12 Third opinion reached, if necessary

We understand where the two medical practitioners are unable to reach a determination regarding an individual's decision making capacity to end their life, a psychiatrist's or psychologist's opinion will be sought.

This section of the Bill concerns the RANZCP for many reasons and we articulate these issues below.

- There is little in this proposed Bill that provides guidance on how competence will be assessed.
- An individual's capacity to make decisions about ending their life is frequently compromised by the terminal illness, delirium and neurodegenerative diseases.
- Individuals who are weakened by illness or medical treatments may find themselves unduly influenced by those close to them.
- People who are living with dementia require special attention as they are a very high risk group with regards to euthanasia. It is very unlikely for people with advanced dementia to retain capacity required for decision-making on euthanasia. It is critical to define whether or not dementia is considered as 'a terminal illness or a grievous and irremediable medical condition'.
- We request that provision is included in the Bill that if an individual is not able to give consent due to their pre-existing mental condition, such as depressive illness, that they are directed to a mental health professional for assistance.
- It should be noted that a person's wish to end their life may fluctuate over the course of their illness and when mental illness is present the patient's view on euthanasia may vary greatly due for example, to their depressive state.
- We argue that third opinions regarding a person's competence should only be provided by a relevantly qualified vocationally registered medical practitioner such as a psychiatrist or a palliative care physician. Making judgements about an individual wishing to end their lives is a clinical problem that requires a medical practitioner trained in psychiatry or palliative medicine.

Section 15 Medication chosen

- Several clauses within this Section of the Bill require refinement. The Bill lists that there are several options that an individual may choose to end his/her life (S 15(3) (b)) but we contend that the indications associated with each method of death will need to be described to the individual.

- We note that many other jurisdiction's legislation relating to euthanasia leave the final administration of lethal drugs to the individual rather than the medical practitioner. Some doctors will struggle to reconcile this section of the Bill with their personal view of what constitutes good medical practice. Evidence from the Netherlands indicates that most doctors do not want or wish to kill their patients but proceed based on their patient's wishes. Giving the lethal dose to end a person's life places a considerable burden on the medical practitioner and may be distressing for them. Subsequently we strongly advocate that there are appropriate support systems in place for those medical practitioners who are engaged in this work.

Part 3 Accountability

Section 19 SCENZ Group

- If the Bill proceeds and before it is enacted, we contend it is critical to develop clinical guidelines relating to ending of life including assessing an individual's competence, key legal requirements and expected standards of care for individuals wishing to die. Developing these components would go some way in ensuring that there is a consistent approach to ending one's life across New Zealand and attempt to reduce subjectivity around the process.

Section 20 Review Committee

- We are not clear if the Review Committee would comprise 3 permanent members or if the third member would be invited to join the Review Committee based on the issues under consideration. We strongly recommend establishing a pool of medical practitioners who may be called upon to join the Review Committee to provide expert specialized advice.

Introduction

The RANZCP appreciates the opportunity to provide feedback to the Justice Select Committee on the End of Life Choice Bill (the Bill).

The submission has been developed by the New Zealand National Committee, *Tu Te Akaaka Roa,* working with the other New Zealand–based Committees: the New Zealand Faculty Committees for Psychiatry of Old Age and Consultation–Liaison Psychiatry.

Nothing in this submission should be taken as explicit or implied support by the RANZCP regarding the legalisation to end one's life.

This submission draws on our earlier submission, *Investigation into ending one's life in New Zealand* made to the Health Select Committee (RANZCP, 2016a).

The RANZCP neither supports nor opposes the proposed Bill but seeks to provide commentary on the potential omissions we have identified in the Bill. Legalising euthanasia does not make it ethically acceptable. The RANZCP notes that the New Zealand Medical Association, the World Medical Association, the Australian Medical Association consider doctors' involvement in assisted dying to be inappropriate and unethical.

The purpose of our submission is to highlight the issues and complexities associated with the psychology of dying and the impact this has on a person's decision-making when they wish to end their life. Psychiatrists have an important role to play as many people choosing to end their life may be depressed or experiencing delirium and expert medical opinion is required to rule out those individuals who may not be competent. Ryan (2012) states *'Non-psychiatrically trained doctors are not well placed to recognize these conditions … nor are they expert at determining a patient's capacity*…'. In addition it is critical that psychiatrists discuss with a dying person their anxieties around their imminent death.

We note the Bill acknowledges the role of psychiatry in the legalization of euthanasia and we consider this adds a certain robustness to the Bill's provisions.

The RANZCP's view on ending one's life is outlined in *Position Statement 67: Physician Assisted Suicide* (RANZCP, 2016b). While this statement's key focus is on Physician Assisted Suicide (PAS), many of the principles outlined in this document are relevant to the proposed Bill. The RANZCP's statement differentiates between PAS and euthanasia. If a doctor prescribes medicines but does not administer the lethal dose to kill the patient then this would constitute PAS. However what is proposed in this Bill is euthanasia, whereby the doctor administers a medicine that deliberately ends a person's life. We will use the term euthanasia throughout this submission.

This Bill proposes to legalise euthanasia, but conversely New Zealand is facing an epidemic of suicide. Advocating that suicide is acceptable for some groups of people and not others will be difficult to reconcile in any public relations materials developed to support the implementation of the Bill.

General Comments on the End of Life Choice Bill

The provisions in this Bill will allow some people to end their life. It will have far reaching consequences on medico-legal practice in New Zealand potentially impacting on the doctor-patient relationship. We concur with the New Zealand Medical Association that deliberately terminating a person's life '*is contrary to the nature of the doctor-patient relationship'* (NZMA, 2016). It will be a difficult balancing act for doctors: they will need to consider their patient's wish to die against medical ethics which states a doctor's role is to 'first do no harm'. This scenario places the doctor in an invidious position.

The proposed legislation requires reflection and careful attention to detail to ensure it is fit for purpose. We note that several clauses in the Bill are scantly defined and there are some notable omissions,

making it difficult to consistently implement the legislation. There is too much room for interpretation which may lead to unintended consequences. Similar Bills in other jurisdictions provide greater clarity around the process and provide clearer operational definitions. The legislation pertaining to euthanasia or PAS is complex and contentious and we note that Australian Bills e.g. New South Wales' Bill and the Victorian Bill are more comprehensive in their approach e.g. the Victorian Bill[1] is 126 pages with 141 sections (NSW Parliamentary Research Service, 2017).

In our view, the proposed Bill requires significant revision and strengthening to ensure processes are robust and there are safeguards in place for both the individual who wishes to end their life and the medical practitioners who are necessarily involved. We would anticipate that once feedback is received from the sector that a revised Bill is reconsidered by the Justice Select Committee.

In this submission we will outline our general concerns with the Bill and then provide an analysis of the specific clauses included in the Bill.

1. Mental disorders

The purpose of the Bill is to provide people with a '*terminal illness or a grievous and irremediable medical condition'* the ability to seek medical assistance in order to end their lives. We note that the Belgium euthanasia legislation explicitly allows people to end their lives if they are suffering from either a somatic or a mental disorder (Macleod, 2012). We strongly advocate that it is explicit in this Bill that a 'medical condition' does not include a mental illness and experiencing mental illness is not a basis for ending one's life. Suicidal thoughts may be symptoms of depressive illness, alcohol and substance intoxications and psychotic illness (Macleod, 2016). These conditions are generally treatable therefore people living with these illnesses should be directed to seek assistance from the mental health professional.

2. The medical practitioner's role

We respect the concept of an individual having autonomy and patient choice in regards to wishing to end their life. One narrative tends to support the view that euthanasia places control in the hands of the patient, giving them the power to end their life when they wish to do so. However, the determination about who can die by euthanasia remains with medical practitioners, as they have responsibility in assessing an individual's eligibility and then delivering the lethal dose to end the person's life. The medical practitioner's role, as outlined in the proposed Bill, removes some of the individual's autonomy and places a significant responsibility upon the medical practitioner. This may be a burden that some medical practitioners are not keen to assume.

3. Cultural perspectives

There does not seem to be any acknowledgment in the Bill of a Te Ao Māori or Pacifica perspective. The view on euthanasia, quality of life and prolonging life will vary from culture to culture (CMC,2015). Therefore we hope key Māori and Pacifica organisations have been consulted on the provisions outlined in the Bill. New Zealand also has a growing Asian population. While the relationship between euthanasia and ethnicity is not well researched, experience from Oregon and Washington in the US indicated that people who died of physician-assisted dying were predominantly White American.

[1] The Victorian Bill is now awaiting royal assent so will soon be an Act.

Cultural perspectives may include the person's spiritual and religious beliefs and these may also influence their decisions around wishing to end their life. We do not see how these perspectives have been incorporated into the Bill or other ethnic groups have been consulted on the Bill.

4. Workforce implications

If the Bill is enacted there will be workforce implications for medical practitioners. Doctors would need to familiarise themselves with the practical medical knowledge associated with euthanasia and also understand the legal aspects of ending a person's life. Medical colleges would need to update their curricula to reflect this new area of medicine and develop clinical guidelines to support their members. These activities would take time and resources to develop, but are essential in ensuring clinical practices are well defined before the Bill is passed and the resulting legislative provisions implemented. We understand that in the Netherlands there are euthanasia consultants who provide expert opinion and guidelines to general practitioners and other doctors (Sheldon, 2004). It may be useful to examine this process with a review to developing a group of experts in euthanasia in New Zealand who would support health professionals and establish clinical protocols and pathways in this area of medicine.

With regards to psychiatry, there would need to be a sufficient number of consultants available to assess the dying patient and provide opinions, and more importantly provide psychiatric care to dying patients. Currently there is a shortage of psychiatrists and they are not evenly distributed. There are few psychiatrists in some parts of New Zealand and this may impact on obtaining timely opinions regarding the individual's competency. Public funding and resources to provide psychiatry opinions and care would need to be considered for equality of accessing services by terminally ill patients.

5. The role of Advanced Care Directives (ACD)

The current provisions are silent on Advanced Care Directives (ACD). ACDs enable people to plan for their future medical treatment and care at a time when they are not competent to make, or unable to communicate, these decisions for themselves. There may be circumstances, for example, a patient with dementia, where the patient cannot give their consent regarding their previously created advance care directive asking to end their life at a certain stage of their illness. The RANZCP strongly advocates that ACD are excluded from the Bill. Enacting an ACD can be difficult as no-one can accurately forecast how they would really feel in a particular situation, so what may seem clear in theory, may look very different when it actually happens. There is evidence that an individual's feelings on this may fluctuate depending upon circumstances, and an ACD does not take account of such changes. Neither does an ACD take into account changes of service provision nor technology development that may have occurred in the interim, which may alter the prognosis or the distress that the patient may otherwise experience.

6. Age of person seeking to end his or her life

We support the provisions in the Bill that the person seeking to end their life must be over 18 years of age. We are strongly opposed to any amendment to the proposed legislation to extend eligibility to children. We have raised this issue as current legislation in the Netherlands allows patients aged 12 years old to end their lives with consent of their parents / guardians and in Belgium there is no age limit for minors (CMC, 2015). We argue that children do not have the capacity or competence to make these decisions.

Thought needs to be given to individuals with a moderate intellectual disability and how they might be assessed regarding capacity.

Analysis of the Bill's Provisions

Part 2 Assisted Dying

Section 8 Request made

- When the person first makes a request to die, some initial assessment should be made regarding the person's competence when there is a clear mental disorder e.g. psychoses or dementia. We understand that competence is "tested" in the latter part of the Bill but it may be prudent to establish the person's competency before starting the process to end their life. For example, if someone in a dementia unit wished to end their life, it may be advisable to seek a psychiatric assessment at this early stage rather than expend resources advancing the process when it is clear the person would not meet the competence test.

- The Bill should include a clause encouraging the person to seek guidance from a psychiatrist or psychologist to have a conversation about death and dying. Helping a person to come to terms with imminent death is part of psychiatric care, therefore it is important to highlight the value of such a discussion allowing the person time to reflect upon their decision to end his/her life.

- We note that the Victorian Bill (Clause 8) states that a medical practitioner cannot initiate discussions with an individual about wishing to die (New South Wales Parliamentary Research Service, 2017). We strongly advocate that a similar clause is adopted in New Zealand to protect the medical practitioner from potential complaints from the dying person's whānau e.g. allegations could be made that the medical practitioner encouraged the individual to die. Encouraging an individual to die should be an offence under the Bill.

S 8 (2) (a) (i)

We do not believe that '*grievous and irremediable medical condition*' is sufficiently defined. While we note overseas legislation uses similar terminology, we contend the proposed legislation must specifically exclude mental illness such as depression, schizophrenia and psychosis as a basis for seeking euthanasia. In Belgium, the Netherlands and Luxembourg, people suffering from a psychiatric illness can end their lives due to their unbearable suffering and the belief these illnesses are grounds for euthanasia are gaining ground (Melville, 2015). We strongly refute that mental illness is a basis for euthanasia and want this explicitly stated in the Bill.

S 8 (2) C

We seek clarification around '*a person understands his or her options for end of life'*. It is not clear what these options might be and who might be assisting the dying person to understand the possible medical options. We argue this clause should include '*and a suitability qualified health professional is consulted regarding the options available'*. Depending on the person's terminal condition relevant clinical information i.e. their diagnosis, prognosis and treatment should be provided and discussed with the dying person allowing them to make an informed decision regarding their future. Medical treatment options should include psychiatric services if required.

Section 9 Request confirmed

S 9 (d) (iv)

It not clearly articulated in the Bill what the options are for an individual who can no longer write or verbalise their wishes around ending his/ her life. The New South Wales Bill (Clause 22, 23) provides useful information about how this might be managed that is, the dying person makes an audio-visual record requesting their wish to die (NSW Parliamentary Research Service, 2017). If the Bill is to be enacted then it has to be equitable and this approach allows those individuals who are seriously physically incapacitated to exercise their right to die. The recorded information could also be evidence that consent procedures were followed and would reduce the chance of a legal challenge from the dying person's whānau.

We do not see where mental disability is defined in the Bill. This term needs to be defined as we are unsure of the parameters associated with 'mental disability' e.g. does this term refer to all of the following: people with an intellectual disability or people living with a mental illness or people with a mental disorder. We note that this term is not listed in the interpretation section of the Bill. We contend this term needs to be defined within the context of the proposed Bill.

Section 11 Second opinion reached

Once the first medical practitioner has deemed that the person is competent and can end his/her life a second independent medical opinion is sought. We suggest that some thought is given to who might be the second medical practitioner.

- The medical practitioner should hold general or vocational registration with the Medical Council of New Zealand for a specified number of years. For example, a provisionally registered doctor, such as a first year house officer, should not be asked to assess a person's eligibility for euthanasia.

- The medical practitioner should hold a vocational registration in the field of medicine that relates to the individual's presenting condition. To make a prognosis that the person has a terminal or '*grievous and irremediable medical condition'* that is irreversible or will cause their death, a specialist should be consulted to provide an opinion based on the most recent research and treatments relating to the person's condition. Including this additional criteria around the assessing medical practitioner is in line with the Victorian Bill that notes either the first or second assessing doctor must have '*expertise and experienced in the disease, illness or medical condition expected to cause the person's death*.' (New South Wales Parliamentary Research Service, 2017). We suggest similar provisions be included in the proposed Bill.

Section 12 Third opinion reached, if necessary

We understand where the two medical practitioners are unable to reach a determination regarding an individual's decision making capacity to end their life, a psychiatrist's or psychologist's opinion will be sought.

This section of the Bill concerns the RANZCP for many reasons and we articulate these below.

1. There is little in this proposed Bill that provides guidance on how competence will be assessed. Stewart et al (2010) report there is a '*lack of consensus in the scientific community in regards to standards to determine competence to consent to assisted suicide'*. Furthermore they posit that clinicians' views '*on the threshold for competence vary on the clinician's ethical stance*". Their view is supported by Howe (2008) who notes that a psychiatrist's determination regarding a person's competency is based on both a clinical component and an ethical component, and

therefore there may be a subjective element in the psychiatrist's final decision (Howe, 2008). For these reasons, it may be necessary to establish an appropriate assessment measurement to be used to objectivity assess those people wishing to end their life (Stewart, 2010).

2. An individual's capacity to make decisions about ending their life is frequently compromised by the terminal illness, delirium and neurodegenerative diseases (Macleod, 2016). Many individuals with a terminal condition and/or seeking to end their lives are depressed: they feel hopeless and sad. Studies from Switzerland and Oregon note that approximately a quarter of individuals seeking euthanasia were clinically depressed (Stewart, 2010). These conditions need to be assessed by a psychiatrist in the first instance before the end of life process is progressed.

3. Individuals who are weakened by illness or medical treatments may find themselves unduly influenced by those close to them (Stewart, 2010). This situation may be particularly important when older members of the New Zealand population are considering ending their lives as they see themselves as a burden or an inconvenience when thinking about their future options (Donnelly, 2012). If the proposed legislation was to be enacted, there must be safeguards in place for older members of the New Zealand population, especially older people with dementia, and to ensure they have access to quality and timely health and social services.

4. People who are living with dementia require special attention. Dementia is an age-related disorder and due to the absence of effective prevention or treatment strategies, a significant number of New Zealanders will experience dementia in the future (Deloitte, 2017). People in this group are at an increased risk of suicide and might possibly consider ending their lives. While this might be regarded as a form of 'rational' suicide, the question of competence to make decisions is of particular importance in this high risk group. Although there is no effective treatment, the course of dementia can run for many years. It is very unlikely for people with advanced dementia to retain capacity required for decision-making on euthanasia. It is critical to define whether or not dementia is considered as 'a terminal illness or a grievous and irremediable medical condition'.

5. We request that some provision is included in the Bill that if an individual is not able to give consent due to their pre-existing mental condition, such as depressive illness, that they are directed to a mental health professional for assistance.

6. It should be noted that a person's wish to end their life may fluctuate over the course of their illness and when mental illness is present the patient's view on euthanasia may vary greatly due for example, to their depressive state (Macleod, 2012.) It is unclear how these issues would be addressed if a medical practitioner is asked to obtain consent from an individual when they have little understanding of the individual's previous medical history.

7. We argue that third opinions regarding a person's competence should only be provided by a relevantly qualified vocationally registered medical practitioner such as a psychiatrist or a palliative care physician. Making judgements about an individual wishing to end their lives is a clinical problem that requires a medical practitioner trained in psychiatry or palliative medicine. Undertaking an assessment about a person's ability to understand the medical options and psychological implications around death and dying is not the same as obtaining consent regarding a surgical procedure. Psychiatrists have extensive experience and training in obtaining consent from individuals undergoing a range of procedures, they have medical training and knowledge of psychological medicine. Given the complexity – both medical, ethical and psychological – we contend clause 12 (2) should be amended to state 'ask *the SCENZ Group for*

the name and contact details of a medial practitioner with the scope of practice in psychiatry and /or palliative medicine'.

General practitioners may not have the confidence and knowledge to perform a capacity assessment. For example, results of a survey of general practitioners and hospital doctors in the Wellington region revealed that they lacked confidence and knowledge about capacity assessments; and a significant portion of them did not consider capacity assessments to be within their scope of practice (Young et al, Unpublished).

Section 15 Medication chosen

Several clauses within this Section of the Bill require refinement. The Bill lists that there are several options that an individual may choose to end his/her life (S 15(3) (b)) but we contend that the indications associated with each method of death will need to be described to the individual e.g. how an intravenous (IV) delivery of lethal drugs would work as opposed to ingestion and if all methods would be available at any location e.g. would all options be available in the person's home. We believe these nuances would need to be presented to the individual and understood by the individual so they can make an informed decision regarding their preferred method of death.

Under clause 15 (4), we wish to know the process whereby pharmacists will be involved in the providing of the medicines used to end a person's life and how this might work in practice e.g. would these medicines only be dispensed from a hospital pharmacy.

Section 16 Medication administered

S 16 (4)

Under the proposed legislation the medical practitioner must administer the lethal dose thus ending the person's life. This action is in direct contravention of the Hippocratic Oath and runs contrary to the ethics of medical practice, including the RANZCP's Code of Ethics.

We note that many other jurisdiction's legislation relating to euthanasia leave the final administration of lethal drugs to the individual rather than the medical practitioner. With Swiss legislation a person may end their life without a doctor e.g. '*it does not give physicians a special status in assisting it'* (Hurst, 2003). We argue that many medical practitioners will struggle to reconcile this section of the Bill with their personal view of what constitutes good medical practice. Evidence from the Netherlands indicates that most doctors do not want or wish to kill their patients but proceed based on their patient's wishes (Macleod, 2012). Giving the lethal dose to end a person's life places a considerable burden on the medical practitioner and may be distressing for them. Subsequently we strongly advocate that there are appropriate support systems in place for those medical practitioners who are engaged in this work. We would like to see additional clauses in this section outlining the support services for medical practitioners and how these might be delivered e.g. a number of counselling sessions etc.

Part 3 Accountability

Section 19 SCENZ Group

The establishment of a Support and Consultation End of Life in New Zealand Group (SCENZ) is necessary to ensure there are sufficient checks and balances in place to protect vulnerable people. The process described in this section of the Bill clearly outlines how the Bill will be managed in practice and the administrative procedures that must be followed to meet the legal requirements of the Bill. The

process is clear and we believe both people seeking to end their life and health professionals involved in assisting the person to die could easily follow the procedures.

If the Bill proceeds and before it is enacted, we contend it is critical to develop clinical guidelines relating to ending of life including assessing an individual's competence, key legal requirements and expected standards of care for individuals wishing to die. Developing these components would go some way in ensuring that there is a consistent approach to ending one's life across New Zealand and attempt to reduce subjectivity around the process.

Services to help people end their lives must be available to all population groups. The data from Oregon shows that the majority of people who accessed assisted suicide were well educated and middle class (Macleod, 2012). If the proposed Bill becomes law then providing equitable access to the service would be a requirement and would require consumer guidelines explaining the legislation and further information around ending one's life.

The RANZCP argues that understanding the individual's competence is central to this Bill and therefore if this Bill is enacted, it would be critical to include psychiatrists in developing these standards and supporting documents.

Section 20 Review Committee

We are not clear if the Review Committee would comprise three permanent members, or if the third member would be invited to join the Review Committee based on the issues under consideration. We strongly recommend establishing a pool of medical practitioners who may be called upon to join the Review Committee to provide expert specialised advice. For example, an expert in clinical pharmacology may be required if there are issues about medication used in the procedure while issues pertaining to an individual's mental state would require psychiatry input. Section 20 (1) (c) could be amended to read *'another medical practitioner with relevant clinical expertise in the matter under consideration'.*

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