HorizonResearch
LISTENING TO NEW ZEALAND

New Zealand Doctor - End of Life Choice survey

This report summarises results of a March 14-25, 2018, survey of identifiable doctors subscribing to New Zealand Doctor.

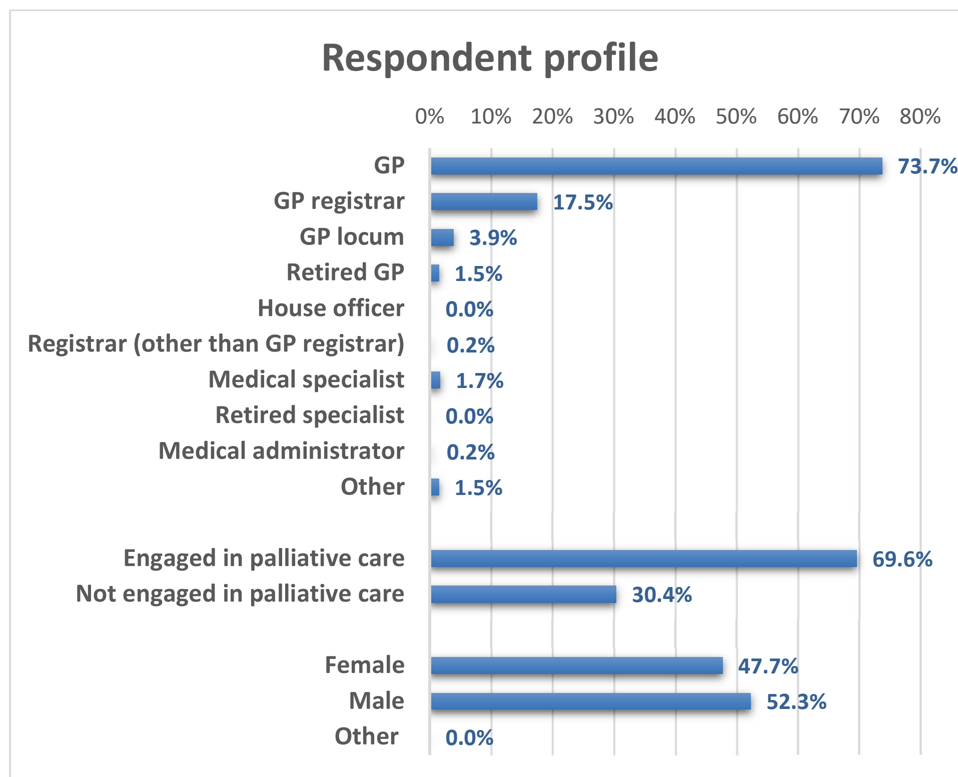
Sample

Invitations to participate in the survey were sent to 1,540 identifiable doctor subscribers on the New Zealand Doctor subscription list. Where a practice had one subscription that was shared by the doctors in the practice, the invitation was sent to the doctor whose name appeared on the subscription only. Multiple responses from an invitation recipient were not possible.

545 of those invited responded – a 35% response rate.

The results are not weighted.

74% of the respondents were GPs while 18% were GP Registrars. 70% overall were engaged in Palliative Care; of those who were not nearly a third were GP registrars.



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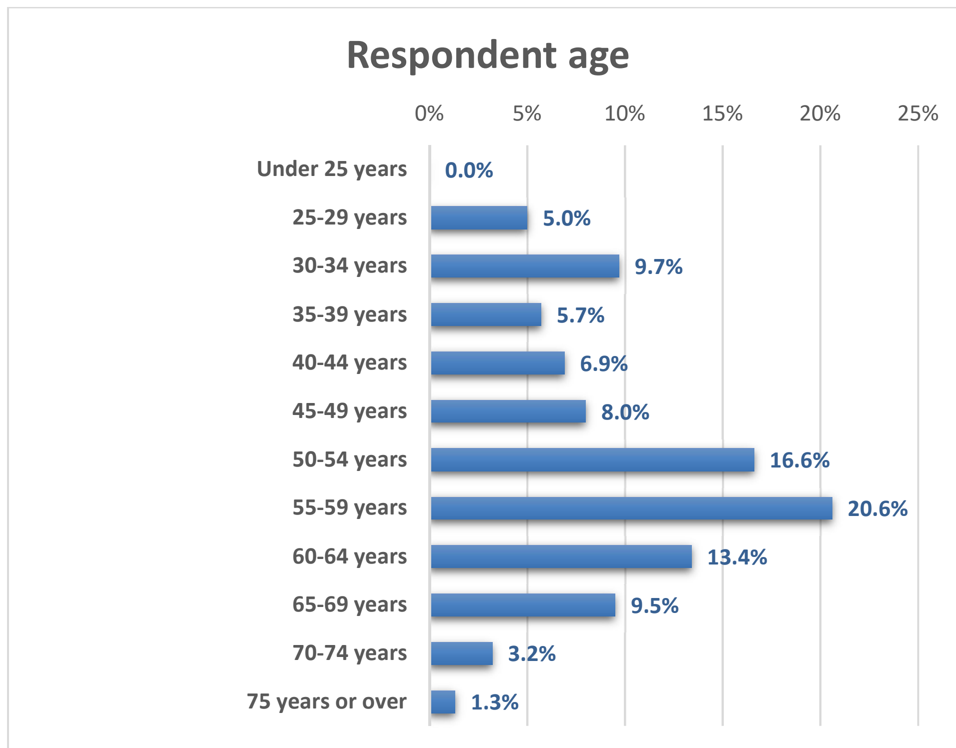

RESULTS

Summary

Among subscribers to New Zealand Doctor who responded to the survey:

- There is majority opposition to the introduction of a law to allow medical practitioners to assist people to die. Comments from respondents indicate that such a position is ethically based.
- Opposition to End of Life Choice options reduces as age increases. Conversely, support increases as age increases and those who support an End of Life Choice law are around 4% older, on average, than those who oppose it.
- Female respondents are more likely to oppose than male respondents.
- Those involved in palliative care more likely to oppose than those who are not.
- Even though doctors may support the introduction of End of Life Choice law, that does not mean that those who support the introduction will prescribe a drug to allow the patient to self-ingest the drug causing their death, or give a drug intravenously causing the patient's death.

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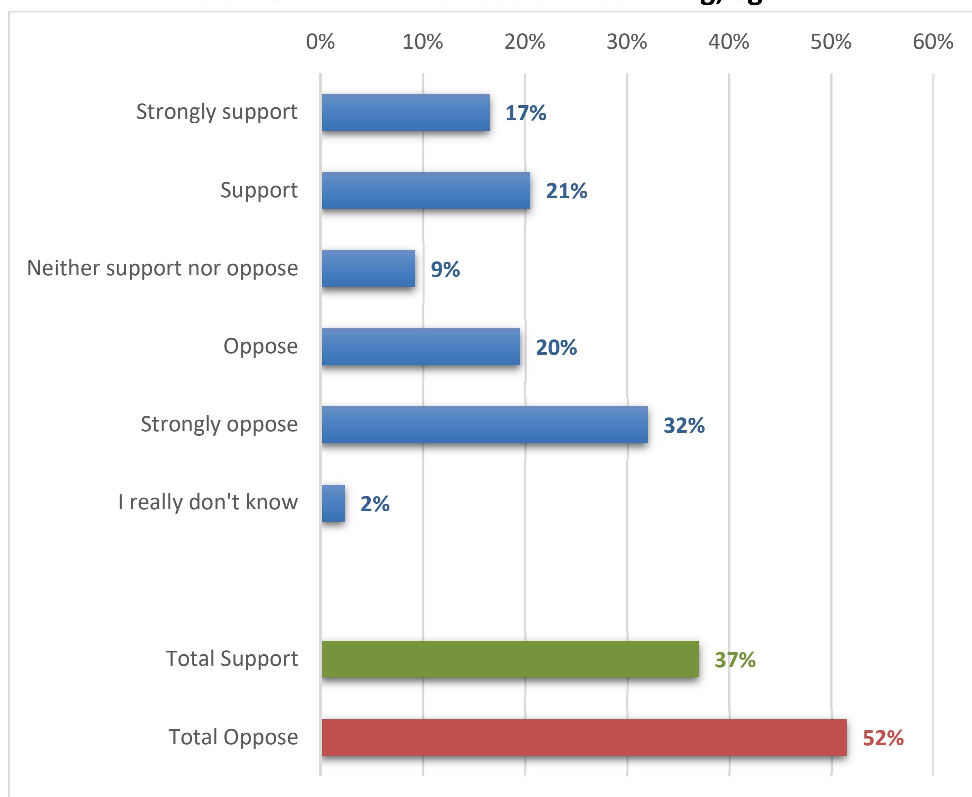
Question results

1. **Support for a law change to allow medical practitioners to assist people to die, where such a request has come from a mentally competent patient, 18 years or over, who has end-stage terminal disease, and is in an advanced state of irreversible decline with unbearable suffering; e.g. cancer.**

- **52%** of respondents **opposed** such a law change. Opposition was strongest among female respondents (57% v 46% for male respondents) and those engaged in palliative care (54%).
- **37%** of respondents **supported** a law change, while 9% neither supported nor opposed. Support was greater among male respondents (43%) than female respondents (32%) and those not engaged in palliative care (41% v 34% for those engaged in palliative care). GP registrars had the lowest support level (30%).

Do you support or oppose a law change to allow medical practitioners to assist people to die, where such a request has come from a mentally competent patient, 18 years or over, who has end-stage terminal disease, and is in an advanced state of irreversible decline with unbearable suffering; eg cancer?



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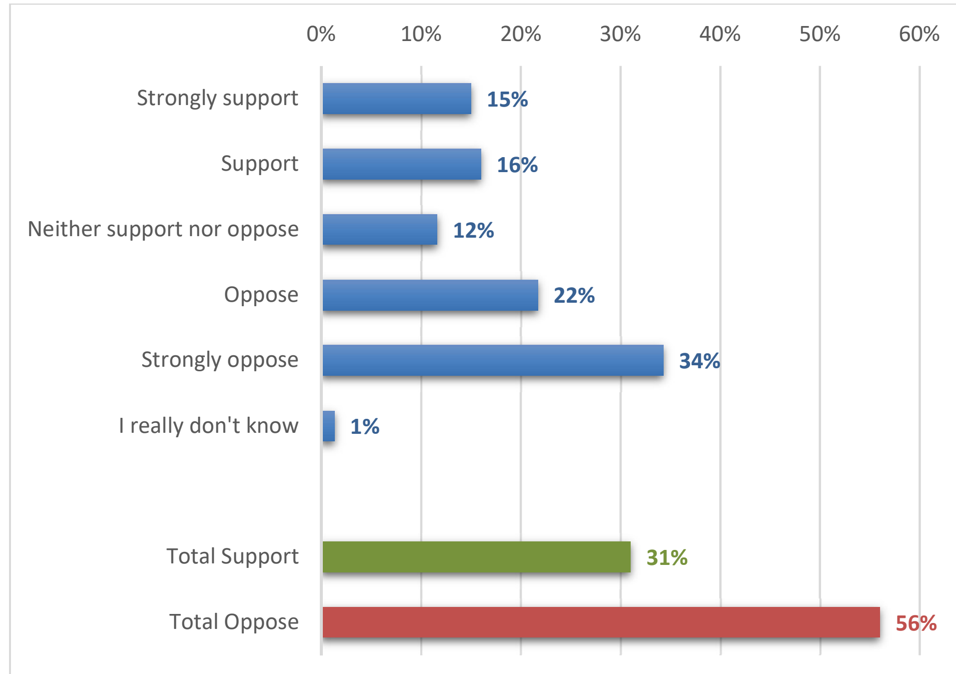
2. Support for a law change to allow medical practitioners to assist people to die, where such a request has come from a mentally competent patient, 18 years or over, who has unbearable suffering, is in an advanced state of irreversible decline, but the disease may not cause death in the immediate future, e.g. motor neurone disease, end-stage respiratory disease.

This option had stronger opposition than the end-stage terminal disease one.

- **56%** of respondents **opposed** such a law change. Opposition was strongest among female respondents (62% v 49% for male respondents) and those engaged in palliative care (55%).
- **31%** of respondents **supported** a law change, while 12% neither supported nor opposed. Support was greater among male respondents (38%) than female respondents (25%) and those not engaged in palliative care (32% v 29% for those engaged in palliative care). GP registrars had the lowest support level (22%).

Do you support or oppose a law change to allow medical practitioners to assist people to die, where such a request has come from a mentally competent patient, 18 years or over, who has unbearable suffering, is in an advanced state of irreversible decline, but the disease may not cause death in the immediate future, e.g. motor neurone disease, end-stage respiratory disease?



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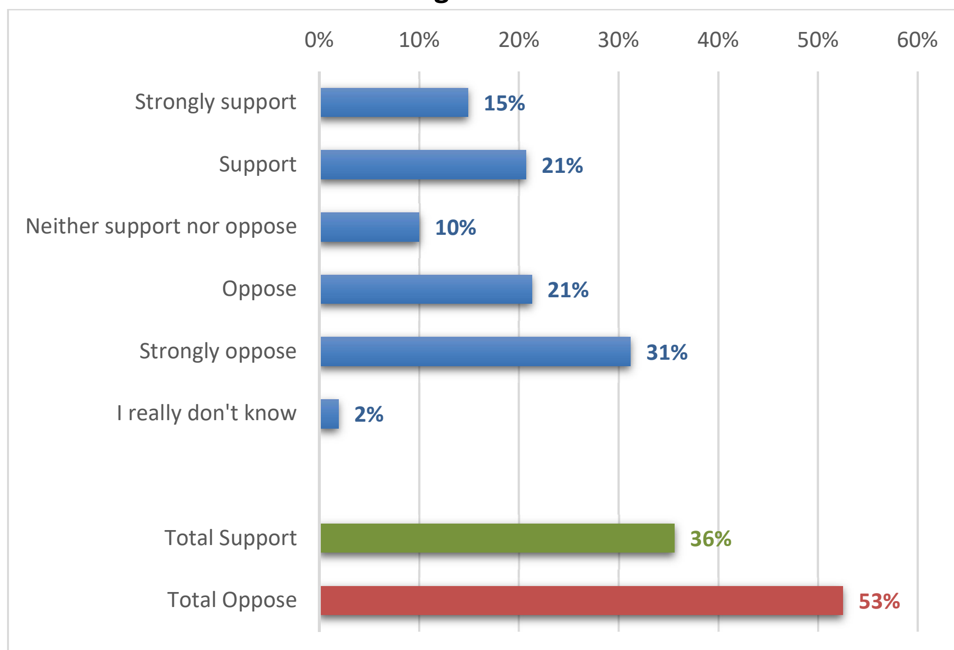
3. Support for a law change to allow a competent patient to write a legally enforceable and binding specific request (an End of Life Choice Directive) to allow medical assistance to bring about death, if a person has unbearable irreversible suffering as a result of a terminal or incurable disease after the patient becomes mentally incompetent; e.g. brain tumour, Huntington's Disease?

This option had more opposition than for the end-stage terminal disease option.

- **52%** of respondents **opposed** such a law change. As with the other questions on support or opposition for a law change, opposition was strongest among female respondents (56% v 48% for male respondents) and those engaged in palliative care (53%). Opposition generally declined as age increased (65% among those 25-29 years, 43% among those 70 years or over).
- **36%** of respondents **supported** a law change, while10% neither supported nor opposed. Support was greater among male respondents (41%) than female respondents (30%). Support generally increased as age increased (27% among 25-29 year olds, 39% among those 70 years or over. GP registrars had the lowest support level (27%).

Do you support or oppose a law change to allow a competent patient to write a legally enforceable and binding specific request (an End of Life Choice Directive) to allow medical assistance to bring about death, if a person has unbearable irreversible suffering as a result of a terminal or incurable disease after the patient becomes mentally incompetent; e.g. brain tumour, Huntington's Disease?



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4. Support for a law change to allow a legally enforceable and binding specific request for assistance to die (an End of Life Choice directive) written in advance by a competent patient in the event of a situation such as possible severe dementia?

The survey raised Dementia as an example of is one of the situations where an End of Life Choice Directive could be applied. The example shown was:

"If I develop severe dementia from Alzheimer's Disease or other degenerative brain disease, and my mental competence has deteriorated to the state that I am no longer able to recognise close relatives or friends; am totally dependent on others for basic physical needs, eg, feeding and drinking and need to have spoon-feeding by others; need toileting for incontinence; and have to be dressed by others - I request that I be given medical assistance to die."

Respondents were asked whether they would support or oppose passing a law which would legalise such a request by an End of Life Choice Directive, using the example of possible future severe dementia.

This option had more opposition than for an End of Life Choice directive in the case of terminal or incurable disease after the patient becomes mentally incompetent.

- **56%** of respondents **<u>opposed</u>** such a law change. Opposition was again strongest among female respondents (58% v 52% for male respondents) and those engaged in palliative care (58%). Opposition generally declined as age increased (54% among those 25-29 years, 46% among those 70 years or over). Although the number of medical specialist respondents was small, indications are that medical specialists were more supportive of this than GPs.
- **30%** of respondents **<u>supported</u>** a law change, while12% neither supported nor opposed. Support was greater among male respondents (35%) than female respondents (26%) and those not engaged in palliative care (32% v 28% for those engaged in palliative care). Support generally increased as age increased (27% among 25-29 year olds, 38% among those 70 years or over. GP registrars had the lowest support level (27%).

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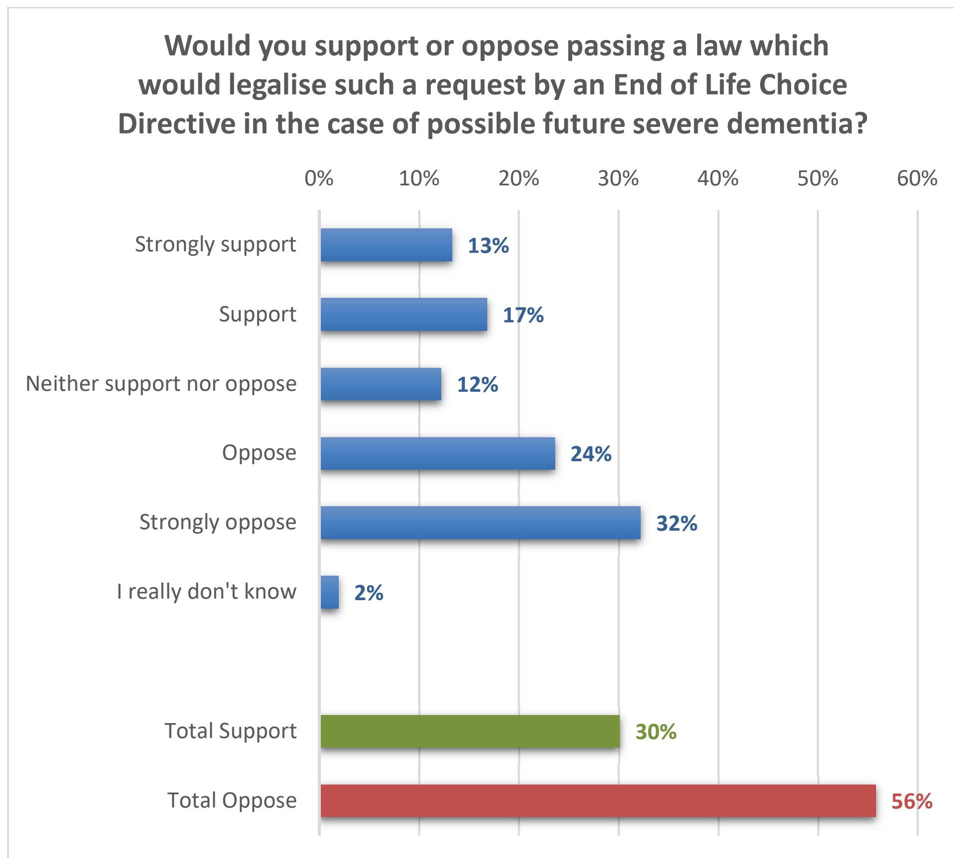
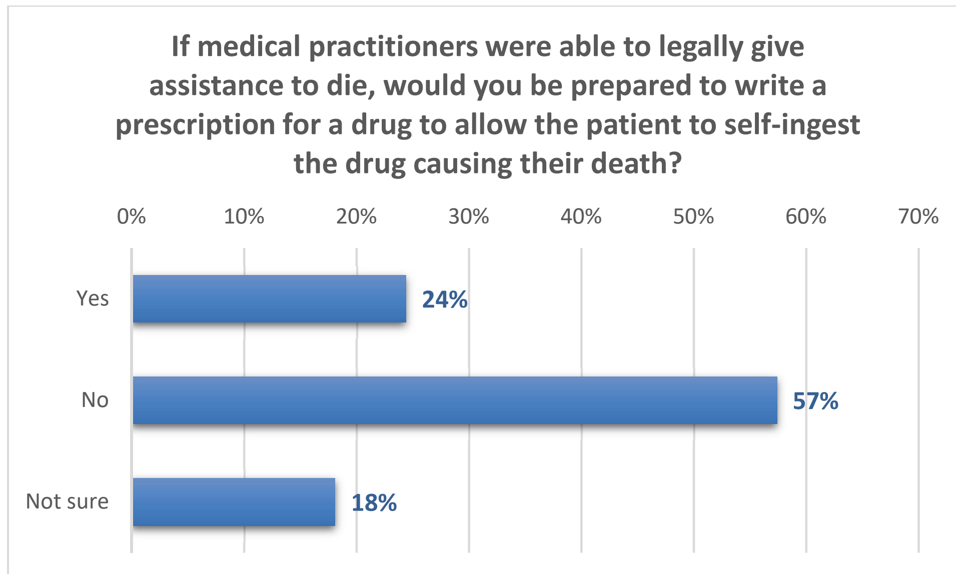


5. Willingness to write a prescription for a drug to allow a patient to self-ingest the drug causing their death.

Respondents were asked, assuming medical practitioners were able to legally give assistance to die, if they would be prepared to "write a prescription to allow a patient to self-ingest the drug causing their death".

- **24%** of respondents were **willing** to write such a prescription. Male respondents (31%) were significantly more willing to prescribe than female respondents (18%). Respondents 45 years of age or over more less willing to prescribe than those under 45 years. Although the number of medical specialist respondents in the survey was small, indications are that medical specialists were more willing to prescribe in these circumstances than GPs.
- **57%** of respondents were **unwilling** to write such a prescription. While most of these people opposed the introduction of End of Life Choice law, 27% of those who supported it were unsure whether they would prescribe and 13% said they would not. Respondents under 40 years of age were less willing to prescribe than those 40 years of over. Female respondents were less willing to prescribe (62%) than male respondents (52%). GP Registrars were least likely to prescribe.
- **18%** were **unsure** whether they would be willing to write a prescription or not.
- **61%** of those who supported an End of Life Choice law said they would be prepared to prescribe, as did 3% of those who opposed an End of Life law. Conversely, 89% of those who opposed an End of Life Choice law said they would be unwilling to prescribe, as did 13% of those who supported such a law.



6. Willingness to give a drug intravenously causing the patient's death.
Respondents were asked, assuming medical practitioners were able to legally give assistance to die, if they would be prepared to "give a drug intravenously causing the patient's death".

Respondents were significantly less willing to give a drug intravenously than to write a prescription.

- **15%** of respondents were **willing** to give a drug intravenously. Male respondents (20%) were significantly more willing to do so than female respondents (10%). Respondents 45 years of age or over were slightly more willing to give an intravenous drug than those under 45 years, but the results suggest that willingness to give a drug causing a patient's death intravenously is effectively unrelated to age.. Virtually all of those willing to give an intravenous drug supported the introduction of End of Life Choice law.
- **68%** of respondents were **unwilling** to give a drug intravenously. Female respondents were less willing to do this (73%) than male respondents (62%).
- 17% were unsure whether they would be willing to give a drug intravenously or not.g. GP Locums and GP Registrars were the most unsure about giving a drug intravenously to cause a patient's death.
- 38% of those who supported an End of Life Choice law said they would be prepared to give a drug intravenously, as did 2% of those who opposed an End of Life law. Conversely, 97% of those who opposed an End of Life Choice law said they would be unwilling to give a drug intravenously, as did 24% of those who supported such a law.

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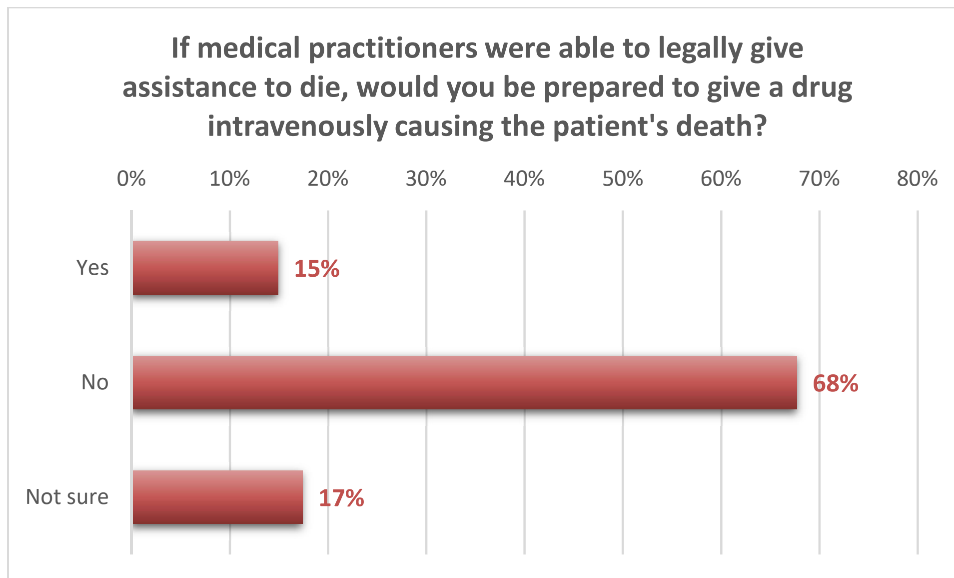

Comments

Comments from respondents indicate the ethical dilemma many doctors feel they are likely to face with regard to End of Life Choice law. Others were realistic about current practice, while some raised issues around properly identifying coercion.

Some illustrative examples follow:

> *"I have no problems treating symptoms, even if the treatment may increase the chance of dying as in increasing morphine levels to alleviate pain and distress. In fact I find it abhorrent that patients are left to suffer out of fear the treatment could accelerate death.*
> *I have no problems stopping all preventative medication, be it aspirin, flu vaccines or even statins and antihypertensives in someone with no quality of life with no wish to continue living.*
> *If the law is passed, the medical profession must push for "opt out" options for GPs in particular, as we are dedicated to support life. This means there would need to be an alternative professional capable of ending life humanely, but the law makers cannot expect doctors to become "executioners"!."*

> *"I suspect my views will continue to evolve, I've not been party as a relative to someone suffering any of the situations in the survey but have to someone who was an alcoholic and wanted to die which I would not be happy to support. I have concerns about situations such as this becoming acceptable. And I have concerns that older people may feel they should end their life when in truth it is not what they wish. I suspect I would only feel comfortable with end of life choice applying to someone who is likely to die within weeks from eg cancer."*

> *"By choosing the vocation of medicine and ipso facto of that choosing to care for people in their care and respecting the sacredness of all life, doctors, individually and collectively, should never intentionally cause or intentionally assist the death of another human being. If they choose these latter paths they undermine and degrade the whole ethos of being a*

doctor and the doctor patient relationship. Parliament must not pass this legislation in response to individual or a number of emotive cases as the implications for the whole of society are huge and cannot be contained by supposed "safeguards"."

"Our job is to eliminate suffering, not to eliminate life. Even 'advanced terminal diagnoses' can be subsequently shown to be wrong. This Bill could exploit vulnerable, unwell, elderly, people for the financial gain of others. What some people actually say, doesn't necessarily reflect what they actually want, but rather, what they perceive that other people might want."

"I have taken an Oath to save lives."

"I strongly support the right for a patient with a terminal disease to die with comfort. All appropriate medicine and palliative care should be available for these patients to achieve this, and NZ needs to improve access to good palliative care for ALL. Making doctors also kill people will alter the relationship and trust that is essential for good palliative care. Even if the task of killing was given to another group e.g. judges. or lawyers, It is very hard if not impossible to ensure that inappropriate pressures do not make people ask for euthanasia "so as not to be a bother" to family / society etc."

"How is a doctor supposed to ensure that a patient is not being coerced in any way? Considering that subjects like family violence often take years for a victim to admit to, and even longer if emotional rather than physical abuse."

"I question whether there can be adequate safeguards for patients. I don't believe doctors, even GPs who have known patients for a long time, can reliably tell if coercion/ abuse is absent in vulnerable patients. How easy would it be to access a psychologist/psychiatrist? There is already less than ideal access in our health system, without the extra workload of end of life choice bill mental competency assessments. If the bill succeeds will there be increased resources and funding for the extra time and assessments required by general practice staff?"

"Doctors need to stop hiding behind the veil of doing everything possible that can be done to care for people and to treat people on the pretext that they feel they are helping to preserve life and that this is the main goal of medicine. At some point this tips over and the preservation of life become a problem in itself. It (the preservation of life) is a weak excuse by fearful doctors for the enforcement of suffering upon patients who have become victims. Death is inevitable but it is not inevitable that it be preceded by avoidable pain, indignity and humiliation. The medical core needs to put their big girl panties on."

"During the course of their life, people, in my experience, sometimes see death as a solution to their pain. In my experience the overwhelming majority of people overcome this attitude and want to keep living."

"As long as there is no coercion and the person is mentally competent I support the person's right to determine their end of life care. This may be palliative care or it may be euthanasia. It is not our right to impose palliative care on someone who does not want it, providing it has

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been adequately explained. Passive euthanasia is practiced quite regularly in New Zealand where medications are withdrawn that may prolong the person's life eg antibiotics."

"Although I am in general agreement with the bill I think that it is potentially a medico-legal minefield and I fear that the amount of paperwork, time and cost likely to be involved will be beyond that available in a primary care setting and that it will necessitate the establishment of a stand-alone multi-disciplinary service."

"In a practical sense, whilst it seems easy to write black and white rules regarding which circumstances would be appropriate (for assisted dying), we in the medical profession know that it will be the areas of 'grey' that will provide the biggest headaches. These instances won't be rare in my view. The other point to note, is that whilst it will benefit a very small number of people, this law change will cost an enormous amount to administer, and we currently can't even fund palliative care sufficiently in its present form."

"The bill is poorly thought out and poorly worded. It compels doctors to participate in a process they don't agree with morally and ethically. It is in opposition to the responsibility to heal and protect."

"While this bill is our best current chance for more reasonable national legislation regarding assisted dying in backward New Zealand, I think no doctors anywhere should be evaluators of a person requesting assisted dying nor should doctors be the direct or indirect killer of a person. Killing people is not medical therapy. Sadly, doctors are forced into this situation because nobody else has the guts to stand up for a person's right to elective death. Vic Eastman MD."

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