

Submission to the Health Select Committee
from the
New Zealand Catholic Bishops Conference
in response to
the Committee's Investigation into
Ending One's life in New Zealand

The Petition

“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 Terms of Reference

In order to fully understand public attitudes the committee will consider all the various aspects of the issue, including the social, legal, medical, cultural, financial, ethical, and philosophical implications. The Committee will investigate:

1. The factors that contribute to the desire to end one's life.
2. The effectiveness of services and support available to those who desire to end their own lives.
3. The attitudes of New Zealanders towards the ending of one's life and the current legal situation.
4. International experiences.

The New Zealand Catholic Bishops Conference

The Conference is the national assembly of the Catholic Bishops of Aotearoa New Zealand. There are currently seven bishops in the Conference: Cardinal John Dew (President, Wellington), Bishops Patrick Dunn (Auckland), Stephen Lowe (Hamilton), Charles Drennan (Palmerston North), Barry Jones (Christchurch), Colin Campbell (Dunedin) and Emeritus Bishop Peter Cullinane (Palmerston North).

Our submission

We make this submission on our own behalf and on behalf of the many Catholic priests and Catholic lay people of Aotearoa New Zealand, who accompany the dying and their families as part of their daily lives. We do this work in people's homes, in rest homes, in hospices and hospitals, and our history of involvement stretches back to the early settlement of our country.

Summary of our main points

- The Catholic Church's long involvement in the pastoral care of the dying and their families provides us with strong credentials to speak in societal debates about dying and death.

- The factors that contribute to the desire to end one's life are complex, and include grief in different forms, fear, loss of hope, and a sense of being trapped.
- We know from our experience with the dying that a fearful, vulnerable, powerless person, religious or not, can be brought with good holistic care into a peaceful place where pain is controlled, their circumstances are dignified, and relationships can be enjoyed prior to death.
- The argument that those opposed to the legalisation of assisted suicide do not have to use it narrows assisted suicide down to a matter of individual choice, and ignores the societal effects of the legalisation which will be experienced by everyone, particularly vulnerable groups.
- International experiences show that legalisation leads to normalization, the expansion of eligibility either legislatively or in practice, loss of patient trust in the medical profession, and a climate of fear among the elderly and ill.
- We like to think that as a country we are independent and courageous enough not to follow an international trend that poses significant risks to our people, especially when quality accessible palliative care is a practical alternative.

Euthanasia and assisted suicide

1. The Catholic Church's position on euthanasia and assisted suicide is well known. We believe in the sanctity of life, and that life should be allowed to end naturally.
2. The Church's involvement in the pastoral care of the dying and their families is less well known and often overlooked, yet it provides us with strong credentials to speak in societal debates about dying and death. The Catholic Church has been caring for the dying for centuries, and has played a critical role in the development of hospices and other forms of palliative care, both in New Zealand and overseas.
3. We do not make this submission from a religious perspective; it is being made as a consequence of our experience with the dying and with those who commit suicide and their families. We deal with death every day, and collectively we have seen dying in all its forms.
4. Caring for a person in the final stages of their life is one of the most valuable things we can do. Whether we do it as pastor, medical professional or hospice carer, or as a relative or friend, doing this well is not just a matter of attending to physical needs. The wholeness of a person is at the core of end of life care, because dying involves not just the body, but the psychological, spiritual, social and relational dimensions of the human person.
5. Focusing only on the terminal illness and its manifestations, and searching for a way to avoid them, makes death less than a part of life. We are more than just the body our

genes construct, and we are more than just our actions. We have a transcendent element which is central to being human, no matter what kind of life we have lived or what kind of gifts we have been endowed with, or what faith we have espoused or no faith. This transcendent element belongs as much to the child who is restricted by physical or mental disability as to the greatest orchestral conductor or scientist. This transcendent element is at the heart of our human dignity, and gives a mysterious dimension to death that we need to honour.

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

The data

6. Most poll questions on euthanasia and assisted suicide focus on having a “a painful incurable disease”, as was done in questions Research New Zealand asked in its polls of March/April and June/July 2015¹. The assumption is that this is the scenario which might drive people to think about assisted suicide.
7. The data from Oregon and Washington States consistently show a substantially different picture of why people might choose assisted suicide. In both states “loss of autonomy” is given as their major end of life concern. In 2014 this was the major concern of 96% of people prescribed lethal medication in Oregon² and of 89% in Washington State³. The second major concern was being “less able to engage in activities making life enjoyable” (Oregon 91%, Washington 94%). “Inadequate pain control or concern about it” was an end of life concern for only 33% in Oregon and 41% in Washington.

The Factors

Grief

8. The two key reasons listed by people prescribed lethal medication in these US states centre on loss of independence and loss of the lifestyle previously enjoyed. These are significant losses, as anyone who has suddenly become disabled will confirm, and as with all loss, there is a grieving process. The first loss is related to increasing disability, and loss of things which previously have been enjoyed. This loss may well have begun before the terminal diagnosis or the diagnosis of an irreversible condition.
9. For those with a terminal illness a second more profound loss is also involved, the realisation that life itself will eventually be lost. The grief that arises from knowing that a final goodbye will eventually be said to loved ones, and that this time is in sight, is often compounded by worry about the future of loved ones and how they will deal with absence and grief.
10. Grief processes underlie the “loss of autonomy” and “being less able to engage in activities making life enjoyable” which dominate the reasons why people in states of

¹ Research New Zealand media release “Should Euthanasia be Legalised in New Zealand?” 23 July 2015

² Oregon Public Health Division, Oregon’s Death with Dignity Act – 2014 report.

³ Washington State Department of Health, Death with Dignity Act 2014 report

Oregon and Washington have chosen to seek lethal medication. These deep grief processes can be so existentially painful for some people that their initial response might be to want to end their life.

11. Palliative care recognises and addresses the loss of autonomy experienced by those who are dying. It was explained well by Dr Rod MacLeod in his affidavit for the Crown in the case of Seales vs Attorney-General:

“Palliative care also seeks to address the other symptoms and emotions that patients experience at the end of life. Autonomy has emerged as a modern criterion of moral worth providing the grounds to distinguish between being merely alive and being meaningfully alive. People’s choices at the end of life are often different to those they may make earlier in their life. Patients’ authority to choose what interventions they have, or to refuse interventions, is seen as one way of protecting dignity and autonomy. This provides patients with a sense of control that they may otherwise feel their illness or disease has taken from them. Respecting and reinforcing a patient’s autonomy is a significant part of palliative care.”⁴

12. Palliative care is a layered multi-disciplinary specialty, involving palliative care physicians, nurses, specialist carers, family and volunteers. Priests or other religious ministers are often part of the team, if that is the person’s wish. The palliative care physician’s focus on ensuring that autonomy is respected is complemented by the other members of the team taking time to address grief, healing broken relationships, and bringing the person into a place of peace. Once these factors which triggered an initial desire to end life are addressed, there is almost always a different response, as Dr MacLeod said in his affidavit:

“In my experience I have found it is often common for patients to express a desire to terminate their lives early or want euthanasia or physician assisted suicide in the early stages of their illness or in the initial phase following a terminal diagnosis. However in my experience palliative care patients almost never persist with requests for euthanasia once they are receiving palliative care and have had time to adjust to their new situation.”⁵

Fear

13. In popular Western culture, fear is often present in thinking about death, and especially about the dying process. Fear leads us to develop defences, and to seek to control that which generates the fear. The onset of serious or terminal illness can undermine all our control mechanisms and leave us exposed to the fear, which creates a sense of vulnerability and powerlessness.
14. The phrase “loss of dignity” is often used as a descriptor for what people fear about the dying process. Dignity is something most people find hard to explain, although they can easily identify a situation in which they would experience a loss of dignity. A commonly used definition of dignity is “the state or quality of being worthy of honour or respect”.

⁴ Seales vs Attorney-General, affidavit of Dr R MacLeod 15, 21 May 2015

⁵ Seales vs Attorney-General, affidavit of Dr R MacLeod 28, 21 May 2015

15. In our experience what people fear when they talk about “loss of dignity” are circumstances which they perceive to be humiliating. Loss of control of bodily functions, unbearable pain and mental incapacity are feared not just because they mean dependence on others, but because they are perceived as being profoundly humiliating.
16. People who have this type of fear have often experienced a friend or relative’s death sometime in the past in which one or more of these factors was present. Proponents of assisted suicide have unfortunately increased the fear of death and dying in the community, ignoring the developments which have taken place, and continue to take place, in palliative care.
17. There have been huge advances in palliative care in the last two decades, and not only in the medical aspect. A palliative care team’s role includes addressing these factors, both the physical aspects and the fear of them. They have many ways of doing this and doing it well.

Normal dying is seldom seen in the media, and most people have very little experience of being with a dying person. In fact, normal dying is as Elisabeth Kubler-Ross, pioneer of understanding the dying process described it in 1969 in her ground-breaking book *On Death and Dying*:

“Those who have the strength and the love to sit with a dying patient in the silence that goes beyond words will know that this moment is neither frightening nor painful, but a peaceful cessation of the functioning of the body.”⁶

18. Catholic priests are regularly involved with palliative care teams, working with people of faith and no faith. We know from our experience with the dying that a fearful, vulnerable, powerless person, religious or not, can be brought with good holistic care into a peaceful place where pain is controlled, their circumstances are dignified, and relationships can be enjoyed prior to death. We know that dying this way is a great gift to those who loved the person, and helps their recovery from grief.

Loss of hope

19. Depression is often cited by expert medical people as being a factor underlying suicide or a request for assisted suicide. Depression is a medical condition and needs a professional diagnosis and treatment, all of which are done for the terminally ill by a palliative care specialist as a normal part of their care.
20. As non-medical companions of the dying, we see loss of hope as a significant factor for some patients in making them wish to terminate their lives. Loss of hope is often the product of a sense of being trapped in circumstances from which there is no escape. For people who have all their lives been able to extract themselves, through ingenuity and intellect, from unfavourable circumstances, being unable to extricate themselves from a situation which they view with great negativity is profoundly disturbing. The sense of being trapped and helpless seriously erodes hope, and after all options such as alternative treatments have been exhausted, hope may be extinguished altogether.

⁶ Elisabeth Kubler-Ross, *On Death and Dying*, 1969

21. At the centre of the hope which has been extinguished was the hope of returning to life as it was prior to the terminal diagnosis. The wisdom of a palliative care team lies in adjusting the horizon and the hopes of a dying person, so that hope may focus on different and more relevant goals. These are often more immediate goals, such as looking forward to seeing someone or celebrating a birthday or Christmas. This change in the person's horizon is crucial in building hope and combating helplessness, and it is part of the work of all members of a palliative care team.
22. It takes time and patience to help those who are in a state of hopelessness rebuild hope. We know it can be done, as we see it done and help in doing it in hospices and other places where the terminally ill and those with difficult irreversible conditions are cared for. Our great concern is that if medically-assisted dying was available, there would be reduced motivation to help the terminally ill or those with irreversible conditions to develop new forms of hope and a sense that they still have something to live for. At the same time, and arising out of that concern, we believe that there would also be reduced motivation for those with a life-limiting illness to strive to live on.
23. The government and the community put a lot of resources into rebuilding hope in those who are suicidal but not terminally ill or with irreversible conditions, particularly young people. At the heart of our societal ethic is the belief that all human beings, of whatever age or physical condition, deserve the same treatment and the same care. That consistency in our valuing of life would be seriously undermined by working hard to prevent one group of people who have lost hope from dying, while facilitating the dying of another group who have lost hope.

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

24. New Zealand has an advanced palliative care network which cares for people who are terminally ill and their families.
25. Hospices in particular have a well-proven track record in the provision of holistic care for the dying. There are 29 hospices, from Kaitaia to Invercargill, and no barriers to accessing them, thanks to the community fundraising which supplements government funding. The extension of palliative care to aged care homes through the Fundamentals of Palliative Care package developed by the Ministry of Health and Hospice NZ has further extended the reach of palliative care services, essential as one-third of people dying in New Zealand die in aged care homes and are cared for there in the later stages of dying.
26. However in our experience there is a patchiness in the provision of services and in the quality of care which needs to be addressed. It is encouraging to see that this has been noted in the Terms of Reference for the Review of Adult Palliative Care services which will report to the Minister next year. In particular, recent studies by Auckland and Waikato Universities have identified issues for Maori in accessing and benefiting from

palliative care services. We assume these will be addressed in the Review, along with wider issues of access and quality.

27. Palliative care providers can – and do – address the issues for those in their care who wish to end their lives, and terminally ill people rarely wish to end their lives once palliative care is established. We would hope that the government continues to review and upgrade services to those who are chronically ill, looking to provide them with a holistic service which parallels that which is available to people who have terminal illnesses. People who have “an irreversible condition which makes life unbearable” can suffer from the same grief, fear and loss of hope as those who are terminally ill, and need a similar level of support.
28. It is our observation from our pastoral experience that where a chronically ill or severely disabled person is cared for in a loving and supportive environment, they seldom wish to end life. The desire to end life is almost always an indicator that something is missing in their care, and often that psychological and emotional issues have not been sufficiently addressed.
29. Our concerns for the chronically ill or severely disabled include ensuring adequate provision is made for the physical and mental wellbeing of the carers, who are often family members. Financial and time-out support, together with good medical care for the chronically-ill person, are vital if care is to be effective and to continue for long periods of time. The effectiveness of care for the ill person must be supplemented with good care for the primary carer.
30. “The effectiveness of services and support available to those who desire to end their own lives” in the terms of reference is not the same statement as “The effectiveness of services and support available to those who are terminally ill or who have unbearable irreversible conditions”. The statement in the Terms of Reference indicates that the Committee (rightly) intends to take into account *all* people who seek to end their own lives, not just those who are incurably or terminally ill. We are aware that the New Zealand government takes suicide prevention seriously, as evidenced by the New Zealand Suicide Prevention Strategy 2006-2016, and the current New Zealand Suicide Prevention Action Plan 2013-2016. The Minister’s Foreword to the current Action Plan sets out the size of the issue:

“Every week, on average, 10 people die in New Zealand by suicide. Many more are treated in hospital after a suicide attempt, having seriously harmed themselves. Suicide is devastating for all those personally affected and a tragedy for our society as a whole. Suicide rates have fallen by almost 24 percent since the peak in 1998, but they are still far too high. Sadly, we have some of the highest youth suicide rates in the developed world, and suicide rates for Māori are 54 percent higher than for non-Maori.”⁷
31. At government level there has been a determined effort for a number of years to reduce the rate of suicide. The Action Plan acknowledges the many reasons why a person might seek to end his or her life:

⁷ Ministry of Health 2013, New Zealand Suicide Prevention Action Plan 2013–2016, Foreword, Hon Peter Dunne

“Multiple risk factors and life events are involved in a person ending their life. The link between mental illness and suicidal behaviour is well known, but other risk factors include exposure to trauma, a lack of social support, poor family relationships and difficult economic circumstances.”⁸

These factors apply equally to persons with a terminal or life-limiting illness.

32. Suicide is a great burden for the family of the person concerned, and we absolutely support government and community initiatives designed to lessen the number of suicide attempts and the deaths from this cause. There were 564 suicides in the 2014-2015 year, and although this is higher than 2013-2014, the number has been in the 500s since the Chief Coroner began releasing annual provisional suicide statistics in 2007.
33. The relatively static nature of the number of suicides indicates that measures being taken are effective, but there is more to be done and the situation could easily be reversed. It would be risky and potentially counter-productive to introduce legislation which facilitates some people legally taking their lives, in contradiction to the substantial efforts being made to keep others alive. The contradiction lies in trying to prevent one group from taking their lives while seeking to assist another group of people to die, when both groups have underlying issues (such as fear, depression, and loss of hope) that are very similar in many cases.

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

34. There have been a number of polls over the years seeking information about New Zealanders attitude to ending one’s life, such as Heylen (1988), Morgan Gallop Poll (1991), NZ Herald Digipoll (2000, 2012), Massey University Department of Marketing (2002, 2008), Colmar Brunton (2008), Research New Zealand (2010, March/April 2015, June/July 2015).
35. These polls have asked similar questions and have similar results, with the conclusions generally being that a majority of New Zealanders are in favour of the legalization of assisted suicide or euthanasia. There is little, if any, polling or analysis of which ethnicities are favouring a change in legislation in New Zealand, and why.
36. The statistics from the States of Oregon and Washington in the USA, where assisted suicide was legalised in 1997 and 2009 respectively, provide detailed information about those who requested lethal doses of medication from a physician.
37. In Oregon in 2014⁹ there were 105 approved requests for lethal medication. In terms of ethnicity, 100 (95.2%) of the requests were from white Americans, with no requests from African Americans, American Indians, or Pacific Islanders. There was one request from a Hispanic person.

⁸ New Zealand Suicide Prevention Action Plan 2013–2016, Introduction

⁹ Oregon Public Health Division, Oregon’s Death with Dignity Act – 2014 report.

38. In Washington State in 2014¹⁰ there were 163 approved requests for lethal medication. Of these 156 (95.7%) were “non-Hispanic white”, and 12 (7.3%) were from “Hispanic and/or non-white”.
39. The white non-Hispanic percentage of the population of Washington State is 70.4%, and of Oregon State it is 77%. Because of the ethnic composition of these states it is to be expected that the majority of people receiving approval for lethal medication would be “white”. However “white non-Hispanics” are significantly over-represented in requests for lethal medication compared to their percentage of the population, in both states.
40. These statistics strongly suggest that there is a cultural component in support for assisted suicide. It is hard to obtain recent statistics about support for assisted suicide by ethnicity in New Zealand, but the Washington/Oregon statistics suggest that polls in New Zealand (which do not usually look into ethnicity) are at least in part reflecting the dominance of New Zealanders of European descent in the population (69% in the 2013 census).
41. If these polls are used to claim that assisted suicide should be legalised in New Zealand because there is majority support for it, it is tantamount to one culture imposing its will on other cultures through sheer numbers. Of particular concern is the lack of attention given to Maori attitudes towards the legalisation of assisted suicide. Maori constitute 14.6% of the population, but their status as the indigenous people and Treaty partner with the Crown means that their input and influence has to be about more than mere numbers.
42. It could be argued that ethnicities which are smaller in numbers should not be able to deny the majority ethnic group the choice of assisted suicide, the argument being that those who oppose the legalisation of assisted suicide do not have to avail themselves of it. This argument narrows assisted suicide down to a matter of individual choice, and ignores the societal effects of the legalisation which will be experienced by everyone. The subtle pressure on the disabled, elderly and terminally ill to end their lives constitutes a harm to the common good, and to the equality and value we place on the life of every New Zealander, whatever their age or level of ability.
43. The polling of NZ Research in March/April and June/July 2015 provides a cautionary note to the question of support for assisted suicide in New Zealand. The two polls used the same questions and methodology and were carried out after the situation of Ms Lecretia Seales became prominent in the media and about three weeks after Justice Collins ruled and Ms Seales died. NZ Research provided this analysis of the results of the two polls:
- “Support for the legalisation of euthanasia decreased between March/April 2015 and June/July 2015. As shown in Table 1, 74 percent of respondents in March/April reported that doctors should be legally able to end a patient’s life if the patient requests it, whereas in June/July, 67 percent believed that this should be allowed.

¹⁰ Washington State Department of Health, Death with Dignity Act 2014 report

The decrease in support may reflect a more considered judgement of this issue amongst the general public following Lecretia Seales' case, the ruling and her natural death.

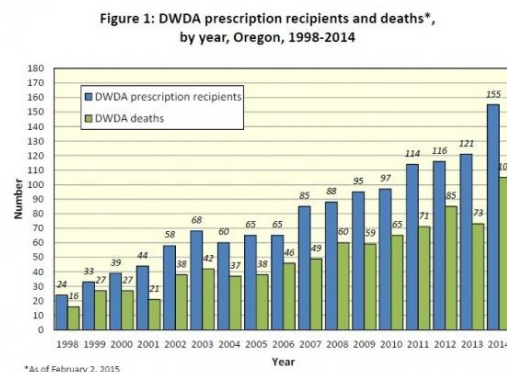
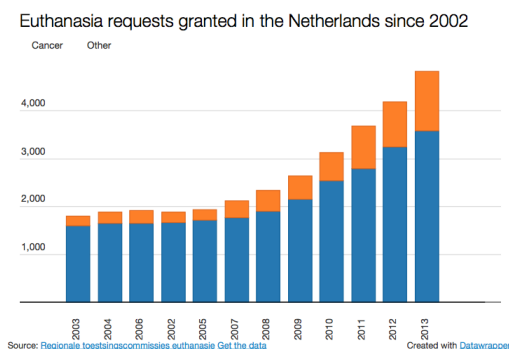
Support for other people being able to euthanize a terminally ill person also appears to have decreased since March/April 2015 (refer Table 2), although the difference is not quite large enough to be statistically significant. Thus New Zealanders remain divided as to whether other people (e.g. close relatives) should be able to help end someone's life, if a person has an incurable disease and wishes to end their life."¹¹

4: International experiences

44. The international experience of euthanasia and assisted suicide is cause for great concern, for the following reasons:

The normalization of euthanasia and assisted suicide

45. The graphs below clearly show the increase in the numbers since assisted suicide was introduced in Oregon in 1998, and euthanasia and assisted suicide were introduced in the Netherlands in 2002.



46. In countries and states which have legalised either euthanasia or assisted suicide, or just assisted suicide, there have been startling increases in the number of people choosing to die in this way. The increase in numbers is out of all proportion to population increase, and can only be properly accounted for in terms of an ongoing expansion of the parameters surrounding eligibility – a phenomenon referred to as “bracket creep”. As noted in a 2010 Report on Euthanasia in Belgium by the European Institute of Bioethics: “Initially legalised under very strict conditions, euthanasia has become a very normal and even ordinary act to which patients are deemed to “have a right”. In the face of certain high profile cases the evident relaxation of very strict conditions has caused many reactions, but also a total absence of any sanctions on the part of the Commission and a very conciliatory silence from the political establishment has given rise to a feeling of impunity on the part of some concerned medical practitioners, and a feeling of powerlessness in those worried about where things are leading”.¹²

¹¹ Research New Zealand media release “Should Euthanasia be Legalised in New Zealand?” 23 July 2015

¹² European Institute of Bioethics Dossier: “Euthanasia in Belgium: 10 years on”, April 2012

47. The increase in numbers indicates that assisted suicide and/or euthanasia have been normalised, and are now even expected in some circumstances.

The effect on the medical profession

48. When assisted suicide and euthanasia are considered to be rights they cease to be the exceptions most laws originally envisaged. The normalisation of assisted suicide and euthanasia and their definition as rights has imposed obligations on doctors to take part in assisting people to die, which are in direct opposition to the nature and ethos of the profession.

49. The elderly and sick have reason to fear doctors who can propose and even subtly persuade vulnerable people to consider ending their lives. The status of a doctor can easily make a suggestion into an obligation, given the power imbalance between a vulnerable person and their doctor.

The expansion of eligible circumstances

50. The original safeguards built into the Belgian and Dutch legislation have in practice over the years become ineffective. The narrow target group of the terminally ill has expanded to include those suffering from psychiatric conditions, dementia and those who are simply old, lonely or have been bereaved. The expansion to include teenagers, children and babies is particularly horrifying.

51. In theory in Oregon those eligible for assisted suicide must have less than six months to live. A footnote in the Oregon annual report for 2014 relating to the category “Other illnesses” (16.9% of lethal prescriptions) describes these other illnesses as “benign and uncertain neoplasms, other respiratory diseases, diseases of the nervous system (including multiple sclerosis, Parkinson's disease and Huntington's disease), musculoskeletal and connective tissue diseases, viral hepatitis, diabetes mellitus, cerebrovascular disease, and alcoholic liver disease”.¹³ These may be illnesses which shorten life, but it is hard to believe that the people concerned were all terminally ill.

52. Support for euthanasia or assisted suicide among the general population is often contingent upon strict controls being in place, and controls which are seen as being strong may be the swing factor for some politicians in voting upon this issue. Belgium and the Netherlands began with what were thought to be strict controls, but over the years there has been a progressive widening of eligibility through changes to the legislation. In Oregon the controls remain in place in the legislation but there has been a widening in the interpretation of the legislation and in the practice of physicians which have effectively undermined the strict controls on eligibility.

The climate of fear

53. The normalization of euthanasia and assisted suicide in places where it has been legalized change the societal perception of those who are ill, disabled, or elderly. Rather than being valued members of the community, they are more likely to be seen and to

¹³ Oregon Public Health Division, Oregon's Death with Dignity Act – 2014 report, page 6

see themselves as a burden. The fear of being a burden is well documented as a reason for people choosing assisted suicide or euthanasia. In Belgium and the Netherlands these vulnerable people rightly fear euthanasia itself, and there is documented evidence of persons being killed without their consent. Family and societal pressures are exercised subtly rather than overtly, which compounds the fear of those whom others might view as a burden. The question becomes who a vulnerable person can trust to act in their best interests, if family and doctors cannot be trusted. That is a point of utter loneliness which no elderly, ill or disabled person should have to experience.

The potential increase in suicides

54. In the 10 October 2015 edition of the Southern Medical Journal research titled “How Does Legalization of Physician-Assisted Suicide Affect Rates of Suicide?” was published. The aim of this study was to examine the association between the legalisation of Physician-Assisted Suicide (PAS) and state-level suicide rates in the United States between 1990 and 2013. In particular it aimed to test claims that legalization of physician-assisted suicide could lead to a reduction in total suicides and to a delay in those suicides that do occur. The conclusion from the study was:

“Legalizing PAS has been associated with an increased rate of total suicides relative to other states and no decrease in non-assisted suicides. This suggests either that PAS does not inhibit (nor acts as an alternative to) non-assisted suicide, or that it acts in this way in some individuals but is associated with an increased inclination to suicide in other individuals.”¹⁴

55. In our experience suicide creates deep emotional wounds and does huge relationship damage in families. We lose more than 500 people to suicide every year, leaving behind networks of friends and family who can take years to recover. Apart from the real loss of so many of our people to suicide, there is a loss to the community in the very real devastation suffered by those close to the person who committed suicide.

56. Research such as that outlined above indicates a need for great caution in doing anything which might give those contemplating suicide a greater impetus to act.

Conclusion

57. The precautionary principle is widely used by the New Zealand government in policy areas such as fisheries, environmental management, public health, conservation and biosecurity. Risk management is integrated into every area of public policy. The experience of countries and states which have legalized euthanasia or assisted suicide or both clearly shows that it poses considerable risks.

58. We are deeply concerned about the risk to the vulnerable people we work with every day, those who are elderly, disabled, chronically ill, depressed or suicidal. Our concern includes those who think that there is no way to deal with their terminal or incurable illness other than by assisted suicide, and those who are not ill but who have a great fear of dying perhaps because of an experience in the past.

¹⁴ A Jones and A Paton, Southern Medical Journal, “How does Legalization of Physician-assisted Suicide Affect Rates of Suicide?” 2015

59. We like to think that as a country we are independent and courageous enough to go against an international trend or pressure from other countries. Why do we need to follow an overseas trend riddled with risks to vulnerable groups in our society, when there is a practical alternative? Quality accessible palliative care addresses the underlying problems which lead people to believe their only option is kill themselves, and helps people to die well. In terms of good risk management, it eclipses the easy and dangerous route of legalizing euthanasia or assisted suicide.
60. In the light of our experience with the ill and dying, it is our considered view that euthanasia and assisted suicide are both unnecessary and dangerous. We strongly recommend that the Health Select Committee rejects the possibility of changing the current legislation, and instead recommends that more resources are made available across New Zealand for services to support those with chronic and terminal illnesses.