

# New Zealand doctors' and nurses' views on legalising assisted dying in New Zealand

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## ABSTRACT

**BACKGROUND:** Assisted dying (AD) has been legalised by statute or court decisions in at least 15 jurisdictions internationally. Nonetheless, only three medical professional bodies (and none in nursing) across those jurisdictions have proactively developed authorised policy, practice standards, guidelines or protocols, or other professional supports for health practitioners who may legally participate in AD services, and the majority internationally remain formally opposed to AD. There is a perceived likelihood that AD may be legalised in New Zealand soon.

**AIM:** This study explored the views of doctors and nurses as to support for or opposition to legalising AD, including reasons for those views, what might deter generally willing doctors and nurses from providing AD services and what professional supports were perceived as essential or desirable to enable willing engagement in AD service provision.

**RESULTS:** While only 37% of doctors supported legalising AD in New Zealand, 67% of nurses were supportive. Of those respondents who were willing in principle to provide AD services, large majorities identified a range of practical and ethical professional supports as essential to safe practitioner engagement. Those respondents overwhelmingly saw the provision of most of those supports as the responsibility of the medical and nursing professional bodies.

**CONCLUSION:** There is a substantial cohort of doctors and nurses in New Zealand who support legalising AD, potentially sufficient for reasonable seeker access to AD services once legalised. However, many doctors in particular still oppose AD, and international research shows that the main barrier to access to legal AD is a lack of capacity and capability among health professionals, due in large part to several related factors, in particular: a lack of either accredited training and education for the AD provider tasks and roles; inadequate immunities within the legislation to protect participating professionals; and most importantly, a lack of practice standards and guidelines authorised by the relevant medical and nursing professional bodies. The challenge is for such protections to be available well in advance of legalisation, so that health practitioners are not at risk ethically or otherwise in early participation.

In the past two decades, more than a dozen jurisdictions internationally have legalised assisted dying (AD) with varying regulatory regimes.<sup>1-3</sup> Where jurisdictions internationally have legalised AD, the intent of the legislation—to ease intolerable suffering through proactive medical intervention to hasten death—has been frustrated by a range of factors, some foreseen and others unforeseen.<sup>4</sup> Major access barriers can occur not only for people seeking AD ('seekers') but also for doctors and other health practitioners who wish to provide legal AD services.<sup>4-6</sup> Barriers identified widely

for doctors wishing to provide AD services include difficulties with the interpretation of legal requirements,<sup>7</sup> but are also often attributed by doctors to the absence of authorised guidelines, protocols and training for safe provision of AD services, resulting in doctors' fearing professional stigma or censure, the potential for making professional errors, and/or collegial or employer pressure to not engage in providing AD.<sup>4</sup>

Surveys and polls over the past 20 years have demonstrated strong and increasing public support for legalising AD in New Zealand.<sup>8-12</sup> In studies over the past decade,

small percentages of New Zealand doctors have acknowledged providing patients with a drug that had been “prescribed, supplied or administered explicitly for the purpose of hastening the patient’s death”, and nurses were identified as having assisted in hastening patients’ deaths in this way.<sup>13,14</sup> The New Zealand Nurses Organisation (NZNO), in its 2016 submission to the Health Select Committee on Assisted Dying, noted that “... some form of euthanasia may be legal in Aotearoa New Zealand in the near future [which will] have serious implications for nurses who are involved in caring for people that are dying ... [and thus] require consideration and input from professional nursing associations, regulatory bodies and national nursing organisations” into the development of the legislation.<sup>15</sup> However, most of New Zealand’s professional medical and nursing bodies have until now consistently either opposed AD or declined to take a stand, and none of them appears as yet to have actively considered its potential role in providing practice standards or guidelines for its members in the anticipation of AD being legalised. The vocal opposition to legalising AD, in particular from faith-based organisations, has been endorsed by some palliative medicine and palliative care professional bodies.<sup>16–19</sup>

Given a perceived likelihood that AD may be legalised in New Zealand, the present research canvassed the following questions:

- What are New Zealand doctors’ and nurses’ views of legalising AD in New Zealand?
- What end-of-life practices, including AD, occur currently in doctors’ and nurses’ practice?
- In what circumstances might doctors and nurses be willing to engage in legal AD?
- What would deter doctors and nurses from engaging in legal AD?
- How might barriers to health practitioner participation be mitigated?

## Method

### Data collection

In October/November 2015, an invitation was disseminated through the electronic newsletters and some websites of key New

Zealand medical and nursing professional bodies (including Australasian bodies) for New Zealand-registered doctors and nurses to take part in an online survey. The survey was anonymous and was approved by the University of Auckland Human Participants Ethics Committee (UAHPEC Reference: 015470) prior to dissemination. The survey questions and structure were developed from a review of the literature on doctors’ and nurses’ attitudes towards AD internationally and the development of professional supports for doctors and nurses participating in legal AD in North America and Europe. A mixed-method survey approach employed quantitative and qualitative data collection. Rating scales and other closed-ended response options were augmented by several open-ended questions for respondents to voice independent views. Rating questions had response options that allowed for the full range of views, from ‘strongly agree’ to ‘strongly disagree’, with options to indicate uncertainty or omit the question if preferred, eg, ‘not applicable’, ‘don’t know’, ‘not sure’, ‘prefer not to answer’. The survey was piloted with five doctors and five nurses working in a variety of specialities. It took from 15 to 30 minutes to complete depending on respondent contribution to the open-ended questions. Quantitative data analysis focussed on response frequency and percentage counts with cross-tabulation of selected variables of interest. Qualitative data were analysed using thematic analysis.<sup>20</sup> Multiple quotes have been included to represent the diversity of viewpoints.

### Respondent attributes

Of the total 969 survey respondents, 197 did not complete the demographic questions. This article reports on the 772 responses identifiable as those of a doctor (n=298) or nurse (n=474). (Accordingly these data differ in some respects from those discussed in our *report* ‘Attitudes of New Zealand doctors and nurses towards legalising assisted dying - Report to New Zealand medical and nursing associations’, disseminated to medical and nursing associations earlier in 2016). Most respondents were highly experienced practitioners, and many had significant experience in end-of-life (EOL) care (see Table 1). The age, sex and ethnic distribution was closely representative of the medicine

**Table 1:** Percent frequency of respondent characteristics by nurse (n=474) and doctor (n=298).

	Age				Gender						
	<30	30–45	46–60	>60	F	M	T/I				
Doctor	2	36	49	14	49.5	50.2	0.3				
Nurse	11	22	51	17	93.5	6.5	.				
	Ethnicity*										
	NZ European/Pakeha		Māori	Pasifika	Indian	Chinese	Other Asian				
Doctor	82		3	1	2	4	18				
Nurse	87		4	1	0.4	1.1	10				
	FTE years professional experience					FTE years EOL care experience					
	1–5	6–10	11–20	21–40	>40	1–5	6–10	11–20	21–40	>40	None
Doctor	3	8	33	49	7	20	8	16	17	1	38
Nurse	16	10	25	37	13	38	16	14	7	1	25
	Location of practice				Religious affiliation						
	City (pop >250,000)	Provincial city	Town	Rural	None	Christian	Jewish	Hindu	Other		
Doctor	55	31	6	8	43	53	.	0.7	3		
Nurse	49	30	15	6	47	47	0.4	0.2	6		

\*Respondents could select as many as applied.

and nursing professions generally in New Zealand.<sup>21,22</sup> Doctors responding were predominantly members of the Royal New Zealand College of General Practitioners (RNZCGP) (40%) and New Zealand Medical Association (NZMA) (20%). Almost all nurses (98%) were members of the New Zealand Nursing Organisation (NZNO), with 21% also members of other professional nursing bodies. Respondents could select more than one professional membership, thus percentages exceed 100%. Just over half of respondents (55%) identified a religious affiliation, predominantly Christian, while the remainder indicated no religious affiliation.

## Results

### Doctors' and nurses' support for and opposition to legalising AD

As shown in Figure 1, 37% of doctors and 67% of nurses responding “strongly” or “mostly” agreed—on a 5-point scale from ‘strongly agree’ to ‘strongly disagree’ or ‘not sure’—that AD should be legalised in New Zealand, assuming provision of appropriate guidelines and protocols. In contrast, 58% of doctors and 29% of nurses “strongly” or “mostly” disagreed with legalising AD. That

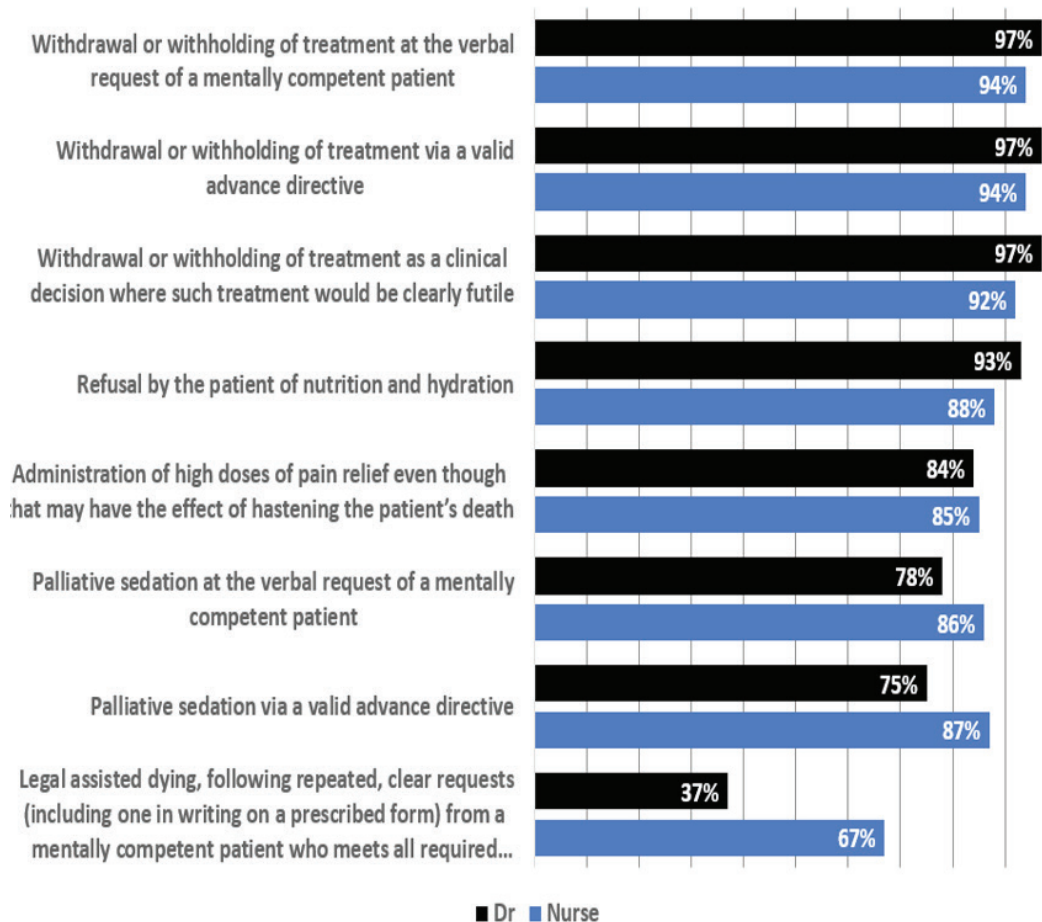
is, respondents tended to hold clear, and polarised, views on the topic, with only 4–5% of doctors and nurses answering “Not sure”.

These findings reflect both recent New Zealand studies<sup>8,23</sup> and research in other countries prior to AD legislation being introduced, where somewhere between 30–40% of doctors have supported legalisation.<sup>24–26</sup> While no previous international research has measured nurses' support for or willingness to participate in AD prior to legalisation, the greater support from nurses than doctors is consistent with research elsewhere.<sup>27–29</sup>

### Reasons for supporting legal AD

The most common reasons for supporting legal AD were respondents' views about (in order of frequency): people's right to autonomous decision-making at the end of their life, irrespective of health practitioners' beliefs (33% of all respondents to this question), 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

**Figure 1:** Agree with various end-of-life medical care options % "strongly" or "mostly" agree by doctor (n=298), nurse (n=475).



futility, resulting in avoidable suffering through prolonging people's lives, without their permission or against their wishes (9%). Percentages may total more than 100% collectively because respondents could give multiple reasons. Respondents' comments are provided verbatim with the original spelling, grammar and punctuation. This is accepted good practice in reporting qualitative data. Typical comments were:

*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. ... 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). [Nurse]*

*Everyone has a right to self-determination. I do not believe that the medicalised healthcare system should be able to override 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. [Nurse]*

*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 [health practitioners] do is cruel at times (despite best intentions) and can cause a lot of pain for very little benefit (if any). [Doctor]*

Collectively, these reasons indicate that respondents' support for legal AD closely reflected the key principles of medical ethics—beneficence, non-maleficence and in particular, patient autonomy as the recognised priority ethical principle in health care<sup>30</sup>—together with a perception by many respondents that the medical profession currently does not always sufficiently respect patient autonomy when it comes to death and dying.

*'Clearly medically futile' treatment is offered/ordered/carried out far too often.*



*Advanced Directives are ignored/dismissed by Doctors too often. [Nurse]*

*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. [Nurse]*

### Reasons for opposing legal AD

The most common reasons for respondents opposing AD were (in order of frequency): a belief that undertaking AD functions was not a proper role for health practitioners (10% of all respondents to this question); a belief that vulnerable people will be pressured to end their lives prematurely (10%); 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) or families coercing dying people (7%); and a belief that there is important spiritual value in suffering (7%). The following comments illustrate these reasons:

*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. [Nurse]*

*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. [Nurse]*

*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. [Nurse]*

These concerns highlight the equivocality and confusion of many health practitioners in relation to respecting patient autonomy when their own moralities may not entirely align with those of patients on this matter.

### Deciding about legalising AD

While a majority of respondents were either “strongly” opposed or “strongly” supportive of legal AD, 21% of doctors and 19% of nurses voiced some level of ambivalence, identifying difficulties in thinking through the pros and cons of legalising AD, often because of lack of information. Only around a quarter of doctors (29%) and nurses (27%) had ever read detailed material or attended an information session on how AD laws are implemented overseas, while less than 10% of doctors and only 4% of nurses rated themselves as “well informed” on the legal safeguards for patients and doctors in jurisdictions where AD is already legal.

*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. [Doctor]*

*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. [Doctor]*

Ambivalence was also apparent, more so among doctors than nurses, in relation to the acceptability of other, already legal end-of-life (EOL) interventions involving palliative sedation or the administration of high doses of pain relief where doing so had a potential to hasten death (see Figure 1). On

the one hand, 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” indicate that the ‘doctrine of double effect’ is accepted practice among the majority of EOL care practitioners in New Zealand, as is the case in many overseas countries.<sup>31</sup>

*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. [Nurse]*

*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. [Doctor]*

However, between one sixth and one quarter of doctors and nurses variously did not support other currently legal EOL interventions, in particular palliative sedation. This response pattern suggests that health practitioners struggle with the ethics, or personal emotional impacts, of supporting patients’ EOL treatment choices where those involve actively administering medication, rather than withholding it, even where the outcome is likely to be the same, the patient has requested it and administering medication may well result in significantly less physical and/or emotional distress for the patient and family.

### In what medical circumstances should AD be legal?

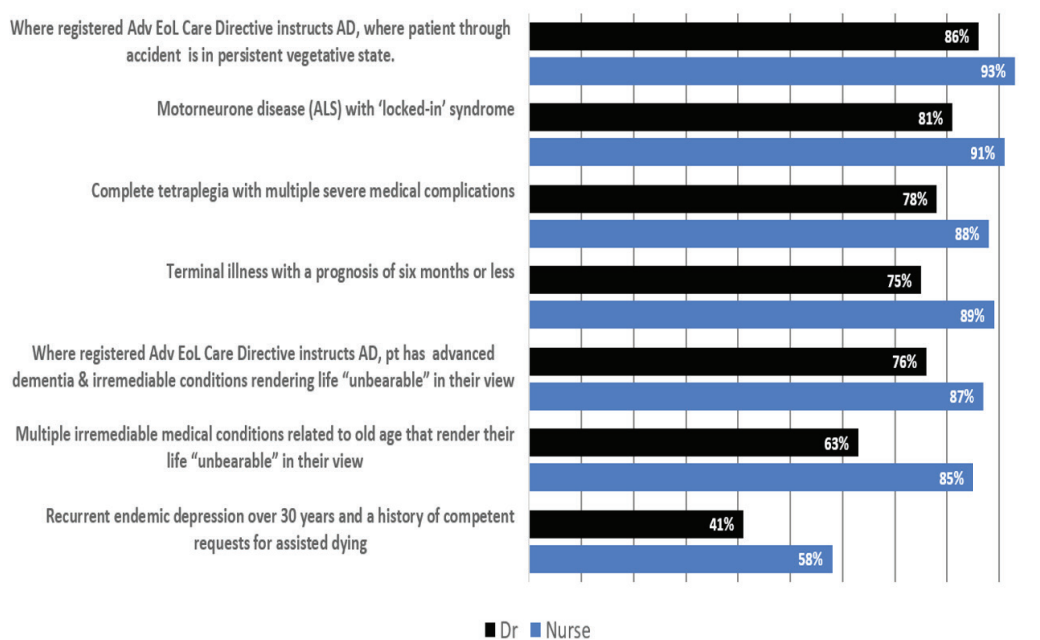
The data discussed in the remainder of this article represent the views of a sub-sample in the study—those respondents who had answered “strongly agree”, “mostly agree”, “mostly disagree” or “not sure” to the initial survey question on whether respondents agreed with legalising AD. Respondents who “strongly” disagreed with legal AD did not complete the remaining questions in the survey, as those were not relevant to opposers.

As Figure 2 illustrates, among the sub-sample there was a high level of support from both doctors and nurses for the availability of legal AD for seekers with a wide range of medical conditions. However, support for AD was greatest where the medical condition most clearly indicated either imminent death or a clear absence of quality of life—conditions such as a terminal illness, profoundly disabling conditions such as motorneurone disease, or being in a persistent vegetative state—that is, in patient contexts where there are arguably fewer ethical dilemmas and the health practitioner does not have to make value judgments or challenge their own belief systems. In contrast, support for legal AD was lowest where the medical decision-making was more ethically complex and open to value judgments, for example, where the person had multiple irremediable age-related comorbidities that made their life unbearable, in their view, or where the person had dementia but had made a clear advance directive while mentally competent instructing AD in certain circumstances which they considered intolerable. In these contexts, where health practitioners would need to make judgments and decisions about concepts such as mental competence, depressive states or the ‘unbearability’ of living, respondents voiced that decision-making as problematic, as it is for many doctors where AD has been legalised.<sup>32, 33</sup>

*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. [Doctor]*

In contrast, doctors’ support for AD for people with multiple age-related medical conditions increased from 63% to 76% where there was a legal advance directive in place validating the person’s pre-considered wishes, so that the doctor was not required to make a judgment for a seeker whose competence was in any doubt. Respondents’ comments commonly reflected their concerns about making value judgments on

**Figure 2:** Agree with the availability of AD for various circumstances % "strongly" or "mostly" agree by doctor (n=155), nurse (n=356).



behalf of patients, highlighting the subjectivity of clinical judgment, and the need to make clinical decisions in a broader social/cultural/psychological context and only after substantial discussion with patients.

*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. [Doctor]*

*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]. [Doctor]*

*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. [Doctor]*

Unsurprisingly, many doctors also voiced the same concerns about the challenges in validating advance directives instructing AD, which remains an issue even where that is available by statute in The Netherlands.<sup>34</sup> However, it was apparent that many respondents had been thinking through how to manage such challenges.

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

*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? [Doctor]*

Figure 2 also shows that nurses were consistently and substantially more supportive of legal AD across the range of medical circumstances, remarkably so for AD to be permitted on the basis of aging-related co-morbidities and recurrent endemic depression, as has been found in overseas research.<sup>27</sup>

### In what circumstances might doctors and nurses be willing to engage in legal AD?

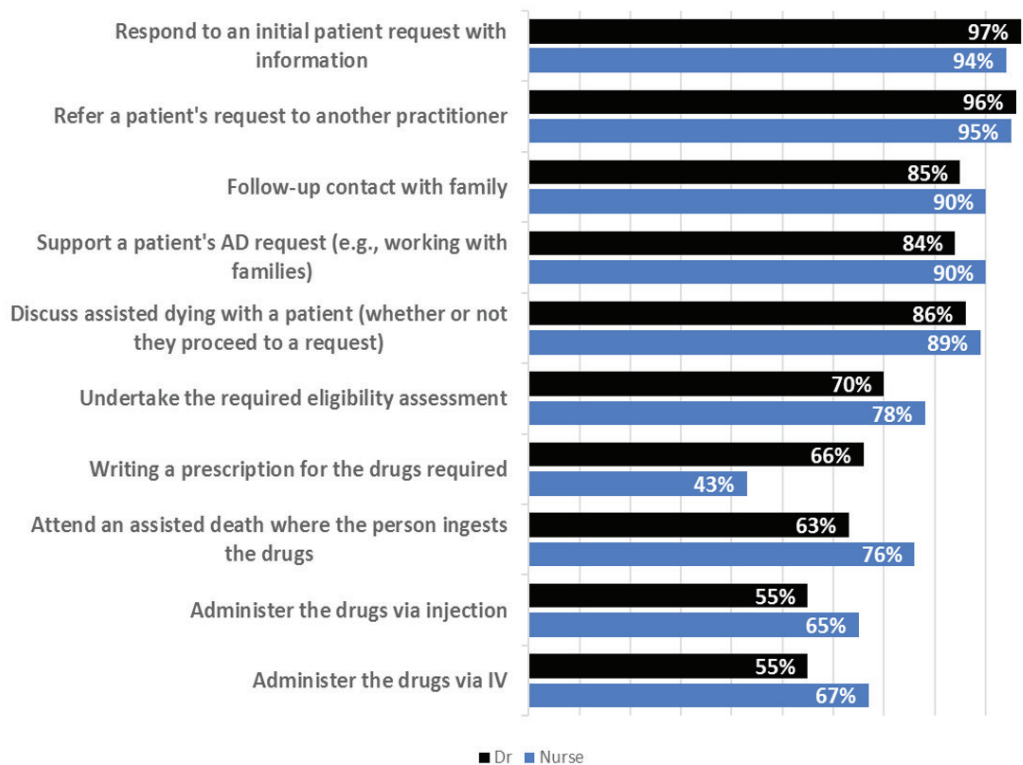
The willingness of both doctors and nurses in the sub-sample to engage in AD tasks and roles, while generally high (see Figure 3), was greatest for the tasks that involve less ‘agency’ in relation to actively providing the means for a hastened death. These results reflect an international finding that doctors are more reluctant to administer the means of death than to counsel or provide other legal prerequisites such as a diagnostic report, especially in the absence of guidelines authorised by the profession.<sup>4,35</sup> In contrast to the AD access issues identified in jurisdictions where AD is already legal, where ignoring of such requests and non-referral to a willing practitioner are major barriers,<sup>4</sup> the great majority of doctors and nurses in this sub-sample were willing to discuss AD with seekers, provide them with

information and refer them to another practitioner if needed. Two thirds or more of these doctors were willing to undertake prerequisite diagnostic and eligibility assessments (70%) and write a prescription for a lethal dose (66%) where a patient had met the eligibility requirements, and over half were willing to administer AD via either injection or intravenous line. Nurses’ willingness to engage in providing AD was high for all tasks except writing the prescription; moreover, a majority of nurses’ qualitative responses demonstrated that many more would be willing to prescribe, if so authorised by law, than the 43% who responded ‘yes’ to the rating question.

*I have answered the question regarding prescribing and administering as a ‘not willing’ only due to my RN status. [Nurse]*

*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. [Nurse]*

**Figure 3:** Willing to participate in activities of legal AD service provision % “very” or “probably” willing by doctor (n=155), nurse (n=356).





This finding supports nurses' willingness internationally to be involved, and to have been involved, in providing AD services.<sup>36,37</sup> A number of jurisdictions with legal AD have considered extending AD functions to nurse practitioners,<sup>38</sup> nurses in fact commonly administer AD in some of those jurisdictions,<sup>36,37</sup> and nurses' participation is considered normal and essential in The Netherlands.<sup>39</sup> Nurse participation in several AD tasks is authorised under the new Canadian federal legislation in acknowledgement of the gaps in medical services in many geographic locations.<sup>40</sup>

Figure 3 shows that there is a sufficient cohort of both professions in New Zealand available to provide AD services, given the provision of appropriate training and support, should AD become legal. Nearly one in 10 sub-sample doctors (n=11) responding to the question about actual provision of AD had at some time either provided or administered a lethal dose of medication "intentionally" to help someone to have a hastened death, and nearly one percent had done so "several" or "many" times. (Respondents could select only one of the response options [from 'never' to 'many

times']). This finding is supported by a *NZ Doctor* survey in July 2015,<sup>23</sup> which showed that the number of doctors either providing AD or being willing to report doing so had doubled in the past decade.

Three percent of sub-sample nurse respondents had also knowingly provided AD "intentionally", one third of them "many times", while others had observed it occurring and tacitly supported that.

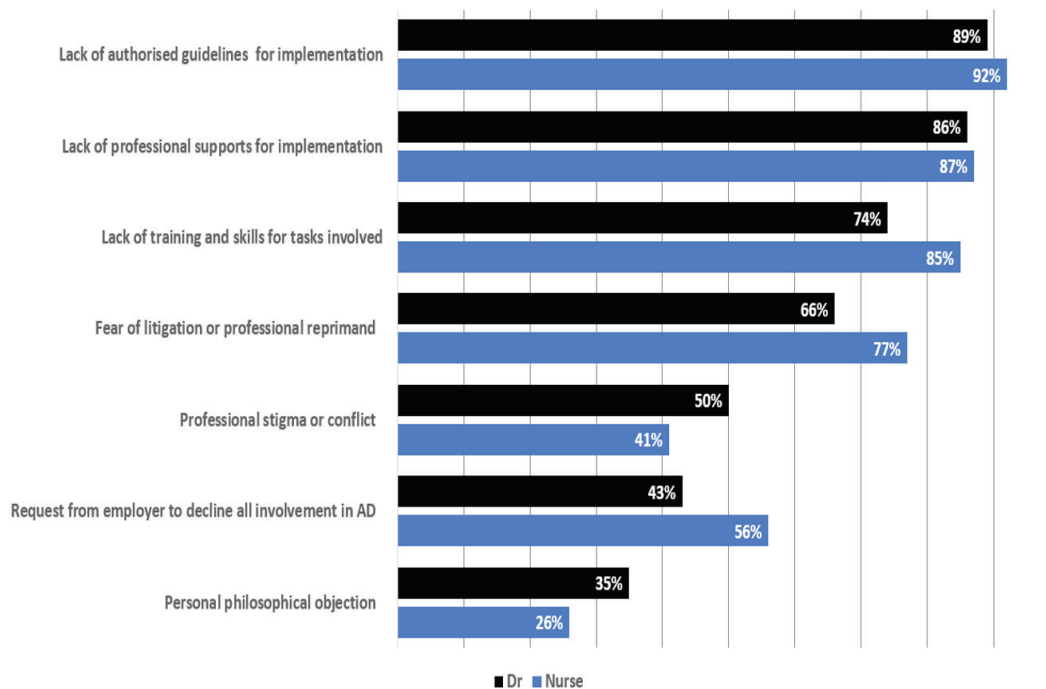
*It is often unspoken but obvious that the amount of drugs going into the subcut pump of an unconscious person are going to hasten death. [Nurse]*

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

*Once again I will mention that I have worked in rest homes and assisted the RN with drugs for dying residents. [Doctor]*

*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. [Nurse]*

**Figure 4:** Factors that may deter health practitioner participation in legal assisted dying % responding "a lot" or "a bit" by doctor (n=155), nurse (n=356).



What would deter doctors and nurses from engaging in legal AD, and how might barriers to health practitioner participation be mitigated?

### Deterrents

As Figure 4 illustrates, the most common reasons why otherwise supportive doctors and nurses might be deterred from participating in legal AD were in three related areas—a lack of authorised guidelines for undertaking AD safely and competently, a lack of professional support and a lack of training and skills—followed closely by concerns about litigation or professional reprimand. Respondents' comments showed that they saw these factors as causally related.

*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.* [Doctor]

*Unclear guidelines, need to be robust and protection of the vulnerable paramount.* [Doctor]

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

*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.* [Doctor]

Small numbers of respondents' comments identified other potential deterrents in the following areas: strong opposition from the person's family; the respondent's personal objection to AD in particular circumstances (eg, 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. Nonetheless they recognised the seeker's right to request a legal assisted death.

*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.* [Nurse]

*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?* [Doctor]

*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.* [Doctor]

Other comments reflected respondents' uncertainty about how the service delivery processes might work, in particular the ethical aspects of decision-making and safety for all participants, and some suggested that AD provision might best be a specialist area.

*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.* [Nurse]

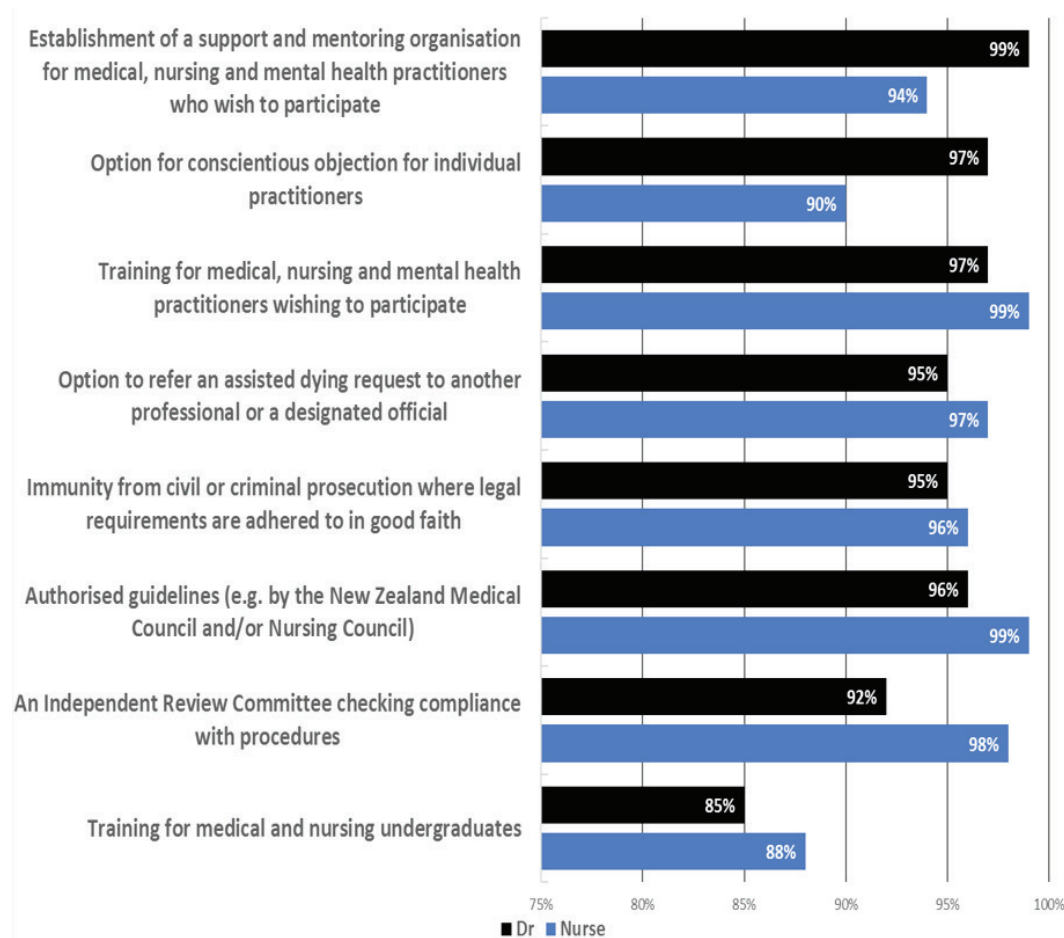
*It is too difficult to envisage a scenario where I would be confident ethically to undertake actions that support assisted death without knowing the precise criteria/guidelines/ protocols surrounding it.* [Nurse]

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

### Professional safety measures

As Figure 5 shows, more than 90% of sub-sample doctors and nurses voiced a need for a range of protections to support their safe participation in legal AD, and more than 85% of both doctors and nurses thought that training for legal AD should be included in their profession's undergraduate curriculum.

**Figure 5:** Importance of measures to support safe participation in legal AD % responding "essential" or "desirable".



*Support and peer review imperative*  
**COMPULSORY. [Doctor]**

*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. [Doctor]*

*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. [Doctor]*

*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. [Doctor]*

*Absolute clarity that drs cannot be coerced into involment with this and no adverse effect on them for declining. [Doctor]*

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

The establishment of rigorous assessment, administration and accountability systems was a priority for many who made comments.

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

Many respondents also commented on the need for mandatory referral of requests by a conscientiously objecting professional, to ensure seekers had fair access to the legislation.

*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. [Nurse]

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. [Doctor]

Conversely, some respondents voiced a concern that there would be pressure on health practitioners from colleagues, employers and the public to not participate.

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. [Doctor]

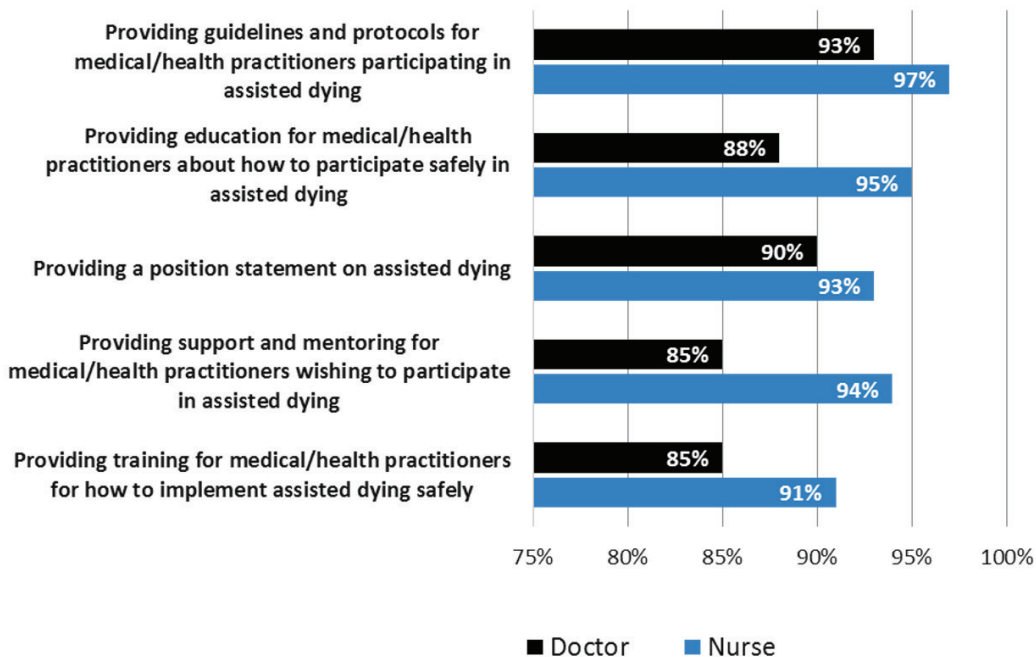
Targeting of practitioners who offer this service by religious zealots / idiots. [Doctor]

That it [legalising AD] 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. [Nurse]

### What is the perceived role of the professional bodies?

Respondents overwhelmingly indicated that it was the “essential” or “desirable” responsibility of their professional bodies to implement or ensure the various protections needed for health professionals to engage in providing AD services safely, in particular the provision of authorised guidelines and protocols, position statements from the professional associations and ensuring the provision of appropriate education and training (Response options for rating the “responsibility of your professional body/ies” were: Essential/Desirable/Optional/Not necessary/They should not be required to have any role/Not sure; see Figure 6).

**Figure 6:** Roles and responsibilities of professional bodies if assisted dying is legalised in New Zealand % "essential" or "desirable" by doctor (n=155), nurse (n=356).





*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. [Doctor]*

*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. [Doctor]*

*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 [Nurse]*

*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. [Doctor]*

A small minority of respondents were concerned that the professional bodies would be ethically compromised by appearing to support legal AD, but nonetheless identified ways in which such compromise could be avoided.

*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. [Doctor]*

*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. [Nurse]*

## Discussion

Based on current trends internationally, it is entirely possible that AD will be legalised in New Zealand in the foreseeable future, and it is vital that the health professions be prepared for that situation. While no survey can claim to be entirely representative of the population surveyed, the results

show that there is a substantial cohort of doctors and nurses in New Zealand who support legalising AD, potentially sufficient for reasonable seeker access to AD services once legalised. However, many doctors in particular still oppose AD, and international research shows that the main barrier to access to legal AD is a lack of capacity and capability among health professionals, due in large part to several related factors, in particular: a lack of either accredited training and education for the AD provider tasks and roles; inadequate immunities within the legislation to protect participating professionals; and most importantly, a lack of practice standards and guidelines authorised by the relevant medical and nursing professional bodies.<sup>4,35, 41-43</sup> Ethicists and others have called repeatedly for AD statutes to include mandatory requirements for referral by objecting health practitioners, and also for medical practice guidelines with regulatory effect to this end.<sup>44</sup> Both doctors and nurses in this study voiced significant concerns about issues in AD provision that might deter their participation, highlighting gaps in relation to the development of essential competencies, strong accountability processes and robust professional supports for the safe provision of AD, together with a potential for professional stigma or coercion against participation.

The research evidence is that participating health professionals feel most confident and competent, and their colleagues and the general public have greatest confidence, where there is a formally established mentoring and guidance agency that supports doctors and nurses who wish to participate.<sup>43</sup> Our survey data show strong support from doctors and nurses for an organisation of this type providing evidence-based practice guidelines and standards, together with other supports for the ethical and emotional aspects of providing AD services, and that approach is proposed in the End of Life Choice Bill 2012 currently in the New Zealand parliamentary Members Bills Ballot. Models for comprehensive, practical evidence-based safe practice guidelines and protocols, and a range of other professional supports, are now readily available from the Royal Dutch Medical Association,<sup>39, 45-47</sup> the Collège des Médecins in Québec<sup>48</sup> and most recently the College of Physicians and Surgeons of Ontario.<sup>49</sup>

The NZNO Submission to the Health Select Committee<sup>15</sup> acknowledges that it is a responsibility of the relevant professional bodies to ensure that these kinds of support are in place once AD is legal. However, the challenge is for such protections to be designed, tested for feasibility and ready for implementation in advance of a law coming into effect, so that health practitioners are not at risk ethically or otherwise in early participation. Planning of this kind was undertaken effectively in both Québec and federal Canada, adapting guidelines already developed in other jurisdictions; that planning avoided the confusion experienced in Vermont when their legislation took effect immediately on being signed into law, resulting in *“doctors and hospitals scrambling to figure out whether they will take part in the law, and ... state officials scurrying to prepare guidelines for doctors”*<sup>50</sup>

A limitation of the study is the lesser number of responses from doctors than nurses, possibly as a result of the survey

being advertised solely through the online newsletters of professional medical and nursing associations, thus confining awareness of the study to doctors who accessed those newsletters within the survey time frame. Nonetheless, representation was strong from GPs and members of the NZMA as well as other medical professional bodies, providing rich qualitative data that mirror findings from similar studies internationally and revealed evidence that many doctors and nurses are already thinking through the diverse issues in preparation for AD becoming legalised in New Zealand.

The strong and compelling voices of respondents in the quantitative and qualitative data are a strength of the survey and mirror findings elsewhere. It was clear from respondents' qualitative comments that considerable time and effort had been put into articulating their attitudes and actions in relation to AD, in wanting strong accountability processes and in professional supports for the safe provision of AD.

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#### **Competing interests:**

Pam Oliver joined the Voluntary Euthanasia Society of New Zealand in 2014 for the purposes of obtaining information on that group's activities for doctoral and other research purposes. Phillipa Malpas is a member of the 'End of Life Choice' Voluntary Euthanasia Society of New Zealand.

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