

Quick Facts: Euthanasia and Assisted Suicide (EAS)

Euthanasia and Assisted Suicide ...



1) ... devalue disabled people

'At the heart of arguments in favour of EAS is a belief that some lives are not worth living.' Disability activists note this belief devalues the lives of disabled people. Legalising EAS increases the risk of premature death and compromises care for disabled people in a society which believes it is 'better to be dead than disabled'. EAS supporters regard autonomy and independence as the key factors that make life worthwhile – the loss of these attributes is then seen as compromising human dignity, sending the message that being disabled is undesirable, undignified and 'worth-less'. EAS cannot be a free choice in a society deeply uncomfortable with incapacity/disability and while disabled people are denied adequate healthcare, housing, personal support, education, employment and community access.

"Health practitioners frequently stated that terminal illnesses and disability are often feared more by those anticipating them than those living with them." (HSC, 19)

"Encouraging the self-destructive urges of persons with disabilities who despair is not merciful or compassionate. It is dangerous for those individuals, for all disabled people as a devalued group, and ultimately for a society founded on equality." (Carol Gill)



2) ... undermine suicide prevention

EAS would normalise suicide by sending a societal message that prematurely ending one's life is an acceptable response to suffering. All suicides are a response to some form of suffering. Given New Zealand's high suicide rate, the danger is that legally sanctioning suicide for some people undermines suicide prevention for everyone. The concept of 'rational' vs 'irrational' suicide' is in direct conflict with the fundamental message of suicide prevention and is not supported by those working in the field of suicide prevention. Numerous submitters to the Health Select Committee, who had suffered serious depression, admitted they would have opted for EAS had it been available.

"Suicide is always undertaken in response to some form of suffering, whether that is physical, emotional, or mental." (HSC, 43)

"...this has the potential not only to undermine the general suicide prevention message by softening cultural perceptions of suicide at the perimeters, but also to communicate an offensive message to certain members of our community (many of whom may be particularly vulnerable) that society would regard it as 'reasonable', rather than tragic, if they wished to end their lives." (SPR, 45)



3) ... are not health procedures

Overseas, most requests for EAS are prompted by existential or social concerns (e.g. loss of independence or fear of being a burden) rather than medical reasons such as pain. Involving health professionals in EAS violates medical ethics and undermines good medical practice. EAS, "even if it were legal, would not amount to 'medical treatment'." (SPR, 34). It would change irrevocably the doctor-patient relationship. In New Zealand, EAS is opposed by major medical groups, including the New Zealand Medical Association, the Australia & New Zealand Society of Palliative Medicine and Palliative Care Nurses. "Doctors are not necessary in the regulation or practice of assisted suicide. They are included only to provide a cloak of medical legitimacy. Leave doctors to focus on saving lives and providing real care to the dying." (DSN)

"The New Zealand Medical Association believes that assisting dying is incompatible with medical ethics." (HSC, 34)

"We believe that crossing the line to intentionally assist a person to die would fundamentally weaken the doctor-patient relationship." (DSN)

"The stakes are too high to have the veneration of doctoring obscure the essential core of what is involved and its potential harms and risks." (Boud/Som, 51)

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4) ... risk coercing our elders

In New Zealand, research shows that more and more of our elders are socially isolated. Loneliness is recognised as contributing to poorer health outcomes, feelings of worthlessness and the loss of a will to live. Elder abuse continues to rise. Age Concern NZ reports 1500 cases of elder abuse every year, a figure that represents only 16% of actual cases. 75% of alleged abusers are family members. It is impossible to detect subtle coercion of older people. The economic pressures on families and the demands of paid work are growing. This context puts our elders at risk of EAS coercion from families and others and from their own feelings of 'being a burden'. Consequently, they will find themselves having to justify their right to life and the so-called 'right to die' will be increasingly perceived as a 'duty to die'. This is not real choice.

"As a practicing geriatrician, I heard time and time again, older people telling me that they 'didn't want to be a burden.' Most were not terminally ill: just sensitive to a society that tends to regard its older population as a burden, and therefore likely to accede to even subtle suggestions that they have 'had a good innings.' Dutch statistics show that more than 30% of people requesting euthanasia do so on grounds including not wishing to be 'a burden.' Is that really freedom of choice?" (David Richmond, Emeritus Professor)



5) ... cannot be contained or made safe

David Seymour's Bill provides EAS for those with "grievous and irremediable medical conditions", not just those with a "terminal illness". This includes people with conditions such as depression or disability. If EAS is considered to be a reasonable response to self-defined 'unbearable suffering', then it must inevitably expand to include children, those with mental health illness, and those who are unable to give consent. Safeguards are not effective: there is robust evidence from Belgium and the Netherlands that the law is being routinely violated; large numbers of cases are not reported and significant numbers of people are euthanised without giving their consent, as is required by the law.

"Once we allow access to euthanasia or assisted suicide for a particular group, it is logically argued that it is discriminatory not to allow it for other persons who are also suffering, even if the source of that suffering is different." (The Nathaniel Centre)

"No society has yet worked out the hardest questions of how to help those patients who desire to die, without endangering others who do not." (Sissela Bok)

The key question is whether euthanasia and assisted suicide are safe to legalise in New Zealand. Euthanasia necessarily involves other people – family friends, health professionals, and government.

"It is not up to opponents to prove beyond doubt that a law would be dangerous. Rather, it is up to proponents of euthanasia and assisted suicide to prove beyond doubt that it would be safe" (John Kleinsman, 2017)



For more resources, check out...

- euthanasiadebate.org.nz
- 10questionsfordavidseymour.nz
- nathaniel.org.nz
- 16000voices.org.nz
- doctorssayno.nz
- carealliance.org.nz

Works cited:

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- **DSN:** *Doctors want no part in assisted suicide: An Open Letter to New Zealanders*, <http://doctorssayno.nz/>.
- **HSC:** New Zealand Health Select Committee Report, Petition of Hon Maryan Street and 8,974 others, August 2017.
- **John Kleinsman:** *Health Select Committee states 80% are opposed to medically-assisted dying*, The Nathaniel Centre Press Release, August 2017.
- **SPR:** Scottish Parliament Health and Sport Committee, *Stage 1 Report on Assisted Suicide (Scotland) Bill*, April 2015.
- **The Nathaniel Centre:** Submission to the Health Select Committee: Investigation into Ending One's Life in New Zealand, Jan. 2016.
- **Sissela Bok:** *Euthanasia and Physician-Assisted Suicide*, G. Dworkin et al. (eds). Cambridge University Press 1998, 139.