Questions from the "End of Life Choice Act – Informing our Vote" webinar 11 August 2020

Thank you to everyone who attended the End of Life Choice Act – Informing our Vote webinar. It was great to see so many attendees for this informative and insightful session and we hope you found value in listening to what our panellists had to say on this topic.

We would also like to thank the moderator and panellists for taking part in this specialised webinar. The panellists were unable to answer all the questions during the session, but we thank Adam Holloway, a partner at Wotton & Kearney Lawyers, for taking the time to answer some of those questions below.

1. I was told that this bill could mean that Palliative Care wouldn't be able to operate as it did currently, because if a doctor is a conscientious objector to VAD and then they prescribe or administer, say a dose of morphine to control pain, that subsequently causes the patient to stop breathing and die that the doctor could be open to legal challenge regarding their conscientious objector status. Is this true?

   No, this is not correct. The Act is not intended to interfere with normal prescribing as supported by the Medical Council's statement on 'Good prescribing practice'. It will remain permissible for medicine to be administered to control pain, even where doing so might as a side effect shorten the patient's life. The fact that a practitioner is a conscientious objector for the purposes of the Act will not change this.

2. At what stage would we refer to SCENZ? i.e. before or after assessing eligibility through life expectancy?

   SCENZ has several roles under the Act. Practitioners who are conscientious objectors will be required to inform patients about their right to ask SCENZ for a replacement practitioner whenever a patient says they want to exercise the option of assisted dying.

   For a practitioner who is not a conscientious objector and becomes the 'attending medical practitioner' to a patient who wants assisted dying, the sequence is:
   - **Request made**
   - **Practitioner's obligations in response to request**
   - **Request confirmed**
   - **Assessment and eligibility opinion by practitioner**
   - **Practitioner asks SCENZ to help arrange a second opinion.**

A patient is never 'referred' to SCENZ as such – the attending medical practitioner holds primary responsibility for the process throughout.

3. If a patient asks their GP, does this make them the attending Doctor who has to do all that work or will there be a list of doctors who will have extra time and funding to do all the papers etc?

   Yes, if you are not a conscientious objector and a patient informs you of their wish to receive assisted dying, you become the 'attending medical practitioner'. How the ensuing obligations are managed and funded (particularly in a primary care setting) remains to be worked out.

4. Does proposed legislation apply to NPs as well as Drs?

   Under the Act only a doctor can perform the role of 'attending medical practitioner'. Nurse practitioners can however take the role of administering the medication and remaining available until the patient dies. The Act also allows nurse practitioners to be conscientious objectors.

5. Can we go over the section 11 obligations, please?

   If a practitioner is not a conscientious objector and a patient – any patient – expresses a wish to exercise the option of receiving assisted dying, the practitioner <u>must</u>:

   - **Give the patient the prognosis for their terminal illness; information about the irreversible nature of assisted dying; and information about the anticipated impacts of assisted dying.**
   - **Personally communicate with the patient about their wish at "intervals determined by the progress of their terminal illness" (email or phone is acceptable).**
   - **Ensure the patient understands their other options for end-of-life care.**
   - **Ensure the patient knows they can decide to not receive the medication at any time before the scheduled administration.**
   - **Encourage the patient to discuss their wish with their family, friends and counsellors.**
   - **Ensure the patient knows they are not obliged to discuss their wish with anyone.**
   - **Ensure the patient has had the opportunity to discuss their wish with whom they choose.**
   - **Do their best to ensure the patient expresses their wish free from pressure by any other person by conferring with (a) other health practitioners who are in**

regular contact with the patient; and (b) approved members of the patient's family.

- **Ensure they keep thorough clinical notes for all the actions taken above.**

6. What level of proof do we need for diagnosis e.g. do we need histology for metastatic pancreas cancer, or could it be based on radiology?

   This remains uncertain. The Act refers to "a terminal illness that is likely to end the person's life within 6 months". If the referendum votes in favour of the Act coming into force, it is possible further guidance will be developed about this and what is necessary for a professionally sound assessment. Litigation may also allow the courts to clarify what is meant by "likely".

7. Is there still opportunity to review the bill or once it passes does it have to stay as it is?

   Parliament has already passed the legislation, so it is an Act. The Act will come into force as already drafted if the referendum votes in favour. Only Parliament can change the Act. If it comes into force then, within 3 years, the Ministry of Health will conduct a review and may recommend amendments to the Minister of Health. The Government of the day will then decide whether to seek to make any amendments by introducing a Bill to Parliament.

8. If I refuse to refer because of conscientious objection what penalty will I face?

   If you are a conscientious objector, the Act nevertheless requires you to tell a patient who wants assisted dying of their right to ask SCENZ for the name of another doctor. If you refuse to do this, then you may be prosecuted and, if convicted, liable for imprisonment for a term not exceeding 3 months and/or a fine not exceeding $10,000.

9. Would "6 months to live" be interpreted as it is being interpreted in Oregon, USA? The Oregon Health Authority confirmed that when interpreting "6 months", "The question is: should the disease be allowed to take its course, absent further treatment, is the patient likely to die within six months?"
   (Submission from Fabian Stahle to the Justice Committee: https://www.parliament.nz/resource/en-NZ/52SCJU_EVI_74307_JU53036/d08f97b150501679cea2fc912c559c9d53645fd7)

It is impossible to know for certain. The Act does not provide a definition of "terminal illness". Should the Act come into force, ultimately the courts may be asked to help interpret this aspect of it.

10. Related but different - what if a patient's EPOA requests this??

    EPOAs are not permitted to make any decisions under the Act.

11. I am concerned that the 6 month criteria would exclude people who are otherwise appropriate candidates for euthanasia. Can someone comment on this please ... ?

    The test of suffering from a terminal illness that is likely to end the person's life within 6 months is what Parliament has decided. Should the Act come into force then it will be open for the Government of the day to seek to amend this test by introducing a Bill to Parliament.

12. Would the patient be able to make an advanced plan if diagnosed with a slow deteriorating condition such as motor neurone disease that may reduce communication later?

    No, the Act states that an advance directive cannot provide for assisted dying.

13. Can a doctor/NP be selectively willing e.g. happy to be involved with assisted suicide but not (voluntary) euthanasia... or happy to assist long-standing patients but not those they don't know well... or is conscientious objection all or nothing?

    The Act is drafted in a way that suggests conscientious objection is all or nothing. This is however a potentially complex area that may require further guidance to be developed if the referendum votes in favour of the Act coming into force. For example, situations may develop where an attending medical practitioner has a crisis of conscience and wishes to no longer be involved in a particular instance of assisted dying part way through the process.

14. What impact would assisted dying have on life insurance pay-outs?

    None, the patient is deemed to have died from the underlying terminal illness.

15. Why does the NZ Act not require any independent witnesses when a person signs their written request, even though this is required in the US, Australian laws and Canada's one?

    This is what Parliament has decided.

16. Why does the Act allow 2 out of the 3 members of the Review Committee to review cases they were personally involved in?

    This is not the case. The Review Committee will be comprised of a medical ethicist and 2 medical practitioners, one of whom must practice in the area of end-of-life care. In the event one of the Committee members is an attending medical practitioner for an assisted death under the Act, the Committee will need to determine how to deal with that potential conflict of interest.

17. And why would the Review Committee be allowed access only to the assisted death reports completed after a death, and not also the documentation completed before a death?

    This is what Parliament has decided. Before a death under the Act, a Registrar (an employee of the Ministry of Health) must check and be satisfied that the statutory processes have been complied with before any medication may be administered.

18. Why is neither the Registrar nor the Review Committee required to review all the documents of a case?

    It seems likely that the Registrar will review all of the statutory documents generated as part of the process.

19. So if I'm meeting a person in ED and they're acutely unwell, and they ask to be referred for assisted dying, am I expected to refer them then and there when I've never met them before? What will be the provisions for a delayed referral? I'm loathe to do this paperwork and ignore other unwell patients needing acute care while doing this...

    This is one of the practical considerations that does not fit well with the Act. The Act seems to assume that only 'serious' candidates will request assisted dying, and that requests will always be directed to the most appropriate medical practitioner.

    An easy option in this situation might be for a practitioner to say they are a conscientious objector and refer the patient to SCENZ. A better solution might be for guidance to clarify that it will acceptable to refer a patient on to a more appropriate practitioner who, upon that person becoming the attending medical practitioner, replaces the prior practitioner and releases them from any obligations under the Act.