

New Zealand doctors and euthanasia—legal and practical considerations of the End of Life Choice Act

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ABSTRACT

AIM: To provide an overview of the New Zealand End of Life Choice Act in comparison with other countries, arguments for and against euthanasia, and consideration of relevant legal and practical issues.

METHOD: Structured descriptive summary of criteria for medical euthanasia in various jurisdictions currently allowing the practice, compared with New Zealand legislation. Narrative review of arguments for and against euthanasia with reference to existing medical literature and legal cases.

RESULTS: A strong case for medical assistance in dying, based on autonomy and quality of life arguments, is countered by a long history of medical and legal tradition protecting life.

CONCLUSION: This highly contentious issue is coming before the New Zealand public as a referendum in October 2020. The results will have profound implications for medical practice as well as reflecting societal shifts in attitudes toward death and dying.

In October 2020, New Zealanders will be asked if they support the implementation of the End of Life Choice Act 2019 (EoLCA): (<http://www.legislation.govt.nz/act/public/2019/0067/latest/whole.html#DLM7285905>).¹

This referendum has particular implications for doctors; as practitioners who may be asked to hold the syringe, there is little room to abstain. Clinicians require a good understanding of the Act and, in the interests of clarity, we have compiled a glossary of relevant terms. For the purposes of this Viewpoint, ‘euthanasia’ signifies both voluntary euthanasia and physician-assisted suicide (see Appendix).

Confusion regarding terminology is widespread among the public; many New Zealanders appear to falsely believe the EoLCA applies to end-of-life practices currently legal, such as turning off life-support, implementing ‘do not resuscitate’ requests, and ceasing active investigation and treatment.² When people are given proper definitions, strong views on both sides of the debate soften.²

The EoLCA Referendum is also binding on an Act that has passed in parliament and received Royal Assent. Accordingly, the specifics and technicalities are finalised, highlighting the importance for voters to understand the Act’s details. A link to the official Government website has been included (though this link may not be functional after the referendum): www.referendums.govt.nz/endoflifechoice/summary.html.³

A brief summary of New Zealand legal criteria is presented in Table 1, alongside those approved in other countries.

The EoLCA additionally stipulates that euthanasia:

- must be indicated on the death certificate, along with the terminal illness that gave rise to the patient’s eligibility
- cannot be requested by anyone other than the patient
- does not require:
 - prior access to appropriate medical or palliative care

Table 1: Comparison of proposed New Zealand law with other jurisdictions.

	Physician assisted (self-admin)	Voluntary euthanasia (other-admin)	Eligible age	Medical prerequisite	Can be requested via advance directive
New Zealand	Yes	Yes	18+	Terminal (6 months)	No
Netherlands	Yes	Yes	12–15 with parental consent, under 1 with parental consent, otherwise 16+	Unbearable suffering with no prospect of improvement	Yes
Belgium	Yes	Yes	Up to 17 with ‘a capacity of discernment’ and parental consent, otherwise 18+	Terminal illness for children, otherwise ‘medically futile condition’	Yes
Canada	Yes	Yes	18+	Grievous and irremediable medical condition	No
Oregon, US	Yes	No	18+	Terminal (6 months)	No
Luxembourg	Yes	Yes	16+ with parental consent, otherwise 18+	Grave and incurable condition	Yes
Colombia	No	Yes	6–13 with parental consent, otherwise 14+	Terminal phase of disease	Yes if in audio or video recording
Western Australia	Yes	Yes	18+	Terminal (6 months, 12 months for neurodegenerative)	No
Victoria, Australia	Yes	Yes, only if unable to self-admin	18+	Terminal (6 month)	No
Switzerland	Yes	No	No limit	No limit	No

- a ‘cooling off’ period between request and implementation
- an independent witness at any stage of the process
- the individual to inform anyone of their decision
- the doctor to reconfirm competence when patients affirm the decision to proceed at the chosen time for administration of the lethal substance

Conscientious objection

Conscientious objection is defined in the EoLCA as any objection to euthanasia on the grounds of conscience. The Act requires medical objectors to inform patients of their objection and advise they can seek a replacement from the Support and Consultation for End of Life in New

Zealand (SCENZ) Group, to be established by the Ministry of Health. Objectors are not required to make onward referrals. The EoLCA is silent on objection for organisations, eg, hospices, though there has been a recent High Court case which granted limited declarations around interpretation of the Act.⁴ Also absent are legal requirements for nurses, pharmacists or other health professionals who may conscientiously object; overseas evidence notably indicates nurses are often approached first with enquiries about euthanasia.⁵

Summary of arguments

Table 2 summarises some of the more common arguments for and against euthanasia. Relevant moral and philosophical considerations are beyond the scope of this paper.⁶

Table 2: Arguments for and against legalising euthanasia.

	For euthanasia	Against euthanasia
Role of doctors	Important facet of medical care for the terminally ill	Antithetical to “First, do no harm”
Legal	<ul style="list-style-type: none"> • Law protects freedoms • EoLCA has suitably restrictive eligibility criteria • Law reflects and adapts to societal shifts • Remedies situations where terminal patients are allowed to die but with unnecessary pain and suffering 	<ul style="list-style-type: none"> • Law protects the vulnerable • Difficult to prevent expansion of eligibility criteria • Violates legal tradition and purpose of protecting life • Difficult to protect patients from coercion
Vulnerable people	Assists those with terminal conditions, intractable suffering, loss of dignity	Possibility of cases progressing to euthanasia without an explicit wish to die
Mental health	Awareness of euthanasia option reduces psychological distress	End of life depression and anxiety are often treatable
Criteria expansion (‘slippery slope’)	<ul style="list-style-type: none"> • Could reflect acceptance of better ways of dying • ‘Right to die’ should exist 	<ul style="list-style-type: none"> • Signals poor legal safeguards • Could make coercion more likely
Moral	<ul style="list-style-type: none"> • Respect for autonomy • Utilitarian benefits from healthcare savings 	<ul style="list-style-type: none"> • Sanctity of life • Perverse incentives for euthanasia • Unintended influences on funding or provision of healthcare
Cultural	Opportunity to constructively reflect and reshape societal attitudes toward death	‘Life unworthy of life’ becomes socially acceptable concept

Role of doctors

The role of doctors in enabling patient autonomy is evident in abortion, which, without medical assistance, may result in unnecessary harm.⁷ Similarly, without assistance, a patient's desire to die may result in cruder methods of suicide, risking more suffering and trauma, or decisions to end life earlier.

Many supporters believe access to euthanasia is vital in ensuring a 'right to die', despite this principle failing to be affirmed by the US Supreme Court,⁸ the UK Supreme Court,⁹ the European Court of Human Rights¹⁰ and the New Zealand High Court.¹¹ Not all legal experts agree, however. As US Supreme Court Justice Souter said regarding assistance in dying, "There can be no stronger claim to a physician's assistance than at the time when death is imminent". Advocates also point out that legal and judicial opinion often move slower than societal shifts in attitude.

Some people from both sides of the issue contend that euthanasia should not be solely a medical decision, and instead advocate court involvement, consistent with other complex medical decisions.¹² Some also posit that a separate profession should ensure that the procedure is done safely from a technical perspective, thus protecting the doctor's role as a healer.

On the other hand, consistent with NZMA's updated Code of Ethics,¹³ opponents disagree with any medical involvement because they see euthanasia as incompatible with the doctor's role. The doctor-patient relationship remains asymmetrical in terms of power; how doctors communicate information can determine whether a patient chooses to undergo risky investigations or treatments. Opponents point to evidence overseas that the primary motivation for requesting euthanasia is not unbearable pain but the perceived loss of dignity^{14,15} and note the crucial role doctors can play in addressing that. Indeed, there is often emotional asymmetry when seriously ill patients look to their doctors for guidance and reassurance. Opponents worry about the risk of subtle coercion and undue influence,⁷ especially in end-of-life situations, and believe that such conversations risk harming the doctor-patient relationship.

The emotional demands of euthanasia work are inadequately understood. In a qualitative study of Dutch doctors involved with euthanasia for patients with dementia (legal in the Netherlands),¹⁶ the value of investing time to improve quality of care was strongly endorsed but seen as challenging, with some choosing to work on days off. All doctors felt there could be more support for those involved, and described the work as emotionally intense, both negatively (moral distress, frustration, anger, insecurity) and positively ('feeling in control', heroism, satisfaction, relief).¹⁶

The nursing role is crucial; a Dutch study showed them to be the first point of contact in almost half of the requests.⁵ Nurses are actively involved in voluntary euthanasia, even when not legally sanctioned (21% in the Netherlands), cf. 59% in Belgium, where it is legal.⁵

Other research suggests a lack of support for nurses who may feel pressured to take part to uphold their 'duty of care', even though conscientious objection is 'legally' permissible. Both supporters and objectors voiced concern about available support and clarity regarding professional and legal requirements.¹⁷ The EoLCA is silent on some of these issues, highlighting the importance of ensuring nurses are supported, and aware of their legal obligations and protections.

Lastly, relatively little is known about the impacts of asking health professionals to participate in euthanasia. Moral distress arises when clinicians believe they are unable to act in patients' best interests and thus includes concerns about wrongly approving or withholding euthanasia. Both possibilities need to be considered and appropriately managed.

Palliative sedation is sometimes misleadingly regarded as an example of 'euthanasia' when it hastens death.¹⁸ To whatever extent this occurs, there is a strong case that palliative sedation and euthanasia remain distinct due to differences in intent (as described by the principle of double effect). Unlike palliative sedation, the doctor who carries out euthanasia will have failed if the patient survives the procedure. Of note, multiple systematic reviews showed no association between palliative sedation and

reduced survival.^{19,20} To the contrary, 12 of the 13 studies found marginally longer survival in those sedated.

Philosophical discussions regarding the principle of double effect may be relevant for end-of-life decisions but are beyond the scope of this paper.^{21,22}

Comparison to abortion

Despite superficial similarities, there are substantial differences between euthanasia and abortion, and they should be considered separately.²³

Similarities:

- both require technical expertise to ensure physical, emotional and legal safety
- both reflect intimate and personal decisions relevant to bodily and personal autonomy
- both decisions can be subject to coercion

Differences:

- Abortion happens far more frequently (one in four women in OECD)
- Euthanasia is seen to be a personal decision, while abortion requires the mother's decision on behalf of the fetus
- Euthanasia is the end of the life of a legal person, whereas abortion involves the loss of a fetus that is yet to have legal recognition as a person

The case for autonomy

The optimisation of individual autonomy via the EoLCA is, for many, an intuitively attractive option for medical assistance at end of life, and consistent with patient-centred care. However, ensuring autonomy is not always regarded as an absolute priority, such as when it may result in harm to self or others. Restrictions on autonomy include mandatory seat belts, prohibition against drink driving, and regulations regarding organ donation; these are deemed appropriate trade-offs in our current social contract.²⁴ This contract can be renegotiated and, indeed, the idea of organ donation euthanasia (where death follows removal of the organs under general anaesthetic, with informed consent) is a hypothetical discussed and advocated by some as consistent with maximising autonomy and contributing to a meaningful

death.^{25,26} The doctor's role in euthanasia thus brings into sharp relief questions about the limits and social context of autonomy.

Role of law

The Act as it stands passed royal assent in November 2019. Accordingly, we are also voting on the Act's details: legal rules, technicalities, practical and cultural implications. It is also widely accepted that law has a pedagogical function and helps shape culture as well as reacting to cultural shifts.

Proponents of euthanasia argue that the purpose of law is to protect people's freedoms, empowering individuals to judge their own quality of life, and to choose when and how to die; others may also benefit from the experience and memory of a loved one's peaceful death.

Even though the UK Supreme Court could not justify authorising euthanasia, an unintended consequence was noted by Lord Browne-Wilkinson—"...How can it be lawful to allow a patient to die slowly, though painlessly, over a period of weeks from lack of food but unlawful to produce his immediate death by a lethal injection, thereby saving his family from yet another ordeal to add to the tragedy that has already struck them? I find it difficult to find a moral answer to that question. But it is undoubtedly the law..."²⁷ Similarly, the US Supreme Court also acknowledged that the state's interest in preserving life at all cost may be outweighed by the liberty interest of those already on the threshold of death.^{7,28}

On the other hand, opponents argue that laws exist to protect society, especially the most vulnerable. These include those from disadvantaged ethnic or socioeconomic groups and those with disabilities. They point to legal tradition in Anglophone countries that has consistently opposed assisted suicide and sought to ensure equal protection for the 'hopelessly diseased, fatally wounded, and even criminals condemned to death'.⁷ Developments in modern medicine have both complicated and drawn attention to issues of dignity and independence at the end of life. Legislative changes around the world have affirmed the right to refuse treatment and enable do-not-resuscitate orders and proxy decision-making, while generally reaffirming bans on assisting suicide.

The EoLCA is intended to give the terminally ill a sense of control and/or to relieve intractable suffering, but some argue this specific Act may not adequately safeguard against ending vulnerable people's lives against their wishes. Many reasons patients seek euthanasia (loss of dignity, suffering, feeling like a burden) may also make them more vulnerable to coercion, highlighting the importance of both legal and practical protections. Indeed, despite comments made by individual judges, the UK and US Supreme Courts and others have consistently ruled that the state's interest in protecting the vulnerable is sufficiently weighty to justify prohibitions against physician-assisted suicide.^{7,27}

The 'slippery slope' is a term that has a wide range of interpretations from both sides of the discussion. This Viewpoint focuses on the anticipated expansion of legal eligibility criteria, as distinct from increased numbers approved for euthanasia each year. The latter statistic fails to distinguish between adoption of a preferable way of dying and concerns regarding expansion of eligibility criteria.

Examples of criteria expansion include:

- Belgium removing the age limit for euthanasia,²⁹ and subsequently a nine-year-old with a brain tumour and an 11-year-old with cystic fibrosis have been euthanised;
- Colombia allowing euthanasia for children aged 6+;³⁰
- Netherlands developing the Groningen Protocol and common law precedents for children under one year of age;³¹
- A proposed bill in Canada removing the requirement that death be foreseeable;³²
- Oregon relaxing the required waiting/cooling-off period for those with a lesser life expectancy, and a proposed bill removing the requirement for a six-month prognosis.^{33,34}

Once euthanasia has been legalised at central or federal level, there is at present no example of a statutory reversal or tightening of euthanasia eligibility criteria in any jurisdiction. US Supreme Court Justice Cardozo noted the tendency of a legal principle to

“expand itself to the limit of its logic”.³⁵ Euthanasia seems to be no exception, with conclusions to this effect from both the US and UK Supreme Courts—that “once a legislature abandons a categorical prohibition against physician-assisted suicide, there is no obvious stopping point”.^{7,27}

Like the EoLCA, legalisation in Canada includes no description of euthanasia as a human right. However, receiving assistance for the procedure was interpreted by the Ontario Superior Court as “a constitutionally protected civil and human right”.³⁶ With this interpretation, it may be difficult to justify denying this right to:

- someone with a degenerative condition expected to lose autonomy before reaching their six-month prognosis
- someone who does not have a terminal condition but experiences intractable suffering
- someone with unbearable mental instead of physical suffering
- someone who is 17 but deemed competent

The last point is immediately relevant as the Attorney-General has concluded that the EoLCA is inconsistent with the New Zealand Bill of Rights,³⁷ which protects all those above the age of 16 from age-based discrimination. This makes it a cogent place for advocates to challenge and expand existing criteria.

The expansion in eligibility criteria seen overseas is not necessarily a moral fault but appears likely, as above, based on both overseas experience and formal judicial commentary. While some advocates of a “right to euthanasia” praise these expansions as egalitarian, allowing more equitable access to a valuable end-of-life option, this will concern those advocating strict eligibility criteria and who believe certain groups should never have access to euthanasia.

A distinct set of ‘slippery slope’ concerns relate to existing euthanasia laws, how strictly they are enforced, and other legal safeguards designed to protect vulnerable patients.³⁸ The Canadian Supreme Court reviewed these concerns and found that laws governing euthanasia could be effectively and rigorously implemented, paving the way for legalisation in that country.³⁹

Concerns about coercion

In New Zealand contract law, determination that individual wishes are free from undue influence involves examination of witnesses, arguments by lawyers on both sides, and consideration of legal precedent. In the context of existing common law and the EoLCA, this means that:

- Similar responsibilities are to be placed on one individual doctor;
- The doctor does not have access to the powers of the court;
- The doctor is presumed to hold a position of power and influence over patients;
- These concern weightier decisions than those typical of contract law.

These challenges are further complicated in scenarios where the primary doctor conscientiously objects: the replacement doctor must assume this responsibility without the long-term relationship and knowledge of the patient and family. The doctor providing the second independent opinion also has no obligation to determine coercion. Finally, there is no requirement to ensure lack of undue influence at the time of final consent to administration of the lethal dose. Advocates point out that these responsibilities would fall within broad professional standards and governance.

Concerns have also been raised regarding the EoLCA's regulatory framework. In particular, its Review Committee does not receive demographic data such as age, gender, ethnicity and socioeconomic status, or indeed any clinical information confirming eligibility or excluding coercion, making it difficult to confirm the statutory requirement of "satisfactory compliance with the requirements of this Act".

These factors have led some to believe the EoLCA does not do enough to ensure patients are making decisions free from coercion. The High Court of England and Wales analysed a comparatively more stringent safeguard in 2017: that each case would be reviewed by the court to ensure the absence of coercion. Their conclusion (upheld by both the Court of Appeal and the Supreme Court) was that even such a process would be considered an inadequate safeguard.⁴⁰

However, as was pointed out by the Canadian Supreme Court,³⁹ the risks of coercion are already present in the existing medical system when it comes to refusal or withdrawal of life support, both of which remain lawful. Proponents highlight this inconsistency and argue that concerns regarding coercion have been overvalued and cannot justify an absolute prohibition of euthanasia. In contrast, opponents point to an additional reason why withdrawal of life support cannot be prohibited, namely that it may result in medication/life support being forced on unwilling patients.

The US Supreme Court goes beyond protecting the vulnerable from coercion and extends the state's interest to protecting disabled and terminally ill people from prejudice, negative and inaccurate stereotypes, and "societal indifference".⁷ In New Zealand, the absence of demographic data required by the EoLCA will make it difficult to measure the impact of the Act at a population level and identify trends, or gaps in access. The EoLCA also has no specific provisions to ensure patients receive culturally appropriate care, including kaupapa Māori considerations as mandated by Te Tiriti o Waitangi.

Mental illness and vulnerability

Depression is common in patients with a terminal illness, with up to 44% fitting a diagnosis of depressive disorder.⁴¹ However, differentiating depressive disorders from grief reactions in the setting of a terminal illness can be difficult. Undertreatment of psychiatric illness is common,⁴¹ for example up to 80% of cases among cancer patients remain unrecognised and untreated,⁴² cancer constitutes the largest proportion of New Zealand's deaths and proportion of completed euthanasia overseas.^{15,43,44} Missed psychiatric diagnoses clearly increase the risk of inappropriate or unnecessary requests for euthanasia.

The New Zealand government has prioritised reducing suicide rates while provisionally approving assisted suicide under the EoLCA. While some posit that legalising euthanasia may affect suicide rates, this is not strongly supported by the numbers; a review found no evidence for an association between suicide rates and legalisation of euthanasia in various countries.⁴⁵

Cases of people who opponents would consider vulnerable being euthanised are well documented in multiple jurisdictions. A Dutch government study revealed that in 1990 there were more than 1,000 cases of euthanasia without an explicit request.⁷ While the situation has apparently improved, this is still an ongoing practice. The most recent data available via the Dutch government website showed that in 2015, 431 people were euthanised without explicit request⁴⁶—around 0.3% of total deaths that year, assuming no underreporting. In 2018, there were 67 reported cases of patients receiving euthanasia for psychiatric indications. A notable case in 2015 was a victim of sexual abuse in her 20s diagnosed with PTSD, anorexia and depression.⁴⁷

A Belgian study found that only half of cases of euthanasia were reported,³⁰ dropping to one in five in the elderly (80+).⁴⁸ The commonest reason (77%) was because physicians did not “view their act” as euthanasia, despite the definition used in the study being the same as the legal definition used in the Benelux. Another 18% stated that they did not report because it was “too much of an administrative burden”, and 12% because they admitted the “legal due care requirements had possibly not all been met”.⁴⁸

In 2019, the United Nations Special Rapporteur on the Rights of Persons with Disabilities expressed extreme concern with Canadian legislation,⁴⁹ and recommended “adequate safeguards to ensure that persons with disabilities do not request assistive dying simply because of the absence of community-based alternatives and palliative care”. Her comments are relevant in light of the known gaps for access to palliative care in New Zealand, as well as the expected 50% increase in deaths in the next 20 years.⁵⁰ New Zealand is a signatory of the same UN International Human Rights Treaty and expected to fulfil similar obligations.⁵¹ While the above examples do not necessarily all indicate abuse or weakness of the law, they illustrate the difficulty of ensuring safe processes, and the challenges doctors may face in protecting themselves and their patients.

Problems in implementation

As noted, there are a variety of matters that have not been adequately specified in the Act, including:

- Which doctors can legally discuss euthanasia with patients (EoLCA refers only to the requirement for practising certificates)
- Specific criteria triggering enforcement of the Act
- Guidelines regarding conscientious objection and prevention of coercion

It remains an open question whether these issues would be better addressed by modification of the Act or by other regulatory instruments and professional bodies. Either way, one set of useful considerations that could be adapted to these purposes have been formulated by Lord Wilson of the UK Supreme Court, who identified factors to assist determination that a person’s wish to end their life was “voluntary, clear, settled and informed”.^{31,52}

(<https://www.bailii.org/uk/cases/UKSC/2014/38.html#:~:text=As%20a%20former%20judge%20of%20the,to%20the%20judges%20of%20the%20Division>)

Conclusion

New Zealand doctors are obliged to consider their legal and professional obligations to patients in relation to the EoLCA. The challenge of managing end-of-life scenarios brings these issues to the fore. Much evidence points to the emotional intensity and potential moral distress associated with euthanasia. Proponents argue clinicians can be part of an intimate and rewarding process enabling patient autonomy and helping them achieve a peaceful death. In contrast, opponents say euthanasia is incompatible with both end-of-life care and medical practice generally.

From a legal perspective, the EoLCA poses many challenges and unanswered questions about how to ensure the process is safe for all involved. Proponents rightly point out that many of these questions should be addressed at a professional level with training programmes, clear guidelines and access to adequate support. On the other hand, opponents point to overseas evidence of underreporting and nonvoluntary euthanasia to illustrate risks of the legislation.

Based on overseas experience, once legalised, euthanasia eligibility criteria will

be challenged, and are likely to be expanded over time. Some regard this as an egalitarian progression towards a better future that includes a ‘right to die’, while others view this as an unacceptable risk of the EoLCA. Either way, it is difficult to imagine a more critical referendum for both our profession and New Zealand society at large.

Appendix

Glossary/definition of terms

Euthanasia: a catch-all phrase for voluntary euthanasia and physician-assisted suicide (see below), both of which are options under the EoLCA; similar to Canada’s “medical assistance in dying”, commonly abbreviated MAiD.

Voluntary euthanasia: administration of a life-ending substance to a consenting patient.

Nonvoluntary euthanasia: administration of a life-ending substance to a patient unable to consent (eg, persistent vegetative state).

Involuntary euthanasia: administration of a life-ending substance to a patient who is able to consent but did not.

Physician-assisted suicide: self-administration of a medically prescribed life-ending substance.

Physician-assisted dying: commonly used as an alternative to ‘physician-assisted suicide’, and may (confusingly) include voluntary euthanasia.

Assisted dying: commonly used to include both voluntary euthanasia and physician-assisted suicide, sometimes used interchangeably with physician-assisted dying.

Palliative sedation: administration of sedative medication to relieve refractory symptoms.

Competing interests:

Nil.

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