



Attitudes of New Zealand doctors and nurses towards legalising assisted dying - Report to New Zealand medical and nursing associations

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A. Acknowledgements

We wish to thank the 969 nurses and doctors who participated in this research, in particular for the often lengthy and always valuable comments that many respondents made to the open questions. Our gratitude goes also to the nursing and medical professional bodies who agreed to support the research by disseminating an invitation to take part to their respective members. We hope that the following information is of value to your consideration of the issues in legalising assisted dying.

This report summarises the research findings for the purposes of providing feedback to the professional bodies and to participants through those bodies.

B. Executive summary

Key findings are as follows:

- Consistent with other recent New Zealand studies, 37% of doctors responding to the survey “strongly” or “mostly” agreed that AD should be legalised in New Zealand, assuming provision of appropriate guidelines and protocols. In contrast, two thirds of nurses agreed that AD should be legalised here.
- Respondents’ main reasons for wanting legal AD revolved mainly around four factors: a belief in people’s right to autonomous decision-making at the end of their life, irrespective of health practitioners’ beliefs; philosophical beliefs about personal dignity and a perceived right for people to avoid unnecessary pain and suffering at end of life; respondents’ professional or personal experiences of witnessing severe suffering at end of life; and a perceived failure of some health practitioners to acknowledge medical futility, resulting in suffering through prolonging people’s lives.
- Respondents’ main reasons for not wanting AD legalised mostly concerned: a belief that undertaking AD functions was not a proper role for health practitioners; a belief that vulnerable people will be pressured to end their lives prematurely; respondents’ professional experience with and/or belief in the adequacy of good palliative care; and moral/ethical (non-religious) objections to legal AD.

- The main influences on both doctors' and nurses' views about legalising AD related to their personal philosophies and ethical beliefs, clinical experiences and personal experiences. Respondents' religious beliefs and the stance of their professional associations were of notably less importance. Just over half of doctors and two thirds of nurses had been influenced by research evidence.
- Doctors' and nurses'¹ approval of making legal AD available was not limited to people with a terminal illness, but extended to people with multiple aging-related comorbidities and to people in a persistent vegetative state or suffering from dementia where the person had made a valid advance directive.
- Nearly one in 10 doctors responding to the question about actual provision of AD had at some time either provided or administered a lethal dose of medication to help someone to have a hastened death, and nearly one percent had done so "several" or "many times".² This finding, supported by a *NZ Doctor* survey in July 2015, shows that the number of doctors either providing AD or being willing to report doing so has doubled in the past decade. Some nurses had also provided AD.
- Seventy-five percent to 90% of doctors and nurses reported feeling comfortable considering AD for themselves and/or supporting it for a family member.
- Two thirds of doctors were willing to write a prescription for a lethal dose where a patient had met the eligibility requirements, and 43% of nurses were willing to undertake that role if it were legally authorised for their profession. Over half of doctors and two thirds of nurses (if so authorised) were willing to administer AD via either injection or intravenous line. Large percentages (86-96%) of both doctors and nurses were willing to discuss AD with patients, provide information about AD to patients and refer them to another practitioner if needed. A majority of both doctors (63%) and nurses (76%) were willing to attend an assisted death by self-administered ingestion
- The most common reasons why both doctors and nurses might be deterred from participating in legal AD were a lack of authorised guidelines for undertaking AD safely and competently, a lack of training and skills and a lack of support from their profession. Personal philosophical objection to AD was the least common reason why doctors and nurses might be deterred from taking part in AD.
- Large majorities of both doctors and nurses voiced a need for a range of protections to support their participation in legal AD, in particular: training for AD skills; authorised guidelines from their regulating bodies; immunities from prosecution; the option of conscientious refusal and referring patients to another professional; mentoring; and a statutory body to check compliance by health practitioners with the legal requirements.

Note, while no survey can claim to be entirely representative of the population, the results from this research appear to show that there is a significant cohort of doctors and nurses in New Zealand who support legalising AD and potentially sufficient to ensure that there will be enough health practitioners available for that eventuality. It is noteworthy to see the emphasis in respondents' answers below on wanting strong accountability processes and professional supports for the safe provision of AD.³

¹ Responses to the remainder of the questions (that is, Q5 onwards) did not include respondents who had answered 'strongly disagree' to the initial question Q1(h) (see Appendix), as the remaining questions were irrelevant to such respondents.

² Respondents could select only one of the response options (from 'never' to 'many times').

³ All survey responses on 16-19 October 2015 were removed from the analysis, due to notice of two faked responses by a TVNZ reporter between those dates.

C. Background and rationale for the research

Legislation to regulate assisted dying (AD) has been increasing internationally in the past two decades, with more than a dozen countries and state jurisdictions legalising AD with varying regulatory regimes⁴. While there is no reference to either euthanasia or AD as such in New Zealand's laws, there are a number of legal provisions that show that assisting a person to take their own life is unlawful here⁵. Surveys over the past 20 years have revealed strong and increasing public support for AD across developed nations^{6 7}. The attitudes of the New Zealand public have been canvassed in a variety of ways over the past decade or so, including opinion polls undertaken by the media^{8,9}, surveys undertaken by the Voluntary Euthanasia Society¹⁰, and some research¹¹. The research findings suggest a strong desire for AD to be legalised in New Zealand. A recent New Zealand study¹² of general practitioners' (GPs) views and conduct in relation to AD found that 4.5% "attributed the patient's death to a drug that had been prescribed, supplied or administered explicitly for the purpose of hastening the patient's death", and nurses were identified by some GPs as the agent who administered a drug with the explicit purpose of hastening the patient's death. These findings mirror results reported in New Zealand in 2004¹³. Most of New Zealand's professional medical bodies have consistently either voiced opposition to AD or declined to take a stand on the matter, and none of these organisations has as yet considered its potential role in providing guidelines for its members in the anticipation of AD being legalised in this country.

Bills for legal AD have been debated twice by the New Zealand Parliament. The first Death with Dignity Bill, introduced by then National MP Michael Laws in 1995, was soundly defeated (61:29 votes). In 2003 a modified Death with Dignity Bill with more stringent eligibility measures was defeated only narrowly, by 60 votes to 58 (with one abstention and one failure to vote or register a proxy). In 2012 the End of Life Choice (EOLC) Bill was submitted to the Members' Bills Ballot by then New Zealand Labour Party List MP Maryan Street but withdrawn prior to the national election in 2014. Subsequent to the Labour Party's decision following that election that legalising AD was not amongst its immediate priorities, a new campaign emerged.

Key components have included Lecretia Seales' High Court challenge (*Seales*)¹⁴, a petition

⁴ Since 1997, 10 jurisdictions – Belgium, The Netherlands, Luxembourg, Albania, the United States (US) states of Oregon, Washington and Vermont, and most recently Colombia, California, and the Canadian province of Quebec - have joined Switzerland in legalising AD, with varying regulatory regimes. The United Kingdom (UK) and Israel have private members' Bills being reviewed through select committee processes, and Canada's new legislation, prompted by the 2015 decision in *Carter v Canada*, is being drafted federally.

⁵ New Zealand Government. "Crimes Act 1961." In 43, edited by Parliamentary Counsel Office. New Zealand Government: <http://www.legislation.govt.nz/act/public/1961/0043/latest/DLM327382.html>.

⁶ Duggan, Andrew. "In U.S., Support up for Doctor Assisted Suicide." Gallup survey, 2015. Accessible at: <http://www.gallup.com/poll/183425/support-doctor-assisted-suicide.aspx>.

⁷ ABC News. "Survey Shows Support for Legalised Euthanasia." 2012. Accessible at: <http://www.abc.net.au/news/2012-11-16/survey-shows-australian-support-for-legalised-euthanasia/4376524>.

⁸ Gower Patrick. "Poll: Kiwis Want Euthanasia Legalised." Newshub. 2015. Accessible at: <http://www.newshub.co.nz/nznews/poll-kiwis-want-euthanasia-legalised-2015072717#axzz44X1qpEHx>.

⁹ Johnston Martin. "Legalising Euthanasia Wins Huge Support." *NZ Herald*, 2010. Accessible at: http://www.nzherald.co.nz/nz/news/article.cfm?c_id=1&objectid=10660398.

¹⁰ Horizon Research Limited. "New Zealanders' Views on End of Life Choices." 1-29. Auckland: Horizon Research, 2012. Accessible at: <https://www.horizonpoll.co.nz/attachments/docs/horizon-research-end-of-life-choices-survey--1.pdf>.

¹¹ Rae, Nicola, Phillipa J Malpas, and Malcolm H Johnson. "New Zealanders' Attitudes Towards Physician-Assisted Dying." *Journal of Palliative Medicine* 18 no. 3 (2015): 259-65.

¹² Malpas, Phillipa J., K. Mitchell, and Heidi Koschwanez. "End-of-Life Medical Practices in General Practice in New Zealand - 13 Years On." *New Zealand Medical Journal* 128, no. 1418 (2015): 29-36.

¹³ Mitchell, Kay, and Glynn Owens. "End of Life Decision-Making by New Zealand General Practitioners: A National Survey." *New Zealand Medical Journal* 117, no. 1196 (2004).

¹⁴ SEALES v ATTORNEY-GENERAL. "Judgement of Collins J." In 1239 edited by NZHC, 1-55. Wellington Registry,

launched but the Voluntary Euthanasia Society New Zealand (VESNZ) that resulted in a Parliamentary Health Committee Inquiry¹⁵, and the submission of a new End of Life Choice Bill¹⁶. Irrespective of the outcome of the Health Committee Inquiry, anticipated for the middle of 2016, it appears unlikely that the issue of AD will disappear from the New Zealand stage any time soon.

The experience internationally shows that, in countries that have legislated specifically for legal AD, there are a number of ways in which the primary intent of the legislation - that is, to assist people experiencing major suffering to ease that suffering through proactive medical intervention to hasten their death - has been frustrated by a range of factors, some foreseen and others unforeseen¹⁷. Moreover, it is apparent that there are major barriers for doctors and other health practitioners who wish to participate in legal AD¹⁸. Barriers for doctors include difficulties with the interpretation of legal terms and concepts, including how to interpret legal requirements, such as what constitutes sufficient evidence of 'unbearable' suffering or a 'terminal' illness¹⁹. Other barriers to participation in legal AD experienced commonly by doctors are the absence of authorised guidelines, protocols and training for safe provision of AD services, a fear of professional stigma and/or censure, fears of making professional errors, and collegial or employer pressure to not engage in providing AD.²⁰

The present research explored the attitudes of New Zealand doctors and nurses towards legalising AD in New Zealand, potential barriers to doctor and nurse engagement in legal AD, and ways in which such barriers might be mitigated. In particular, the research sought information on the following topics:

1. What are New Zealand doctors' and nurses' views of legalising AD in New Zealand?
2. What end-of-life practices, including AD, occur currently in doctors' and nurses' practice?
3. What factors influence the attitudes and practices of doctors and nurses in relation to end-of-life (EOL) practices?
4. In what circumstances might doctors and nurses be willing to engage in legal AD?
5. What would deter doctors and nurses from engaging in legal AD?
6. How might barriers to health practitioner participation be mitigated?
7. What do doctors and nurses see as the responsibility of their professional bodies in relation to legalised AD?

D. Research methodology

Doctors and nurses were invited to take part in an online questionnaire survey in

2015.

¹⁵ New Zealand Parliament "Make a Submission: Petition of Hon Maryan Street and 8,974 others" www.parliament.nz.

¹⁶ End of Life Choice Bill, 14 October 2015 <www.parliament.nz>.

¹⁷ Oliver, Pam "Another week? Another week! I can't take another week' Addressing barriers to effective access to legal assisted dying through legislative, regulatory and other means" (A thesis submitted in fulfilment of the requirements for the degree of Doctor of Philosophy in Law, The University of Auckland, 2016).

¹⁸ Buiting, H. M., J. K. Gevers, J. A. Rietjens, B. D. Onwuteaka-Philipsen, P. J. Maas, A. Heide, and J. J. van Delden. "Dutch Criteria of Due Care for Physician-Assisted Dying in Medical Practice: A Physician Perspective." *Journal of Medical Ethics* 34, no. 9 (2008): e12; Gordijn, Bert, and Rien Janssens. "Euthanasia and Palliative Care in the Netherlands: An Analysis of the Latest Developments." *Health Care Analysis* 12, no. 3 (2004): 195-207; Oliver, P (2016) Ibid.

¹⁹ Pasman, H R W, M L Rurup, D L Willems, and B D Onwuteaka-Philipsen. "Concept of Unbearable Suffering in Context of Ungranted Requests for Euthanasia: Qualitative Interviews with Patients and Physicians." *BMJ* 339, no. b4362 (2009).

²⁰ Oliver, P (2016) Ibid.

October/November 2015²¹. The invitation was disseminated through the electronic newsletters and websites of key New Zealand medical and nursing professional bodies (colleges and associations, including Australasian bodies, with invitations to registered New Zealand practitioners only). The survey²² was anonymous and was approved by the University of Auckland Human Participants Ethics Committee²³ prior to dissemination. Four prize draws of a \$100 donation to a registered charity of the practitioners choosing was included as an incentive.

To inform the survey questions and structure, a review was undertaken of the literature on surveys of doctors' and nurses' attitudes towards AD internationally and on the development of professional supports for doctors and nurses participating in legal AD in North America and Europe. Rating scales and other closed-ended response options were employed for the majority of questions, to minimise the time required to complete the questionnaire, and augmented by open-ended questions for respondents to voice independent views. All survey questions had response options that allowed for the full range of views, from 'strongly agree' to 'strongly disagree', with options to omit the question if preferred²⁴. The survey was piloted with five doctors and five nurses working in a variety of specialties including general practice, general medicine and palliative care. Minor adjustments were made to refine the survey questions. Depending on how much each respondent wanted to contribute open-ended responses, it was estimated the survey took from 15 to 30 minutes to complete.

Data analysis combined qualitative and quantitative approaches²⁵. The quantitative analysis focussed on response frequency and percentage counts. Cross-tabulation was used for selected variables of interest relevant to particular question topics. Tests of significance for correlations were not performed for the purposes of this report, as the variation in responses was evident without doing so. Respondents' comments were analysed using thematic analysis.²⁶

Research focus and objectives

The research sought to:

- Establish a clear baseline of doctors' and nurses' viewpoints, for the purposes of (1) understanding the likely response of both professions to legalising AD in New Zealand, (2) understanding the likely support needs of both professions in a legal AD context, and (3) monitoring those attitudes and views over the next decade
- Provide information to the various medical and nursing associations and colleges on their members' views and anticipated support needs
- Clarify levels and kinds of support for or opposition to legalising AD in New Zealand, to inform the health sector and politicians.

²¹ See Appendices.

²² See Appendices.

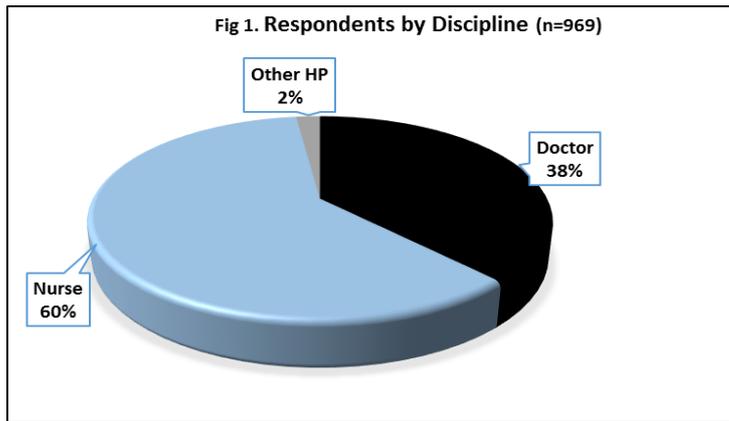
²³ UAHPEC Reference: 015470.

²⁴ E.g. 'not applicable', 'don't know', 'not sure', 'prefer not to answer'.

²⁵ All survey responses from 16-19 October 2015 were removed from the analysis, due to notice of two faked responses by a TVNZ journalist between those dates.

²⁶ Patton, Michael Quinn. *Qualitative Research and Evaluation Methods: Integrating Theory and Practice*. Los Angeles: Sage, 2015. Chapter 8. Qualitative analysis and interpretation.

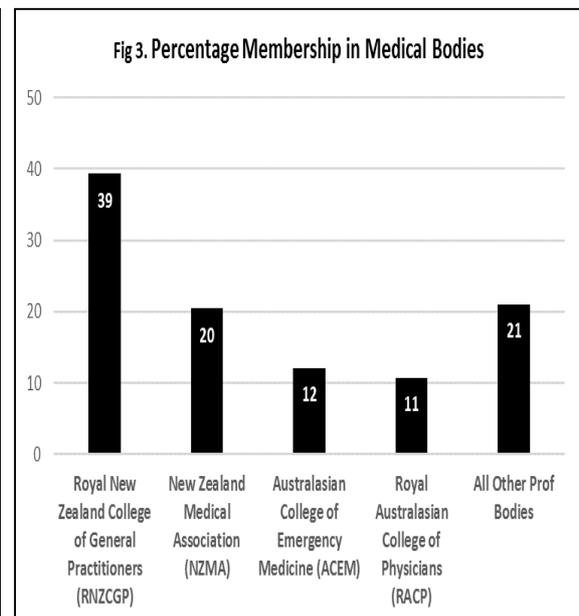
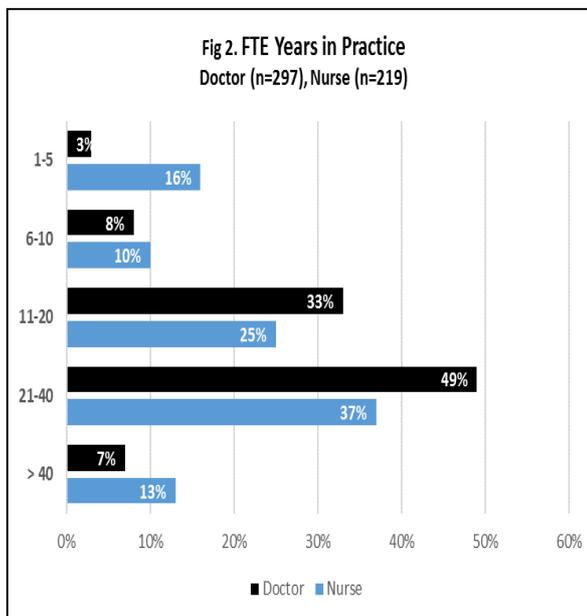
Respondent demographics



The survey returned a total of 969 responses, comparable with similar surveys internationally, with 38% from doctors, 60% from nurses and 2% from a range of allied health professionals (Figure 1). Ninety-two percent of respondents were over 30 years of age and 65% were over 46.

Eighty-five percent identified as Pākehā/NZ European, with nearly four percent identifying as Māori. Around 19% of respondents variously identified as other ethnicities.²⁷ Nearly 70% of respondents had between 11 and 40 years of full-time professional work experience, and 40% had worked in end-of-life care for more than five years and 10% for more than 20 years (Figure 2).

Figure 3 displays the distribution of participating doctors' membership by medical association. Nearly 40% of doctors were members of the RNZCGP²⁸, 20% were members of NZMA²⁹, and 47% belonged to the colleges of physicians, emergency medicine, neurologists and various other professional bodies³⁰.



²⁷ Respondents could select any ethnic affiliation that applied to them thus percentages do not equal 100

²⁸ Royal New Zealand College of General Practitioners

²⁹ New Zealand Medical Association

³⁰ Respondents could select more than one professional membership thus percentages do not equal 100

Ninety-eight percent of nurses were members of the NZNO³¹, nearly five percent were members of the College of Nurses Aotearoa, and 16% also belonged to the New Zealand College of Mental Health Nurses, Te Kaunihera o Ngā Neehi Māori and various other bodies³². Half of respondents practised in a city of more than 250,000 people. Thirty percent practised in a provincial city, 12% in towns, and seven percent in rural practices.

Nearly half of respondents identified as Christian, while 45% indicated no religious affiliation. Respondents who identified as Muslim, Jewish, Hindu, or another religious affiliation accounted for six percent of the total sample.

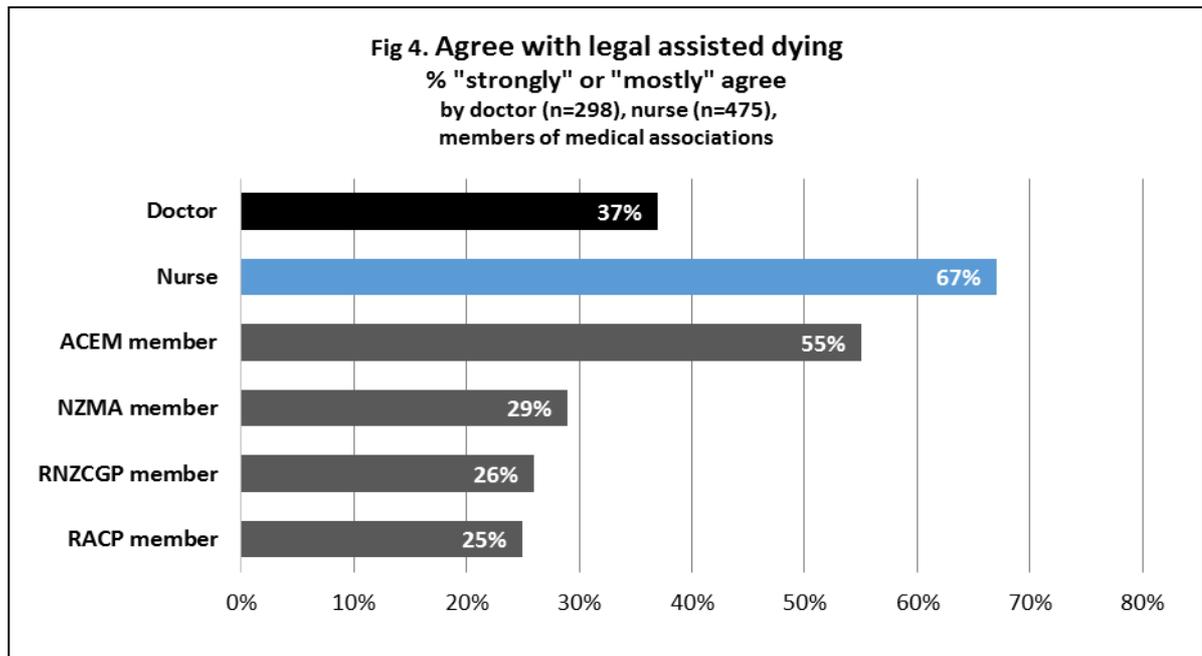
³¹ New Zealand Nurses Organisation.

³² Respondents could select more than one professional membership thus percentages do not equal 100.

E. Results

The research findings are presented for each question in the order in which it was asked in the survey.

1. In principle, how much do you agree that legal assisted dying should be available to people as part of end-of-life medical care, given appropriate protocols and ethical/practice guidelines for medical/health practitioners?



Doctors' and nurses' views

- Thirty-seven percent of doctors responding to the survey “strongly” or “mostly” agreed³³ that AD should be legalised in New Zealand. This is consistent with other recent New Zealand studies.³⁴
- Two thirds of nurses agreed that AD should be legalised. Their greater approval than doctors of legal AD is consistent with research in other countries.³⁵
- Of the medical professional bodies, members of ACEM were the most likely to support legal AD, with members of the other identified bodies substantially less likely. However, a quarter or more of members of all medical professional bodies were ‘mostly’ or ‘strongly’ supportive of legalising AD in New Zealand.

³³ On a 5-point scale from ‘strongly agree’ to ‘strongly disagree’ or ‘not sure’.

³⁴ Rae, Nicola, Phillipa J Malpas, and Malcolm H Johnson. "New Zealanders' Attitudes Towards Physician-Assisted Dying." *Journal of Palliative Medicine* 18 no. 3 (2015): 259-65.; Taylor, Cliff. "GPs Admit to Helping Patients Die, Amid Calls for Law Change." *New Zealand Doctor* 8th July (2015): 20.

³⁵ De Bal N, Gastmans C, and Dierckx de Casterlè B. "Nurses' Involvement in the Care of Patients Requesting Euthanasia: A Review of the Literature." *International Journal of Nursing Studies* 45, no. 4 (2008): 626-44. Trowell., Frances. "Exploring the Nursing Implications of Physician-Assisted Suicide in the Uk." *Nurs Times* 105, no. 30 (2009): 31-33.

2. What are the main reasons for your views about whether assisted dying should be a legal and regulated option as part of end-of-life medical care?

- Comments were made by 784 respondents (81% of total respondents to this question). Many respondents made lengthy comments outlining a range of arguments for and/or against AD.
- Fifty-eight percent of the comments were supportive of AD, 39% were opposed, and 3% were neutral.
- The most common reasons enunciated by respondents for supporting legal AD were respondents' views about:
 - ✧ People's right to autonomous decision-making at the end of their life, irrespective of health practitioners' beliefs (33% of all comments)
 - ✧ Philosophical beliefs about personal dignity and a perceived right for people to avoid unnecessary pain and suffering at end of life (23%)
 - ✧ Respondents' professional or personal experiences of witnessing severe suffering at end of life (11%)
 - ✧ A perceived failure of some health practitioners to acknowledge medical futility, resulting in suffering through prolonging people's lives (9%)
 - ✧ A belief that AD can be provided safely with appropriate safeguards (4%)
 - ✧ Respondents' professional experiences of witnessing the inadequacies or limitations of palliative care (4%)
 - ✧ That respondents would like the option of AD themselves (3%).³⁶

Typical supportive comments³⁷ were:

Personal and professional experience has shown me situations where terminally ill people have suffered unnecessarily and against their wishes.

As a nurse I have lost count of the number of very elderly patients who, faced with a lingering end of life, have said they wished they could hasten the process rather than drag it out in a manner which they felt compromised their dignity and comfort. I also think, to a degree, that the medical profession has lost sight of the fact that people have a natural lifespan and try to keep some patients alive at no benefit to those patients (those that request cessation of treatment etc and the doctors ignore their wishes).

Everyone has a right to self-determination. I do not believe that the medicalised healthcare system should be able to over ride this right. People should be able to live and die on their own terms, according to their own personal and cultural values. Currently, without legalised euthanasia, people have to relinquish control of the last period of their life to whichever health care provider is providing their care. In my experience this often results in a death that is not defined by the person or their family as 'good'. We should all be entitled to a 'good' death.

Due to the many undignified and frankly awful deaths I have seen over the past several years working in various hospitals. A lot of what we do is cruel at times (despite best intentions) and can cause a lot of pain for very little benefit (if any). We palliate people far too late, I have seen palliative care referrals being made minutes before people have died.

³⁶ Note that percentages may add up to more than 100% because individual respondents commonly made more than one point in their comments.

³⁷ Comments are provided verbatim with the original spelling and punctuation.

I feel we have the right to live our lives and our deaths as we see fit, not dictated by others. If I had an illness or had had an accident that made me unable to do the activities that gave my life meaning I have the right to end it. There are many worse options than being dead and it is easier for family. if one death is not protracted.

It is humane. It can work well in a rigorous and well organised system. Suffering for no reason is not necessary. It is not the same as suicide. Medicine sometimes goes too far in treating when it should not.

- The most common reasons for opposing AD were:
 - ✧ A belief that undertaking AD functions was not a proper role for health practitioners (10%)
 - ✧ A belief that vulnerable people will be pressured to end their lives prematurely (10%)
 - ✧ The respondent's professional experience with and/or belief in the adequacy of good palliative care (9%)
 - ✧ Moral/ethical (non-religious) objections to legal AD (9%)
 - ✧ Slippery slope arguments – that legalising AD will result in doctors and nurses providing non-voluntary euthanasia (NVE) (7%)
 - ✧ A belief that there is spiritual value in suffering (7%)
 - ✧ The respondent's religious beliefs (5%)
 - ✧ A belief that the focus should be on improving palliative care, not on providing AD (3%)
 - ✧ Concerns about potential abuses of the compliance systems (3%)
 - ✧ A concern that health practitioners will be obliged to take part in AD (3%).

Typical opposing comments were:

I don't believe legally assisted dying is necessary, as patients should be able to receive high quality palliative care which includes withdrawal from treatment and high doses of sedation and analgesia to assist in a comfortable, humane death.

SHOULD NOT BE LEGAL! 1) Moral. No one should be put in a situation to end another person's life, despite it by request. It is a kin to murder. 2) Medical profession are trusted to alleviate suffering and to promote wellbeing - it would blur our role if we were to assist in dying.

I am worried that families will put pressure on palliate patients to agree to assisted dying/death because of the burden they are to their families or for financial reasons to hasten access to estate/financial benefits.

Have cared for dying people in a variety of organisations and situations and feel that GOOD palliative care will enhance the quality of their (and their families) lives and death. This has been proven and supported by research. It is society's attitude toward death that needs to change; death is a normal part of life and needs to be approached as this. Healthcare professionals enter the profession to care for people NOT to end their lives.

We are born, live and die, to take away the process (transitions of birth and dying) is to rob humanity of growing in courage and spiritual potential that can only birth with raw pain and the emotions that go with it.

It makes health professionals obliged to assist death, and this could have psychological/moral issues for them. It is unfair for someone to be expected to do this and be held accountable for someone else death. Good palliative care should negate the need for this issue. I feel more resources should be put into palliative care.

3. Please describe ... any other factors that have significantly shaped your views towards legalising assisted dying.

- Comments were made by 455 respondents (51% of total respondents to this question). Sixty-eight percent of comments were supportive of AD, 30% were opposed, and 2% were neutral.
- The majority of respondents' comments reflected the influences that respondents had been asked to rate (see Figure 4 above).
- The most common *additional* influences on respondents' views amongst those supporting legal AD were:
 - ✧ Experience of seeing serious stress on the families of suffering people at end of life (7%)
 - ✧ Positive experiences of having provided AD to patients at their explicit request (7%)
 - ✧ Personal experience of participating in legal AD overseas, or knowing others who had been involved (7%)
 - ✧ Media coverage of legal AD (4%)
 - ✧ Experience of professional education about legal AD (2%)
 - ✧ A perceived need to move away from medical paternalism (2%)
 - ✧ A perception that legal AD can prevent violent suicide by suffering patients (2%).

Typical comments were:

My work experiences have been the main driving force, however the strongest driver that convinces me that this can be a process that is safe and secure for individuals was to see it in practice. A friend's mother underwent assisted death in Holland and she went peacefully with her family around her. Her grandchildren stayed with us in New Zealand at the time and their Uma was able to phone them and say goodbye on the day of her death. Although any death is sad this was the most gentle passing I had seen any family experience.

When a patient is empowered to actively take part in their own care, their quality of life improves greatly. Choosing the time and manner of their own death, as I have seen in my time caring for dying people, has improved the experience of these people AND their families.

I have been reading legislation and journal articles regarding euthanasia and assisted suicide since the *Lucretia Seales* (?spelling) decision, and this has increased both my knowledge and understanding of the subject. I also believe in personal choice. There are places across the globe that have laws in place regarding assisted dying and as a country that endeavours to be a leading country in many issues why not this.

Hearing the voices and experiences of those in end of life or anticipated end of life situations, including their arguments for and against various options of care/intervention review of existing case studies, case law and ethical exemplars cited in support of or in refutation of the various arguments presented.

The most common *additional* influence on respondents' views amongst those opposing legal AD was coverage by various media (3% of total comments). Typical comments were:

I heard an excellent talk on euthanasia discussing the international literature on this topic; after learning about what happens overseas, I have become an ardent supporter of Euthanasia-Free NZ

Family First has taken the time to print a significant booklet with much research on this matter. I feel this research should be read before we in NZ pass such a critical piece of legislation.

Saw interview and documentary about a Dutch doctor assisting with legalised assisted dying and the emotional effects it had post procedure. It strongly confirmed to me that this not an area for us medical professionals to enter in to.

A small number of respondents commented that they lacked sufficient information about legal AD to form a clear viewpoint. Many others identified the difficulty in deciding whether AD should be legal.

I have been in a personal situation where my wife was terminally ill with cancer. Providing the appropriate amount of pain relief was what she wanted and what the team looking after her (including myself) agreed was appropriate. She died a dignified death but I believe lived a shorter time than would have otherwise potentially happened. I have no doubt that it was the right thing to do and it was to provide the appropriate care without striving to extend life at all costs. However I believe that there is a fine line between this and purposefully giving patients medication to end their life. The ethical issues are too great to allow medical practitioners to be involved with that decision and or act.

I have spent the whole of my professional career to date trying to save lives and alleviate suffering; helping someone to end their life is a complete reversal of this mindset. Any decision on whether to be involved would require a great deal of discussion and soul-searching. I am not sure, at the moment, under what circumstances I would be prepared to help someone to die. It would very much depend on the individual circumstances.

I have not taken the time to read all of the relevant information so am relatively ill informed. I think choices around end of life are very personal. I'm hugely anxious about the potential for abuse, but I'm also hugely anxious about inflicting suffering on those for whom existence is miserable. When I worked in intensive care, part of my job was telling people when further intervention was futile. I found that a) doctors in general are very bad at this and b) people were often very relieved to have what they already thought out in the open and would often have stopped treatment earlier had they felt they had the choice. I believe strongly that dignity and comfort are the least we can give the dying. Sometimes that means letting them choose the time and manner of their deaths.

4. What are your main concerns or misgivings around legalising assisted dying in New Zealand?

- Comments were made by 870 respondents (97% of total respondents to this question). Fifty percent of comments were supportive of AD and 50% were opposed.
- The comment made most commonly was that respondents did not have any concerns about legalising AD (20% of total comments).
- The most common concerns voiced by respondents opposing legal AD were:
 - ✧ 'Slippery slope' concerns about NVE and coercion of vulnerable people (19% of total comments)
 - ✧ Religious and other moral objections (11%)
 - ✧ That there would be insufficient safeguards in the legislation (8%)
 - ✧ Pressure on health practitioners to participate (5%)
 - ✧ Negative impacts on the quality of palliative care (3%)
 - ✧ Negative impacts on families (2%)
 - ✧ The fallibility of individual health practitioners providing AD (2%).

Typical comments were:

Indication creep. Ie using for more and more things with progressively weaker indications
That it becomes a fear based thing and patients are scared doctors will kill them

The doctor or doctors involved can be placed under pressure by patient and / or family in a situation where uncertainty exists - and in medicine there is always a degree of uncertainty. I personally have had patients survive and return to functional life when I had given up any hope of recovery - had the pressure of a patient in pain and a demanding family I COULD have been pressured into ending life when it was salvagable - had the option to 'assist dying' been available.

That families will think it's an easy way to rid themselves of " bothersome" elderly relatives. There has to be strong rules around section making and by whom. The person dying has to be the one to make the decision unless they are too far gone and begging for release or uncivilised with no chance of survival and that should be more of a medical final say in conjunction with the family.

Again, I am concerned that I will be emotionally traumatised if I have to be directly involved in this. I also think that we should encourage people with depression etc to utilise good treatment so they will see their lives differently.

It will be abused by people wanting to end their life for other reasons rather than terminal illness (ie suicide) that there would not be clear rules/guidelines for people eligible and no safe place for this to occur as there will always be people who will protest about this issue.

- The most common responses by respondents supporting legal AD were that:
 - ✧ They had no concerns about legalising AD (20%)
 - ✧ The legislation would need to contain adequate safeguards for both patients and health practitioners (9%)
 - ✧ The legislation might contain too many barriers for equitable access (8%)
 - ✧ There would be insufficient protocols for health practitioners (5%)
 - ✧ Impacts for families would be poorly managed (4%)
 - ✧ Opposition to legal AD would defeat legalisation (2%)
 - ✧ There would be pressure on health practitioners to not participate (2%).

Typical comments were:

That the uninformed, uneducated masses will rise to their soapboxes, on the internet, the press and various other media and spread misinformation and fear throughout the general public. Otherwise, I feel we are capable of legislating and implementing a secure, safe, ethical, auditable system to provide legal assisted death.

That it will not happen soon enough, and that when it happens, the red tape involved will act as a barrier to those that are not as health literate and/or are resource poor. Legalised assisted dying legislation should take a multi cultural approach to the issue.

A long drawn out and complicated system of paperwork. This needs to be a simple process that does not cause further stress for the patient. It must not be able to be overruled or challenged by family members.

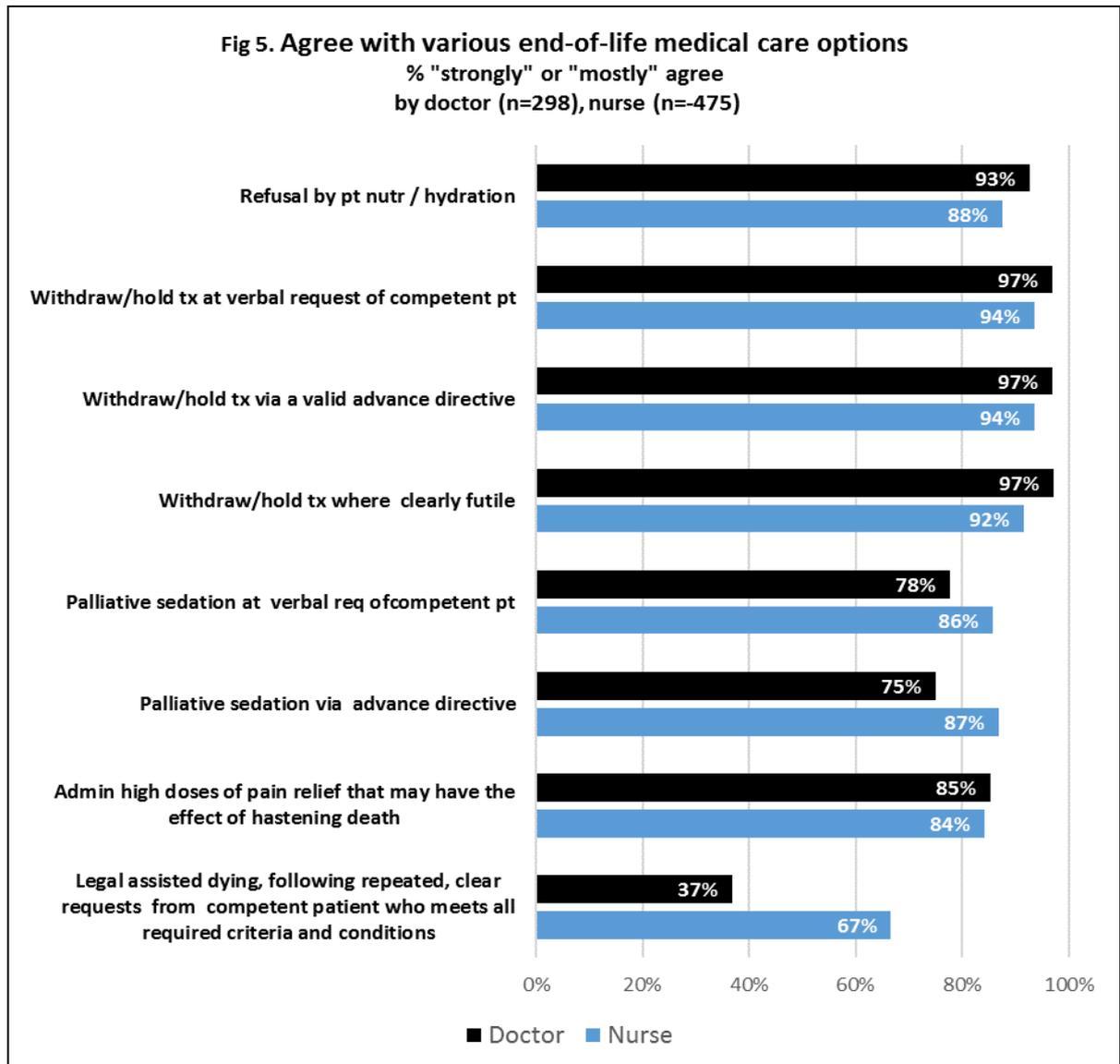
Ensuring that the process is well governed, and guidelines are tight. Also that there is resource available for implementation, and that the patients and families are supported and engaged.

Targeting of practitioners who offer this service by religious zealots / idiots

There need to be fairly tight criteria, especially early after legislation is introduced Eg, extensive metastatic disease, severe neurological disease

That a law might prove unworkable for those not extremely educated and assertive.

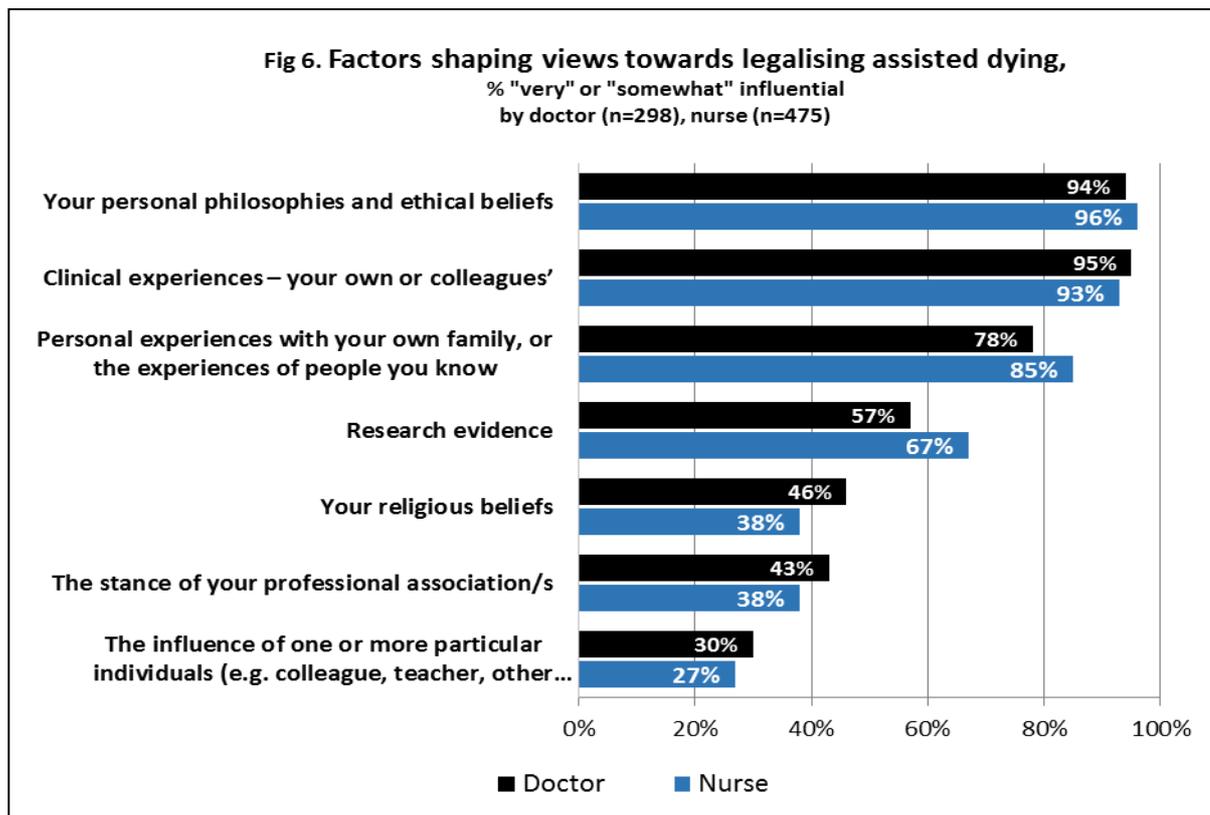
5. In principle, how much do you agree that each of the following options should be available to people as part of end-of-life medical care, given appropriate protocols and ethical/practice guidelines for medical/health practitioners?



Doctors' and nurses' views

- Even though all of the EOL options surveyed in this question are legal in New Zealand, between one sixth and one quarter of doctors and nurses variously did not support treatments involving palliative sedation or the administration of high doses of pain relief where doing so had the potential to hasten death.
- Nurses were somewhat more supportive of palliative sedation than were doctors.
- While only 37% of doctors agreed with legally providing or administering a medication with the intention of hastening death, 85% of doctors agree with administering medication in doses in the knowledge that doing so may have the effect of hastening death.

6. How influential have each of the following factors been on shaping your views towards legalising assisted dying?



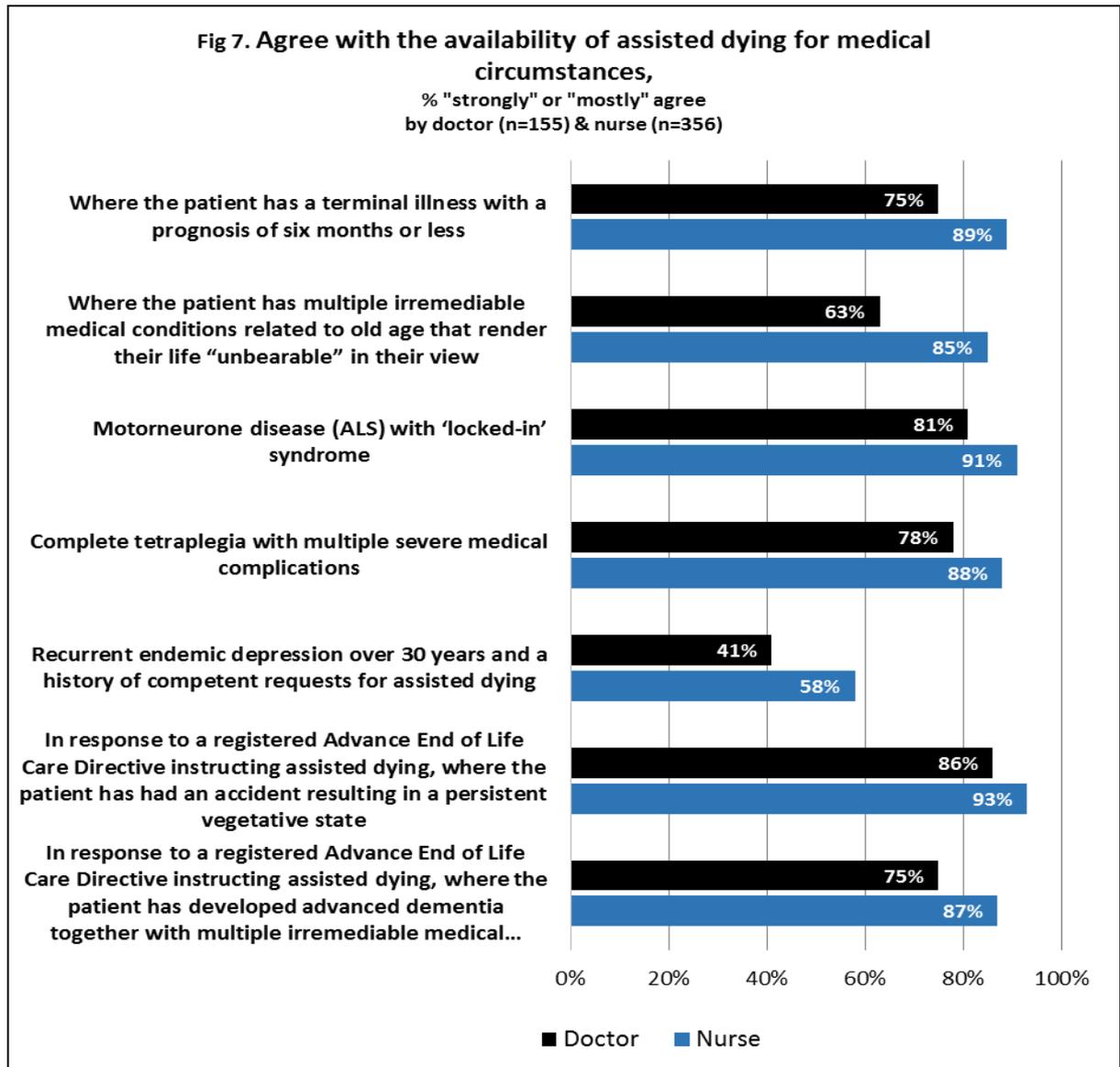
Doctors' and nurses' views

- The pattern of influences on their views towards AD was similar between nurses and doctors.
- Personal philosophies and previous clinical experiences were the influences identified most commonly by the great majority of both nurses and doctors.
- Previous experiences with one's own family or the vicarious experience of respondents' acquaintances were also highly influential in shaping doctors' and nurses' views towards AD.
- About half of doctors and two thirds of nurses recognised research evidence as an influence on their views towards AD.
- Fewer nurses (just over a third) than doctors (nearly half) were influenced by their religious beliefs. That is, more than half of both professions did not see their views as influenced by religious beliefs.
- Significant minorities of both doctors and nurses had been influenced by the positions of their respective professional associations.
- More than a quarter of both nurses and doctors recognised the influence on their views of a particular individual.
- New Zealand doctors are much less influenced by religious beliefs than United Kingdom (UK) counterparts, who cited religion as the strongest factor influencing attitudes toward legalising AD³⁸.

³⁸ McCormack, Ruaidhri, Margaret Clifford, and Marian Conroy. "Attitudes of UK Doctors Towards Euthanasia and

7. In principle, given the provision of appropriate protocols and ethics/practice guidelines, how much do you agree that legal assisted dying should be available following repeated clear requests from a mentally competent patient, in each of the following medical circumstances?

Note: The remainder of the findings discussed in this report reflect the views of doctors and nurses whose views ranged from “strongly agree” to “mostly disagree” with legalising AD or who were unsure.



Doctors' and nurses' views

- There was a high level of support (greater than 50%) for the availability of legal AD for persons with a wide range of medical conditions, including non-terminal conditions. In

Physician-Assisted Suicide: A Systematic Literature Review." *Palliative Medicine* 26, no. 1 (January 1, 2012): 23-33.

contrast, support was markedly lower for AD access for people with long-standing depression, even where their requests were made during mentally competent periods.

- Nurses were consistently more supportive than doctors of legal AD for all of the medical conditions described, notably so for people with depressive disorders or multiple age-related comorbidities.
- Support for legal AD was greatest where the medical condition most clearly evidenced either imminent death or clear absence of quality of life – that is, where medical decision-making was less ethically complex.
- Doctors’ support for AD for people with multiple age-related medical conditions increased from 63% to 75% where there was an Advance End of Life Care Directive in place evidencing the person’s pre-considered wishes.

Respondents’ comments

- Comments were made by 104 respondents (18% of total respondents to this question).
- The comments were mostly about the following:
 - ✧ General support for AD (across conditions) (40% of total comments)
 - ✧ Advance directives – the increasing value of making them; ensuring that they are current and valid; difficulties in validating them (e.g. patients with dementia) (25%)
 - ✧ Difficulties with clinical judgments (e.g. the subjectivity of clinical judgments; determining what is ‘unbearable’) (12%)
 - ✧ The need to make clinical decisions in broader social/cultural/psychological context (10%)
 - ✧ Issues in assessing patient competence and informed consent (10%).

Typical comments were:

Re dementia and end of life care directive. My concerns would be that the directive would need to have some clear statement that at the time of writing the person was competent to give the directive. How would you know this still is the persons wishes

As a Geriatrician, I am constantly enlightened to discover a person with many disabilities who enjoys life. It is not the diagnosis, rather the suffering and loss of love for life that an individual has that may make assisted suicide/dying desirable.

The boundaries for some decisions for assisted dying in the cases of mental health I believe should not be treated the same as palliative. Many people experiencing depression or dementia will repeatedly state that they want to die. I believe this would be dangerous to give the option of assisted dying as there will be some that will recover from their depression.

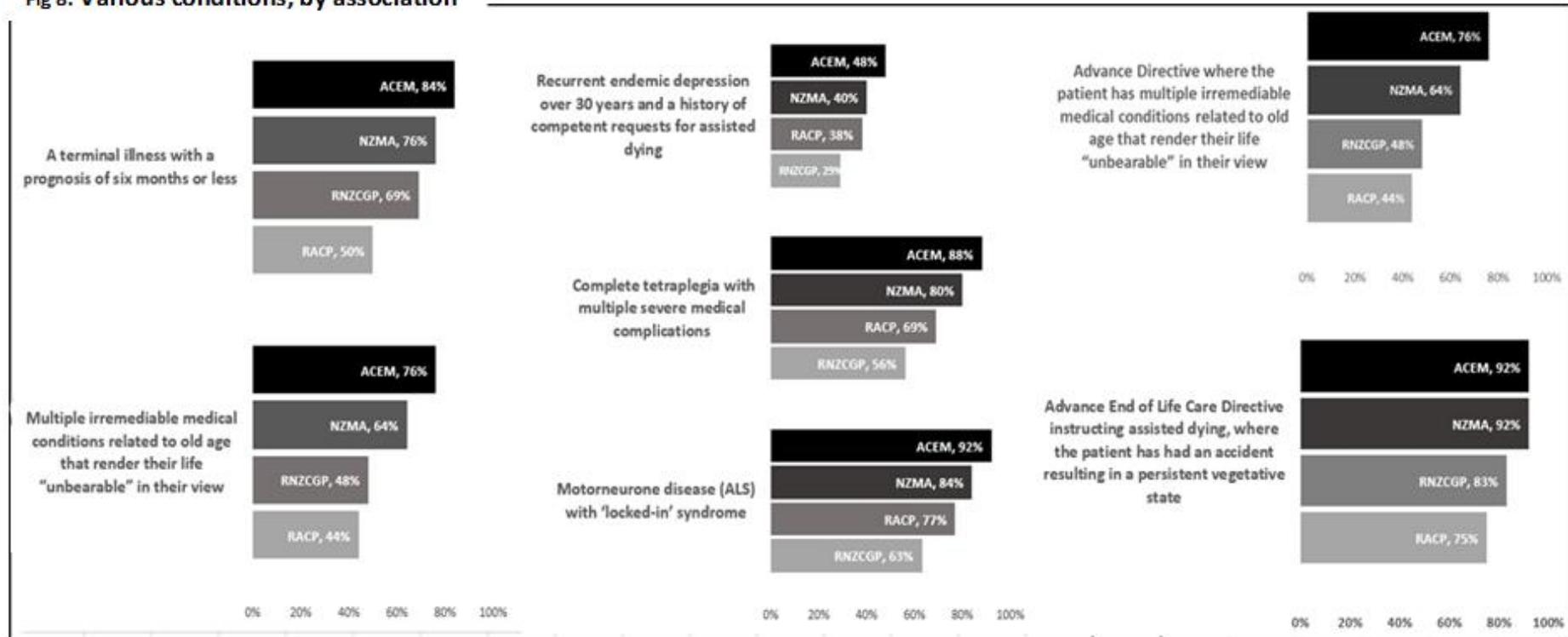
The difficulty I think is in the wording. How to interpret clearly what is unbearable for a patient based on an advanced directive written years before.

I have experienced clients with a Mental illness (Major Depression and Self Harm) become life focused when given a terminal illness diagnosis this is why I have answered unsure on question III [AD requested by a competent person with chronic depression].

The safeguards described above for assisted dying seem robust. There also needs to be realistic, culturally appropriate, discussions with patients and their families about desirable thresholds of care in acute illness. The GP would seem to be the best resource for this, but these discussions take time to organise and conduct, and there will be a paperwork burden. Adequate funding would need to be provided. A number of elderly patients with multiple comorbidities come in to ED with "Resus" forms filled out requesting CPR, but I have yet to meet a single one who would actually want this when I talk to them about it. Most patients and families just want us to alleviate pain and suffering in a timely fashion in the face of imminent (not unexpected) death. Patients in private hospitals frequently come to ED with an acute end of life illness, often sepsis, (the old mans friend), with the occasional family seemingly unprepared for their death- wanting precious antibiotics normally held in reserve for multiply resistant organisms. A few very good retirement villages have a "patient passport" which gives a glimpse of the whole person, past and present, not just the illness- I would dearly like this to become more prevalent for all patients with chronic illness likely to need intermittent acute healthcare- as I believe it would improve compassion in healthcare.

Figure 8 displays the responses by doctors to Question 7 by percentage membership in those medical associations where at least 10% of respondents claimed membership (ACEM, NZMA, RNZCGP, RACP).

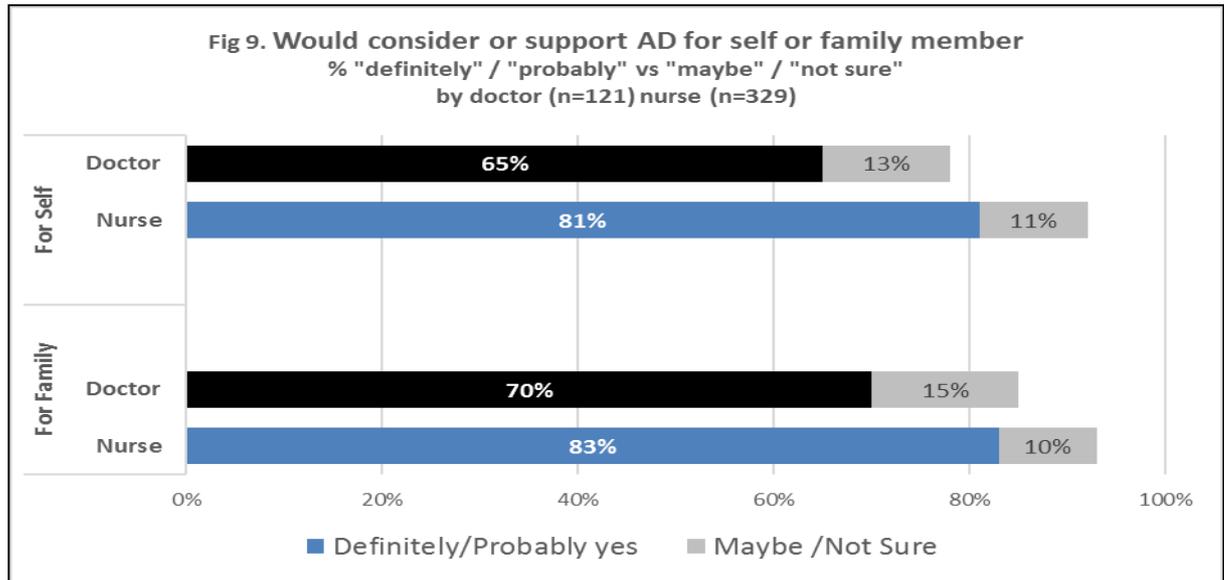
Fig 8. Various conditions, by association



Comparing responses across the members of various medical professional bodies:

- ACEM members were the most likely to support AD across a range of medical circumstances and RACP members the least likely, and those differences were mostly statistically significant. [check]
- NZMA members were consistently somewhat more supportive of AD across medical circumstances than were RNZCGP members.
- In general, doctors showed moderate to high support for AD for medical circumstances that required potentially less complex clinical and/or ethical judgments by clinicians.

8. Is assisted dying something you would consider for yourself or support for a family member?

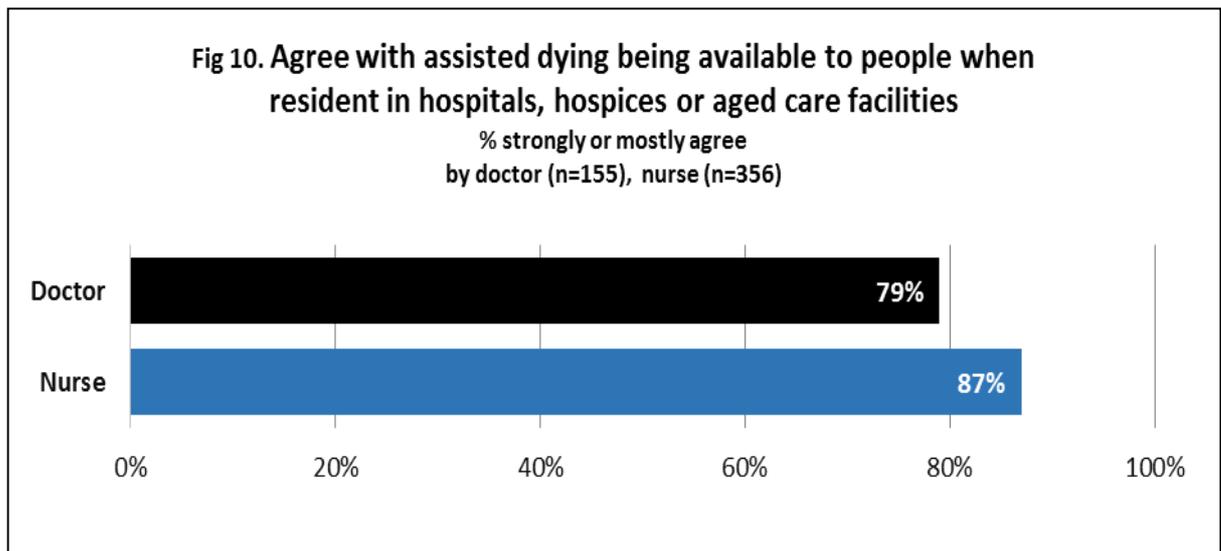


Doctors' and nurses' views

- A large majority of both nurses and doctors would “definitely” or “probably” consider having an assisted death themselves and/or supporting it for a family member. A further 10-15% were equivocal about considering AD for self or a family member.
- Support was markedly stronger on both parameters amongst nurses than amongst doctors.
- These findings are consistent with research with Swiss palliative doctors and nurses, where even those firmly opposed to AD in principle were often unsure whether ultimately it might be an option they would consider personally.³⁹

³⁹ Gamondi, Claudia, Gian Domenico Borasio, Pam Oliver, Nancy J Preston, and Sheila Payne. "Palliative Care Physicians' Accounts of Their Attitudes and Experiences of the Swiss Civil Model of Assisted Suicide: A Qualitative Interview Study." To be presented at the *European Association of Palliative Care [EAPC] Conference* Dublin, May, 2016.

9. How much do you agree that assisted dying, if legalised, should be available to people when resident in hospitals, hospices and aged care facilities?



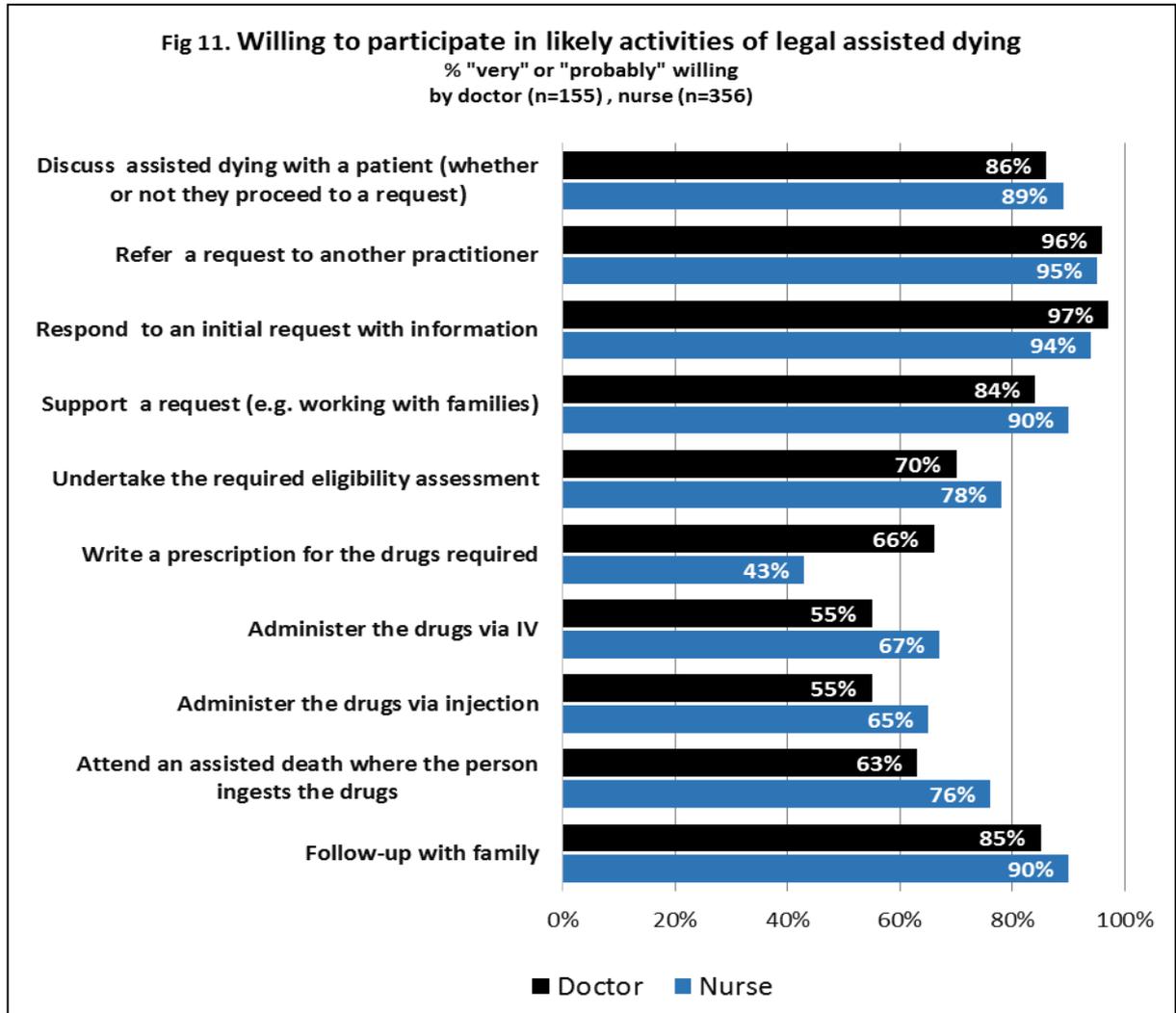
Doctors' and nurses' views

There was strong support from both nurses and doctors for people to be able to have an assisted death in the facility where they are resident, that is, in the place that is their current home. This finding contrasts with the current policy of many facilities, in particular faith-based providers, in some jurisdictions where AD is already legal (e.g. Switzerland and the US states of Oregon and Washington)⁴⁰. However, those policies are being relaxed in recent years.⁴¹

⁴⁰ Gamondi and others, op cit.

⁴¹ Oliver, op cit.

10. To what extent would you be willing to participate in the following range of likely activities in legalised assisted dying in NZ, assuming (i) the provision of clear guidelines and protocols authorised by the appropriate professional bodies, and (ii) that your profession has been *given the delegated authority* for such tasks?



Doctors' and nurses' views

- The willingness of both doctors and nurses to engage in the various tasks and roles involved in providing AD was generally high. This finding suggests that there is a sufficient cohort of both professions available to provide AD services, should AD become legal, given the provision of appropriate training and support.
- For both doctors and nurses, willingness was greatest for the tasks that involve less 'agency' in relation to actively providing the means for a hastened death.

- The very high levels of willingness to discuss AD with patients, provide information and refer requests to another practitioner indicate that in general New Zealand doctors and nurses will respect patient autonomy in relation to AD choices. In contrast, ignoring of such requests and non-referral to a willing practitioner are major barriers to accessing AD in jurisdictions where AD is already legal.⁴²
- Two-thirds of doctors were willing to write a prescription for a lethal dose where a patient had met the eligibility requirements and 43% of nurses were willing to undertake that role if that function were legally authorised for their profession. The qualitative comments indicate that the lesser apparent support for prescribing by nurses was due to their acknowledgement that nurses currently cannot prescribe such drugs (see below). Given that a number of jurisdictions with legal AD (and Canada, where it will soon be legal by statute)⁴³ have considered extending AD functions to nurse practitioners,⁴⁴ and there is already evidence that nurses in fact often administer AD in some of those jurisdictions and in New Zealand,⁴⁵ this finding supports nurses' willingness to be involved in providing AD services.
- The similarity of rates of willingness to administer AD via injection or intravenous line indicates that doctors and nurses regarded these methods as equally acceptable.
- The high levels of willingness to attend an assisted death by ingestion (higher for nurses than for doctors) are in contrast to the current usual practice in the US states and Switzerland, where doctors attend such deaths in only around 25 percent of cases.⁴⁶

Respondents' comments

- Comments were made by 80 respondents (14% of total respondents to this question).
- The comments made most often were about the following, in this order of frequency:
 - ✧ Current limitations on nurse prescribing (one third of all comments)
 - ✧ Importance of the patient/doctor relationship (e.g. the value of involving the patient's GP; respondent would only provide AD for their own patients) (15%)
 - ✧ Importance of nurses' and whole health team involvement in AD decision-making (13%)
 - ✧ Would prescribe and deliver if so authorised by the law (13%)
 - ✧ Importance of specific training and/or formal guidelines in the various AD functions (7%).

Respondents' comments often reflected their uncertainty about how the processes might

⁴² Oliver, op cit.

⁴³ *Provincial-Territorial Expert Advisory Group on Physician-Assisted Dying Final Report* (Ontario Minister of Health and Long-Term Care and Attorney General, Toronto, 30 November 2015).

⁴⁴ Bernadette Dierckx de Casterlé, Yvonne Denier, Nele De Bal & Chris Gastmans "Nursing care for patients requesting euthanasia in general hospitals in Flanders, Belgium" (2010) 66 *J Adv Nurs* 2410.

⁴⁵ De Bal, Nele, Bernadette Dierckx de Casterlé, Tina De Beer, and Chris Gastmans. "Involvement of Nurses in Caring for Patients Requesting Euthanasia in Flanders (Belgium): A Qualitative Study." *International Journal of Nursing Studies* 43, no. 5 (7// 2006): 589-99.; De Beer, T, C Gastmans, and B Dierckx De Casterle. "Involvement of Nurses in Euthanasia: A Review of the Literature." *J Med Ethics* 30, no. 5 (2004): 494 - 98.; Malpas, Phillipa J., K. Mitchell, and Heidi. Koschwanez. "End-of-Life Medical Practices in General Practice in New Zealand - 13 Years On." *NZMJ* 128, no. 1418 (2015): 29-36.

⁴⁶ Lewis, Penney, and Isra Black. "Reporting and Scrutiny of Reported Cases in Four Jurisdictions Where Assisted Dying Is Lawful: A Review of the Evidence in the Netherlands, Belgium, Oregon and Switzerland." *Medical Law International* 13, no. 4 (December 1, 2013 2013): 221-39.; Oregon Public Health Division. "Oregon's Death with Dignity Act: 2015 Data Summary." edited by Available at: <https://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Documents/year18.pdf>, 1-7, 2016.

work, in particular the ethical aspects of decision-making. Typical comments were:

My willingness to be part of the actual assisted dying process would be influenced by whether or not the person met my personal criteria for who should/should not be able to access assisted dying. In saying that, I believe it is much like abortion - a right to choose is a right to choose, not choose in only some instances.

There should be a specific medical facility where the procedure happens or alternatively in a person's home but with more than one health care professional present to witness procedures for safety of the health professional. It is important that the patient and their family are surrounded by health professionals who support the legislation and can support families going through this process.

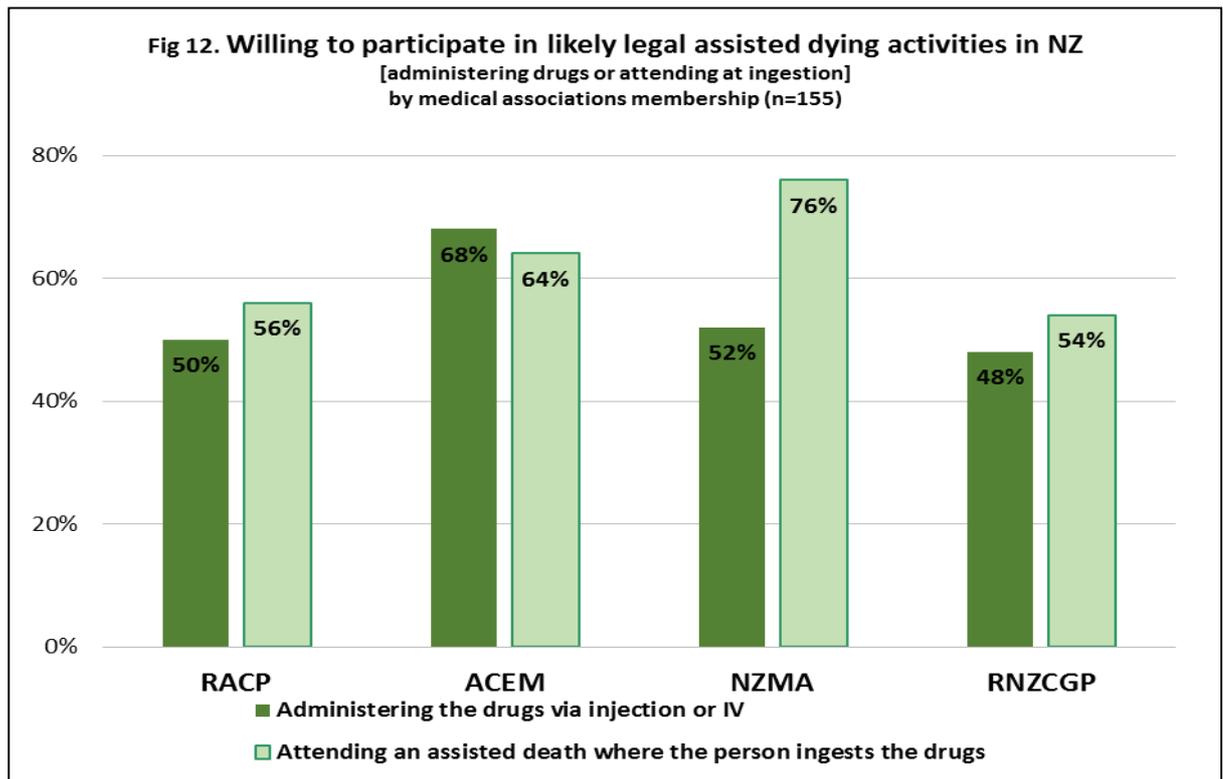
It is too difficult to envisage a scenario where I would be confident ethically to undertake actions that support assisted death without knowing the precise criteria/guidelines/ protocols surrounding it.

I see this responsibility as more within the scope of nursing than medicine/psychiatry. Nurses are all about skilled caring, rather than focusing on curing.

Education/training re: legalised assisted dying would have to be over and above and other Nursing/Medical training, possibly a specialist area.

While this may be relatively straightforward in a younger person with no neurological or psychiatric illness this starts to become very difficult with any concerns about mood or cognitive deficit. It would be an assessment of competence with the highest stake and high potential to challenge (eg from family members) as it is not an exact science. There is no single 'test' to do to answer the question.

Figure 12 displays doctors' responses about willingness to participate in legal administration or attendance at the self-administered ingestion of a lethal drug.

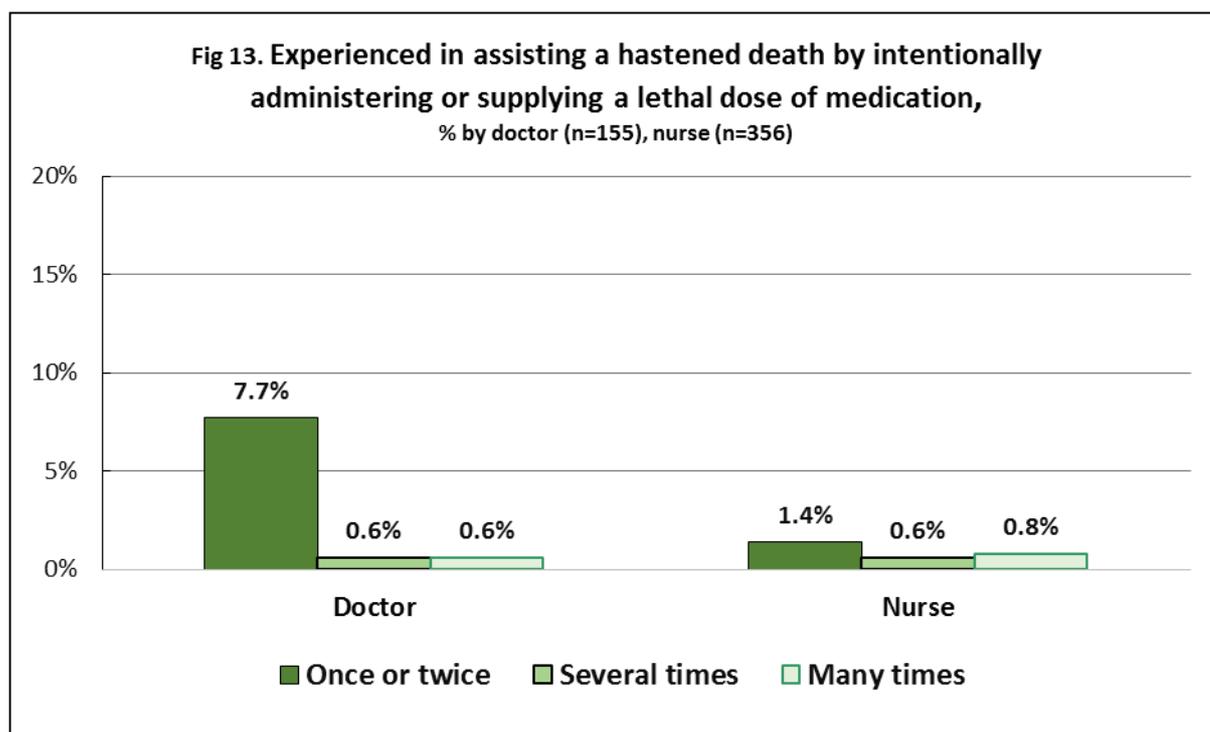


Doctors' and nurses' views

- More than half of responding doctors across all membership groups were 'very' or 'probably' willing to attend an assisted death by ingestion or to administer AD by a lethal dose.
- Across the main four medical professional bodies, willingness to attend an assisted death by ingestion was consistently greater (around two thirds of doctors) than willingness to administer the drug via injection or IV line (55 percent).
- Members of NZMA were more often willing than those of other professional bodies to attend an assisted death by ingestion, while ACEM members were significantly more willing than members of other professional bodies to administer a lethal drug via injection or IV.

11. Have you ever been involved in any of the following actions yourself as part of a patient’s end-of-life medical care?

This question⁴⁷ asked respondents to indicate their actual participation previously in various end-of-life treatments, including having administered “*high doses of pain relief even though that may have the effect of hastening the patient’s death*” (that is, the doctrine of ‘double effect’) and “*Assisting someone to have a hastened death by intentionally administering or supplying a lethal dose of medication*”.



Doctors’ and nurses’ experience

- Almost one tenth (9%) of doctors responding to this question had already at some time either provided or administered a lethal dose of medication to help someone to have a hastened death. More than one percent had provided AD in these ways “several” or “many” times. These figures are consistent with previous New Zealand research showing from 4%-12% of doctors acknowledging they have provided AD on at least one occasion.⁴⁸
- This study and the *NZ Doctor* survey in July 2015 show that reported engagement in AD has more than doubled since the studies in the early 2000s. This may indicate an increase in the practice, or an increase in doctors’ willingness to report it in surveys, or both.⁴⁹

⁴⁷ See Question 9 in Appendix.

⁴⁸ Malpas, Phillipa J, Kay Mitchell and Heidi Koschwanez. "End-of-Life Medical Practices in General Practice in New Zealand - 13 Years On" *NZMJ* 128, no. 1418 (2015): Mitchell, Kay, and R. Glynn Owens "National Survey of Medical Decisions at End of Life Made by New Zealand General Practitioners." *BMJ* 327, no. 7408 (July 24, 2003 2003): 202-03; Taylor., Cliff. "GPs Admit to Helping Patients Die, Amid Calls for Law Change." *New Zealand Doctor* 8th July (2015): 20-20.

⁴⁹ Merry, Alan F, Magdi Moharib, Daniel A Devcich, M Louise Webster, Jonathan Ives, and Heather Draper. "Doctors’ Willingness to Give Honest Answers About End-of-Life Practices: A Cross-Sectional Study." *BMJ Open* 3, no. 5 (January 1, 2013 2013).

- Collectively the responses to this question confirm that AD has been a regular practice in New Zealand over more than a decade and suggests that there is a cohort of doctors who feel ethically comfortable with the practice.
- The findings also confirm that some nurses have knowingly participated in providing AD, as also evident in their comments in this survey (see below).
- The high levels of respondent support for administering “*high doses of pain relief even though that may have the effect of hastening the patient’s death*” (85% of doctors and 84% of nurses) indicate that the ‘doctrine of double effect’ is accepted practice amongst the majority of end-of-life care practitioners in New Zealand, as is the case in many overseas countries.⁵⁰

Respondents’ comments

- Comments were made by 80 respondents (14% of total respondents to this question).
- The comments made most often were about the following:
 - ✧ Acknowledgement that intentional AD does occur currently in New Zealand (23%)
 - ✧ The focus should be on relief of suffering and on all legal options to achieve that result (19%)
 - ✧ The primary consideration should be what the patient wants, as long as it is legal (15%)
 - ✧ Other comments generally supporting legal AD (15%)
 - ✧ Comments generally supporting the administration of very high doses of analgesics⁵¹ as an alternative to AD (15%).

A small number of respondents (5-7) also made comments about each of the following topics: the need for better advance care planning; problems with current standard practices in emergency departments and palliative care that do not respect patient autonomy; and issues for nurses in accepting instructions from doctors that do not accord with their own ethics.

Typical comments were:

It is often unspoken but obvious that the amount of drugs going into the subcut pump of an unconscious person are going to hasten death

As a nurse I have often witnessed (h) [an intentional AD] and I agreed with it.

Patients deemed to be competent under my care in their last hours/days of a terminal illness, who request not to receive nutrition and medical interventions that would prolong their death have my support and respect and I have no scruples about administering sufficient pain relief to maintain their level of comfort even if that would result in hastening death. However I acknowledge the dangers of interpretation concerning competency and criteria which must influence such decisions and would be cautious as to advocating a change of law which would disadvantage the vulnerable by removing current safeguards that protect them.

I know of maybe 5 cases that when I left private homes family members/patient administered doses that would hasten death. The people asked before hand questions which implied what they were going to do. No one wanted me there so that I could not be implied if anything arose or I could not see what they were doing as they knew it was not legal.

⁵⁰ Sykes, Nigel, and Andrew Thorns. "The Use of Opioids and Sedatives at the End of Life." *The Lancet Oncology* 4, no. 5 (5// 2003): 312-18.

⁵¹ The doctrine of ‘double effect’ recognises that such a treatment does not amount to euthanasia if the intention of the health practitioner is only to relieve suffering and not to hasten death.

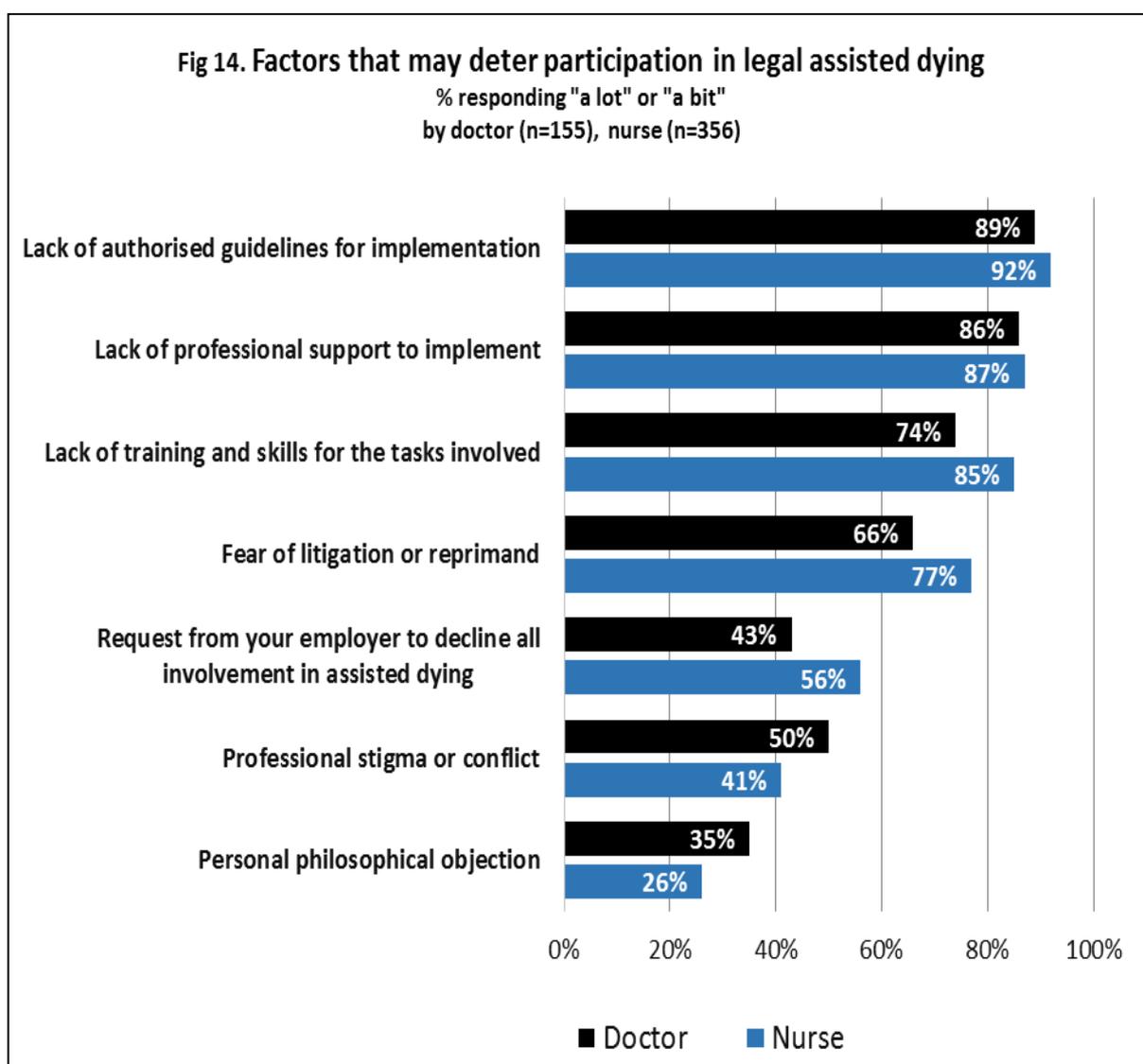
I feel strongly about delivering good palliative care - both for the patient and for their families. Usually we can do that under our current legal system and the few days it takes for someone to pass gives good time for most family members to come to grips with what is happening - especially if it is a young person or a sudden illness. But I have only worked in acute medicine, not in hospice. Usually when we withdraw treatment it is clear to families that the patient is not going to recover, the patient may no longer be able to communicate even. For those with more protracted conditions, assisted dying may give them dignity they will otherwise forgo - there's little dignity in long term bedsores and nappies. Or advanced dementia.

'Clearly medically futile' treatment is offered/ordered/carried out far too often. Advanced Directives are ignored/dismissed by Doctors too often.

Although I complied with the resus attempt at the time I was upset that a patient who'd decided & had marked on his file Not For Resus did have an [unsuccessful] resus attempt made on him.

We have to allow people to die and if it means assisting them to make death with dignity under their own terms, so be it.

12. To what extent might you be deterred from participating in legal assisted dying due to concerns about any of the following factors?



Doctors' and nurses' views

- The responses on this question were relatively similar across doctors and nurses.
- Personal philosophical objection to AD was the least common reason why doctors (one third) and nurses (one quarter) might be deterred from taking part in AD.
- The most common reasons why both doctors and nurses might be deterred from participating in legal AD related to the pragmatics of AD provision, as follows (in order):
 - ✧ A lack of authorised guidelines for undertaking AD safely and competently
 - ✧ A lack of support from their profession generally
 - ✧ A lack of training and skills for the tasks involved
 - ✧ Concerns about a potential for litigation or professional reprimand. (Because the survey asked about this factor as a single question, it is not possible to tell which of litigation or professional reprimand was of greater concern.)

- Both doctors and nurses might also be deterred by pressure from employers to decline participation or by professional stigma or conflict; however the greater weight of concern was on having sufficient education, skills and professional support.

Respondents' comments

One hundred and four respondents (19% of total respondents to this question) added comments to their ratings of possible deterrents. A quarter of those comments were an expansion of particular features of guidelines, training, protocols or professional supports that respondents believed might be lacking, and a further one fifth related to concerns that the legal framework might be inadequate. Examples of potential deterrents were as follows:

If it is legalised I would assume that there will be training, protocols and guidelines around any occurrence. I would not want to be involved without any of these controls.

Unclear guidelines, need to be robust and protection of the vulnerable paramount.

An overall sense that an organisation did not have the correct policies or that they were not well entrenched and followed, leaving doubt.

Not a rigorous or well thought out system leaving room for error or confusion.

Small numbers of respondents (4-8) identified potential deterrents in the following areas: strong opposition from the person's family; the respondent's personal objection to AD in particular circumstances (e.g. minors; people with dementia); requests from personal acquaintances; concerns about sufficient moral support for participating professionals; fear of stigmatisation of participating professionals by the media, "anti-euthanasia organisations" or colleagues; potential negative impacts on their careers; or being harassed by opponents of AD. Typical comments were:

You would need the support of your employer and your facility should be able to accommodate people wanting to do this or there should be provision in the community or in the persons home to facilitate this.

If I felt that the legal framework was poor or I personally disagreed that the specific case qualified (despite the legal decision).

Disagreement with a person who wanted to die where I thought that was a poor decision, a young person with depression for example, a younger person who was quite well at present but fearful of worsening, an advance directive I did not feel confident about, when I thought a person was under duress. I find this all quite hard, but I try to put myself in their shoes, and who am I to say I would not help them in their time of need and relief from suffering. I am very comfortable with terminal sedation, what's so different?

If not everyone you are working with is comfortable with it

Knowing family of the dying person

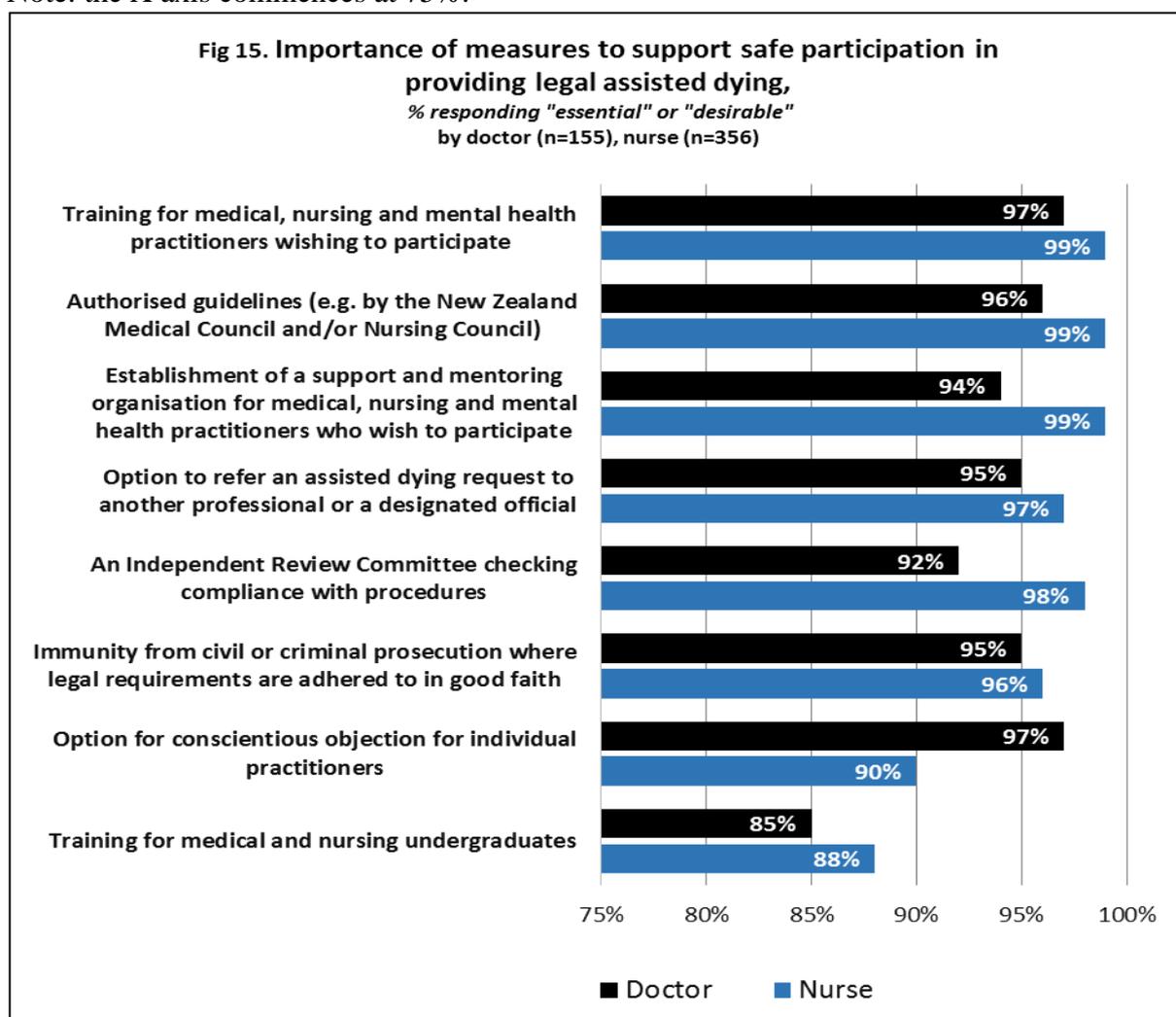
Personal emotional response. To me more important than philosophical objection - and not the same.

The taking of a persons life is a conflict to me therefore if the person is able to be set up to take their own life by administering it to themselves that would be preferable to me.

I would need to be absolutely certain there would be no complaint by family, employer etc, and crystal clear guidelines would need to be provided along with a transparent pathway for actioning the request.

13. How much do you think the following measures will be needed to support safe participation by medical/health practitioners in the various processes of providing legal assisted dying?

Note: the X axis commences at 75%.



Doctors' and nurses' views

- Very large majorities of both doctors and nurses voiced a need ('essential' or 'desirable') for a range of protections to support their participation in legal AD.
- The most important supports sought by both professions were:
- Training specifically for AD skills
- Authorised guidelines, to be provided by their respective regulating bodies
- Availability of a mentoring and support agency specifically for health practitioners' participation in AD
- Legal immunities from both criminal *and* civil prosecution
- An *independent* body reviewing health practitioners' compliance with the regulations
- The option to make a conscientious refusal and refer patients to another professional.

- There was also strong support for training in relation to AD at the undergraduate level for both nurses and doctors.

14. Is there another type of support that you would like to see available to medical/health practitioners participating in any stage of assisted dying?

Respondents' comments

One hundred and four respondents (19% of total respondents to this question) identified additional supports that they would like for participation in AD. Nearly one third of those (34%) wanted structured supports for individual practitioners such as mentoring, supervision, peer review or debriefing opportunities, and a further one sixth wanted counselling to be available. Typical comments were:

Support and peer review imperative COMPULSORY

To be able to debrief each case with an independent body

To have counselling available for staff. Even if you chose to help people in this area. Dealing with death dying all the time can impact on you unless able to discuss your work in safe environment

24 hour access to advice/support from colleagues

Probably a group of doctors set up like the SCENS group in the Netherlands who can provide and independent doctor and also provide experience help and guidelines

Some development of Good Medical Practice in Assisted Dying. This is so this is just not a default procedure but an active positive culture as to how assisted dying should be a praiseworthy part of clinical work.

All health professionals should be legally obliged to refer a patient who requests assistance in dying to a suitable health professional, regardless of whether they professionally or personally object to assisted dying. I think mandatory education, independent review/auditing, and support/mentoring/clinical supervision is vital.

Other supports suggested by 10-12% of respondents were: that the review of AD provision must be by an independent committee; that undergraduates or newly graduated professionals should not participate in AD; that AD provision might be a specialist area; that employer and workplace support was essential. Typical comments were:

I don't think that the young trainee is the person to be subjected to this type of clinical situation. While death and dying is part of the "business", I don't think that it is good to have to happen any sooner than necessary. Trainee level is not appropriate save for a war time scenario

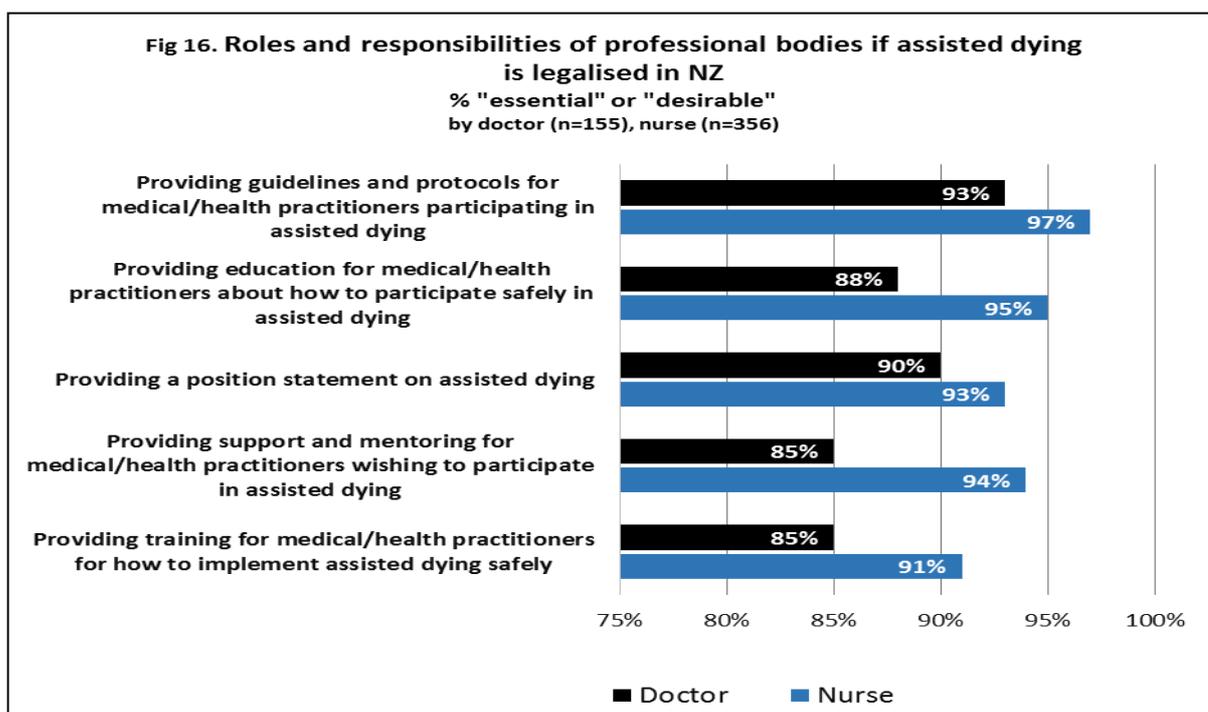
Consensus decision-making similar to multi-disciplinary meetings to determine plans for cancer patients. Could be national and performed via telehealth. Guidance from international experts and local ethicists and cultural experts

Regular auditing to safe-guard against criminal or conflict of interest (as evidenced by health professionals aiding relatives)

If this becomes legal then roadblocks need to be removed for the patient by professionals who will object due to their own beliefs. It needs to be mandatory that onward referrals are made and that the patient can Self Refer

15. What do you see as the role or responsibility of your professional body/ies (together with others) if assisted dying is legalised in New Zealand?

This question asked doctors and nurses to indicate the extent to which they saw providing safeguards for participating health practitioners as the responsibility of their professional bodies. Response options were: *Essential / Desirable / Optional / Not necessary / They should not be required to have any role / Not sure*.



Doctors' and nurses' views

- Very large majorities of both doctors and nurses viewed it as the responsibility of the relevant professional bodies to provide the 'essential' or 'desirable' supports identified in this graph
- Generally, nurses were more likely than doctors to see the responsibility for such supports as lying with their professional bodies.
- In particular, the provision of guidelines and protocols by the professional bodies and the provision by them of position statements were seen as essential.

Respondents' comments

Thirty-six doctors and 58 nurses made comments. Doctors' comments focused on the following perceptions of responsibilities:

- That it is the responsibility of the professional bodies to support their members in any area of medicine that is legal, especially a new area of practice (n=9)
- That it is not necessarily the responsibility of the professional bodies to ensure practice standards and guidelines for AD if it becomes legal, if they do not agree with the practice (n=6)

- That the professional bodies need to provide support for doctors who do not wish to participate in legal AD (n=5)
- That there needs to be an independent body undertaking audit and review of legal AD and/or providing guidelines and training (n=4)
- That the professional bodies may feel compromised or challenged ethically, will have to determine a solution, and should involve members in that (n=3)
- Other roles for the professional bodies (e.g. be “heavily involved” in the development of the legislation; “ensure that ethical standards are always adhered to”; n=4).

The remaining comments expressed general support for AD.

Typical comments were:

Guidance on ethics, programme structure and governance, checks and balances etc would be welcomed from the professional bodies. It will still be up to the individual practitioner as to whether their own moral conscience allows them to support the practice of legally assisted dying or not.

Each body needs to be very clear what their role/remit is. i.e. which body regulates, which body educates, which body reviews etc. Blurring roles, or a lack of role clarity would be disastrous.

I suspect that a separate body should administer protocols, standards and mentoring. The role of the colleges is education and integrity. This would be against many professionals views and should be kept separate. I could imagine that many would resign as a matter of conscience if their professional body officially endorsed and trained and mentored this activity.

I suspect that a separate body should administer protocols, standards and mentoring. The role of the colleges is education and integrity. This would be against many professionals views and should be kept separate. I could imagine that many would resign as a matter of conscience if their professional body officially endorsed and trained and mentored this activity.

Absolute clarity that drs cannot be coerced into involvement with this and no adverse effect on them for declining.

It is a difficult debate. I think the Geriatric society has been quite divided on the issue. I think there will need to be an agreement to disagree, not unlike abortion.

Nurses’ comments focused on their perceptions that the professional nursing bodies should take responsibility for the following:

- *Ensuring* provision of adequate guidelines, standards, training and education, though not for actually providing these things as such (n=21)
- Ensuring the availability of indemnity insurance and legal assistance, should it be needed (n=11)
- Providing leadership for the profession in the transition (n=5)
- Support for nurses choosing not to participate (n=2).

In contrast, ten respondents thought there should be another body or bodies taking responsibility for these kinds of functions, including large health sector employers, and two criticised the NZNO and Nursing Council respectively as being ineffectual for such roles. The remaining comments were of general support for legal AD.

Typical comments were:

Indemnity insurance for medical professionals who may be subject to litigation from families when they have acted in good faith

Provide legal guidelines absolving staff from criminal charge where all protocols and procedures have been adhered to. Immunity from criminal charge or prosecution for all medical staff and nursing staff involved where all protocols and procedures have adhered to.

I do not think the nursing council should issue an official stance on the issue - it's role would be to support its members in carrying out the process in accordance with any new legislation. It should have a responsibility to ensure its members are well educated on the matter and aware of all legal and ethical issues relating to any new legislation.

When assisted dying becomes legal, the professional bodies need to support it and the rights for patients to self determine.

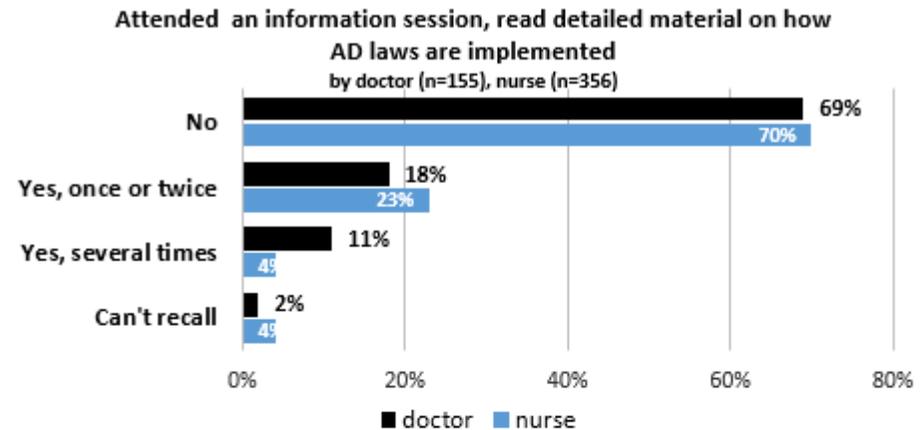
Nursing Council to go around giving talks about how they can support nurses. NOT JUST SEND OUT LETTERS, SAYING HOW THEY ARE GOING TO DO IT

Support for those who choose not to participate in assisted dying.

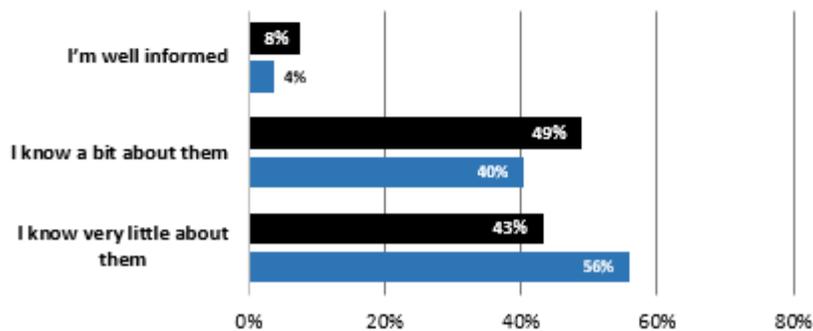
I see a potential conflict if it is passed as government legislation but is not supported by say Medical Council or Nursing Council. For example there are many medical practices undertaken by trained physicians and nurses that are unsupported by the statutory councils as being 'alternative' however break no legal boundaries. I would hate to see this legislation blocked by a few in positions of power on certain legislative boards..

16. i. How aware are you of the detailed safeguards *for patients* included in assisted dying laws in other countries (e.g. eligibility limitations; waiting times; procedural requirements)? ii. How aware are you of the detailed safeguards *for doctors* included in assisted dying laws in other countries (e.g. conscientious objection; immunity from prosecution)? iii. Have you ever attended an information session or read detailed material focused on how the assisted dying laws are implemented elsewhere?

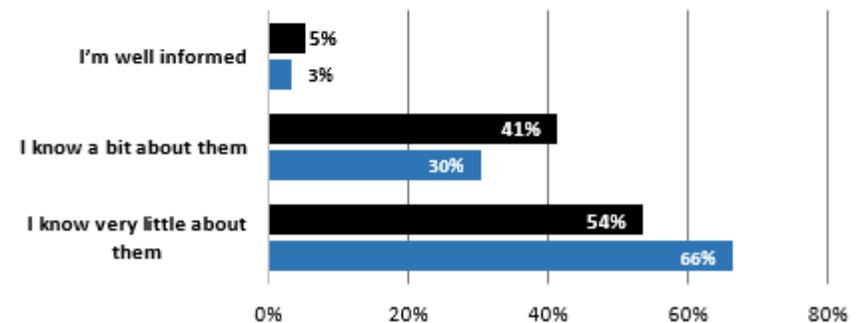
Fig 17. Awareness of legal AD requirements where AD is already legislated, including safeguards for patients and for doctors



Extent of awareness of the detailed safeguards *for patients* included in assisted dying laws in other countries,
by doctor (n=155), nurse (n=356)



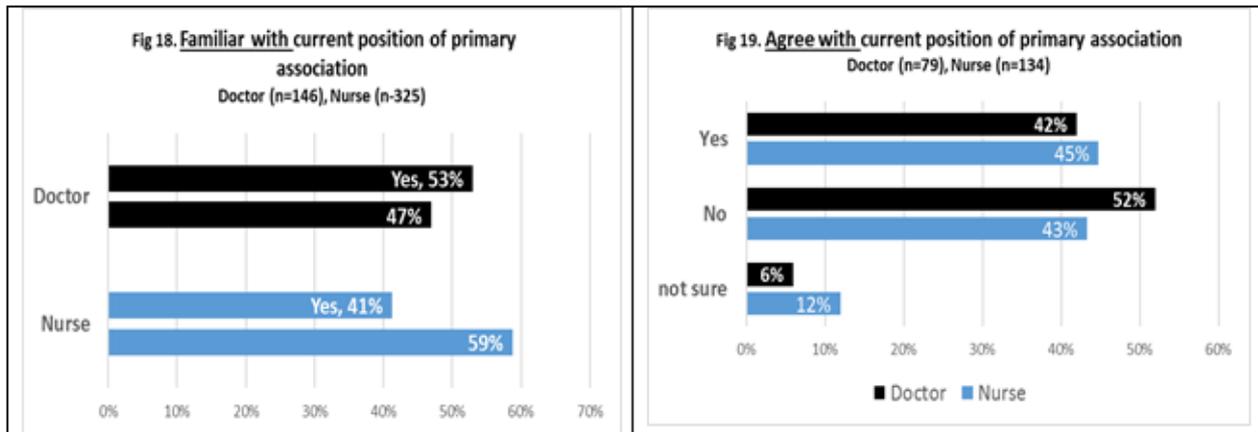
Extent of awareness of the detailed *for doctors* included in assisted dying laws in other countries,
by doctor (n=155), nurse (n=356)



Doctors' and nurses' views

- In general, both doctors and nurses felt poorly informed about the kinds of safeguards provided for both patients and doctors by the legislation in jurisdictions where AD is already legal.
- Only around a quarter of doctors (29%) and nurses (27%) had either read detailed material or attended an information session on how AD laws are implemented overseas. Despite such reading or attendance, fewer than 10% of doctors and only 3-4% of nurses rated themselves as “well informed” on the legal safeguards for patients and doctors.

17. Are you familiar with the current formal position on assisted dying of your primary professional association (if any)? Do you agree with that position? ... Do you wish to make any comments?



Doctors’ and nurses’ responses

- 50% of doctors were aware of the position of their professional body; 42% of those agreed with it, 52% disagreed, and 6% were not sure.
- 41% of nurses were aware of the positions of their professional body; 45% of those agreed with it, 43% disagreed, and 12% were not sure.

Respondents’ comments

Fourteen doctors (10% of total respondents to this question) and 33 nurses (10%) made comments. Ten doctor comments were critical of the stance of their association/s, naming in particular the NZMA and New Zealand Medical Council. The other four comments were generally supportive of AD but did not comment specifically on the stance of any professional body. Typical comments were:

The position of the NZMA is opposition to Euthanasia no matter what the law says. This should at the very least be the subject of input from members.

As I understand it administration of medicines to alleviate pain and suffering is allowed, even where the required palliative dose may hasten the patients inevitable death. Planned administration to plan a death is not allowed. If assisted dying was legal the position of professional bodies would change I am sure.

I think those governing medical bodies need to change with the times. What policy suited one era and one epoch is not going to be one that stands for eternity. Only if we are flexible and nimble, will we survive the changes that inevitably come with time. Otherwise, these bodies run the risk of becoming irrelevant.

It is a traditional position that is out of step with technological advances & will benefit from ethical review.

Nearly half of the nurses’ comments (14/33) gave a qualified agreement with the stance of their organisations, specifically naming the New Zealand Nurses Organisation and the Nursing Council of New Zealand. Six nurses were critical of the stance of their professional bodies, a further three made statements generally supporting AD, and the remainder were neutral.

Typical comments were:

Currently assisted dying is not legal therefore my professional bodies stance is appropriate at this time.

Until it is legal, sadly the regulatory bodies have to adhere to current law.

The NZNO cannot support assisted dying while it is illegal. I would expect them to change their position should that change.

Sometimes I think these governing bodies are still in the dark ages. I don't think they have a need to have a 'position' in the matter whatsoever.

I understand that a professional body must be guided by law, and support members to stay within those laws. However as I do not agree with the law as it currently stands I cannot agree with their position.

I am aware that the Palliative Care Council is against assisted dying. I strongly disagree with this position. I am unaware of the NZ Nursing Council's stance however I suspect that it would also be against as many would see it as undermining the populations trust in nurses.

There was not one to be found on the Nursing Council of New Zealand website. I would assume they would be against it, following the lead from the Medical Council

F. Declaration of interest

Pam Oliver is in principle supportive of legal assisted dying, provided that sufficient safeguards are incorporated into the legislation, and also supportive of the rights of health practitioners to exempt themselves from participation in legal assisted dying. She joined the Voluntary Euthanasia Society of New Zealand in 2014 specifically to access its Newsletters as part of the evidence review for her doctoral studies in law on barriers to legal assisted dying and has attended two VESNZ events since then for the purposes of data collection for her research. She is not active in VESNZ governance or member activities. Her involvement in the present research was based on a wish to see up-to-date information on doctors' and nurses' views towards legal assisted dying being available to the various medical and nursing professional bodies and the current Health Select Committee on Assisted Dying.

Phillipa Malpas has been a member of the Voluntary Euthanasia Society of New Zealand for almost twenty years as she believed then (and still does) that as a last-resort option, she ought to be legally permitted to determine the timing and manner of her death. She has been on public record stating her support for legal physician assisted dying (PAD) in qualified circumstances. In 2007, after completing her PhD, she became interested in the ethical dimension of PAD. She is aware that her continued membership of VES may cause some people to question her integrity, research findings, and trustworthiness. As a researcher she is trained to approach questions and data not from the perspective of her own personal views, but from evidence and critical analysis, as well as being guided by the expertise, experience and peer review of colleagues.

Mike Wilson is a registered nurse (Australia) with a background in public and mental health research, clinical practice and health workforce development. He is active in crisis support service with an emphasis on suicide prevention. He does not have a membership in any organisation related to euthanasia or assisted dying. His interest in this research is for the best information to be made available to legislators considering bills on this topic and for nursing and medical associations to have greater awareness of their members' attitudes.

G. Appendices

Email invitation to participants

Survey document

Attitudes towards legalising assisted dying: Survey of doctors and nurses – Invitation to take part



MEDICAL AND
HEALTH SCIENCES

Greetings and kia ora

Surveys in New Zealand this year have shown respectively that up to 12% of doctors polled had engaged in assisted dying, 45% believed that there should be a role for doctors in assisted dying and that the relevant law needed to be changed (*NZ Doctor*, 8 July 2015), and that nurses appear to have been involved in assisted dying also (Malpas et al *NZMJ* 24 July 2015).

The University of Auckland School of Medicine is now undertaking research to explore the range of attitudes of medical practitioners and nurses towards legalising physician-assisted dying. The aim is to obtain information that can (1) inform the development of any potential legislation on this important issue and (2) provide information of value to the relevant medical and nursing professional bodies. The survey has ethical approval from the University of Auckland (see below).

*Your participation in the survey will be **completely confidential** – it takes only around 15 minutes. Additional confidentiality information is provided in the survey.*

*Everyone who completes the survey **before 31 October** will go into the draw for one of four prizes of \$100 to a registered charity of your choice.*

To begin the survey, please click on this link:

http://m.marketpulseinternational.com/s/AD_survey/

This survey invitation is being emailed out by various medical and nursing associations and colleges in order to reach the greatest number of practitioners. We apologise for cross-postings to members of more than one organisation.

If you have any queries or concerns about the survey or the research, you are welcome to contact the researchers - Dr Phillipa Malpas 09 9233775 / p.malpas@auckland.ac.nz or Dr Pam Oliver 0800 847484 / pamo@clear.net.nz

Many thanks for your valuable input.

*Mai e te tipua, mai e te tawhito, mai e te kahui o ngā Ariki
Tihei mauri ora, maioha atu.*

For any queries regarding ethical concerns you may contact the Chair, The University of Auckland Human Participants Ethics Committee, The University of Auckland, Research Office, Private Bag 92019, Auckland 1142. Telephone 09 3737599 extn. 87830/83761. Email: humanethics@auckland.ac.nz APPROVED BY THE UNIVERSITY OF AUCKLAND HUMAN PARTICIPANTS ETHICS COMMITTEE ON THE 12th August, 2015, for 3 years, Reference Number 015470



Attitudes of doctors and nurses towards legalising assisted dying in New Zealand

Aim of the research

To inform the shape of any future laws in New Zealand. This survey is asking doctors and nurses their views on various end-of-life care treatment options, including palliative sedation and legal assisted dying.

Assurance of confidentiality

Research has shown that NZ doctors can be reluctant to give fully honest answers in research on assisted dying, due to confidentiality concerns^[1]. All information provided by you will be treated in the strictest confidence and the data reported only in a consolidated form, **so we encourage you to be as open and honest as you can**. We are independent (that is, not funded by any organisation with a particular point of view, such as the New Zealand Voluntary Euthanasia Society or Euthanasia-Free NZ).

For any queries regarding ethical concerns you may contact the Chair, The University of Auckland Human Participants Ethics Committee, The University of Auckland, Research Office, Private Bag 92019, Auckland 1142. Telephone 09 3737599 extn. 87830/83761.

Email:humanethics@auckland.ac.nz

APPROVED BY THE UNIVERSITY OF AUCKLAND HUMAN PARTICIPANTS ETHICS COMMITTEE ON THE 12th August, 2015, for 3 years, Reference Number 015470

Information about legal assisted dying

If you would like a quick summary of places where assisted dying is currently legal, [click here](#).

[1] Merry et al. 2013. Doctors' willingness to give honest answers about end-of-life practices: a cross-sectional study. *BMJ Open* 3[5]

Definitions – please read before starting the survey

For the purposes of this survey:

Assisted dying is defined as - the legal prescription and administration of a ***lethal dose of medication***, at the request of a mentally competent patient at end of life, ***with the intention of ending their life***, where strict eligibility and procedural requirements are all met in the view of two doctors, including one independent doctor, and that decision is subsequently endorsed by an independent Review Committee.

Palliative sedation is defined as – ***purposefully inducing unconsciousness continuously until death***, through the use of medications, to relieve intractable and unendurable symptoms, at the request of a mentally competent patient who, given their disease state, progression and symptom constellation, is expected to die within hours or days.

Advance directive is a consent given, usually in writing, by a mentally competent person, advising which treatments the person does or does not consent to if they are not able to give consent in the situation needed.

Click 'Next' below to start the survey

Your views of end of life care options

1. In principle, *how much do you agree* that each of the following options should be available to people as part of end-of-life medical care, given appropriate protocols and ethical/practice guidelines for medical/health practitioners?

[Click here](#) if you wish to view the definitions again.

	Strongly agree	Mostly agree	Mostly disagree	Strongly disagree	Not sure
a. Refusal by the patient of nutrition and hydration	<input type="radio"/>				
b. Withdrawal or withholding of treatment at the verbal request of a mentally competent patient	<input type="radio"/>				
c. Withdrawal or withholding of treatment via a valid advance directive	<input type="radio"/>				
d. Withdrawal or withholding of treatment as a clinical decision where such treatment would be clearly futile	<input type="radio"/>				
e. Palliative sedation at the verbal request of a mentally competent patient	<input type="radio"/>				
f. Palliative sedation via a valid advance directive	<input type="radio"/>				
g. Administration of high doses of pain relief even though that may have the effect of hastening the patient's death	<input type="radio"/>				
h. Legal assisted dying, following repeated, clear requests (including one in writing on a prescribed form) from a mentally competent patient who meets all required criteria and conditions	<input type="radio"/>				

Page 4

2. What are the *main reasons for your views* about whether assisted dying should be a legal and regulated option as part of end-of-life medical care?

Type here

3. How influential have each of the following factors been on shaping your views towards legalising assisted dying?

	Very influential	Somewhat influential	Not at all influential	Not sure
a. Your personal experiences with family, or the personal experiences of people you know	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
b. Clinical experiences – your own or colleagues'	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
c. Your personal philosophies and ethical beliefs	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
d. Your religious beliefs	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
e. The stance of your professional association/s	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
f. The influence of one or more particular individuals (e.g. colleague, teacher, other acquaintance)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
g. Research evidence	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

3h. Please describe in the box below any other factors that have significantly shaped your views towards legalising assisted dying.

Please answer in your own words; if you have no comments to make, write 'none'

Type here

Page 5

4. What are your main concerns or misgivings around legalising assisted dying in New Zealand?

Please answer in your own words; if you have no concerns, write 'none'

Type here

If you would like to review the usual key features of assisted dying laws before answering the remaining questions, [click here](#).

Click *Next* to continue the survey

5. In principle, given the provision of appropriate protocols and ethics/practice guidelines, how much do you agree that legal assisted dying should be available *following repeated clear requests from a mentally competent patient*, in each of the following medical circumstances?

	Strongly agree	Mostly agree	Mostly disagree	Strongly disagree	Not sure
a. Where the patient has a terminal illness with a prognosis of six months or less	<input type="radio"/>				

b. Where the patient has multiple irremediable medical conditions related to old age that render their life “unbearable” in their view	<input type="radio"/>				
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c. Where the patient has a non-terminal but “grievous and irremediable” medical condition that renders their life “unbearable” in their view, e.g.:

	Strongly agree	Mostly agree	Mostly disagree	Strongly disagree	Not sure
I. Motorneurone disease (ALS) with ‘locked-in’ syndrome	<input type="radio"/>				
II. Complete tetraplegia with multiple severe medical complications	<input type="radio"/>				
III. Recurrent endemic depression over 30 years and a history of competent requests for assisted dying	<input type="radio"/>				

5(cont). In principle, given the provision of appropriate protocols and ethics/practice guidelines, how much do you agree that legal assisted dying should be available *following repeated clear requests from a mentally competent patient*, in each of the following medical circumstances?

	Strongly agree	Mostly agree	Mostly disagree	Strongly disagree	Not sure
d. In response to a registered Advance End of Life Care Directive instructing assisted dying, where the patient has had an accident resulting in a persistent vegetative state	<input type="radio"/>				
e. In response to a registered Advance End of Life Care Directive instructing assisted dying, where the patient has developed advanced dementia together with multiple irremediable medical conditions that render their life "unbearable" in their view	<input type="radio"/>				

Do you wish to make any comments?

Please answer in your own words; if you have no comments to make, write 'none'

Type here

6. Is assisted dying something you would:

	Definitely yes	Probably yes	Maybe	Probably not	Definitely not	Not sure
Consider for yourself	<input type="radio"/>					
Support for a family member	<input type="radio"/>					

7. How much do you agree that assisted dying, if legalised, should be available to people when resident in hospitals, hospices and aged care facilities?

- Strongly agree
- Mostly agree
- Mostly disagree
- Strongly disagree
- Not sure

Willingness to participate in *legal* assisted dying in NZ

8. To what extent *would you be willing to participate* in the following range of likely activities in legalised assisted dying in NZ, assuming (i) the provision of clear guidelines and protocols authorised by the appropriate professional bodies, and (ii) *that your profession has been given the delegated authority* for such tasks?

	Very willing	Probably willing	Probably not willing	Definitely not willing	Not sure
a. Discussing assisted dying with a patient (whether or not they proceed to a request)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
b. Referring a request to another practitioner	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
c. Responding to an initial request with information	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
d. Supporting a request (e.g. working with families)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
e. Undertaking the required eligibility assessment	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
f. Writing a prescription for the drugs required	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
g. Administering the drugs via IV	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
h. Administering the drugs via injection	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
i. Attending an assisted death where the person ingests the drugs	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
j. Follow-up with family	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Psychiatrists only

8k. Would you be willing to undertake an assessment for mental competence?

- Very willing
- Probably willing
- Probably not willing

Definitely not willing

Not sure

Do you wish to make any comments?

Please answer in your own words; if you have no comments to make, write 'none'

Type here

9. Have you ever been involved in any of the following actions yourself as part of a patient's end-of-life medical care? (**Note: all answers are anonymous**)

[Click here](#) if you wish to view the definitions again

	Never	Once or twice	Several times	Many times	Can't recall	Never been involved in a patient's end of life decision-making	Prefer not to answer
a. Complying with a refusal by the patient of nutrition and hydration	<input type="radio"/>	<input type="radio"/>					
b. Withdrawal or withholding of life-prolonging treatment at the verbal request of a mentally competent patient	<input type="radio"/>	<input type="radio"/>					
c. Withdrawal or withholding of life-prolonging treatment via a valid advance directive	<input type="radio"/>	<input type="radio"/>					
d. Withdrawal or withholding of life-prolonging treatment as a clinical decision where continuing treatment would have been clearly medically futile	<input type="radio"/>	<input type="radio"/>					
e. Providing continuous palliative sedation at the verbal request of a mentally competent patient	<input type="radio"/>	<input type="radio"/>					
f. Providing continuous palliative sedation via a valid advance directive	<input type="radio"/>	<input type="radio"/>					
g. Administration of high doses of pain relief even though that may have the effect of hastening the patient's death	<input type="radio"/>	<input type="radio"/>					
h. Assisting someone to have a hastened death by	<input type="radio"/>	<input type="radio"/>					

intentionally administering or supplying a lethal dose of medication.

Never
 Once or twice
 Several times
 Many times
 Can't recall
 Never been involved in a patient's end of life decision-
 Prefer not to answer

Do you wish to make any comments?

Please answer in your own words; if you have no comments to make, write 'none'

Type here

Concerns about potentially participating in *legal* assisted dying in NZ

10. To what extent *might you be deterred* from participating in legal assisted dying due to concerns about any of the following factors?

	A lot	A bit	Not much	Not at all	Not sure
a. Professional stigma or conflict	<input type="radio"/>				
b. Lack of training and skills for the tasks involved	<input type="radio"/>				
c. Lack of authorised guidelines for implementation	<input type="radio"/>				
d. Lack of professional support to implement	<input type="radio"/>				
e. Fear of litigation or reprimand	<input type="radio"/>				
f. Personal philosophical objection	<input type="radio"/>				
g. Request from your employer to decline all involvement in assisted dying	<input type="radio"/>				

10h. Please describe in the box below any other factors that might deter you from participating in legal assisted dying.

Please answer in your own words; if you have no comments to make, write 'none'

Type here

11. How much do you think the following measures will be needed to support safe participation by medical/health practitioners in the various processes of providing legal assisted dying?

	Essential	Desirable	Optional	Not necessary	Potential disadvantage	Not sure
a. Immunity from civil or criminal prosecution where legal requirements are adhered to in good faith	<input type="radio"/>	<input type="radio"/>				
b. Option for conscientious objection for individual practitioners	<input type="radio"/>	<input type="radio"/>				
c. Option to refer an assisted dying request to another professional or a designated official	<input type="radio"/>	<input type="radio"/>				
d. Training for medical, nursing and mental health practitioners wishing to participate	<input type="radio"/>	<input type="radio"/>				
e. Authorised guidelines (e.g. by the New Zealand Medical Council and/or Nursing Council)	<input type="radio"/>	<input type="radio"/>				
f. Establishment of a support and mentoring organisation for medical, nursing and mental health practitioners who wish to participate	<input type="radio"/>	<input type="radio"/>				
g. An Independent Review Committee checking compliance with procedures	<input type="radio"/>	<input type="radio"/>				
h. Training for medical and nursing undergraduates	<input type="radio"/>	<input type="radio"/>				

12. Is there another type of support that you would like to see available to medical/health practitioners participating in any stage of assisted dying? Please describe.

Please answer in your own words; if you have no comments to make, write 'none'

Type here

Do you wish to make any comments?

Please answer in your own words; if you have no comments to make, write 'none'

Type here

Role of the professional bodies in regulating for legalised assisted dying

13. What do you see as the role or responsibility of your professional body/ies (together with others) *if assisted dying is legalised* in New Zealand?

	Essential	Desirable	Optional	Not necessary	They should not be required to have any role	Not sure
a. Providing a position statement on assisted dying	<input type="radio"/>	<input type="radio"/>				
b. Providing guidelines and protocols for medical/health practitioners participating in assisted dying	<input type="radio"/>	<input type="radio"/>				
c. Providing for education for medical/health practitioners about how to participate safely in assisted dying	<input type="radio"/>	<input type="radio"/>				
d. Providing for training for medical/health practitioners for how to implement assisted dying safely	<input type="radio"/>	<input type="radio"/>				
e. Providing for support and mentoring for medical/health practitioners wishing to participate in assisted dying	<input type="radio"/>	<input type="radio"/>				

13f. Please describe in the box below any other role or responsibility of your professional body/ies (together with others) *if assisted dying is legalised* in New Zealand?

Please answer in your own words; if you have no comments to make, write 'none'

Type here

14. Are you familiar with the current formal position on assisted dying of your primary professional association (if any)?

- Yes
- No
- N/A

15. Do you agree with that position?

- Strongly agree
- Mostly agree
- Mostly disagree
- Strongly disagree
- Not sure
- I don't know their position

Do you wish to make any comments?

Please answer in your own words; if you have no comments to make, write 'none'

Type here

Awareness of the safeguards in existing laws overseas

16. How aware are you of the detailed safeguards for **patients** included in assisted dying laws in other countries (e.g. eligibility limitations; waiting times; procedural requirements)?

- I'm well informed
- I know a bit about them
- I know very little about them

17. How aware are you of the detailed safeguards for **doctors** included in assisted dying laws in other countries (e.g. conscientious objection; immunity from prosecution)?

- I'm well informed
- I know a bit about them
- I know very little about them

18. Have you ever attended an information session or read detailed material focused on how the assisted dying laws are implemented elsewhere?

- Yes, several times
- Yes, once or twice
- No
- Can't recall

19. Have you ever read the End of Life Choice Bill 2012 (Maryan Street's NZ Bill) or any other Bill or Act for assisted dying?

- Yes, in some detail
- Only a skim read
- No
- Can't recall

Do you wish to make any comments?

Please answer in your own words; if you have no comments to make, write 'none'

Type here

About you

Note: the following information will be separated from your responses to the foregoing questions.

20. Are you a: (Select one)

- Doctor
- Nurse
- Other health practitioner

20A. What has been your main area of specialisation?

- Accident and medical
- General medicine
- General practice
- Geriatrics/Gerontology
- Intensive care
- Neurology
- Oncology
- Paediatrics
- Palliative medicine
- Psychiatry
- Public health
- Surgery
- Urgent care
- Emergency medicine
- Radiology
- Other (Please specify)

20B. What is your registered scope of practice?

- Enrolled nurse
- Registered nurse
- Nurse practitioner

21. Your age group is:

- Under 30
- 30-45
- 46-60
- Over 60

22. How many full-time years equivalent have you worked in medical or nursing practice?

- 1-5
- 6-10
- 11-20
- 21-40
- More than 40

23. How many full-time years equivalent have you worked in end-of-life or aged care?

- 1-5
- 6-10
- 11-20
- 21-40
- More than 40
- I haven't worked in end of life care

24. Gender:

- Female
- Male
- Transgender/Intersex

25. Ethnic affiliation/s: (Select any that apply to you)

- Pākehā / NZ European
- Māori

- Pasifika
- Indian
- Chinese
- Other Asian
- Other ethnicity

26. Professional memberships: (Select any that apply to you)

Medical bodies

- Australian and New Zealand Society of Palliative Medicine (ANZSPM)
- Australian & New Zealand Association of Neurologists (ANZAN)
- Australasian College of Emergency Medicine (ACEM)
- College of Intensive Care Medicine of Australia and New Zealand (CICMANZ)
- Gerontology Association of New Zealand
- New Zealand Medical Association (NZMA)
- New Zealand Society for Oncology (NZSO)
- Pasifika Medical Association
- Royal Australasian College of Physicians (RACP)
- Royal New Zealand College of General Practitioners (RNZCGP)
- Royal Australian and New Zealand College of Psychiatrists (RANZCP)
- Royal New Zealand College of Urgent Care (RNZCUC)
- Royal New Zealand College of Public Health Medicine (RNZCPHM)
- Te Ohu Rata o Aotearoa – Māori Medical Practitioners Association (Te ORA)
- Other (please specify)

Nursing bodies

- College of Nurses Aotearoa
- New Zealand College of Mental Health Nurses
- New Zealand Nurses Organisation (NZNO)
- Samoan Nurses Association
- Te Kaunihera o Ngā Neehi Māori (Māori Nurses Association)
- Tongan Nurses Association
- Other (please specify)

27. Where do you mostly practice currently?

- City of more than 250,000
- Provincial city
- Town
- Rural practice

28. Do you have a religious affiliation?

- Christian
- Jewish
- Muslim
- Hindu
- Other
- None

29. Frequency of religious observances (e.g. attendance at church or prayer group):

- More than once a week
- Weekly
- Monthly approximately
- Only for special events (e.g. weddings, funerals)
- Never
- N/A

Thank you for giving your valuable time and thoughts for this survey, it's greatly appreciated.

You are welcome to send the survey invitation to other doctors and nurses currently registered in New Zealand.

FINALLY...

If you would like to offer further comments or discuss your answers to the survey or other matters, you are welcome to contact Pam Oliver on 0800 847484 or pamo@clear.net.nz

If you are interested in further reading about assisted dying, you are welcome to contact Dr Pam Oliver pamo@clear.net.nz for a selection of academic and non-academic materials.

If you would like to be entered into the prize draw, please [click here](#) to provide your email address. To ensure your anonymity, it will be recorded separately from your survey responses.

If you do not wish to be entered into the prize draw, please click 'Submit' below.

