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End of Life Choice Bill

The New Zealand Society of Anaesthetists (NZSA) appreciates the opportunity to provide feedback on the above Bill to the Justice Select Committee. Our Executive Committee have worked on this submission, which had included seeking comments and feedback from our members, some of whom are submitting as individuals in response to the Bill.

About the NZSA

The NZSA is a professional medical education society, which represents over 600 medical anaesthetists in New Zealand. Our members include specialist anaesthetists in public and private practice, and trainee anaesthetists. We facilitate and promote education and research into anaesthesia and advocate on behalf of our members, representing and championing their professional interests and the safety of their patients. As an advocacy organisation, we develop submissions on government policy and legislation, work collaboratively with key stakeholders, and foster networks of anaesthetists nationwide. The NZSA, established in 1948, also has strong global connections, and is a Member Society of the World Federation of Societies of Anaesthesiologists (WFSA).

Overview

The End of Life Choice Act 2017 seeks to legalise voluntary euthanasia in certain circumstances. The explanatory note states that the Bill gives: "People with a terminal illness or a grievous and irremediable medical condition the option of requesting assisted dying.[1]

The issue of legalised voluntary euthanasia is very important for anaesthetists and specialist pain medicine physicians, who may be involved in end of life discussions and decisions. The Bill stipulates that if a person chooses "assisted dying" (i.e. the administration by a medical practitioner of a lethal dose of medication to relieve his or her suffering by hastening death), subject to the process described in this Bill's Digest, the "attending medical practitioner" (the person's medical practitioner) must administer the medication which will cause the death of the person (and which has been chosen by that person) by:

- Ingestion, triggered by the person
- Intravenous delivery triggered by the person or
- Ingestion through a tube
- Injection.

[1] End of Life Choice Bill, 2017 No.269-1. Explanatory note, General policy statement, p.1.

There is a diversity of opinion within the profession on the ethics of euthanasia, and it is the position of the NZSA that this should be an issue for the personal conscience of each of our members, within the framework of the law. We strongly hold the view that medical practitioners must have the right, if they choose, not to be involved in euthanasia or physician-assisted dying.

Given the broad scope of choice that the Bill offers the patient, the NZSA wishes to approach this issue from the perspective of both the patient and medical practitioners, who may receive requests to be involved in the process.

In our submission we will also address:

- that patients need to have the right to make an informed choice, free from coercion and based on the Patient Code of Rights. Ensuring that these rights are met will require the provision of adequate support for the patient as well as changes to the current Patient Code of Rights.
- the need for medical practitioners who choose to be involved to have the appropriate training and guidance, with support from their Colleges and the Medical Council of New Zealand, the registration body for doctors.
- the need for universal access to high quality palliative care services and improved access to Specialist Pain Services, which requires adequate funding for both.

Compliance with College guidelines and statements
As the majority of our members are fellows of the Australian and New Zealand College of Anaesthetists (ANZCA), they must comply with ANZCA's professional guidelines and statements and adhere to the College's mission statement:

"To serve the community by fostering safety and quality patient care in anaesthesia, intensive care and pain medicine."

ANZCA's PS 38: Position statement relating to the relief of pain and suffering and end of life decisions, includes the following stipulations:

1. Support the concept of death with dignity and comfort, and the right of terminally ill patients to receive expert palliative care. They further support the provision of adequate pain relief and treatment of other symptoms to relieve suffering in the terminally ill.

5. Do not support the application of medical interventions in which the primary intent is to end the life of the patient.

For anaesthetists to be part of the process the College would have to alter this statement.

The ANZCA statement on respecting the individual beliefs and rights of fellows and patients is one we strongly agree with and the NZSA fully supports this for the End of Life Bill.

The rights of patients and medical practitioners
The NZSA believes that patients' rights under the Code of Rights (see also p.13 of this submission) must be protected and that patients must be provided with assurance to exercise those rights, including being able to make informed decisions regarding their end of life choices.

It is also imperative to ensure that medical practitioners, particularly specialist anaesthetists and pain medicine specialists, are protected under legislation, and not required to undertake activities which they deem inappropriate or contrary to their personal beliefs or their professional responsibilities towards their patients.

To adequately address the aims outlined in the Bill it is important to consider the legal and ethical perspectives from overseas, and to review practices as they occur in other parts of the world.[2] [3] Some information is provided in the tables below:

Table 2 Assisted suicide and euthanasia in six European countries: target group (bold) of legislation or proposed bills

	Target group of (proposed) legislation	According to statutory regulation or proposed legislation
Belgium	**doctors only**	Act Concerning Euthanasia, May 2002: Conditional decriminalisation of euthanasia performed by a physician*
Germany	**not specified**	Non-penalty of assisted suicide holds for everyone†
The Netherlands	**doctors only**	Review Procedure Act, April 2002: exemption for doctors from penalty of assisted suicide and killing on request
Norway	***not specified***	Penal Code Commission, minority proposal, no mention of doctors; rejected in May 2005 by the Norwegian Parliament

[2] Bosshard G, Broeckaert B, Clark D et al. A role for doctors in assisted dying? An analysis of legal regulations and medical professional positions in six European countries. J Med. Ethics 2008:34:28-32.
[3] Varadarajan R, Freeman R.A., Parmar J.R. Aid-in dying practice in Europe and the United States: legal and ethical perspectives for pharmacy. Research in social and administrative pharmacy. 12 (2016): 1016-1025.

	Target group of (proposed) legislation	According to statutory regulation or proposed legislation
Switzerland	**not specified**	Non-penalty of assisted suicide without motives of self-interest holds for everyone
United Kingdom	***doctors only***	*Assisted Dying for the Terminally Ill Bill targeted at doctors only; rejected in May 2006 by the House of Lords*

- Unless specified, all statements refer to both assisted suicide and euthanasia. Italics: bill/proposal
- * The legal status of (physician-) assisted suicide — not regulated by the euthanasia law — is unclear.
- † Physician-assisted suicide may legally conflict with a doctor's obligation to save life ("Garantenpflicht"). Current legal developments aim at exempting doctors from a particular "Garantenpflicht."

Table 3 Assisted suicide and euthanasia in six European countries – current official medical professional positions (bold), and developments since 2000

	Allowance of doctors' involvement	According to
Belgium	*no* → **neutral***	Code of Medical Deontology of the Belgian National Council of Physicians, position modified in March 2006
Germany	**no**	Principles of the German Medical Association, position maintained in May 2004
The Netherlands	**yes**	Guidelines of the Royal Dutch Medical Association, position maintained in April 2002
Norway	**no**	Ethical Rules of the Norwegian Medical Association, position maintained in June 2002
Switzerland	*no* → **neutral** (AS)	Medical-ethical Guidelines of the Swiss Academy of Medical Sciences, position modified in December 2004
	no (E)	

	Allowance of doctors' involvement	According to
United Kingdom	**no** ↔ *neutral*	Official view of the British Medical Association, June 2000 (confirmed by a BMA representative vote, July 2006)†

- Unless specified, all statements refer to both assisted suicide and euthanasia
- Italics: developments since 2000
- * Concerns both euthanasia and assisted suicide as long as requirements of the euthanasia law (including presence of a physician) are met.
- † Abolishing an earlier BMA representatives' vote in July 2005 in favour of a neutral stance

Tables 2 and 3 from J Med Ethics article.

Definitions of physician assisted death and euthanasia
There are various terms used by the media, in the literature and in the Bill to describe physician-assisted death. Terms such as physician-assisted suicide, death with dignity, assisted suicide, and mercy killing are all used interchangeably mainly by the lay public. These terms need to be clearly defined as they have different legal ramifications.

- Physician assisted death is defined as the 'administration of drugs with the explicit intention of ending a patient's life with or without the patient's explicit request.'
- Physician assisted suicide is defined as 'the prescription or supplying of drugs with the explicit intention of enabling the patient to end his or her own life.'
- Euthanasia. This term originally meant only a 'good death' but in modern society it has come to mean a death free of anxiety and pain, most often through the use of medication. The interpretation of this term can be different with the Pro-Life Alliance defining it as: 'Any action or omission intended to end the life of a patient on the grounds that his or her life is not worth living' whereas the Voluntary Euthanasia Society says a modern definition is: 'A good death brought about by a doctor providing drugs or an injection to bring a peaceful end to the dying process.'

The Bill, as proposed, would allow for both physician assisted suicide and euthanasia.

Countries and US states that have legalised euthanasia and physician assisted suicide are as follows:

Euthanasia

- Belgium
- Netherlands
- Luxembourg

Physician assisted suicide

- Switzerland (under specific laws)
- United States, in the states of:
  - Oregon
  - Washington
  - Vermont
  - Montana (remains disputed in 2016)
  - New Mexico (only in Bernalillo County)
  - California from 2016
- Canada

Table 1. Legal requirements for physician-assisted suicide

State	Date passed	Legislature	Patient Residency required	Minimum age	# of requests to physician
Montana	Dec 31, 2009	Montana Supreme Court in *Baxter v. Montana*	Yes	–	–
Oregon	Nov 8, 1994	Ballot Measure 16	Yes	18	Two oral (at least 15 days apart) and one written
Vermont	May 20, 2013	Act 39 (Bill S.77 "End of Life Choices"	Yes	18	Two oral (at least 15 days apart) and one written
Washington	Nov 4, 2008	Initiative 1000	Yes	18	Two oral (at least 15 days apart) and one written
New Mexico	Jan 13, 2014	New Mexico District Court, *Morris v. Brandenberg*. In effect only in Bernalillo County	–	–	–
California	Oct 5, 2015	End of Life Option Act; Bill signed on Oct	Yes	18	Two oral (at least 15 days apart) and one written

State	Date passed	Legislature	Patient Residency required	Minimum age	# of requests to physician
		2015; Law goes into effect in 2016.			

To understand the process, it is important to provide a summary of end of life options, the clinical practices that would be required and the potential advantages and disadvantages of each option. These are outlined below:

Active euthanasia
In this process the physician is responsible for administration of a lethal injection at the patient's request. The physician would sedate the patient to unconsciousness and then administer a lethal injection of a muscle relaxant, such as curare.

The advantages of this process would include:

- Active and direct participation of the physician, which helps ensure that the patient is provided with the best care and is under professional supervision throughout the process.
- The process is quick and effective; and does not need the patient to swallow any pills or have an intact GI system.

The disadvantages include:

- This process conflicts directly with the legal, moral, ethical and professional responsibilities of the physician, by causing death. Physicians, and in particular anaesthetists and pain specialists given the nature of their work, may be more reluctant to participate in this practice even if it is legal.
- It has the potential to be abused if explicit request has not been sought from the patient, as per the legal requirements.

Physician assisted suicide
After the patient explicitly expresses interest and follows the legal protocol, the physician prescribes a lethal dose of either barbiturates or benzodiazepines, by which the patient can choose to end his or her life. Although the physician is morally responsible for prescribing the medications, the patient has to carry out the final act.

The advantages:

- Access to the lethal dose gives patient a sense of freedom about their choice to live or to end their life.
- It is explicitly a voluntary act, as patients must self-administer the medications. This option may find more favour with physicians who may face moral, professional and legal conflicts about having to administer the lethal medication dose to the patient.

The disadvantages:

- Although this process requires self-administration it may not signify voluntariness or lucidity. The patient may not be competent at the time of administration to make this choice or may be influenced by external pressures.
- It can only be used by patients who can self-administer. Patients may suffer side effects such as vomiting, seizures and other complications that may prolong death and which in some cases may not lead to the desired outcome.
- The presence of a physician is not required thereby leaving the patient and/or their family to deal with complications that may arise due to the medications or be party to a process they have moral or ethical conflicts about. The legal implications on the family must be considered.

Other options available include Terminal Sedation where the patient is sedated to unconsciousness by continuous infusions of either barbiturates or benzodiazepines. The patient dies due to dehydration, starvation or other intervening complications. This process can take days or weeks.

The advantages:

- The patient is deeply sedated and is thought to be free from suffering
- It can be argued that this death is foreseen, but not intended, and that the sedation itself did not result in death. This can help alleviate any moral/ethical conflicts that physicians may have to prescribing lethal medications.

The disadvantages:

- Must be undertaken in the healthcare setting so the patient is unable to die at home
- Due to the prolonged duration family suffering may be increased
- Some conflict in the literature that the patient is actually free of pain and suffering.

A further option is voluntarily stopping eating and drinking. This gives the patient independence and respects their rights. It requires no intervention by physicians nor requirements for medications. It is however a torturous form of dying and may cause moral and ethical conflicts for the physician and within the patient's family.

Existing legislation affecting medical practitioners

The provisions of the proposed Bill extend beyond the definition of physician assisted dying by stating that the "attending medical practitioner must administer the medication which will cause the death of the patient", that they must "be available to the person until the person dies" or "arrange for another medical practitioner to be available until the person dies." This by definition is euthanasia.

There are underlying principles in the current law, which clearly show that euthanasia is illegal in New Zealand. The Crimes Act 1961 covers the taking of one's own life and bringing about the death of another. Relevant sections include:

- Section 151: Duty to provide the necessities of life
- Section 157: Duty to avoid omissions dangerous to life. Everyone who undertakes to do any act, the omission to do which is or may be dangerous to life, is under a legal obligation to do that act, and is criminally responsible for the consequences of omitting without lawful excuse to discharge.
- Section 158: Homicide is defined as 'the killing of a human being by another, directly or indirectly, by any means whatsoever.'
- Section 164: Acceleration of death
- Section 179: Everyone is liable to imprisonment for a term not exceeding 14 years who:
  - Incites, counsels, or procures any person to commit suicide, if that person commits or attempts to commit suicide in consequence thereof; or
  - Aids and abets any person in the commission of suicide
- Section 180: suicide.

Anaesthetists in New Zealand have been particularly affected by another section of the Crimes Act i.e. Section 155: Duty of persons doing dangerous acts: Everyone who undertakes (except in the case of necessity) to administer surgical or medical treatment, or to do any other lawful act the doing of which is or may be dangerous to life, is under a legal duty to have and to use reasonable knowledge, skill and care in doing any such act, and is criminally responsible for the consequences of omitting without lawful excuse to discharge that duty.

By 2004, 10 health professionals had faced charges for manslaughter for alleged negligence in the normal conduct of their work. Not surprisingly some doctors, particularly those working in high-risk specialties such as cardio thoracic surgery and anaesthesia, felt especially vulnerable.[4]

Professor Alan Merry states:

"In 1997, the New Zealand Crimes Act was amended to require 'a major departure' from the standard of care expected of a reasonable person in the circumstances. This aligned the New Zealand position with those countries (notably Australia, the United Kingdom, the United States, and Canada) in which the requirement is generally expressed by reference to "gross negligence."

Whilst this change has provided some comfort to those involved in high-risk professions such as anaesthesia, doctors in other countries continue to be charged with manslaughter.[5]

[4] Merry A F. Mistakes, Misguided Moments and Manslaughter. J Extra Corpor Technol. 2009 Mar; 4 (1): P2-P6
https://www.ncbi.nim.nih.gov/pmc/articles/PMC4680227

[5] Ferner RE, McDowell SE. Doctors charged with manslaughter in the course of medical practice. 1795-2002: A literature review. J.R. Soc. Med. 2006; 99:309-14

The implementation of the End of Life Bill would necessitate major changes to the Crimes Act, as well as a change of mindset among medical practitioners who have been undertaking their normal duties working under the present Act.

In addition, under the New Zealand Bill of Rights:

"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."

When considering the changes to Canadian legislation, as a consequence of the case Carter v Canada (Attorney General) Supreme Court of Canada, Professors Chan and Somerville state:

"Making euthanasia and assisted suicide part of medical practice is not, as pro-assisted death advocates claim and the Supreme Court's reasoning affirms, a small incremental change consistent with accepted interventions such as honouring patients' refusals for life-sustaining treatment. Allowing physicians to inflict death on their patients is different in kind – and not just in degree – from other interventions we accept as legal and ethical."[6]

The NZSA upholds the right for practitioners to be conscientious objectors and believes that:

- Participation by medical practitioners and health services in assisted dying/euthanasia should be voluntary with no need for the objection to be qualified.
- There may be difficulties compelling such practitioners to make a personal referral to another practitioner when the patient requests information on assisted dying/euthanasia. Some practitioners will consider such a referral to be a violation of their personal values.

As such, there would need to be a process to protect the rights of the patient to receive information to enable them to make informed choices, but which is not reliant on medical practitioners.

Practitioners who do choose to participate in assisted dying and euthanasia should be required to undertake appropriate education and training, as part of continuing medical education, to develop the skills needed to participate and to provide appropriate advice to those seeking it. They should also have education regarding the legal requirements of participating in the process.

Palliative care

The NZSA believes that it is essential to ensure that assisted dying and euthanasia do not become substitutes for expert palliative care and adequate palliative care funding, training and research. Resources must also be made available so that minority groups and patients

[6] Chan B and Somerville M. Converting the 'Right to Life' to the 'Right to Physician assisted Suicide and Euthanasia': an analysis of Carter V Canada (Attorney General), Supreme Court of Canada. Medical Law reviews; Vol.24, No.2, pp143-175

in rural and remote areas have access to suitably qualified healthcare professionals in the field of palliative care.

Foremost, support should be shown for the concept of death with dignity and comfort, and the right of terminally ill patients to receive expert palliative care.

The European Association for Palliative Care edited a white paper on euthanasia and physician assisted suicide explicitly affirming that:

"Individuals requesting euthanasia or physician assisted suicide should have access to palliative care expertise."[7] They also affirmed: "It is the responsibility of palliative care professionals to hear and explore the implicit and explicit requests for euthanasia and address the suffering underlying these requests."

Where assisted dying is legal, palliative care physicians are involved in up to 90% of cases, from decision making to drug delivery. The majority of patients who have died under the Death with Dignity Acts in Oregon and Washington were enrolled in hospice programmes, and in Belgium and the Netherlands euthanasia and assisted suicide are practised commonly in in-patient hospices.[8] [9] [10]

Historically, palliative care and assisted dying have been considered incompatible by various palliative care bodies.[11]

We recommend that the Ministry of Health consult with palliative care specialists within New Zealand to ascertain the compatibility of the proposed Bill with their views on assisted dying.

A recent New Zealand paper: "Doctors Shouldn't Underestimate the Power that they Have; NZ Doctors on the Care of the Dying Patient," surveyed 3420 New Zealand GPs regarding the care of dying patients and provides valuable insights into the current New Zealand situation.[12] In the survey, GPs were asked about access to and use of palliative care services. The vast majority (94.5%) reported that they used these services. One respondent argued that moves to legalise physician assisted dying in New Zealand was missing the point and that we should instead be debating the provision of palliative care:

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[7] Radbruch L, Leget C, Bahr P, et al. Board Members of the EPAC. Euthanasia and physician assisted suicide: a white paper from the European Association for Palliative Care. Palliat Med. 2016; 30: 104-16

[8] Chambaere K, Vander Stichele A, Desmet M, et al. Recent trends in euthanasia and other end-of-life practices in Belgium. N Engl j Med 2015;373:1179-81

[9] Vanden Berghe P, Mullie A, Desmet M, et al. Assisted dying- the current situation in Flanders: euthanasia embedded in palliative care. Euro J Palliat Care 2013; 266-72

[10] Oregon Public Health Division. Oregon annual report 2015. https://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Documents/year17.pdf

[11] Pereira J, Anwar D, Pralong G, et al. Assisted suicide and euthanasia should not be practiced in palliative care units. J Palliat Med. 2008; 11:1074-6

[12] Malpas P J and Mitchell K. Doctors shouldn't underestimate the power that they have: NZ Doctors on the Care of the Dying Patient. American J of Hospice and Palliative Medicine 2017; Vol. 34 (4): 301-307.

"I think if we had a bill going through that everyone had decent, appropriate palliative care that it (PAD) would be a very rare request and in my years of doing general practice and palliative care I've literally had one request…"

Interview respondents did concur that not all suffering could be relieved by palliative care but argued that good palliative care could manage pain 'well enough' to provide a good death for the patient.

In their perspective piece "Dying at Home – Our Grandfather's Great Escape"[13] Drs Benjamin and Nicolas Chin-Yee comment:

"Palliative care is all too often viewed as 'giving up.' Its true value often goes unrecognised, which like all of medicine lies in the relief of suffering. In addition to improving access to palliative care through timely discussion and early consultations, when it is possible and preferred, we should further advocate for our patients to receive these services at home, rather than in in-patient settings."

The NZSA supports the education of palliative care specialists in the management of severe pain problems through the Faculty of Pain Medicine. The field of pain medicine recognises that the management of severe pain problems require the skills of more than one medical craft group and that a multidisciplinary approach is needed. Pain problems include:

- Acute pain (postoperative, post trauma, acute episodes of pain in 'medical conditions')
- Cancer pain (pain directly due to tumour invasion or compression, pain related to diagnostic or therapeutic procedures, due to cancer treatment)

- Persistent (chronic) pain (including over 200 conditions described in the International Association for the Study of Pain).

One in six New Zealanders suffers of chronic pain and Professor Edward Shipton describes this as a health crisis. www.noted.co.nz/health/health/breaking-the-pain-barrier/ (Feb 21, 2013).

As at 30 June 2017 there were 38 Fellows and 11 Trainees in New Zealand in the field of pain management. Professor Shipton has called for increased government funding over many years to increase the number of training posts for pain specialists in New Zealand to meet the demand for pain services.

The NZSA supports Professor Shipton's views and his request for increased training posts and funding of pain services within New Zealand.

[13] Chin-Yee B and Chin-Yee N, Dying at Home – Our Grandfather's Great Escape. JAMA Internal Medicine Published on line Dec 2017.

Advanced care planning
Death can be an uncomfortable topic for the lay public and healthcare professionals alike, which can lead to delays in discussions and planning for the end of life.[14]

Advanced care planning (ACP) has been touted as a holistic way to address the needs of both the patient and their family and to enable a decision-making process that is in accordance with the preferences of the dying.

Two New Zealand studies have reviewed what is known about the topic while also adding important local perspectives:

1. Advanced Care planning for Maori, Pacific and Asian people: the views of New Zealand Healthcare Professionals.[15]

- What is known about this topic:
    - Facilitating knowledge about ACP with patients and families can increase the likelihood that preferences for end-of-life care are known and respected.
    - In pluralistic and multicultural societies such as New Zealand, significant differences exist in the uptake of ACP between European-based populations and other cultural groups.
    - ACP is more complicated in a culture where decision making by whanau is important.

- What this paper adds:
    - Knowledge about ACP may increasingly involve techniques to improve access and improve information access and the use of shared norms and values to assist with discussions between Maori, Pacific and Asian health professionals and their patients and families/ whanau.
    - The importance of engagement with Maori, Pacific and Asian health professionals in developing ACP education resources for patients, families/whanau, as well as healthcare providers.
    - A need for more family/whanau-centered models of care (including for ACP) much earlier in the healthcare process and doing this within a community setting.

2. Living with Death: a Case for an Iterative, Fortified and Cross-Sectional Approach to ACP.[16]

- There is a need to acknowledge the important factor of culture related to age, generation, sex, faith and ethnicity when engaging in conversations about ageing,

[14] Larson DG, Tobin DR. End of Life conversation: evolving practice and theory. JAMA 200; 284(12): 1573-1578
[15] Frey R, Raphael D, Bellamy G and Gott M, Advance care planning for Maori, Pacific and Asian people: the views of New Zealand healthcare professionals.
Health and Social Care in the Community 92014) 22 (3); 290-299
[16] Llewellyn R, Jaye C, Egan R, and et al. Living with death: a case for an iterative, fortified and cross-sector approach to advance care planning. Anthropology and Medicine, 2017 Vol 24 (3): 360-365

death and dying. By doing so, health professionals will be best equipped to assist their patients to live well into death.

The NZSA acknowledges the findings of these studies and supports appropriate ACP within the New Zealand context, especially in light of the proposed End of Life Bill.

The Patient Code of Rights:
In relation to the Patient Code of Rights we have provided comments below on the following:

Right 6: Right to be Fully Informed – this must be adhered to.

Right 7: Right to Make an Informed Choice and Give Informed Consent – this choice is particularly relevant to protecting the rights of the patient especially:

Right 7 (4) where the consumer is not competent.

These rights should not be able to be applied in the End of Life situation i.e.

4(i) if the provider believes it is in the consumer's best interest.

4 (ii) if a suitable person with interest in the welfare – i.e. a welfare guardian or if an application has been made to the court.

Right 7 (5) An advanced directive has been made – at present this can be either verbal or written.

An advance directive should not be applicable to the End of Life Bill. A patient must be competent at the time of application to take part in this process. This will help protect the elderly and the vulnerable, such as those with disabilities.

The Code of Rights would need to be changed to include these provisions should the End of Life Bill be passed.

Summary
It is fundamentally important to consider the perspectives and rights of both patients and medical practitioners in the end of life process and we believe that the legislative aspects and safeguards we have raised need careful consideration.

We wish to conclude our submission by referring you to an article "A Role for Doctors in Assisted Dying," Bosshard et al (JMed Ethics 2008) which states:

"Against the background of increasing acceptance of assisted dying in Europe, the fundamental question of the appropriate role of doctors in an area that goes beyond medicine remains contentious. A society striving for an open approach towards assisted dying should carefully identify the tasks that should be assigned exclusively to medical doctors and separate out those that might be better performed by other professions."

(These include clergy, nurses, pharmacists, social workers and others with sufficient experience of life who are prepared to bear joint responsibility).

“Open regulation of assisted dying brings doctors into a basic conflict. On the one hand, many doctors do not wish to have anything to do with a practice that they regard as incompatible with professional ethics. On the other hand, once opening up seems inevitable, they want to introduce the safeguards they deem necessary.”

The NZSA is happy to discuss aspects of our submission or to answer the Committee’s questions. I can be contacted at president@anaesthesia.org.nz.

Yours sincerely

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