

NZ Parliamentary Report on Attitudes to Medically-Assisted Dying A Summary

(Pg 15) Submitters' attitudes towards assisted dying:

(Over 21,000 Submissions received)

Another way to measure public opinion on assisted dying and euthanasia is to analyse the submissions made to this committee in response to this petition. These submissions provided not only a numerical indication of submitters' sentiments, but also allowed them to explain their position in more detail than could be provided in response to a simple question in a poll.

The majority of submitters were opposed to legislation that would allow assisted dying in New Zealand. Advisers reported that 80 percent of submitters opposed any change to assisted dying legislation, while 20 percent favoured a law change to permit assisted dying.

We heard from a wide variety of submitters. They included many individuals speaking from personal experience. In some instances it was their own pain or experience of health issues, but more often they recounted the experience of a family member, friend, or loved one. We heard from a range of academics, including lawyers, ethicists, and bioethicists. We also heard from a significant number of medical and health professionals—doctors, nurses, palliative care experts, psychologists and psychiatrists, hospice workers, carers, youth workers, grief counsellors, and social workers.

Submitters included representatives from various organisations, including cultural, religious, and professional bodies, as well as advocacy groups from both sides, disability groups, and suicide prevention organisations. We also took the opportunity to speak with numerous people overseas, often those leading calls for, or opposition to, change in their respective jurisdictions. In respecting the petitioner's request to "investigate fully public attitudes", we were pleased to hear from such a wide cross section of New Zealand society. A statistical analysis of all submissions was undertaken by one submitter. According to that report, the majority of those writing in support of a law change did so for reasons of choice—both individual freedom and that the law should enable such choices to be made (74 percent of those in favour).

The majority of those writing to oppose a law change did so on the basis that human life has an innate value that should be upheld in law (40 percent of those opposed). Other arguments that predominated among those supporting a law change included the desire to not lose their abilities or a sense of self (41 percent of those in favour), and the desire to not suffer (41 percent of those in favour). Key arguments from those against included the dangers to vulnerable people (38 percent of those opposed) and that modern palliative care is sufficient to treat suffering (31 percent of those opposed). Another common message in support of a law change was the desire to save families from watching a family member suffer. For those against a law change, a further common issue was concern about sending mixed messages about suicide.

(Pg 40) Submitters' views on palliative care:

...Submitters generally agreed that, in most cases, good palliative care services are available and adequately relieve pain at the end of life. A few submitters suggested that assisted dying and euthanasia could be a further option within the palliative care space. We heard from a significant number of palliative care specialists, doctors, nurses, and support workers. Almost all stated that assisted dying or euthanasia was incompatible with the principles of palliative care.

Some submitters believed that palliative care does not always relieve pain and suffering. Specialists acknowledged that such rare cases do exist, but said they are always due to issues of access, delivery, and misperceptions. We heard that access to palliative care services is not uniform throughout New Zealand, particularly in rural and provincial areas. Late referral to palliative care services and other delays could also potentially diminish the efficacy of the care. Some medical practitioners noted that access to palliative drugs was also restricted by regulations. In these cases, an attending doctor would require the approval of a separate authority. This sometimes leads to the drugs not being used, or a delay in their use.

Some submitters noted that as palliative care has become a very specialised service, more training is needed for doctors and nurses who are not palliative care specialists to better understand what palliative medicine consists of. ...

Some submitters argued that even if access was uniformly available, there are examples in which palliative care has failed to relieve loved ones' pain and suffering.

When we put these examples to palliative care specialists, nurses, and others working in the field, they stressed that such instances were anomalies. Such cases indicated errors in the delivery of palliative care services, not in the nature of the services themselves. They also noted in these cases that family members frequently misunderstand what is happening to their loved one and this creates a perception that palliative care was ineffective. It is clear that better communication is needed by some palliative care workers to ensure that not only the patients, but family and friends, fully appreciate what is happening.

Specialists stressed that pain is always manageable within palliative care. However, they noted that it is important to acknowledge that life-limiting conditions frequently involve more than just physical pain. In addition to physical discomfort, such conditions often include elements of psychological and emotional pain. These can include anxiety, depression, and feelings of hopelessness. Some medical specialists, including psychologists and psychiatrists, reported that terminal diagnoses were often accompanied, initially, by severe depression, though this often abates with time. Treatment for such pain is an important part of palliative care. People suffering from depression and suicidal thoughts are treated in the same way regardless of whether their underlying condition is terminal or not. A few specialists, and several disabilities advocates, expressed serious concern that terminal patients might seek assisted dying and euthanasia while suffering from the depression related to their diagnosis. Such depression almost always passes if given time and treatment. Concerns about making it easier to end one's life during such episodes were also echoed by suicide prevention groups.

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Some submitters were concerned that any change to legislation would lead to reduced support for palliative care services. However, the only study on this issue, conducted in 2015, did not support this assertion. (It compared the development of palliative care services in three countries where assisted dying is allowed with four countries where it is not.) In fact, the legislation may have promoted the expansion of palliative care in Belgium.

(Pg 42) Our response:

We note that there appears to be a lack of understanding from the general public and some submitters about what palliative services can do. We urge the Government to invest in a campaign to better communicate the role of palliative care services in New Zealand, with particular emphasis given to communities that do not generally access the services.

...We were concerned to hear that access to palliative care may be uneven around New Zealand, particularly in rural communities and some ethnic communities. We suggest that the Government investigate how it can promptly reduce the inequities in palliative care across the country.

We were concerned to hear that some areas have difficulties in recruiting palliative care specialists and that the sustainability of the workforce is uncertain. ... Some doctors expressed concern that it is difficult for primary care doctors to prescribe palliative care drugs, such as dexamethasone. This can create unnecessary delays for patients requiring these drugs. We encourage the Government to improve primary care access to palliative care pharmaceuticals.