FEATURES: MĀORI HEALTH REVIEW SERIES

Health politics and Māori equity: euthanasia, cannabis, and the abortion law reform

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Welcome to the second NZMSJ Māori Health Review. In this edition, the author looks ahead to issues facing the electorate this year: assisted dying, cannabis legalisation and control, and abortion law reform. The decision to bring the End of Life Choice Act 2019 and the Cannabis Legalisation and Control Bill into law will be decided by referendum at the general election, with the Abortion Legalisation Bill voted into law in March. Each has implications for Māori health equity. The context in which these changes may be enacted are assessed and the expert views and evidence for their impact on Māori health are considered.

NZMSJ readers know that these are hotly debated issues with a wide range of views among both students and health professionals. In this article, the author is not attempting to assign a moral imperative to support or reject any of the proposed changes, but to stimulate thinking about the social justice issues inherent in these proposed law changes for Māori health.

End of Life Choice Act 2019[1]

At the general election voters will be asked: "Do you support the End of Life Choice Act 2019 coming into force?" The Act's purpose is to give people who have a terminal illness and who meet certain criteria the option of lawfully requesting to end their lives. It will also establish a lawful process to assist those eligible to exercise this option.

The Act proposes to enable the Director General of Health to establish the Support and Consultation for End of Life in NZ (SCENZ) Group. This group will create and maintain a list of eligible health professionals who are willing to support those who request to end their lives.[1]

Should the referendum succeed, medical practitioners will have a choice to participate or to conscientiously object. Those who object must inform the person of their conscientious objection and of their right to ask the SCENZ Group for the name and contact information of a medical practitioner who will assist them.[1]

The New Zealand Medical Association (NZMA) submission to the Justice Select Committee conveyed opposition both in principle to the concept of physician assisted suicide, and to the Bill as it was written at the time of submission.[2] The NZMA stated that the Bill was ethically incompatible with the practice of medicine and that it would fundamentally change the doctor-patient relationship.

Similar sentiments are expressed by The Royal New Zealand College of General Practitioners (RNZCGP) in their submission.[3] While the RNZCGP acknowledges a range of views among their members, they clearly state that they are unable to endorse the Bill. They also emphasize the difficulty in providing accurate prognoses in terminal conditions, and the need to invest in palliative care and specifically to invest in culturally appropriate palliative care for Māori. The RNZCGP urged the Government to facilitate a public information campaign on the definition of euthanasia and physician assisted suicide, noting that both are poorly understood among the public.[3]

A recent survey of New Zealand doctors and nurses provides insight into some of the drivers of health professionals' views on euthanasia (called "Assisted Dying" in the survey).[4] The survey found 30–40% of doctors supported assisted dying, with a higher percentage of nurses supportive at 67%.[4] The authors state this is consistent with evidence from international studies. They found that the most commonly held views among those supportive of assisted dying included respect for patients' autonomy of choice at the end of their lives, and philosophical beliefs about a person's right to die with dignity. The most common reasons to not support assisted dying included a belief that it did not fall within the remit of a health professional's role, that it would offer an avenue for abuse of vulnerable patients, and that existing palliative care services are sufficient.[4] The New Zealand Nurses Organisation (NZNO) recommend the inclusion of mandatory cultural competence requirements across the SCENZ Group and in the legislated roles of those involved in end of life care in their oral submission.[5] Disability, palliative, and aged care advocates have expressed concerns about the opportunity for abuse of marginalised groups including Māori through the enactment of this legislation.[6]

In contrast to the concerns of some health professionals and advocates, public polls have reported a majority of public support for the rights of patients to make end of life decisions, including to end their own lives, when there is a terminal diagnosis present. A Horizon Research poll conducted in 2019 on behalf of advocacy group End of Life Choice Society found 74% of respondents answered "yes" to the question, "Do you support a law change to allow medical practitioners to assist people to die, where a request has come from a mentally competent patient, 18 years or over, who has end stage terminal disease and irreversible unbearable suffering e.g. cancer?"[7] The research group note that support for medically assisted dying has trended upwards since their first survey on the subject in July 2012, which found 63% supported a law change.[8]

While the NZMA, RNZCGP, and NZNO each reference concerns for health equity for Māori with respect to the Act,[2–4] there is a paucity of literature relating to Māori perspectives of end of life care, euthanasia, and physician assisted suicide.[9,10] A study published in the New Zealand Medical Journal (NZMJ) examined the demographic and psychological factors which correlate with support for euthanasia.[11] The authors found that Māori ethnicity did not predict support nor objection to the practice, whereas Asian and Pacific peoples were more likely to be opposed to euthanasia than NZ European groups.

Writing in the NZMJ, Anderson et al. (2017)[9] note there are two small qualitative studies[9,10] which have contributed to the understanding of Māori attitudes towards physician assisted dying. However, much more research is needed to fully appreciate the issue. The authors of one of these qualitative studies voice their concern regarding potential harm to Māori: without full compliance and an appreciation of the breadth and depth of tikanga Māori and perspectives around

end of life practices, any legislation which enables physician assisted death risks significant harm to Māori.[9]

Cannabis Legalisation and Control Bill[12]

The second referendum taking place alongside the general election in 2020 relates to drug law reform. Voters will be asked: "Do you support the proposed Cannabis Legalisation and Control Bill?" This referendum asks whether the recreational use of cannabis should be legalised and is accompanied by a draft bill so that voters are informed about the proposed direction the government intends to take if the referendum result favours law change.[12]

The use of cannabis under the supervision of a medical practitioner has already been legalised under the Misuse of Drugs (Medicinal Cannabis) Regulations 2019.[13] From 1 April 2020, a medicinal cannabis agency will be established to administer the scheme. This is separate to the 2020 referendum and medicinal cannabis will remain within the law regardless of whether or not recreational use is legalised.

By the age of 21, approximately 80% of New Zealanders have tried cannabis.[14] Māori have higher rates of cannabis use than any other population group at 25% in the last 12 months, compared with 11% of European/Others, 9% of Pacific people, and 2.9% of Asians.[15] Māori men have higher rates of use than Māori women at 32% compared to 19% respectively.[15] Drug harm from cannabis use in New Zealand has been quantified in the Drug Harm Index at $1.2 billion NZD or $47,000/kg, annually comprising personal, community, and intervention costs.[16] This compares with $364 million NZD for amphetamine-type stimulants annually, which attract $1,239,000 of harm per kg. This reflects the greater harm caused by amphetamine-type stimulant use but their relative lack of regular users compared with cannabis.[16]

Expert advisors to Parliament on drug law reform state that the main health risks of cannabis use are: involvement in a motor vehicle accident; respiratory illnesses; dependence; and detrimental effects on those with existing mental health problems, including the potential onset of schizophrenia earlier than it would have otherwise occurred in vulnerable individuals.[17]

Exacerbating the health-related harms from cannabis use, prosecutions for possession, use, supply, and distribution of cannabis have punished Māori more than other ethnic groups.[18] In a 2007 report into the over-representation of Māori in the criminal justice system commissioned by the Department of Corrections, an ethnic bias in action beyond what could be explained by factors such as severity and frequency of offending was identified.[18] The authors of the report also inferred that Māori were inadequately served by the legal profession, highlighting the increased incidence of "guilty" and "no plea" when prosecuted, and the lower rates of the use of diversions.[18] Figures from the Ministry of Justice supplied to the New Zealand Drug Foundation under the Official Information Act show that in 2018, Māori made up 41% of those convicted of a cannabis related offence, despite only representing 16.5% of the overall population.[19]

An independent poll conducted by Horizon Research, commissioned by Māori current affairs show The Hui reported 75% of Māori participating in the survey said they were likely to support the referendum.[20] This compares with 48% of the general population as outlined in a separate Horizon Research poll conducted in December 2019 on behalf of Helius Therapeutics.[21] Horizon Research has conducted several polls on this issue and the numbers have fluctuated, with an August 2019 poll showing 39% in support, April 2019 showing 52% in support, and the highest level of support reported in November 2018 at 60%.[20]

In contrast, the response from the NZMA to the announcement of the referendum was unequivocal.[22] In a statement, the Chair of the NZMA, Kate Baddock, said, "In addition to the physical harm caused by cannabis, its use creates social and psychological harm, particularly for younger people, and we are disappointed that the government is not showing leadership on a matter that has far-reaching effects for all New Zealanders.[22(p1)]"

Dr Baddock goes on to urge the government to instead focus on investment in reducing the social inequalities that increase the risk of harm from drug use, including a public education campaign. The NZMA statement supports the diversion of users, particularly youth, into civil penalties and treatment rather than criminal convictions.[22]

In a statement following the Royal Australian and New Zealand College of Psychiatrists (RANZCP) 2019 New Zealand conference, Dr Susanna Galea-Singer, Chair of the RANZCP's New Zealand Faculty of Addiction Psychiatry Subcommittee, notes the range of views of the professional body's members and outlines the College's position.[23] She says that if legalisation goes ahead it must be regulated heavily by the government, underpinned by a harm reduction approach and accompanied by a comprehensive education campaign. She reiterates, "Cannabis is not a harmless substance and can result in dependency in serious cases. If the use becomes problematic, through abuse or dependence, impacting the individual or whānau's life, it then becomes a health service issue.[23(p1)]"

Abortion law reform

The Abortion Legalisation Bill was recently brought into law, with a conscience vote tallying 68 in favour and 51 against.[24]

Until now, abortion had been written into sections 10 to 46 of the Contraception, Sterilisation, and Abortion Act 1977 (CSA Act),[25] sections 182 to 187a of the Crimes Act 1961,[26] and section 38 of the Care of Children Act 2004.[27] Previously, the law required two certifying consultants to authorise a woman's abortion.[25] Conscientious objection was accounted for in section 46 of the CSA Act[25] and section 174 of the Health Practitioners Competence Assurance Act 2003 (HPCA Act)[28] which recognise health practitioners' rights to refuse to provide treatment. The New Zealand Bill of Rights Act 1990 (NZBORA)[29] also confers freedom of conscience and belief.

The new law removes abortion from the Crimes Act 1961, and allows for a termination of pregnancy to occur before 20 weeks' gestation without the requirement for a legal test. Abortions taking place after 20 weeks' gestation still require approval that the procedure is deemed necessary to save the woman's life or prevent serious injury.[24]

In the year ended December 2018, 13,282 abortions were performed in Aotearoa.[30] For comparison, there were 58,020 live births.[31] Trends over time have seen a significant decrease in abortions among women aged 15–19 from 26.2/1000 in 2008 to 8.4/1000 in 2018, and an increase in the proportion of abortions performed before 10 weeks of gestation from 46% in 2008 to 64% in 2018.[30] Women in their 20s have the highest rates of abortion and this has been relatively stable since 2008.[30]

In a literature review identifying barriers and enablers to Māori women's access to abortion, Rebekah Laurence notes 23.4% of all abortions in 2016 were performed on Māori women.[32] The majority of all abortions are performed on the grounds that the mother's mental health would be significantly damaged should the pregnancy continue, but Laurence found no analysis of this justification specific to Māori women. The literature review also identified specific barriers to access to abortion for Māori women, including lack of cultural competence among healthcare professionals. The NZNO agree that reform should include strengthening of cultural competency of practitioners involved in abortion care for women in their submission in support of reform.[33]

This is a view also shared by the Abortion Supervisory Committee (ASC), the statutory body with responsibility for oversight of abortion provision in Aotearoa, which is comprised of three members appointed by the Governor-General.[25] The ASC notes in its submission to the Law Commission inquiry into abortion law that the development of models of health care in Aotearoa have involved the "devaluing, invalidation and marginalisation of mātauranga Māori through the process of colonisation".[34(p62)] The authors of the Commission's report state that this is in direction opposition to the public health system's responsibility to Te Tiriti.[34]

The ASC is also responsible for the standards of care for abortion services in Aotearoa. Standard 6.3 states:

> *All Health and Disability service providers need to recognise the cultural values and beliefs that influence the effectiveness of services for Māori. An abortion service must be provided in a way that will contribute to the objectives of He Korowai Oranga (Māori Health strategy as referred to in the New Zealand Health Strategy) It should aim to improve Māori Health and reduce inequalities between Māori and Non-Māori.[35(p13)]*

Elsewhere in the standards examples are given which include consultation and inclusion of Māori in service delivery and design and the recognition of cultural practices such as karakia, and discussions around the preservation of the products of conception for burial, including the provision of appropriate vessels for this purpose.[35]

Māori views on abortion have not been well documented in the literature. Le Grice in 2017 offers the first empirical investigation in this area.[36] The author finds perspectives on abortion are complex among Māori, and are related to the experience of colonisation including the importation of Judeo-Christian traditions, the socio-cultural milieu, and relationships with whānau. Le Grice cites evidence of pre-colonial Māori abortion practices and asserts existing tikanga and matauranga relating to induced abortion, while also giving examples of modern interpretations of tikanga applied among Māori women to facilitate their experience of abortion.[36]

The paucity of research in this area, acknowledged among the literature accessed for this article, suggests we should view the findings with caution and encourage continued research to support a culturally safe enactment of the new law.

Reflection

It has been demonstrated that there is a paucity of evidence regarding both Māori perspectives on these issues, and the potential implications for Māori health equity. This can be seen as unethical given our awareness of the well-documented evidence base for historical and ongoing racism in the practice of medicine in Aotearoa. As future health professionals we will be required to filter our response to issues that test our conscience personally through our duty under the law and our responsibility to our patients. This review illustrates the multifaceted nature of this task when we prioritise cultural safety and equity. Irrespective of our personal views, we must therefore approach our interactions with Māori with regards to these and all other health matters reflecting on whether our practice is culturally safe.

There are resources available to guide our practice and ensure we are working within our responsibility to Te Tiriti including He Korowai Oranga,[37] New Zealand's Māori Health Strategy, The Medical Council of New Zealand's Best Health Outcomes for Māori: Practice Implications[38] and Statement on Cultural Competence and the Provision of Culturally-Safe Care,[39] as well as the professional and region-specific resources provided by specialist training colleges and DHBs. It is important to recognise that the inclusion of culturally safe practice means recognising the views of Māori outlined in this piece do not replace the need for consultation with Māori individuals and their whānau on a case by case basis.

Once we enter the workforce, we will gain relative autonomy in practice which necessitates self-direction to maintain our knowledge and skills. Curtis et al. (2019)40 clearly show the reasons why cultural safety must be integrated into ongoing professional development alongside any other clinical skill. The three political issues outlined in this review highlight the changing nature of health policy and the additional complexity conferred by issues specific to Māori. If we continue to develop our pro-equity and cultural safety toolkit, we will be well placed to meet the challenges of providing equitable care to all New Zealanders once we are working as medical practitioners.

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Acknowledgements

Thank you to the student reviewers for their time in offering a critical review and pertinent revisions to this feature.

Conflicts of interest

The author has researched and presented an objective assessment of all the issues raised in this review. However, for full transparency it is important to note that she has submitted in favour of the abortion law reform bill.[41]

The author has no other conflicts of interest to declare.

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