

An analysis of "Attitudes of New Zealand doctors and nurses towards legalising assisted dying - Report to New Zealand medical and nursing associations".¹

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Introduction

1. The research report by Dr Phillipa Malpas, Dr Pam Oliver and Mr Michael Wilson was distributed in May 2016 and reports on a survey conducted in October/November 2015.
2. Our analysis focuses on three issues:
 - Issues with the survey methodology, definitions and ethics approval processes
 - Inconsistent and unclear data analysis in the research paper
 - Unreliable interpretation of results arising from the above

Issues with the survey methodology, definitions and information, and ethics approval processes

Methodology

3. Medical and nursing organisations were requested to distribute an invitation (by way of electronic newsletters and websites) to their members to participate in the survey. Some organisations declined to do so, citing concerns with the researchers' objectives and methodology.²
4. When organisations did distribute the request, recipients were directed to a website.
5. The researchers cannot verify that participants in the online survey were, in fact, doctors and nurses or that they were from New Zealand.
6. There was no verification in the online survey that participants only responded once.

¹ Malpas, P., M. Wilson, and P. Oliver. "Attitudes of New Zealand Doctors and Nurses Towards Legalising Assisted Dying - Report to New Zealand Medical and Nursing Associations." Auckland: The University of Auckland, May 2016.

² Notably ANZSPM Aotearoa (the New Zealand chapter of the Australia New Zealand Society of Palliative Medicine) and PCNNZ (Palliative Care Nurses New Zealand) did not circulate the invitation to participate to their members.

7. Responses provided from 16 to 19 October 2015 were “removed from the analysis, due to notice of two faked responses by a TVNZ journalist between those dates.”³
8. The survey fails to ask respondents about their level of education and training in end-of-life or palliative care. It is not known, consequently, what knowledge/experience respondents have of all the options available to them to address end-of-life suffering apart from AD.

Definitions and Information

9. The term ‘assisted dying’ is used inconsistently throughout the survey and the research paper. The difference between euthanasia (an external party administering a drug with the intention of causing the death of a patient) and assisted suicide (an external party providing a drug for the patient to administer themselves) is not consistently explained or applied. This extends to the information provided about overseas jurisdictions which have very different approaches and rules.
10. With respect to question 9, it is not possible to know whether all of the doctors and nurses actually broke the law or whether they just think they *may* have. Many doctors and nurses *think* they have given a drug that shortened life when in reality that was not the case.⁴
11. Question 9 of the survey also referred to ‘palliative sedation’ which was defined as “purposefully inducing unconsciousness continuously until death”. The European Association of Palliative Care⁵ defines ‘palliative ‘sedation’ as “the monitored use of medications intended to induce a state of decreased or absent awareness (unconsciousness) in order to relieve the burden of otherwise intractable suffering in a manner that is ethically acceptable to the patient, family and healthcare providers. Palliative sedation is an accepted, ethical practice when used in the appropriate situations”. That is, palliative sedation is reversible, continuously monitored and assessed, and used with the intention of providing pain relief. The differences in definition are particularly problematic in relation to questions 9e, 9f, 9g, and 9h.
12. There is a distinct lack of clarity built into the survey questions from the start which makes it highly likely that participants’ responses reflect very different understandings relating to the controversial and often complex notions and concepts being surveyed.
13. Many of the questions in the survey are leading questions, biased towards assuming that AD is acceptable if not desirable.
14. The survey provided limited information about overseas jurisdictions that have some form of legal ‘assisted dying’ (including a link to a Wikipedia article). Some

³ It is not explained how it is known there were two ‘faked responses by a TVNZ journalist’ when it is also claimed that responses were anonymous. It is not stated how many responses were excluded in total. Neither do the researchers acknowledge the possibility of other ‘faked responses’ being submitted.

⁴ See, Sheahan, L. "Exploring the Interface between ‘Physician-Assisted Death’ and Palliative Care: Cross-Sectional Data from Australasian Palliative Care Specialists." *Internal Medicine Journal* 46, no. 4 (April 2016): "... the best available evidence to date has dismissed the long-held myth that proportional opioid titration to symptoms in end-of-life care hastens death. This is a very important misconception throughout the literature on assisted death, with many of the larger and most influential studies relying primarily on physician self-reporting of their actions with respect to hastened death to gather data on current end-of-life practices in both non-legalised and legalised jurisdictions. It is possible that many clinicians in the generalist setting, or in specialties other than palliative medicine, still hold to this unfounded belief about the role and effect of opioids at end of life, and thus report their actions in a way that reflects this misconception" (pp. 447-448).

⁵ Radbruch, L., C. Leget, P. Bahr, C. Muller-Busch, J. Ellershaw, F. de Conno, and P. Vanden Berghe. "Euthanasia and Physician-Assisted Suicide: A White Paper from the European Association for Palliative Care." In, *Palliative Medicine* (2015). <http://www.eapcnet.eu/LinkClick.aspx?fileticket=28Vb6OIn9SQ%3D>, p. 6.

of the information in the survey and research paper is incorrect or out of date. No information was provided about jurisdictions that have considered and rejected legalisation.⁶ This potentially had the effect of conveying the impression that the legalisation of assisted dying is becoming broadly acceptable and inevitable, and that the remaining major issue is the modality of legalisation.

Ethics approval process

15. The research project was the subject of a complaint to the University of Auckland's Human Participants Ethics Committee about such matters as the lack of disclosure of the funder of the research, the statement that the researchers were "independent" and bias in the definitions, information and questions.
16. UAHPEC, while acknowledging "that there were some deficiencies in the processes surrounding the approval of protocol 015470", declined to suspend approval to allow the deficiencies to be remedied.⁷
17. The introduction to the survey advised prospective participants that "We are independent (that is, not funded by any organisation with a particular point of view, such as the New Zealand Voluntary Euthanasia Society or Euthanasia-Free NZ)."
18. The declaration of interest in the report, by contrast, states that Pam Oliver is "in principle supportive of legal assisted dying" and that she joined the Voluntary Euthanasia Society of New Zealand in 2014 specifically to access its Newsletter as part of the evidence review for her doctoral studies in law". Phillipa Malpas discloses that "she has been a member of the Voluntary Euthanasia Society of New Zealand for almost twenty years as she believed then (and still does) that as a last-resort option, she ought to be legally permitted to determine the timing and manner of her death."
19. In relation to the issue of *Inadequate information provided*, the UAHPEC complaint reviewer stated that "This research project was for a closed community of medical and health care practitioners where the research topic is already well known, highly debated, is subject to existing legal obligations, and has been studied in many other research projects. There is already a high level of knowledge on this topic, and the information provided was for participant interest only." To the contrary, the survey results show that there is a very low level of knowledge amongst those respondents who stated they were in favour of legalisation.⁸

Inconsistent and unclear data analysis in the research paper

20. The research paper reports that there were 969 responses to the survey.
21. The research paper uses a bewildering array of sample sizes throughout its analysis.
22. Most importantly, footnote 1 discloses that "Responses to the remainder of the questions do not include respondents who had answered 'strongly disagree' to the initial question." There is no explanation for this decision, and it is impossible

⁶ For example, the 2015 Report by the Scottish Committee on Health and Sport: "Stage 1 Report on Assisted Suicide (Scotland) Bill." The Scottish Parliament, available at http://www.scottish.parliament.uk/S4_HealthandSportCommittee/Reports/her15-06w.pdf

⁷ Professor Dugald Scott, "Report on Issues Relating to Complaints about UAHPEC Protocol 015470", 13 November 2015.

⁸ For example, fig. 17 on page 40 shows that for those respondents who "strongly agree", "mostly agree" or were unsure of legalising 'assisted dying' (n=155 for doctors, n=356 for nurses), 92 and 96 percent respectively, knew only "a bit" or "very little" about safeguards for patients in jurisdictions with legalised 'assisted dying'.

to reconstruct from the data provided what impact it has on the authors' conclusions.

23. Mr Michael Wilson, the co-author, has stated on social media that "The point of the survey was to understand what the supporters were thinking" and "Focus of survey was on those who Agreed".⁹ This is contrary to statements in the ethics application, survey and report, including advertisements for the research (stated aim is to "explore the range of attitudes of medical practitioners and nurses") as well as the Title, Rationale and explanation of research methodology, all of which imply the findings are representative of a broad group of health professionals, i.e. those who are supportive *and* others who are opposed.
24. On page 18, another reduction in sample size is noted without explanation: "The remainder of the findings discussed in this report reflect the views of doctors and nurses whose views ranged from 'strongly agree' to 'mostly agree' with legalising AD or who were unsure." That is, the authors have now excluded any respondents who "mostly disagree" with legalising 'assisted dying' in addition to those who had already been excluded for "strongly disagree".
25. The progressively different sample sizes can be summarised:

Ref	Topic	Doctors	Nurses	Other	Total	Comment
Fig 1 p.6	"Demographics"	38%	60%	2%	969	This is the last reference to "other"
<i>Respondents who "strongly disagree" are now excluded</i>						
Fig 4 p. 8	"Agree with legal assisted dying"	n=298`	n=475		773	From this we can deduce that about 70 doctors and 106 nurses "strongly disagree"
<i>Respondents who "mostly disagree" are now excluded</i>						
Fig 7 p.18	"Agree with the availability of assisted dying for medical circumstances"	n=155	n=356		511	From this we can deduce that about 143 doctors and 119 nurses "mostly disagree"
Fig 9 p.22	"Would consider or support AD for self or family member"	n=121	n=329		450	The basis of the sample size is not explained.
Fig 18 p.42	"Familiar with current position of primary association"	n=146	n=325		471	The basis of the sample size is not explained.
Fig 19 p.42	"Agree with current position of primary association"	n=79	n=134		213	The basis of the sample size is not explained.

⁹ See Appendix 1 attached.

26. One particular problem with this changing of sample sizes is the reference to qualitative responses throughout the text. For example, Research Finding 13 on page 34 discusses responses from 511 participants to Question 11 in the survey. But at Research Finding 14 on page 36 (which reports the qualitative follow up), the research paper refers to "One hundred and four respondents (19% of total respondents to this question)": that is, 547 responses.
27. There is no explanation of these variances, and it is possible that some of the verbatim responses included are actually from people whose tick responses were excluded from the statistical analysis. At the very least, it shows inconsistency in the treatment of quantitative and qualitative data, without any explanation or even disclosure of the differences.

Unreliable interpretation

28. Throughout the research paper the authors make statements that can only be justified in relation to the progressively restricted sample size, as discussed above.
29. For example, the authors state in Research Finding 8 on page 22 that "A large majority of both nurses and doctors would 'definitely' or 'probably' consider having an assisted death themselves and/or supporting it for a family member." In fact, this ratio refers only to those 450 participants whose responses are being analysed by this point. That is, it specifically does not include the views of participants who had previously stated that they "strongly disagree" or "mostly disagree" with legalising 'assisted dying'. Further, the reduction in the total number of responses between figure 7 (total of 511) and figure 9 (total of 450) is nowhere explained.
30. If all doctor respondents were included in the analysis (n=368), the percentage of doctors who would definitely/probably consider 'assisted dying' for themselves (Figure 9) *may* be as low as 21 percent, and for a family member *may* be as low as 23 percent. That would undermine the researchers' statement that "A large majority of ... doctors would 'definitely' or 'probably' consider having an assisted death themselves and/or supporting it for a family member."
31. Figure 9 also manages to avoid stating the interesting result that 22 percent of the doctors in the reduced sample (that is, doctors who are already largely supportive of "assisted dying") would not consider it for themselves, and 15 percent would not support it for a family member.
32. In Research Finding 11 the authors state that "Almost one tenth (9%) of doctors responding to this question had already at some time either provided or administered a lethal dose of medication to help someone to have a hastened death." This statement must be approached with extreme caution for the following reasons:
 - a. First, the action being described is highly vulnerable to the *post hoc ergo propter hoc* fallacy.¹⁰ That is, if a doctor or nurse administered extra pain medication and the patient died soon after, they may believe that the former caused the latter, even if that was not actually the case. As noted above (see Point 10 and footnote 3), it is possible that many of the respondents still hold to the unfounded belief that opioids given at the end of life hasten death and have mistakenly reported their actions as having hastened death.
 - b. Secondly, as noted above, the sample of doctors being analysed (155) is significantly smaller than the total number of doctor respondents (368).

¹⁰ A Latin phrase for "after this, therefore, because of this." The term refers to a logical fallacy that because two events occurred in succession, the former event caused the latter event.

Taking into account the fact that the figure of nine percent is drawn only from respondent doctors “whose views ranged from ‘strongly agree’ to ‘mostly agree’ with legalising AD or who were ‘unsure’” means that the real percentage in respect of all doctors who responded to the survey is between 3.8 and 9 percent. Indeed, the figure is potentially much closer to the lower end of this range given that those doctors who “strongly disagree” or “mostly disagree” with AD are arguably less likely to have been involved in intentionally helping to hasten a patient’s death.

- c. Thirdly, as noted above, the survey did not verify that participants were doctors or nurses, or that a single response was made by each participant.
 - d. Fourthly, the question did not ask in which jurisdiction the action took place. It may well have taken place in an overseas jurisdiction where some form of AD was legal in which case it cannot be reliably concluded that the incidents reported reflect “regular practice in New Zealand” (p. 29).
 - e. Fifthly, even if all the participants were genuine and unique, it must be emphasised that the doctors participating in the survey were a self-selecting small minority of all New Zealand doctors: 368 of more than 12,000 registered doctors. (The same can be said about the 45,000+ nursing workforce in New Zealand, especially in the absence of participants taken from organisations such as PCNNZ.)
33. That is, the statement in Research Finding 11 refers, at most, to anonymous self-reporting of illegal activity (some of which may have occurred legally overseas) by a self-selecting group with potentially inaccurate knowledge of the effect of opioids, a group further reduced by excluding those who expressed strong disagreement with the underlying premise. The researchers’ conclusion that “reported engagement in AD has more than doubled since the studies in the early 2000’s” in New Zealand (p. 28) is quite simply not substantiated by the data provided.
34. It is particularly egregious that such statements in the body of the report are then presented in the Executive Summary without also explicitly stating their limitations.
35. One of the worst examples of this mis-statement is the first key finding in the Executive Summary on page 1:
- Consistent with other recent New Zealand studies, 37% of doctors responding to the survey “strongly” or “mostly” agreed that AD should be legalised in New Zealand.*
36. That statement is drawn from page 8 (illustrated by Figure 4) when doctors n=298; that is, after the 70 doctors who “strongly disagree” have already been excluded. Using the original doctors n=368, the correct ratio is 30 percent.

Conclusion

37. The serious implications of euthanasia and assisted suicide demand that all research in this area exhibit a high level of clarity, accuracy, transparency and robustness. We conclude that the myriad flaws in the survey’s design, data selection, interpretation and reporting mean this research paper is of little or no value in understanding New Zealand doctors’ and nurses’ attitudes towards legalising ‘assisted dying’.

Appendix 1

Notifications

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mikewilson @mw108adelaide · 2h
[@CareAllianceNZ](#) The point of the survey was to understand what the supporters were thinking. That's why. Didya read the method section? Oh.

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mikewilson @mw108adelaide · 2h
[@CareAllianceNZ](#) [@familyfirstnz](#) No, the were completely accounted for. They chose not to answer Agree Focus of survey was on those who Agreed

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