

Reflections on EOLC Act Referendum

Rowan Stephens

I am a retired GP, and I will be voting a resounding YES in the EOLC Act Referendum. Over a lifetime of practice, I have seen many patients die. I am haunted by the knowledge that I have abrogated my responsibility to a small number of my patients. I was prevented by law from fully easing their requests to end their unbearable suffering.

“Be there at the end and help me die.”

“Please give me some dignity in death.”

“Put me out of my misery, you wouldn’t let your pet suffer like this.”

I failed in my duty of care because of the existing law. People who trusted me and looked to me for help, for skill and compassion at the end of their lives, looked in vain. I was prevented from giving them what they needed and begged for, compassion, choice, the certainty that their inevitable death could be peaceful and dignified.

‘Primum non nocere’ encourages us to consider the consequences, the possible harm, of what we do and what we do not do, every intervention or omission and how they may cause harm, especially in the complex circumstances that often surround dying. Failing to provide assisted dying to those who request it and who meet the strict legal and medical criteria of this Act, does significant harm.

I trust my fellow colleagues to implement this law to the best of their ability; the EOLC Act will be a safe move towards better deaths.

International and New Zealand evidence

The latest and largest international review concluded from 20 years of data that assisted dying is safe.¹ Data demonstrate that no ‘vulnerable’ groups are overrepresented in those who access assisted dying in Oregon and the Netherlands,² or Belgium.³ Oregon’s Act, which the EOLC Act is based on (plus adopting several safeguards from

the Victorian legislation), has remained a strict piece of law.

Australian data tells us that 2–5% people suffer unbearably as they die, in spite of excellent hospice/palliative care (H/PC).⁴ This translates to at least 225–250 Kiwis every year. Additionally, the Coroner’s office attributes 52 deaths/year, about one death per week to terminally ill, mentally competent Kiwis, ending their lives to end their suffering.^{5,6} They have no kinder alternative. They deserve legal autonomy, to have choice about how, when, where and with whom.

Out of compassion for this suffering, research shows that doctors are already carrying out assisted dying. Over 5% of New Zealand GPs who responded to an international standardised survey admit they are intentionally hastening death regardless of the legality, and not always with patients’ consent.^{7,8} It is safer for us and our patients to bring the practice of hastening death out into the open so doctors who are willing to participate can be protected under strict regulations and patients can give informed consent.

Research shows 45% of GPs and 37% of doctors support choice for the terminally ill.⁹ This number will grow with legalisation as we feel more comfortable discussing what has felt like a taboo topic within medicine for too long.

The gift of comfort

Dr David Grube, from Oregon, is a deeply compassionate GP and H/PC Physician with 22 years of experience of working with physician-assisted dying. Dr Grube recognises the comfort patients and families feel when they are able to discuss such choices, palliation in itself. He describes the “gift” of a good death for patients and their loved ones and describes this process as an intrinsic part of end-of-life care. In Oregon almost 90% of patients who access their law are already receiving H/PC and are estimated to

only shorten their lives by 10 days,¹⁰ not long in the context of a whole life, but an eternity if you are suffering unbearably. Of those who qualify, about one quarter do not need to use it; they talk movingly of the relief of knowing that they can.

A ‘yes’ vote is the compassionate choice

When my patients were dying, I wanted to be able to care for them in the way they choose. Dying patients deserve the benefit of our skill and experience in providing expert symptom control, emotional support for the patient and their family, and much needed

reassurance through the challenges of a terminal illness, with the input of hospice as required. We know that our patients ought to have autonomy and choice over their lives. To emphasise patient self-determination and patient-centredness and then refuse to honour it is inconsistent.

Voting yes in the referendum will give Kiwis of sound mind, over 18, dying, with less than six months to live and irremediable suffering, the choice I have been unable to give some of my patients, the hope that they may die in peace and dignity. Voting yes is my way of facilitating the gift of a good death to patients who need it.

Competing interests:

Nil.

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