



**National Council of
Women of New Zealand**

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S16.04

Submission to the Health Select Committee on the Petition of Hon Maryan Street and 8,974 others

That the House of Representatives investigate fully public attitudes towards the introduction of legislation which would permit medically-assisted dying in the event of a terminal illness or an irreversible condition which makes life unbearable.

The National Council of Women of New Zealand, Te Kaunihera Wahine O Aotearoa (NCWNZ) is an umbrella group representing 288 organisations affiliated at either the national level or to one of our 20 branches. In addition to our organisational membership, about 260 women are individual members of branches. NCWNZ's function is to represent and promote the interests of New Zealand women through research, discussion and action. This submission has been prepared by the NCWNZ Parliamentary Watch Committee after consultation with the membership of NCWNZ. Responses were received from branches across the country as well as from affiliated organisations – mostly women's religious groups – and their branches.

Many of the responses used the terms euthanasia, assisted suicide, and assisted dying interchangeably and these terms have been used within this response.

1. The factors that contribute to the desire to end one's life

1.0. Many factors are relevant to the issue of euthanasia. The right to die is a moral principle based on the belief that a human being is entitled to commit suicide or to undergo voluntary euthanasia. The factors will be different for each individual.

1.1. Social factors

1.1.1. Social factors could influence a person's wish to end their life, but they are not sufficient grounds in themselves. Social factors are the responsibility of both the community and the government.

1.1.2. Circumstances can so easily change, and at any one time support may appear from an unexpected source which could see the person change their mind about ending their life.

1.1.3. Social factors include:

- a. A lack of social connection – a sense of being unwanted and unloved, feeling a burden or liability. Pressure from family and the wider community who may see them as a burden. Evidence from overseas talks of the “Right to Die becoming a Duty to die.” This burden can be perceived as using resources that could be used for more worthy individuals – time and money related. 40% of people asking for assisted suicide in Oregon cite “being a burden” as a reason for their request¹.
- b. Loneliness, isolation and isolated by distance from family and friends. A number of respondents commented on the isolation that occurs when a person has moved location, leaving behind a social network and neighbours.
- c. Lack of support from family and friends.
- d. Alcohol or drug addiction.
- e. Confined to the house as the person has lost mobility and relies on friends to visit.
- f. Elder abuse. There are more than 2000 complaints of abuse of the elderly in New Zealand every year. Concern was raised about the ability to protect our elderly should euthanasia be allowed.
- g. Not being able to participate in community activities, such as attending church or other social groups, and even getting out into the fresh air. These privations often contribute to a feeling of loss.
- h. Breakdown of a close relationship.
- i. Grief from the loss of a loved one.
- j. Distress experienced by family members watching a loved one going through the latter stages of an illness.
- k. Desperation.
- l. Guilt or shame from a wrongful action.
- m. Hostility and unpleasantness from family members, including disputes over inheritance.
- n. Loss of independence, especially if confined to a locked area (possibly with people who are suffering dementia), or by being trapped in a body that the person can no longer control (perhaps by motor neuron disease).
- o. Stress on the person’s partner who has to care for the family member.
- p. Difficulties experienced by family members caring for the person, e.g. discrepancies of weight and size can cause many difficulties.

¹ Care Alliance NZ

1.2. Legal factors

- 1.2.1. Disempowerment can be a contributing factor especially if the person feels they have lost control of any faculties which affect their ability to make decisions about themselves. During their life individuals have the option of undergoing treatments to prolong life and also the legal right to refuse treatments, yet they cannot request medical assistance to die.
- 1.2.2. Legal issues identified are:
- a. Some respondents felt that the person themselves could not make the decision to undertake a medically assisted dying process.
 - b. Respondents identified that there needed to be well defined protections especially for those who are unable to 'speak' for themselves.
 - c. Mentally incapable people could not consent to assisted suicide.
 - d. Current rules concerning the Power of Attorney are unclear; e.g., who should authorise the medically assisted dying procedure. It was felt there could be pressure or imagined pressure from those with the Power of Attorney. Some respondents did not believe that Power of Attorney was the appropriate mechanism for approving the ending of a person's life as the person holding the Power of Attorney may be too closely involved.
 - e. Some identified the right to die with dignity as a human right, yet overlook the second half of this right. Section 8 of the New Zealand Bill of Rights Act 1990² states:

Right not to be deprived of life. No one shall be deprived of life except on such grounds as are established by law and are consistent with the principles of fundamental justice.

1.3. Medical factors

- 1.3.1. For some this is the only factor that could contribute to consideration of legally assisted dying.
- 1.3.2. The level of pain was identified as the most common factor for people to request ending their life. Uncontrolled pain that cannot be managed even with the best palliative care is unbearable and robs a person of any quality of life. If a person cannot have their pain brought under control they may well think that death is a good solution and they should have the right to die with dignity. Prolonging the agony of dying in extreme pain seems an unnecessary hardship, especially for people who are clear that they do not want to extend their lives under such circumstances and want to prevent loss of agency and dignity. While palliative care is of great importance in terminal illness, it is not always the universal panacea that some claim it to be as some pain is unresponsive to the most powerful analgesics. It was also noted that pain medication, especially when it is long term, can sometimes lead to mental disorientation.

² New Zealand Bill of Rights Act 1990. Accessed 1 Feb 2016

http://www.legislation.govt.nz/act/public/1990/0109/latest/DLM224792.html?search=ta_act_N_ac%40ainf%40anif_an%40bn%40rn_25_a&p=4

- 1.3.3. There are already the options to refuse treatment and to request a Do Not Resuscitate order. These are passive measures and not active euthanasia mechanisms.
- 1.3.4. A number of respondents cited the Hippocratic Oath and the Declaration of Geneva in relation to medical staff. Doctors are expected to keep people comfortable. Most respondents acknowledged that during the palliative care phase there are very few people that who cannot be made comfortable. Loss of dignity, such as using a machine to breathe, body not functional, inability to feed or toilet oneself without assistance, was identified as a medical factor.
- 1.3.5. Terminal illness or an irreversible condition which makes life unbearable were identified as other relevant medical factors. These do not include the category of 'loss of mobility' (there are many people in wheelchairs who lead lives of good quality) and neither does it include loss of 'mental capability' (e.g. depression, where the first option should be treatment of depression/psychotic problems/etc.)
- 1.3.6. If mental capability refers to age related problems such as dementia – the person when dementing would not be capable of choosing to end their life. However, if the person had, when of sane mind, signed documents requesting medically assisted dying should they suffer severe dementia, then this would be a possibility that we should consider. No one would choose to live with severe dementia.
- 1.3.7. Another medical factor to be considered is mental incapacity resulting from an accident and subsequent brain injury, when the person is bedridden, undergoing percutaneous endoscopic gastrostomy (PEG) feeding, doubly incontinent and cannot respond. It is hard to see that there is any quality of life for that person at all. They are in fact being forced to keep alive by being fed and cared for, but this is not humane. No one would choose to live like that. It should be noted that some respondents stated that a legal document requesting medically assisted death in the event of such severe incapacity, must have been signed before such an accident.

1.4. Cultural factors

- 1.4.1. It is vitally important to keep at the forefront that the individual is the one making the decision. Different people react with different attitudes to life and suffering.
- 1.4.2. For some, old age means not being respected and cherished, and feeling a burden. If old age is no longer cherished, some suggested this is a societal problem and our societal norms need to change.
- 1.4.3. Some respondents had personal experiences of dealing with older dying members of their family and the positive effect this has had on them as they cared for them. Others talked of the strength of community that came from accepting dying as part of life and being expected to be there for those dying as part of the community way of life. To these people, assisting someone to die is anathema.

1.5. Financial factors

- 1.5.1. Some respondents did not see money as an issue. While costs of medication and treatment can be expensive, financial help is usually available. Others identified there was frequently an inability to pay for treatment. Financial concerns are a contributory factor but not a reason to legalise medically assisted dying.

1.5.2. Comments included:

- a. Unhelpfulness of government agencies such as Work and Income
- b. Difficulties in acquiring the equipment required to sustain life.
- c. Not having medical insurance and having to languish in severe pain due to waiting times for medical treatment and surgery.
- d. Growing awareness of the economic constraints in health and elder care. Quality of life being tied into usefulness rather than 'being'.

1.6. Ethical factors

- 1.6.1. There are sound reasons for not putting the power solely in the hands of the medical professional. Primary consideration must be given to the person wishing to die because their life has become unbearable and that they be enabled to do this without the assisting medical professional being prosecuted.
- 1.6.2. Many respondents did not feel this should be entirely left to the medical profession, but that any decision should include family and people who know the person's wishes.
- 1.6.3. Other respondents considered that the person and their immediate family should be making the decision, not the medical profession.
- 1.6.4. Others noted that some people do not discuss their requirements or want other people informed.
- 1.6.5. Bioethics considerations are possibly the most delicate factor. A debate exists within bioethics over whether the right to die is universal, or only applies under certain circumstances such as terminal illness.
- 1.6.6. A law change will change the moral compass of our society. Giving people the right to kill another will change us all forever.

1.7. Philosophical factors

- 1.7.1. Respondents understood that mainstream religions support living life to the full while allowing people to help them. All religious beliefs need to be respected. One respondent said that God is the strength that helps make these decisions.
- 1.7.2. Some said that the Anglican Church in NZ believes that euthanasia has a place in society. Other Anglicans stated that taking steps to end one's life is to act as if one were God, which is an unacceptable position for a Christian. In the Catholic faith suicide is considered a grave sin. Hinduism accepts the right to die. Other religious views on suicide vary in their tolerance, and include both the denial of the right as well as condemnation of the act.

1.7.3. Some quoted from the Ten Commandments³ that “thou shalt not kill”.

1.8. Other contributing factors

1.8.1. In recent years there has been significant growth in the belief in personal autonomy and the legal right to make decisions affecting oneself, as illustrated by contemporary attitudes to abortion and contraception. The underlying principle is the right to make decisions about one's health and body, which could include end of life choices. The individual's wishes are paramount.

1.8.2. Additional factors:

- a. Emotional distress.
- b. Some very elderly people have simply got to a stage where they are tired of living. They have lost most of their peers, have no prospect of a good quality of life in the future and just want to go to sleep and cease to live.
- c. A spirit of generosity – the desire to leave money to the family rather than prolong one's life.
- d. Losing one's dignity and imposing pain on loved ones are paramount factors. The most common reason for requesting assistance in dying is not intolerable physical suffering, rather, it is existential suffering including loss of meaning from the ability to relate to others. The prospect of being unable to interact can be as intolerable as physical suffering and cannot be alleviated by hospice or other palliative care.
- e. That currently medically assisted dying is a crime.

2. The effectiveness of services and support available to those who desire to end their own lives

2.1. One respondent believed that the current services are inadequate because they don't offer the option of medically assisted dying.

2.2. Another response stated that legalising euthanasia will not improve any inequalities.

2.3. There are many services and support available all over New Zealand for a wide variety of needs. Better marketing could increase societal awareness of the existence of these providers and thereby make lesser known services more accessible to people in need. The services identified by the respondents include:

- a. Social – Churches of many denominations, Salvation Army, Meals on Wheels, Citizens Advice Bureau, local social clubs e.g. Lions, Rotary, Altrusa.
- b. Legal – Citizens Advice Bureau

³ The Bible. Exodus 20: 1-17 Authorised Version.

- c. Medical – GP, District Nurses, Hospice New Zealand, Community occupational therapy, Physiotherapy, Psychiatric Services, Cancer Society, Canteen
 - d. Cultural – Community groups that cater for the elderly e.g. New Zealand Indoor Bowls, Senior Net, Age Concern, Retirement Villages – many have multiple activities on offer.
 - e. Financial – Budgeting Services.
 - f. Philosophical – most churches offer support groups not only to their own congregation but for the wider community. There are also chaplaincy services.
- 2.4. A number of respondents commented on the requirement for people to be cared for at home, but that services were not necessarily available for this to occur in all areas.
 - 2.5. There were some respondents who categorised the existing services as bad, and likely to get worse.
 - 2.6. Respondents' experiences from the services provided throughout New Zealand varied. According to a recent report by the Palliative Care Council of New Zealand. Services are very effective for the people who have access to them but not everyone wishes to have their life extended by hospice care⁴.
 - 2.7. Effectiveness varies considerably around paid assistance, private and public services.
 - 2.8. Many of the services provided rely on volunteers and public donations.
 - 2.9. For some, access to medical specialists was an issue.
 - 2.10. There were concerns expressed that the person was not treated as a whole. Multi-disciplinary consultations were seen as being helpful.
 - 2.11. Respondents felt that the present situation, where doctors have the ability to make people comfortable and prevent them from being in pain, is a factor in not legalising medically assisted dying.
 - 2.12. Further training and swifter recognition of or response to the need for palliative care is required. Health professionals appear reluctant to move a patient once diagnosed with a terminal illness into the care of a hospice to begin palliative care. Rest home care for patients is very often by inadequately trained staff.
 - 2.13. Those who are terminally ill and their support network need to be prepared to ask for help and to engage with the service on hand. Respondents commented that Hospice New Zealand was a service that provides many opportunities to those with terminal illness while they are well enough to take advantage of these e.g. art and craft groups, writing one's life history with assistance.
 - 2.14. There was a difference of opinion on Hospice services when the person is actually dying, suffering with pain and/or has difficulty breathing, unable to move much, unable to talk, unable to swallow etc. Some felt Hospice services are good while others felt that Hospice does not meet these needs

⁴ Palliative Care Council of New Zealand. 2015. *Updated projections of deaths in New Zealand*. Accessed 1 Feb 2016
<http://palliativecare.hiirc.org.nz/assets/sm/Resource35337/attachments/d9c3vzgf9x/Updated%20Projections%20Deaths%20in%20New%20Zealand%202015%20vF.pdf>

reliably. People's families are told "we are not here to hasten death, just to manage symptoms" but medication is often insufficient to manage symptoms of agitation, pain, distress over night. Services for clients who are at home are often not available over the weekend.

- 2.15. District Nursing services are severely constrained and more Government funding is needed for this and for palliative care generally.
- 2.16. Availability of services varies across the country:
 - a. While there is equal entitlement to the services, these services are harder to access, and there is not the variety, in rural communities and small towns outside of urban centres. Services are also difficult to access if there is no transport available.
 - b. Having medical insurance or the ability to pay assists in the affordability and immediacy of access to the services.
 - c. Long waiting lists, geographic isolation, (in some rural areas access to hospice services is difficult), requirement to utilise internet based advice and assistance means public services are significantly restricted too often for the most vulnerable people.
 - d. Their availability does not, however, mean that people will make use of them.
- 2.17. Most respondents believe that services to and support for those who still desire to end their own lives should be State funded. It is deemed inappropriate for profits to be made from people choosing to end their lives.
- 2.18. GPs should be the first point of contact to discuss this. For those who do not have a GP, the State should appoint and fund a doctor for this duty. Their duties should be clearly described so that they know that they would be supported legally (and morally) in this role. There should be two doctors who have to agree that the client meets the criteria. The client should be able to choose medically assisted dying in their own home or in a medical facility designed for that purpose.
- 2.19. Doctors who work in this field should be chosen for their caring and compassion. Consideration should be given as to whether this would be part of a GP's role or the role of a specialist. Respondents suggested that it would be extremely demanding for one single doctor to work solely in the area of medically assisted dying.
- 2.20. Consideration should be given to a Ministry for the Aged, and an Ombudsman for the Ageing.
- 2.21. There needs to be set criteria for medically assisted dying:
 - a. Terminal illness or irreversible medical condition which makes life unbearable.
 - b. Informed consent from person who wishes to end their life.
- 2.22. Robust protocols should be in place. There should be an assisted dying law supported by strong policies and procedures. Criteria for this legislation include patients being mentally healthy, 18 or older, who have had two physicians determine that they have no more than six months to live.

- 2.23. The Oregon, USA legislation⁵ was deemed a good model. The patient must make three separate requests (two oral and one written). The oral requests must be separated by at least 15 days, and the written request must be independently witnessed by two people. The patient can rescind these requests at any time.
- 2.24. Respondents suggested that a Medical Ethics Committee should be established. Such a committee would have the authority to review each application on its merits and ensure that the appropriate protocols are followed.
- 2.25. Issues concerning the validity of life insurance policies in the event of assisted death should be clearly regulated.
- 2.26. The person's desire, clearly articulated on a number of occasions, should be the prime criterion. This request must be made in writing, and there should be no coercion evident.
- 2.27. Those who identified a process suggested the process should start with a request to their GP or nominated doctor.
1. A minimum of two doctors should make the decision based on medical grounds.
 2. The person would be unlikely to sustain life for 6 months without medical intervention due to their medical condition.
 3. The person with a terminal illness should be of sound mind and be able to sign consent for ending of life when they are still well enough.
 4. Consideration should be given to any person who is healthy and of sound mind wishing to sign documentation requesting medically assisted dying should they later in life be in an accident or contract a medical condition which causes extreme brain damage which is not compatible with a reasonable quality of life or develop dementia (by which time they would not be able to request this assistance) e.g. a Living Will, which many people currently arrange with their lawyers. However, a Living Will is not a guarantee that you would not be resuscitated in the event of an accident. Usually there is not time in an Accident and Emergency setting to check if a dying patient has a Living Will. There should be a way of ensuring that the person's request will be legally applied and not ignored, perhaps through a Medic Alert bracelet.
 5. Under general circumstances, medically assisted dying should be carried out in the person's own home, or in a suitable facility, with family present as the person chooses.
 6. Effective records need to be kept.

3. The attitudes of New Zealanders towards the ending of one's life and the current legal situation

- 3.1. NCWNZ members were asked to discuss the attitudes that they have found amongst their networks.

⁵ Oregon (US). 1997. Death with Dignity Act. Accessed 1 Feb 2016
https://www.oregonlegislature.gov/bills_laws/ors/ors127.html

- 3.2. In general, respondents found that there is compassion for those confronting the fear of pain and loneliness of terminal illness. We all fear dying alone and in pain but these are issues that people can be helped with. People felt that assisted living is far harder than assisted death but its inevitabilities are far greater as well⁶.
- 3.3. Fear can motivate the arguments both for and against legalising euthanasia and medically assisted dying. New Zealand should have a society that nurtures its members and their lives at all ages.
- 3.4. There were respondents who considered that if there was to be a law change permitting medically assisted dying it could be open to abuse.
- 3.5. In the final days of life, many terminally ill patients struggle to breathe, are not able to move in bed, are very frail and difficult to be moved by a carer, and so are prone to pressure sores. Many are unable to swallow and become dehydrated and experience poorly controlled pain. (Although pain is always noted as the main reason for discomfort when near death, there are many other problems that dying people can suffer besides pain or in addition to pain.) A recent survey identified nearly half of doctors in the Waikato favour physician-assisted dying⁷.
- 3.6. Some respondents indicated that doctors are sometimes prepared to administer stronger medications to suppress symptoms (which can put the dying person into a deep sleep and which can possibly hasten death by hours or a day). Not all doctors are prepared to do this, choosing to 'go lightly' on the medications for fear of being accused of carrying out medically assisted dying. Some medical staff give tacit consent for this, but there is nothing in writing to assist these caring doctors who are effectively risking their licence to indirectly assisting the dying process.
- 3.7. The very value that doctors put on enhancing people's lives means that to expect them to aid the end of a life, or be put into a situation where ultimately the decisions are theirs is a contradiction to their Hippocratic Oath. In talking with medical members of families and medical friends, the recommendation is that we not expect the medical profession to become deliberate agents of death. Gerontologists talk of leaving their profession (including providing hospice and other care) if they were expected to help aid the end of life rather than add to its quality and care of their patients.
- 3.8. If medically assisted dying was legalised, then all doctors would be able to make this choice knowing that they were not breaking the law, but helping the dying person to have a well-managed, easy death. This is kinder for the patient and the family who do not have to witness their loved one struggling, groaning, becoming agitated, etc. Some respondents felt that the current legally correct practice is inhumane.
- 3.9. Other respondents stated that there should not be services provided to assist in euthanasia. There was a fear that if services and support were not forthcoming from the Government through Health and Social services, then it would make assisted suicide and euthanasia financially viable. Fewer and

⁶ Gawande A. 2014. Being mortal: illness, medicine and what matters in the end. Profile Books.

⁷ Havill J. 2015. Physician-assisted dying—a survey of Waikato general practitioners. *New Zealand medical journal*, 128(1409). Accessed 1 Feb 2016 <https://www.nzma.org.nz/journal/read-the-journal/all-issues/2010-2019/2015/vol-128-no-1409/6443>

fewer services would be provided, because as people aged, had mental or social problems, instead of supporting them, euthanasia would be an easy way out, and financially beneficial to the Government

- 3.10. The current legal situation leads to many elderly, infirm people starving themselves to death in a hospital or rest home because this is the only way they can control their own dying. Some of the respondents to this submission commented they had witnessed this.
- 3.11. Respondents agree that death should be dealt with dignity for those who are terminally ill. The current legal situation causes people to commit suicide to avoid the symptoms that they fear. In this case, the person has to commit suicide earlier perhaps than they would have chosen medically assisted dying, because they need to have the physical ability to commit suicide. Medically assisted dying would ironically have allowed those people to live longer.
- 3.12. Suicide methods available to desperate people can cause unnecessary suffering prior to death. Apparently hanging is a common choice in New Zealand. In reality this is often a slow death by strangulation and not instantaneous.
- 3.13. Families can be tormented by not being able to help their terminally ill loved ones who wish to die. They will be charged with homicide or murder if they do. If legislation permitting medically-assisted dying is passed, families will be able to support their loved ones through this difficult time.
- 3.14. The word 'euthanasia' is negative for many people. It suggests forced killing, or being put down against one's will. That is not the choice people are wanting to have. 'Medically assisted dying' is a far kinder and more appropriate term. It implies humane attitudes towards very ill people, gentleness and caring.
- 3.15. The terminology of 'suicide' or even 'medically assisted suicide' is not acceptable in this context. If this was made legal, it could encourage young people who have considered suicide, to carry it out because it is now a legal option.
- 3.16. Some felt there is a need to be very clear on what is and isn't euthanasia. It is about the intent. Many people have a misapprehension that the only way to help terminally ill and suffering patients is through euthanasia. There already exists within our law provision for the withdrawal of treatment, anyone can refuse treatment. When we decide for medical reasons to withdraw or withhold certain treatments we allow the patient to return to their dying. This is not euthanasia. When the intention is solely the relief of pain, then the use of pain relief is acceptable even if it inadvertently, unintentionally and regrettably leads to an earlier death. This is not euthanasia.
- 3.17. There was some support among respondents for the Living Will or Advance Directive concept which sets out the person's wishes to be helped to die if the person is completely incapacitated and has no hope of recovery.
- 3.18. A measure of civilisation is how one treats the vulnerable in one's community. Some felt it would be better to work on improving existing services and supporting those who are vulnerable rather than assisting their suicide.
- 3.19. Some respondents considered that medically assisted suicide is potentially dangerous to a society, leading to terminating the lives of people whose quality of life does not appear to meet the expected

norm. Life is a precious gift which some do not believe anyone has the right to end through assisted suicide.

- 3.20. Some said that law change would be a threat to our society. We need to be a society that cares for the vulnerable and suffering not one that kills. Legalising medically assisted dying will send a strong societal message that suicide is an acceptable way of dealing with suffering and will undermine our attempts to deal with the tragedy of youth and elderly suicides.
- 3.21. Society should not judge a person's worth and right to live. To say that a person's life is "no longer worth living" because they have pain, rely on others for some of their personal care, or can no longer do some normal things, marginalises those who live with such challenges on a daily basis.
- 3.22. Many believe that if medically assisted dying is legalised, it does not mean that all people have to choose this path. Those who prefer not to, can leave their disease to follow its course. There is no compulsion with this law.

4. International experiences

- 4.1. Many respondents were familiar with the information about the situation overseas, either from research or experience of people known to them. Depending on their point of view, people quoted information for or against medically assisted dying.
- 4.2. When Belgium introduced euthanasia in 2002 it was considered to be only for terminally ill adults, deemed to be in their right mind, with full consent given. Doctors were required to report cases of euthanasia to a nominated authority. A little over a decade later, the Belgium Parliament has now legalised euthanasia for children of all ages and for dementia patients. Studies show only half of euthanasia cases are reported to the authority.
- 4.3. A study in Flanders⁸ showed that 66 of the 208 cases or 32% of euthanasia occurred without explicit consent.
- 4.4. In the Netherlands, despite the supposed safeguards, the Dutch Government's own statistics⁹ show that more than 300 people die each year from euthanasia without explicit consent. From its strictly controlled beginnings, euthanasia in the Netherlands has grown to include the unconscious, disabled babies, children aged 12 and over, and people with dementia and psychiatric illnesses.
- 4.5. Belgium, the Netherlands and Oregon are showing escalating numbers of cases which point to assisted suicide and euthanasia becoming a normal response to suffering. Euthanasia and assisted suicide cannot be legislated safely¹⁰.

⁸ Chambaere K, Bilsen J, Cohen J, Onwuteaka-Philipsen B, Mortier F. 2010, Physician-assisted deaths under the euthanasia law in Belgium: a population-based survey. *Canadian Medical Association Journal*. Accessed 1 Feb 2016
<http://www.cmaj.ca/content/early/2010/05/17/cmaj.091876.full.pdf>

⁹ Statistics Netherlands. 2012. Deaths by medical end-of-life decision; age, cause of death. Accessed 1 Feb 2016
<http://statline.cbs.nl/StatWeb/publication/?VW=T&DM=SLen&PA=81655ENG&LA=en>

¹⁰ Oregon (US). 1997. Death with Dignity Act. Accessed 1 Feb 2016
https://www.oregonlegislature.gov/bills_laws/ors/ors127.html.

- 4.6. Oregon's pioneered the ground-breaking Death with Dignity Act¹¹. The legislation does not specify who must pay for the services. Individual insurers determine whether the procedure is covered under their policies (just as they do with any other medical procedure). Oregon statute specifies that participation under the Act is not suicide, so should not affect insurance benefits. However, federal funding cannot be used for services rendered under the Act. For instance, the Oregon Medicaid program, which is paid for by federal funding, ensures that charges for services related to the Act are paid only with state funds. Yet some respondents felt that as the legislation allows lethal drugs to be administered without medical oversight, there was enormous scope for family pressure or elder abuse to be applied¹².
- 4.7. One respondent commented that she knew of voluntary euthanasia in Holland as being very humane and even "rather wonderful". All the members of the family gathered together to support the patient at the time and place decided upon

5. Conclusions

- 5.1. What many NCWNZ respondents wished for themselves and the population of New Zealand, is that they could each have the option of choosing an easy, well managed death, overseen by a compassionate doctor who is able to act legally to end their suffering and release them to death. Having the option to choose does not mean that a decision will be made to choose medically assisted dying.
- 5.2. A number of respondents identified that medically assisted dying should only be allowed when survival is estimated at six months or less.
- 5.3. Other respondents valued the sanctity of life and that all people have a fundamental right to life.
- 5.4. Some respondents wanted a better understanding of the drivers to legalise medically assisted dying. Is it a societal reluctance to care for the aged and frail, the expense of the care and the medicines, the non-availability of hospital / palliative care beds and staff?
- 5.5. There was also a strong recommendation that there should be more funding for palliative care and for palliative training.



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National President



Beryl Anderson
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¹¹ ibid

¹² New Zealand Catholic Bishops Conference. 2015. Euthanasia and assisted suicide: myths and facts. Accessed 1 Feb 2016
<http://www.manurewacatholic.org.nz/LinkClick.aspx?fileticket=9KCP5FLQDGo%3d&tabid=1236&mid=18287>

Additional References

Respondents also referred to:

- ¹ Anderson B. 2015. Glimpses of Te Omanga: 100+ hospice stories.
- ² Background about Euthanasia in The Netherlands. Accessed 1 Feb 2016 <http://www.patientsrightscouncil.org/site/holland-background>
- ³ The big sleep. Accessed 1 Feb 2016 <http://www.smh.com.au/interactive/2016/the-big-sleep>
- ⁴ How doctor-assisted dying works. Accessed 1 Feb 2016 <http://www.economist.com/blogs/economist-explains/2015/06/economist-explains-18>
- ⁵ Last cab to Darwin. [Movie].
- ⁶ McCormick RA. 1981. How brave a new world? Dilemmas in bioethics. Doubleday.
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