

# End of Life Choice Bill submissions to the Justice Select Committee

Report prepared on behalf of the Care Alliance by  
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## Introduction

This report provides an analysis of 38,707 written submissions made to the Justice Select Committee on the End of Life Choice (EOLC) Bill, each of which was read by volunteers of the Care Alliance.

The overall impression when reading these submissions is that they represent the views and stories of a large, diverse and thoughtful cross-section of all New Zealanders; young and old (aged 8–94), different ethnicities (Maori, New Zealand European, Pasifika, Asian), different occupations and walks of life, religious and non-religious, conceptual and experiential. In short, the submissions paint a heart-felt and deeply human picture of the views held by many New Zealanders who have considered the implications of legalising euthanasia and assisted suicide, and had sufficient strength of feeling to write in and make their views known.

Most submitters wrote as individuals in their own right. There were 1,979 submissions from doctors, nurses and others involved with the health care sector, and 133 submissions from a variety of organisations with a strong interest in the Bill.

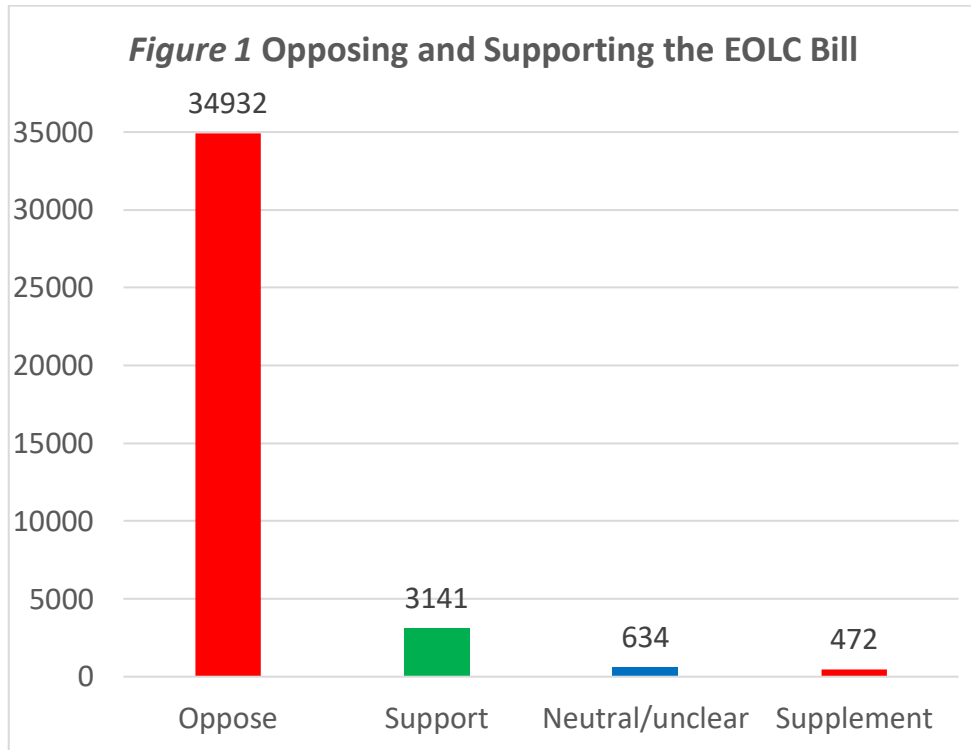
This report summarises the views, opinions and concerns presented by all of the submitters, along with some sub-groups of particular interest. It provides an overview of the main themes, insights and areas of concern to emerge, along with a description of key points and illustrative snippets drawn directly from the underlying submissions.

At the outset we would like to acknowledge each of the more than 38,000 ordinary New Zealanders who took the time and effort to share their insights, experiences, deeply personal stories, hopes and fears about these life and death issues.

## Overview of findings

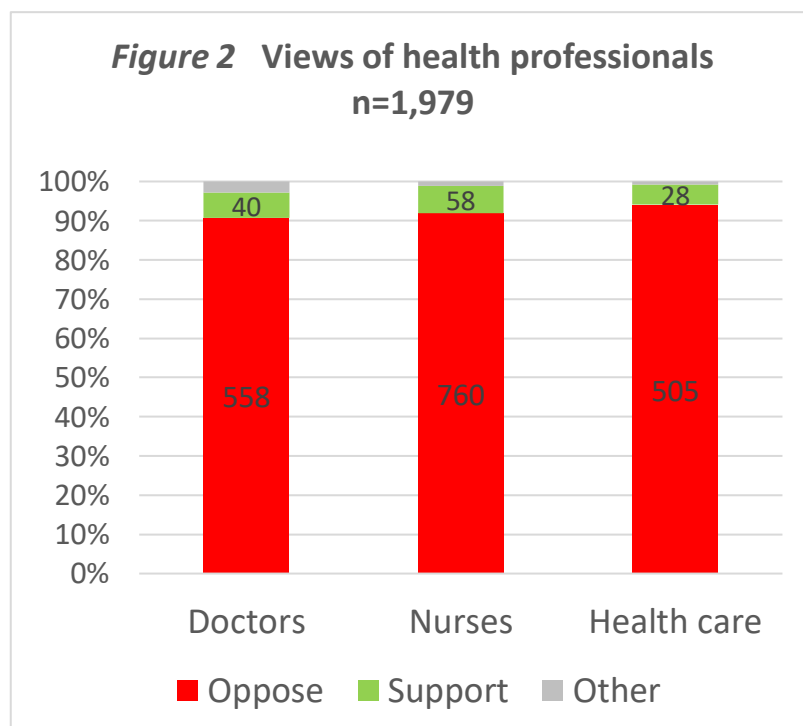
A substantial majority of submissions made to the Justice Select Committee oppose the legalisation of euthanasia and assisted suicide, and call for MPs to not pass the End of Life Choice Bill in any form. Of all 38,073 submitters expressing a position, 91.8% were opposed to the Bill.

Many submissions talked about the inadequacies of various provisions in the EOLC Bill, but in the end most people concluded that the adverse societal impacts of allowing doctors to end the lives of patients in some circumstances far outweigh any benefit that is argued. These concerns were found to apply both to the broader eligibility criterion of “grievous and irremediable,” and to the more restrictive “terminal illness” criterion proposed. This is because the ripple effects of euthanasia and assisted suicide spread throughout the society beyond the individuals immediately affected and irrespective of the eligibility criteria used.



*Doctors, nurses and other health care staff*

An overwhelming majority (93.5%) of submissions received from doctors, nurses and other health care staff who expressed a position were opposed to legalising euthanasia and assisted suicide as required under the EOLC Bill.



This finding is significant because the EOLC Bill imposes a specific moral duty on medical practitioners (i.e. doctors) to administer lethal drugs in response to patient wishes. While some provision is made in the EOLC Bill for conscientious objection by doctors, many submitters identified a range of adverse follow-on consequences and contradictions in managing end of life care both for health practitioners directly, and for institutions providing palliative and end of life care. Hospices, for example, would be forced to participate in the practice of euthanasia and assisted suicide, despite this being diametrically opposed to their philosophy of holistic care, which is to neither prolong nor hasten death. These and other consequential effects are addressed more fully below.

#### *Other interested groups*

Out of 133 submissions made by organisations, 96 took a position on the EOLC Bill and 90.6% were opposed to euthanasia and assisted suicide. Of the more than twenty organisations representing the medical, aged care and palliative care sectors, not one argued in support of legalising euthanasia and assisted suicide.

All 131 submissions made on behalf of New Zealand churches (100%) were opposed to the Bill, observing that the protection of human life is a fundamental cornerstone of society, and that true compassion means to stand with and hold each other in times of adversity, rather than placing vulnerable people at risk. These submissions were from across all of the mainstream Christian denominations in New Zealand.

There was a submission from a Muslim charitable organisation supported by 13 other Muslim welfare groups and organisations within New Zealand, emphasising that Muslims will never contemplate committing suicide or requesting any form of compassionate killing in a community where the values of duties of care, maintenance, compassion and kindness are a priority.

There was also a submission from a Buddhist group opposed to the Bill.

There were many submissions from people engaged in some way with the disability sector who focused on how disabled people would be impacted by the EOLC Bill. These were overwhelmingly opposed to euthanasia and assisted suicide because of the adverse impacts that it would have on disabled people, irrespective of the scope and specifics of how the Bill in practice might be implemented.

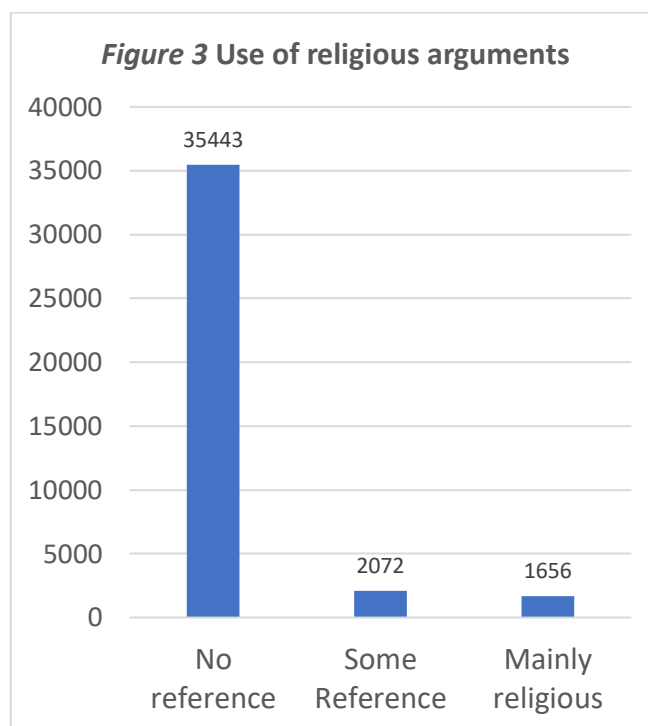
#### *Length and form of submissions*

The average submission was about 250 words in length, and 53,435 pages of submissions were received in total. Most of the 3,141 people supporting the Bill made their submissions electronically. The 34,932 people opposed to the Bill were equally likely to either submit electronically, or in handwritten form which was subsequently scanned and converted to a pdf. This reflects a much broader-based constituency of people opposed to the Bill compared to those in favour.

There were very few instances of pre-prepared or “form” submissions on either side. By and large, everybody who wrote to the Justice Select Committee provided a unique submission outlining their own particular views, convictions, opinions and, for the overwhelming majority, deep-seated concerns about the End of Life Choice Bill.

### Religious arguments

Each submission was assessed for the extent to which, if at all, it made use of religious arguments against euthanasia and assisted suicide. While having personal religious views did not and should not exclude anyone from presenting to the Select Committee, it is useful to know the extent to which written submissions relied specifically upon religious arguments.



In the event, it was found that 90.5% of submissions made no reference at all to religious arguments.<sup>1</sup> Further analysis revealed that religious arguments sat in a largely independent category of thought represented by 5–10% of submitters. There was no systematic connection between their points of view and the broader range of perspectives and concerns represented across the majority of submissions. A small number of submitters in support of the EOLC Bill also made use of religious arguments.

<sup>1</sup> In appendix 1 it can be seen that the “God” theme emerged largely independent of other themes. This means that a small minority brought a religious perspective to their submission, but the large majority relied on a set of arguments and concerns independent of religious thinking.

## Content analysis of submissions

Distilling down and summarising the views of almost 39,000 submitters on a Bill as complex as the EOLC Bill is challenging given the breadth and intertwined nature of the issues, its far-reaching societal impacts, the overturning of long-established medical and health care ethics and codes of practice, and the gravity of a wrongful death.

To assist in this process, a content analysis was carried out on submissions using notes made during the analysis of each submission, aided by a text analytics tool. This allowed the generation of a themes map (appendix 1) highlighting the main insights, perspectives and concerns which emerged from the submissions – and how they are related to each other.

The central argument made by submitters in support of the EOLC Bill was for people to be granted access to lethal drugs administered by a doctor, on compassionate grounds, to relieve pain and suffering in response to a terminal illness, or other irremediable condition. In some instances, they added the opinion that ‘dignity in dying’ could, in some circumstances, only be achieved by such means.

Some talked about palliative care, either to argue that euthanasia and assisted suicide can co-exist with palliative care as “just another treatment option,” or to argue that palliative care cannot provide the desired relief in all cases. It is noteworthy at this point that none of the organisations involved in the delivery of palliative care agreed with the notion that the two can co-exist, highlighting rather that they are diametrically opposed.

A number of submissions made in support argued that giving people the option of ending their own lives, when in the person’s own opinion there was no other means of relieving their suffering, should be legal as is the case in several other jurisdictions overseas.

The arguments advanced by submitters opposed to the EOLC Bill were more wide-ranging, with a focus upon the broader societal and health sector impacts of legalising euthanasia and assisted suicide. They fell into six main categories:

1. Implementing the Bill would lead to multiple adverse societal impacts on vulnerable people including the terminally ill.
2. Experience in the few overseas jurisdictions that have legalised assisted suicide and euthanasia is not reassuring, and it inevitably leads to broadened eligibility criteria.
3. State-approval through legalisation sends a powerful message that assisted suicide and euthanasia are socially acceptable, undermining suicide prevention efforts.
4. Ending patient lives is not a part of healthcare, medical treatment or what doctors are trained to do, and it will erode doctor-patient relationships and trust.
5. Terminating a life through administering lethal drugs is contrary to a medical ethics tradition that can be traced back to the Hippocratic Oath in Greek times.
6. Palliative care properly implemented and resourced adequately relieves suffering and demonstrates true compassion without loss of hope.

The following sections expand upon these six categories which were consistently raised in many submissions, along with illustrative quotes directly from the underlying submissions.

## Theme 1: Adverse impacts on vulnerable people and society overall

A majority of people opposed to the EOLC Bill made various references to what its effect on people in New Zealand would be, with around one third anticipating some form of negative societal impact in the event that the Bill was passed. Others expressed the conviction that vulnerable people across New Zealand would be badly affected one way and another.

Specific groups identified as being placed at risk by this Bill included:

1. Elderly people (with mentions of elder abuse and fear of being a burden specifically)
2. People with mental health issues
3. People suffering from depression
4. Disabled people

Broadly speaking, the concerns related to the generalised adverse social signalling that would follow from allowing doctors to administer lethal drugs to end peoples' lives, and the genuine risk of wrongful deaths as a result of undetected coercion.

### *Illustrative quotes from submissions*

Individual submission [para 3]: "I am also concerned at the effects this law change would have on the way society thinks about caring for people. There is a major social justice issue at stake here, in protecting the vulnerable. Our country invests huge amounts of time and money (as it should do!) protecting the vulnerable in our society - the sick, elderly, mentally ill, young people (including millions of dollars spent trying to prevent youth suicide). Why would society suddenly turn the tables and allow the legalised killing of certain members of society? Especially when there is such an enormous scope for potential abuse? Vulnerable people may feel they are a burden on relatives or the tax-paid health system, and very easily, with state-sanctioned killing, a 'right' to die could become a 'duty' to die." [Link 541](#)

Registered Nurse [para 2]: "Where I work, I have seen people who are suffering and cannot see the light at the end of the tunnel, and who have told me they wish they could die, however I have also seen these same people recover and gain a new lease of life. These are people who would be so vulnerable to this Bill or it's future inevitable expansions." [Link 946](#)

### *Elderly people*

Practicing Geriatrician [para 3.1]: "In my practice as a geriatrician I frequently see cases of people entering residential care, or making health decisions, not because this is their preferred decision, but because it is 'best for the family'. It is important for the committee to note that elder abuse is a) common in society b) frequently unreported and c) most often perpetrated by those closest to the individual. As such these familial reasons quoted for desire of hastened death are highly open to pressure and coercion, which is unlikely to be documented ..." [Link 1156](#)

Individual submission [para 2]: "Supporters of the Bill insist it is creating a choice. No one is going to be forced to commit suicide and the Bill protects against such pressure. This statement is disingenuous. Vulnerable people will feel pressured to commit suicide, and of course they will feel pressured into signing documents attesting to the fact that they are making this choice freely of their own accord. Humans are like that ... We want to leave some inheritance to our children rather than seeing it all go in medical and hospital costs. Innocent people who do not wish to die will die as a result of this Bill. It is impossible to safeguard against people lying about their motivation." [Link 1264](#)

### *People with mental health issues*

Palliative Care Nurses [para 36]: "... there are significant implications for young people in the context of an already growing mental health crisis and high adolescent suicide rate ([Brazier, 2017](#) [page 22]). A law that allows access to assisted dying for people of 18 years places other young people in our society at significant risk. Legislation supporting assisted dying has been associated with an increased rate of total suicides and no decrease in non-assisted suicides ([Jones & Paton, 2015](#)). We acknowledge and support the draft MOH, [NZ Suicide Prevention Action Plan](#), and consider that a law supporting assisted dying would critically undermine suicide prevention strategies." [Link 1956](#)

General Practitioner [para 1]: "As a doctor I have had the privilege of caring for people in immense suffering and seeing people of all ages and identities struggle with physical pain and mental illness. I have seen patients recover from places of immense suffering to enjoy and achieve great things. I have also seen young New Zealanders with so much future potential take their own lives and have lifted a 20-something year old girl up by her legs to take the weight off the noose that was holding her blue head. I find it astonishing that our country is considering legalising euthanasia and to me it is a very scary and sad prospect." [Link 973](#)

### *People with depression*

Herbalist treating people with serious illnesses including neurological conditions and advanced cancer [para 6]: "... after the diagnosis of a serious chronic illness or after an accident that is likely to cause chronic disability, people often become temporarily depressed as they grieve the lost possibilities in their life that they may have had to relinquish due to illness or disability." [Link 2098](#)

Palliative care nurse [para 1]: "A depressed person does not know that their depression may pass and they will feel the joy of living again. They need hope, not an exit strategy." [Link 57](#)

Disability Rights Commissioner: [para 44] "The absence of a specific period to allow reflective consideration of options and choices is concerning. This is relevant in the context of both terminal and non-terminal conditions – both of which are known to give rise to periods of grief, despair and depression of varying intensity and duration. Quick or reactive decisions could be made in times of low mood ..." [Link 1935](#)

### *People with disabilities*

Former OT [para 2]: "For many years I practiced as an occupational therapist in mental health services. I worked with severely disabled and terminally ill people who were challenged by so many aspects of day to day life that we take for granted. I was regularly moved by how most of these individuals were able to make the most of their challenging circumstances through small achievements and nurturing relationships ... It is these people that I worry will be put under stress to end their lives if this bill is passed." [Link 15892](#)

Registered nurse and mother [para 2]: "I am very concerned that this bill will negatively affect the disabled community. I have 3 adult children aged 25, 27 and 33 who have a progressive neurological condition. At times they feel very disheartened and down about their condition and the continuing loss of function it causes. I am very concerned that this bill will devalue their lives and they will feel they are a burden to society. They experience many down times when they possibly would consider ending their life however they bounce back from these times often stronger than how they were before." [Link 993](#)

## Theme 2: Overseas experience not reassuring

About one in ten people opposed to the EOLC Bill made reference to what has happened in countries where euthanasia and/or assisted suicide have been legalised. Many of these specifically identified the Netherlands and Belgium by name, in part because these are the euthanasia regimes closest to that proposed in the EOLC Bill. Three areas of concern in particular were raised by submitters. The first was the evident growth in deaths in the years following legalisation, well beyond the rate of growth in the overall death rate. In the Netherlands for example, there were 2,120 euthanasia deaths in 2007 which grew over a one decade period to 6,585 in 2017.

The second concern raised was that the criteria for eligibility are inevitably expanded over time, because once the door is opened to euthanasia and assisted suicide the arguments for an expanded regime shift from the relief of suffering to a rights-based argument for eligibility so as to avoid discrimination. Submitters opposed to the EOLC Bill made reference to, and in some instances provided evidence for, such a “slippery slope” phenomenon whereby eligibility criteria are increasingly liberalised over time.

The third concern raised in submissions echoes an earlier point about societal shift whereby euthanasia becomes increasingly normalised as the default option for those approaching the end of life, rather than an isolated last-ditch response in extreme circumstances. Many submitters expressed alarm at the seeming inevitability of such normalisation.

### *Illustrative quotes from submissions*

Individual [para 4]: “I do not think the reasons to promote this Bill have validity now and I think in future it will be even less valid as the taking of life would be so open to further exploitation. My reading of data from Holland and Canada indicate the ever increasing numbers of assisted deaths after their legislation allowing termination of life.” [Link 27081](#)

Individual submission [para 2]: “I come from the Netherlands where euthanasia is legal and I have seen the steady progress, in a remarkably short time, from the legalization of voluntary euthanasia with many safeguards to a situation where there have been cases of non-voluntary euthanasia forcefully administered, euthanasia administered for any and every reason where life is considered not sufficiently pleasant, comfortable or secure. There is increasing pressure on those who are aged, sick, impaired or dependent to choose euthanasia rather than be a financial or social burden.” [Link 849](#)

Dutch Professor and former Euthanasia Review Committee member [para 2]: “The fact that PAD is made legal, may have contributed to a gradual paradigm shift from PAD as a last resort to PAD as a default way to die. The fact that the quality of palliative care has become much better in the past 15 years has not prevented the numbers from going up. PAD is increasingly seen not as a last resort but as 'a good death after a trajectory of excellent palliative care' To illustrate: in some Dutch cities, such as Alkmaar and Almere, euthanasia now accounts for about 9% of the total mortality rate. Within these cities, there are postal code areas in which euthanasia accounts for up to 15% of deaths. The consequence may be that valuable knowledge in the field of palliative care will leak away. I conclude that the legalization of euthanasia is not only the end of discussions and not only the official recognition of hitherto unrevealed practice, but also creates new realities.” [Link 25952](#)



### **Theme 3: Assisted suicide and euthanasia undermine suicide prevention efforts.**

A dominant theme in submissions from those opposed to the Bill was concern that State approval of assisted dying sends a powerful message that assisted suicide and euthanasia are socially acceptable, thereby undermining suicide prevention efforts specifically, and the treatment of those who suffer from mental health illnesses more generally. Many people in the front line working with those who struggle with suicidal ideation, anxiety, depression, and mental health issues were deeply concerned about the impact of this Bill and its implicit endorsement that hope can be lost, and that some lives are simply not worth living. A number observed that this was exactly the opposite of what true compassion should be.

Some medical practitioners (including six oncologists) who submitted against the Bill observed that depression and despair are not uncommon reactions when patients are told that they have a terminal illness such as cancer. By working with patients through this initial sadness and despair however, many were able to enjoy months (and in some instances years) of life before finally dying of their illness. Some submitters told of working with young people who struggled with suicidal thoughts, or attempted suicide, but who with good support and loving care were able to come through and experience a better life. Other submitters told of the devastating impact that suicide can have on families and their wider social circles, and expressed the view that adverse impacts upon wider family and friends still occur even when it is an assisted suicide. Some were shocked that, under this Bill, a person could opt for assisted suicide without family or friends being told in advance.

#### *Illustrative quotes from submissions*

General Practitioner South Auckland [para 5]: “I am concerned about the message sent to our youth about the validity of suicide - we are telling youth that suicide is not the answer and yet, saying to our disabled and terminally ill that it is. Those youth that have talked to me about the issue have mentioned the double standard.” [Link 1046](#)

Individual submitters [bullet point 5]: “We question the purpose of such a Bill when it is clear that Government is concerned about so many people – especially young – committing suicide. It seems to us that Government appears to promote a double standard in looking into plans to prevent people from committing suicide yet, at the same time, enabling the law to permit euthanasia. On January 23 of this year, when announcing an inquiry into mental health the Prime Minister stated, “Our suicide rate is shameful.” How can we reconcile this with an attempt to introduce assisted suicide?” [Link 11438](#)

Registered Nurse [para 1]: “I have worked as a registered nurse for the past 40 years, majority of that time spent in Mental health, predominantly acute nursing and for the past 15 year as the sole community mental health nurse for \_\_\_ on the West coast. Over the many years I have nursed probably hundreds of people who have at some time “wished to die” usually in response to severe depression / anxiety or just the burdens of life as we know it. My experience is that most of these people have recovered and gone on to lead normal lives and often spoke of the terrible experience and the disbelief that they could have been so unwell as to think of taking their own lives or wishing that they could simply have the means ‘just to die’.” [Link 12665](#)

Individual submitter [para 3]: “I disagree with the agents of the State being involved in intentionally ending the lives of some of its citizens.” [Link 7225](#)

Registered Nurse [para 2]: “I am a registered nurse and so I do see a lot of suffering. In my particular place of work I have seen a lot of attempted suicides and while you do understand the patient's suffering that led up to their suicide attempt and feel your heart break for them, what breaks my heart even more is to see the hurt of the friends and family members of the patient. They are hurt that the person could find no support or hope in them ... They feel betrayed, angry, and sad. Suicide may have made the patient relieved of their suffering, but it creates a whole new kind of suffering for their loved ones. I feel that the assisted suicide bill would be no different in its effects.” [Link 911](#)

Dutch Professor and former Euthanasia Review Committee member [para 7]: “The claim is often made that if we want to prevent violent suicides, we should provide people a way out. The availability of PAD is said to be an alternative for patients who want to have a suicide. This may be true for some. But as for the Netherlands, despite the wide availability of PAD and despite the numbers rising from 1,800 to 6,091 in the period 2007-2016, the number of suicide cases went up by 40%. The rise was all the more significant since in exactly that same period we made assisted dying possible for the categories of people that do commit suicide. I see two reasons for the increase in suicides. First, PAD-procedures (especially for patients with a psychiatric condition) are bound to take weeks and months, which is way too long for a patient with an acute death wish. Second, the ever ongoing discussions and media attention for death as a solution to suffering may contribute to a cultural climate in which death is seen as a solution to any form of severe suffering. This mechanism (‘speaking about assisted dying leads to more death wishes’) was officially suggested by Spokesperson [Jan Latten of the Dutch Bureau of Statistics](#) (CBS) in June 2017, when he presented the latest suicide figures.” [Link 25952](#)

General Practitioner high needs area [para 9]: “[The EOLC Bill] is a massive shift in thinking to the current practice of dealing with a suicidal person. Currently when someone is suicidal I treat them with the aim of recovering from their suicidality and maintaining their safety. Instead, I will have to weigh up whether or not their desire for suicide is reasonable and meets the very broad criteria. The phrases "grievous and irremediable medical condition", "advanced state of irreversible decline in capability" and "unbearable suffering" are very open to interpretation. If their request does meet the criteria, I will then have to actively assist them to die or lead them to someone else who will.” [Link 964](#)

Individual submitter [para 1]: “I strongly oppose the End of Life Choice Bill. I work with high at-risk and behavioural teenage boys. My husband and I have cared for over 400 youth, over 16 years of working as Specialist Caregivers for MVCOT. We have dealt with youth suffering from severe depression, youth who self harm, and many youth who have lost a friend or family member to suicide. I personally lost my Mum to suicide 8 years ago. Hence we are all too aware of the suicide epidemic NZ has. I do strongly believe that by legalising euthanasia, we are sending the wrong message to our youth.” [Link 17075](#)

## Theme 4: Doctor patient relationship

As noted above, 615 medical doctors made submissions to the Select Committee. Of the 598 who had a clear position, 92.4% were opposed to the EOLC Bill. Their general view is that administering lethal drugs to end the lives of patients is contrary to all that doctors stand for and are trained to do. Many cited the [position of the NZMA](#) that “allowing death to occur is fundamentally different from a deliberate act that has the primary intent of terminating life. ... If doctors are authorised to purposefully terminate a person’s life, or help terminate a person’s life, however carefully circumscribed the situation, they acquire an additional role that is contrary to the nature of the doctor-patient relationship.”

Apart from doctors themselves, many other submitters who were opposed to the EOLC Bill made reference to the role of doctors and their longstanding tradition of bringing healing where that remains a possibility, and relief of suffering to those facing life-threatening illnesses. Some made reference to the trust relationship between doctors and patients, and how this would be compromised by the EOLC Bill. The views and opinions of doctors are very influential for many people, and the present law allows for wide ranging discussions between patients and their doctors for care, treatment, symptom management and palliation – while stopping short of considering lethal drugs as “another treatment option.” Changing the law to include this option would place a large burden on doctors, knowing the extent to which patients rely upon their advice and their sensitivity to even subtle nuances in the way that doctors respond to people enquiring about assisted dying.

### *Illustrative quotes from submissions*

Individual submission [para 1]: “With respect to the medical community, our doctors are the very people who should protect, care and heal, and with whom we should have a relationship based on trust. ... Please do not ask those who train to care for us to participate in what they consider to be unethical. Leave them instead to focus on saving lives and providing real care to the dying.” [Link 7906](#)

Pacific Child, Youth and Family Integrated Care Trust [para 1]: “We, as medical doctors and leaders in the Tongan and Pacific community in New Zealand, OPPOSE any and all efforts by the New Zealand Parliament to legalise euthanasia or medically-assisted suicide in the event of a terminal illness or an irreversible condition that makes life unbearable.” [Link 1957](#)

Individual submission [para 2]: “Doctors already have a stressful job. This could add enormously to their stress. ... What a burden for a doctor to carry - knowing they informed someone they had a terminal illness and as a result they chose to end their life when perhaps the illness may not have been terminal after all. This could affect the way doctors diagnose patients, their relationship with the patient and the patient's family.” [Link 7530](#)

General Practitioner [para 6]: “I am greatly concerned how the legalisation of euthanasia will impact doctors and other health professionals across the country. The great majority of New Zealand doctors are opposed to this bill, evidenced by the New Zealand Medical Association's position statement. The legalisation of euthanasia would disregard the opinion of a large, trusted, essential profession and require it to facilitate the very thing it is opposed to. ... None would be impacted as greatly as the palliative care and hospice services which are already understaffed and underfunded for the essential and excellent services they provide.” [Link 973](#)

General practitioner [para 6]: “I am concerned that this Bill fundamentally alters the relationship of doctor and patient from one of trust and power given by the patient to the doctor to strengthen, extend and improve that patient's health/life, to one where the power to end life becomes part of the package. I want to remain totally committed to the LIFE of my patients, not having to then work with them as they decide if they want me to refer them for termination of that life ... I work in a South Auckland low decile practice with mostly Maori, Pacifica and Indian patients. I have not encountered the desire to end life or this intense need for control and autonomy that was present in the previous white middle class practice that I worked in. There seems to be great faith that family can be trusted to be there for them in their dying days, that they will be well cared for.” [Link 1046](#)

Specialist palliative care doctor [final para]: “I believe that there are other ways to deal in compassion with suffering people. I do not believe that changing the Law of the Land is right or needful. On the other hand, it will change our society over the next generations, ethically, relationally, and in medical interactions. I don't believe this has been adequately considered by either the elected representatives who voted for the Bill or by the population as a whole who are afraid of death, the unknown that surrounds it, and do not understand the options already available to manage suffering.” [Link 1487](#)

Public Sector Doctor [para 4]: “this bill asks doctors to put aside their professional opinions and experience and act as handmaidens to others. Assisted dying is provided at the patient's request, regardless of what the doctor, in their professional opinion, thinks is best for the patient. There is no provision for doctors to discuss the benefits and risks of the proposed action and yet this would happen before any other proposed treatment.” [Link 1160](#)

Oncologist [para 2]: “I have been involved in the treatment of cancer patients since 1995 and have as one of my specialty areas, the treatment of patients with high grade, terminal brain cancer. This background has given me the enormous privilege of walking alongside patients and their families at a stressful, harrowing time in the lives and subsequently for many, being alongside them as they die. It is this background which I feel has fashioned my views such that I stand in opposition to “active euthanasia/ physician assisted suicide (PAS)” and wish to submit against Mr Seymour's bill.” [Link 37347](#)

Psychotherapist and Hospice Counsellor [page 2 para 3]: “If health providers do not have the resources to spend the time required to uncover the less conscious suffering of a person, decisions will be made in reaction to minimal superficial information resulting in poor treatment decisions. If decisions to euthanize are made under these circumstances people will die without the opportunity to work through their suffering or to change their mind.” [Link 35070](#)

## **Theme 5: The Bill breaches a long-standing societal and ethical understanding that doctors should not intentionally end a patient's life.**

A number of individual submitters, medical practitioners, and nurses made reference to the millennia-long understanding that a doctor should not administer any lethal substance or otherwise intentionally end the life of a patient. They noted that this ensures continued confidence and absolute trust on the part of patients that medical practitioners and nurses will always act in their best interests, and in accordance with widely accepted bioethical principles. Many affirmed the position of the New Zealand Medical Association, the World Medical Association and other peak bodies in medicine and palliative care which have maintained a longstanding position that euthanasia and assisted suicide are unethical.

Many of the medical doctors who made a submission were concerned about the potential for parliament to impose on New Zealand society a practice that has historically and continues to be seen by the large majority of doctors as totally unethical. They also argued that the conscientious objection provision does nothing to ease the ethical contradiction.

### *Illustrative quotes from submissions*

Medical practitioner [page 3 bullet point 3]: “This bill puts the GP in a conflict between ethics and the law. The law will allow doctors to bring about a patient’s death while our professional bodies regard the practice as unethical.” [Link 2230](#)

General Practitioner [para 2]: “The act of taking somebody’s life through an active process is not a peaceful action. One of the cornerstones of medical ethics is non-maleficence, to do no harm, and it is difficult for me to reconcile this with the participation in the active taking of a patient’s life.” [Link 37321](#)

Individual submission [para 4]: “For doctors to deliberately end the lives of their patients is a contradiction and an affront to their professional ethics. There is no such thing as a right to ask another person to kill you.” [Link 25815](#)

Individual submission community care worker [para 1]: “I oppose the intent of the End of Life Choice Bill because I believe in the value of all life. I believe God made us and we do not get to decide when we are born or when we die ... I work as a carer in the community and see many people suffer with a variety of conditions. Their conditions do not make them any less valuable ...” [Link 3468](#)

Muslim charitable group [page 10 para 7]: “Islam provides ... an atmosphere in which the individual is morally, emotionally and physically supported, more especially by those who suffer ailments and terminal illness. Muslims will never contemplate committing suicide or request for any form of compassionate killing in a community where the values of duties of care, maintenance, compassion and kindness are a priority.” [Link 13](#)

General Practitioner [page 2 para 4]: “Whichever profession is called upon to execute the euthanasia process would severely damage its social trust ... It should be noted that current medical ethics place a responsibility to that ethic above the law of the land. The conflict would be a very negative one for the profession and for our society.” [Link 26378](#)

Registered nurse [para 3]: “I became a nurse to make a positive difference by caring for my patients with the goal of sustaining life, irrespective of the anticipated length of my patients lives. Those two principles, the ending or sustaining of life, are incompatible.” [Link 396](#)

## Theme 6: Palliative care works but needs proper resourcing

A large number of people opposed to the EOLC Bill made reference to aspects of palliative care within New Zealand, and the value of its holistic approach to care for those who need it. These include rapid advances in palliative medicine over recent years, the international standing of the New Zealand palliative care sector, and the emergence of palliative medicine as a specialist field within its own right. Palliative care is strongly linked to the work of hospices around New Zealand, which enjoys a remarkable and sustained level of goodwill and volunteer support from the public. A number of submissions noted that the Bill imposes euthanasia and assisted suicide upon the whole hospice sector, as has happened elsewhere, despite this being contrary to the very essence and approach of hospice care.

Palliative medicine specialists and nurses, speaking from their personal professional experience, argued that no one needs to suffer unbearable pain under well-managed palliative care. There was recognition that the quality and consistency of palliative care services around the country is not yet to the required standard, particularly in rural areas. It was also argued, however, that investing in additional services and qualified palliative professionals to achieve the necessary quality of service is a far more compassionate and effective way to make progress than simply resorting to lethal drugs to end peoples' lives.

Many submitters opposed to the EOLC Bill made reference to the importance of family in walking with a loved one facing daunting circumstances such as a terminal illness. These comments were intertwined with numerous personal accounts of hospice care, and the loving supportive environment provided for the dying person as well as for family members.

### *Illustrative quotes from submissions*

Doctor [para 6]: "I strongly believe that if the public were educated about real palliative care and experience it to the highest standard then they will change their minds about wanting assisted suicide to occur. The public have unfortunately a very wrong and skewed view of palliation. This country needs to place more funding and training into palliation for ALL conditions where the patient has a life limiting disease, not just cancer." [Link 1081](#)

Individual submission [para 2]: "We had my mother-in-law come to stay with us when she knew she had just a few months to live. This bill would have short circuited those last few weeks, she didn't want to be a burden, but it was a time of great love for us all. Yes the whole family put ourselves out to have her there, but it was an enrichment, a deepening understanding of life, and i found it a privilege." [Link 11801](#)

Palliative medicine specialist [para 2]: "I believe that [the Bill] will impact adversely on hospices which currently can be seen as a place of 'safety' for patients. It will impact on my role as a palliative medicine specialist and possibly make the role unsustainable for me personally. I could not and will not refer a patient to medical colleagues for the purpose of facilitating euthanasia." [Link 1128](#)

Public Sector Doctor [para 1]: "... this bill approaches death with an individualistic lens. It fails to speak to the communities and whanau groups that an individual exists within. It extracts death and the individual and places them in a vacuum. Yet death affects those left behind. The way we as a society approach death affects our communities and our nation. Death should not be simply a matter of choice. We must hold it carefully, we must provide love and care to those who are dying, but we must not see it simply as a choice." [Link 1160](#)



## Appendix 2

### Technical note

Submissions were downloaded from the [submissions and advice section](#) of the New Zealand Parliamentary website as they became available until March 22<sup>nd</sup> 2019, using Bill reference 74307. They were sorted into batches for reading and analysis by Care Alliance volunteers. Each analyst was provided with instructions on how to read and extract the required information so as to ensure consistency of approach. The subsequent coding was checked and moderated by Professor Thirkell and combined into a unified dataset for analysis.

Submitters clearly in support of or against the EOLC Bill were recorded directly as ‘support’ or ‘oppose’ respectively. If a submitter made comments about aspects of the Bill without stating their own overall position, they were recorded as ‘neutral/unclear.’ Similarly for submitters who were unclear about their overall position.

Where an uploaded submission provided supporting or supplementary material related to another submission, it was recorded as a ‘supplement.’ Where a covering letter had been uploaded separately from the main submission, this also was recorded as a ‘supplement.’ In some instances a person’s main submission had an identifier appended by Parliamentary staff such as “Supp 1” or similar (389 instances). In this case the covering letter rather than the submission itself was coded as a supplement (192 instances).

Every effort was made to minimise double counting of submissions by this and other means, but it remains possible that a few submissions were double counted. To the extent that this did occur, it is unlikely to affect the proportions of those in support of and against the Bill.

Opposing, supporting and neutral/unclear submissions were included in the content analysis – but supplements were excluded.

There were ten instances where a listed submission could not be downloaded. These were coded as ‘supplements’ and excluded from further analysis.

Final tally to reconcile 39,179 submissions loaded on the JSC site as of March 22<sup>nd</sup> 2019:

Submissions opposed to EOLC Bill	34,932
Submissions supporting EOLC Bill	3,141
Submissions neutral or unclear about Bill	634
Supplements/covering letters/misc	472
<b>TOTAL</b>	<b><u>39,179</u></b>