



**NZ
Human
Rights.**

Human Rights Commission
Te Kāhui Tikā Tangata

Investigation into End of Life Matters.



**Human Rights Commission Submission
to the Health Select Committee**

2016



Human Rights
Commission

Te Kāhui Tika Tangata

Submission to the Health Select Committee in Relation to its Investigation into End of Life Matters

29 January 2016

NEW ZEALAND HUMAN RIGHTS COMMISSION SUBMISSION TO THE HEALTH SELECT COMMITTEE IN RELATION TO ITS INVESTIGATION INTO END OF LIFE MATTERS

Introduction

1. The Human Rights Commission ('the Commission') welcomes the opportunity to provide a submission to the Health Committee ('the Committee') in relation to its investigation into end of life matters, following its receipt of the Petition of Hon. Maryan Street and 8,974 others ('the Petition').
2. The Petition itself follows the landmark High Court case brought by Lecretia Seales¹ which sought to challenge the current legal prohibition against physician-assisted voluntary euthanasia. The Commission appeared as an intervener in those proceedings, pursuant to its functions under the Human Rights Act 1993.² Ms Seales' case generated considerable public interest in this issue and has reignited the policy debate in New Zealand.
3. The Committee has identified four areas that it will consider during its investigation. The Commission has focused its submission on the human rights aspects of areas 3 and 4, these being the current legal situation and international experiences.

Summary of the Commission's position

4. This submission represents the agreed collective views of the Commission on matters where consensus has been reached. The Commission's position can be summarised as follows:
 - a. The Commission acknowledges the complexity of the issues being considered by the Committee and the need to balance competing principles such as the right to life, respect for human dignity, personal autonomy and the protection of vulnerable members of society.

¹ *Seales v Attorney-General* [2015] NZHC 828

² Human Rights Act 1993 s 5(2)(a) and 5(2)(j).

- b. The Commission is strongly of the view that any legal change that might be contemplated by Parliament in this area must incorporate sufficient safeguards in order to eliminate risk to vulnerable citizens. Minimum safeguards that should be included are set out later in this submission.
 - c. The Commission considers that a legal framework permitting assistance to be given to a competent terminally ill adult to end his or her life (if he or she freely and autonomously chooses to do so), would likely be acceptable if accompanied by adequate legal and procedural safeguards and in the context of appropriate palliative care services being available and accessible.
 - d. The Commission notes that the New Zealand Bill of Rights Act 1990 (NZBORA) does not specifically include the core human rights principles of dignity, personal autonomy or the liberty and security of the person as free-standing rights. This stands in contrast with some overseas jurisdictions. This position is particularly relevant to consideration of end of life matters but also has broader application. The Commission recommends that the Committee consider whether the current form of the NZBORA adequately engages the human rights issues that arise from end of life matters.
5. The Commission's position is set out in more detail below. The Commission would appreciate the opportunity to speak to its submission.

The Current Legal Position in New Zealand

- 6. The current legal position is well established and is noted only briefly in this submission to establish the basis for the discussion that follows. *Seales v Attorney General* confirmed that any action taken by a physician to assist a terminally ill person to take his or her own life upon their request constitutes a serious criminal offence under the Crimes Act 1961³.
- 7. The primary basis for the decision in *Seales* can be found in section 63 of the Crimes Act, which provides that no person has the right to consent to the infliction of death upon themselves, and that the existence of such consent does not affect the criminal responsibility of any person who is party to such an act. In line with the text and purpose of section 63, and with reference to similar UK law,

³ Culpable homicide (s160) and Aiding and Abetting Suicide (s179(b))

Justice Collins concluded that Ms Seales' consent would not provide her doctor with a lawful excuse to administer "aid-in-dying" to Ms Seales.⁴

8. Lecretia Seales had sought to test the current position by seeking a declaration that her doctor would not be liable for culpable homicide under the Crimes Act if she "administered aid in dying" to her; nor aiding and abetting suicide if she "facilitated aid in dying". Alternatively, Ms Seales sought a declaration that the provisions of the Crimes Act that prohibited her doctor from administering or facilitating aid to end her life were inconsistent with her rights under the NZBORA.
9. In declining to grant the orders sought, Justice Collins held that the implications of such a change to the law could not appropriately be effected through the Court, concluding that *"the complex legal, philosophical, moral and clinical issues raised by Ms Seales' case could only be addressed by Parliament passing legislation to amend the effect of the Crimes Act"*⁵.

Core Human Rights Principles

10. In his judgment, Justice Collins identified four core principles engaged by Ms Seales' case⁶. They are:
 - a. The sanctity of life
 - b. Respect for human dignity
 - c. Respect for human autonomy;
 - d. Protection of the vulnerable.
11. Each of these core principles invokes corresponding human rights principles. The manner in which these core principles apply in the context of end of life decisions is a vexed issue and there is an absence of international consensus.

⁴ *Seales v Attorney-General* [2015] NZHC 828, paragraphs [89]-[99]

⁵ *Seales v Attorney-General* [2015] NZHC 828, paragraph [211]

⁶ *ibid* at [62]

The sanctity of life

12. In *Seales v Attorney General*, Justice Collins described the sanctity of life as "*one of society's most fundamental values*"⁷. It conceptually underpins the human right to life, itself the most basic human right⁸. It is also included in various forms across a wide range of international human rights instruments, constitutional charters and bills of rights. Article 6.1 of the International Covenant on Civil and Political Rights ["ICCPR"], to which New Zealand is a signatory, states:

"Every human being has the inherent right to life. This right shall be protected by law. No one shall be arbitrarily deprived of his life"

13. A truncated version of the right is incorporated into New Zealand statutory law by section 8 of the New Zealand Bill of Rights Act 1990, which states:

"No one shall be deprived of life except on such grounds as are established by law and are consistent with the principles of fundamental justice."

14. Justice Collins found that the right to life under s 8 of NZBORA was directly engaged by Ms Seales' case. In doing so, he noted that it is well established that the right to life is not absolute, stating that "*...the sanctity of life.... underpins s 8. Section 8 does not, however, require all human life be preserved in all circumstances.*"⁹¹⁰

15. In the medico-legal context, this qualification permits physicians to withdraw life support for patients in extreme vegetative states without fear of criminal prosecution for culpable homicide, as confirmed in the landmark 1993 case of *Auckland Area Health Board v Attorney-General*¹¹. In that case Justice Thomas observed that the sanctity of life was "not an absolute value" for the purposes of section 8 and noted that it could be offset by values of human dignity and privacy, values "central to our concept of life." This qualification also permits the

⁷ Ibid at [163]

⁸ Butler & Butler, para 9.2

⁹ [2015] NZHC 828 at [163]

¹⁰ Butler and Butler have also noted that the Attorney General's report on the 2003 Death with Dignity Bill suggested that one meaning of "deprive" is to "take without permission" the right not to be deprived of life under s 8 or NZBORA something is discretionary and can be waived by individuals who, for example, consent to suicide

¹¹ *Auckland Area Health Board v Attorney-General* [1993] 1 NZLR 253

provision of appropriate levels of pain relief in accordance with good medical practice even if such doses may hasten death, as long as the primary intention is to relieve pain and not to end life.

16. Overseas jurisdictions have taken various approaches when interpreting and applying the right to life in assisted suicide cases. In the case of *Pretty v United Kingdom*, both the UK House of Lords¹² and the European Court of Human Rights¹³ concluded that the right to life under Article 2 of the European Convention on Human Rights primarily reflected values pertaining to the sanctity of life. Lord Bingham held that the right to life cannot be interpreted as conferring a right to die or enabling a person to enlist the aid of another person in bringing about their death¹⁴. The European Court of Human Rights agreed, finding that the right to life “cannot be interpreted as involving a negative aspect”.¹⁵

17. However, in its more recent decision in *Haas v Switzerland*¹⁶, the European Court of Human Rights shifted its interpretative approach and focus towards an emphasis on personal dignity, and in particular, personal autonomy. In *Haas*, the European Court interpreted Article 8 of the European Convention on Human Rights, which provides for the right to self-determination and a private life, as a basis for a right to exercise personal autonomy in end of life decisions. In doing so, the Court reframed its interpretation of the right to life under Article 2 to provide a basis for procedural safeguards that “*establish a procedure capable of ensuring that a decision to end one’s life does indeed correspond to the free wish of the individual concerned.*”¹⁷

18. The Supreme Court of Canada took a very different approach to the right to life in its March 2015 decision in *Carter v Canada*¹⁸, finding that the right to life does not require an “absolute prohibition in assistance in dying”¹⁹. The Supreme Court also considered that²⁰:

¹² *R v Director of Public Prosecutions ex parte Diane Pretty & Ors* [2001] UKHL 61

¹³ *Pretty v United Kingdom* [2002] ECHR 2346/02 29 April 2002

¹⁴ *R v Director of Public Prosecutions ex parte Diane Pretty & Ors* [2001] UKHL 61 at [5]

¹⁵ *Pretty v United Kingdom* [2002] ECHR 2346/02 29 April 2002 at [39]

¹⁶ *Haas v Switzerland* [2011] Ap. 31322/07

¹⁷ *Ibid* at [54]

¹⁸ *Carter v Canada (Attorney General)* [2015] SCC 5

¹⁹ *Ibid* at [63]

²⁰ *Ibid* at [57]

"The right to life is engaged when the law of the state imposes death or an increased risk of death on a person, either directly or indirectly. Here, the prohibition [against physician assisted dying] deprives some individuals of life, as it has the effect of forcing some individuals to take their own life prematurely, for fear that they would be incapable of doing so when they reached the point where suffering was intolerable."

19. However, it is important to emphasise that there is a crucial distinction between the framing of the right to life under the Canadian Charter of Rights and the NZBORA. Section 7 of the Canadian Charter includes the rights to liberty and security of the person, alongside the right to life. These concepts are missing from s 8 of the NZBORA. Protection of the individual's right to liberty and personal security were decisive factors in the Court's judgment in *Carter*.
20. Interpretive guidance about aspects of human rights treaties can also be issued by United Nations treaty bodies in the form of "general comments". These comments provide guidance on the interpretation and application of various treaty provisions. However, to date, the UN Treaty bodies are yet to develop any definitive position on the human rights implications of assisted suicide.
21. The United Nations Human Rights Committee (UNHRC) issued a general comment on the right to life as expressed in Article 6 of the ICCPR in April 1982. This comment does not contain specific mention of matters pertaining to end of life matters, such as physician assisted suicide, although it notes that the right to life should be interpreted broadly. The UNHRC is currently preparing an updated General Comment on the right to life following its day of discussion on the right to life at its 114th session in July 2015²¹. Once available, this updated comment may be relevant to the deliberations of the Health Committee on this matter.
22. However, after reviewing the Netherlands' compliance with the ICCPR in 2009, the UNHRC expressed concern at the "extent of assisted suicide and euthanasia" in that country, noting in particular the lack of independent judicial oversight to guard against the existence of undue influence or misapprehension²². The UNHRC

²¹ <http://www.ohchr.org/EN/HRBodies/CCPR/Pages/GC36-Article6Righttolife.aspx>

²² UN Human Rights Committee, Concluding Observations" Netherlands, CCPR/C/NDL/CO/4, paragraph 7, 25 August 2009

recommended that the statute that legally authorises physician-assisted suicide in the Netherlands²³ be reviewed in light of Article 6 of the ICCPR.

23. In the Commission's view, the right not to be arbitrarily deprived of life does not directly translate into an absolute prohibition on parliament implementing a legislative framework that would permit terminally ill people to obtain assistance to end their lives. This position is subject to the provisos and safeguards identified later in this submission.

The Right to Dignity

24. Human dignity is a core human rights concept. Human rights themselves have been described as *"fundamental rights which empower human beings to shape their lives in accordance with liberty, equality and respect for human dignity"*²⁴ and as a *"manifestation of human dignity"* that provides the conceptual nucleus from which all existential human rights derive²⁵.
25. The first recital of the Universal Declaration of Human Rights states that the *"recognition of inherent dignity and of the equal and inalienable rights of all members of the human family is the foundation of freedom, justice and peace in the world"*. The same statement is included in the preamble of the ICCPR and the preambles of both the ICCPR and International Covenant of Economic Social and Cultural Rights ("ICESCR") recognise that the rights contained therein *"derive from the inherent dignity of the human being"*. Article 3(a) of the Convention on the Rights of Persons with Disabilities ("CRPD") provides that the principles of the Convention *"shall be respect for inherent dignity, individual autonomy including the freedom to make ones' own choices, and independence..."*
26. In New Zealand, a free-standing right to dignity is not expressly provided for in the Bill of Rights and other human rights legislation. This contrasts with jurisdictions such as South Africa, where the right to dignity is included in the South African Bill of Rights, which states at section 10 that "Everyone has inherent dignity and the right to have their dignity protected and respected."

²³ The Termination of Life Upon Request and Assisted Suicide Act

²⁴ Nowak (2003), *Introduction to the Human Rights Regime*, Martinus Nijhoff Publishers, Leiden p 1

²⁵ *ibid*

27. The absence of a justiciable right to dignity in New Zealand law was highlighted by Justice Collins in *Seales v Attorney General*, stating²⁶:

"I fully acknowledge the consequences of the law against assisting suicide as it currently stands are extremely distressing for Ms Seales and that she is suffering because that law does not accommodate her right to dignity and personal autonomy"

28. Despite the absence of the right to dignity in New Zealand human rights legislation, the New Zealand courts have affirmed the centrality of the concept of dignity in human rights law. In *Auckland Area Health Board v Attorney General* Justice Thomas found that loss and degradation of bodily functions invoked the values of human dignity and personal privacy²⁷. His Honour also emphasised that *"dignity and worth of the human person is a key value underlying the rights affirmed in the Bill of Rights"* in the 2007 case of *Brooker v Police*²⁸.

29. The right to dignity has been a central factor across the body of international case law on assisted suicide. In *Carter v Canada*, the Supreme Court of Canada held that the rights to liberty and security of the person are underpinned by *"a concern for the protection of personal autonomy and dignity"*²⁹. The Supreme Court of Canada also drew a connection between an individual's respective senses of bodily integrity and dignity, observing that an individual's response to a grievous and irremediable medical condition is a matter critical to their dignity and autonomy.³⁰

30. In the 2015 South African assisted case of *Stransham-Ford v Ministry of Justice*³¹, Justice Fabricius referenced South African legal authorities that establish the concept of dignity as a justiciable and enforceable right intertwined with the right to life³². In that case, the judge found that a number of conditions suffered by the applicant, who was in Stage 4 of terminal cancer, compromised his dignity³³.

²⁶ [2015] NZHC 828 at [192]

²⁷ [1993] 1 NZLR 253 at p 245

²⁸ *Brooker v Police* [2007] NZSC 30, 3 NZLR 91 at [177]-[192]

²⁹ *Carter v Canada* [2015] SCC 5 at [64]

³⁰ *Ibid* at [66]

³¹ *Stransham-Ford v Minister of Justice & Ors* [2015] 27401/15

³² *Ibid* at p 14, 16

³³ *Ibid* at p 18

31. The observations of the Canadian and South African courts reflect the close connection between the general concept of personal dignity and the ability to maintain control over one's body and circumstances so as to prevent events or insult that the individual might find subjectively offensive. In this respect, it is a corollary of the right to be treated humanely and with respect.

The right to personal autonomy

32. Like the right to dignity, human rights concepts derived from the concept of personal autonomy have been influential in court decisions concerning the lawfulness of physician assisted suicide.

33. In *Carter v Canada*, the Canadian Supreme Court described the right to liberty under section 7 of the Canadian Charter of Rights as protecting "*the right to make fundamental choices free from state interference*" and the right to security of the person under that same section as "*encompassing a notion of personal autonomy involving control over ones bodily integrity free from state interference*", noting that "*it is engaged by state interference with an individual's physical or psychological integrity, including any state action that causes harm or suffering*".³⁴

34. In the European jurisdiction, the European Court of Human Rights in *Haas v Switzerland* interpreted the right of the individual to self-determination under Article 8 of the European Convention as creating an inalienable right to exercise personal autonomy on end of life decisions.

35. In *Seales v Attorney General*, Justice Collins noted that the concept of personal autonomy was "multi-faceted and subject to much debate" amongst ethicists. His Honour referred to the concept as encompassing:³⁵

"self-rule that is free from both controlling influence by others and limitations that prevent [the individual from making] meaningful choice[s] [about his or her body.]"

³⁴ *Carter v Canada* [2015] SCC 5 at [64]

³⁵ [2015] NZHC 828 at [71], quoting Beauchamp and Childress, *Principles of Biomedical Ethics*, 7TH Ed, Oxford University Press, New York, 2013, at p 101

36. Justice Collins noted that the concept of person autonomy was reflected in s 11 of the NZBORA, which establishes the right of an individual to refuse to undergo medical treatment. However, as set out above, he found that New Zealand law does not accommodate the right of the individual with a terminal illness to exercise their right of personal autonomy to end their life with the assistance of a physician.³⁶

Protection of the Vulnerable

37. The most fundamental public policy impact of any potential change to the law regarding assisted dying, whether judge-led or through legislation, is that it could be regarded as qualifying the State's protection of the sanctity of life. Related to this is a fundamental human rights concern about protecting the vulnerable from harm and exploitation³⁷.

38. In the present context vulnerable groups may include children, older adults, those whose decision-making ability may be affected in some manner, those who may be susceptible to influence or who are unable to access optimal social or clinical care.

39. This is an area of particular interest to disabled members of the community for several reasons. There is concern that external influence (covert or overt) and/or internal belief systems shaped by inaccurate perception could lead to inappropriate access to, or disproportionate rates of, utilisation of any end of life assistance if this were legally available.

40. There is social and historical context associated with how society values and treats disabled people. Community attitudes to people with a disability and concepts such as "quality of life" affect the way that disability is perceived and the way in which disabled people value themselves and form their own identity.

³⁶ At [192]

³⁷ For example, in respect of persons with disabilities, Article 12.4 of the CRPD provides: *'States Parties shall ensure that all measures that relate to the exercise of legal capacity provide for appropriate and effective safeguards to prevent abuse...such safeguards shall ensure that measures relating to the exercise of legal capacity respect the rights, will and preference of the person, are free of conflict of interest, are proportional and tailored to the person's circumstances...the safeguards shall be proportional to the degree to which such measures affect the persons rights and interests.'*

Fear of becoming disabled, or of becoming a “burden”, on family members and others can have an impact on the decisions that disabled people might make around end of life choices.

41. Such views may not be based on lived experience or personal knowledge of a particular disability but on information or attitudes shaped by the broader community. These can also be influenced by actual or perceived difficulty accessing appropriate services and support that would allow disabled people to participate equally in the community on the same basis as others. It is likely that these societal influences and attitudes, at least in part, may shape the views of some members of the broader community as to decisions they might make in future if they were incapacitated or became ill. Irrespective of any potential change to end of life options, it is essential that the community strive to eradicate stigma and incorrect information about living with a disability or serious long term illness. Ensuring appropriate access to services and assistance so that disabled people are able to participate fully in society on the same basis as others will also assist in this regard.

42. The situation is of particular concern in the context of non-terminal but serious and irreversible illness. The difference between taking active steps to shorten life in the face of a terminal illness/ imminent death compared with intervening to foreshorten life in a situation where an individual finds their situation unbearable but is not otherwise facing a shortened lifespan is complex.

International Policy Positions and Approaches

43. A number of countries have explored both the human rights and broader policy implications associated with legalisation of physician assisted dying. In Australia, the Australian Human Rights and Equal Opportunity Commission’s 1996 paper *Human Rights and Euthanasia* considered these human rights policy implications in detail in its analysis of the Northern Territory Rights of the Terminally Ill Act, which (ultimately unsuccessfully) sought to legalise physician assisted dying in that jurisdiction. The report concluded³⁸:
 - a. The right to life is a fundamental human right but is not absolute.

³⁸ Human Rights and Equal Opportunity Commission, *Human Rights and Euthanasia*, December 1996, p 18, https://www.humanrights.gov.au/sites/default/files/content/pdf/human_rights/euthanasia.pdf

- b. In certain prescribed circumstances, there would appear not to be a violation of the right to life if the law seeking to diminish the absolute effect of the right does not involve an arbitrary deprivation of life and legal protections are in place to ensure this.
- c. A legal waiver may be able to operate in certain restricted circumstances if it is reliable, authentic and subject to appropriate safeguards.

44. In reaching these conclusions, the Australian Commission ultimately concluded that political and moral judgments about euthanasia are not ultimately capable of resolution through the application of international human rights standards. The Commission found that any final political or moral judgment must be made by the legislature.

45. It is notable that a number of jurisdictions have legalised or decriminalised some form of assisted dying. For example, Belgium, the Netherlands and the U.S. state of Oregon have passed legislation authorising physician assisted dying, albeit with contrasting approaches and thresholds. In the cases of Belgium and the Netherlands, this includes permitting the prescription and administration of lethal medication by a physician to both terminal patients and those patients experiencing intolerable suffering as a result of a serious incurable illness. In Oregon, authorisation is limited to the prescription of lethal medication for self-administration by a terminally ill adult patient.

46. In Switzerland, the provisions of its 1937 Criminal Code³⁹ do not prohibit assisted suicide if there is no "selfish motive". Accordingly, while there is no specific legislation authorising physician assisted dying, this feature of the Swiss criminal law has led to the establishment of non-profit agencies such as Dignitas and Exit that provide assisted suicide services in Switzerland. Legislative change can probably be anticipated in jurisdictions such as Canada and South Africa, where the Courts have held that criminal provisions prohibiting assistance in dying are inconsistent with relevant constitutional rights.

47. The UK has also considered the implications of legalising physician assisted suicide. In 1994, the Parliamentary Select Committee on Medical Ethics

³⁹ Article 115, Swiss Penal Code

examined issues surrounding withholding life-prolonging treatment, including euthanasia. The Select Committee recommended that euthanasia remain illegal in the UK, although strongly endorsed the right of a competent patient to refuse medical treatment, positions endorsed by the UK Government⁴⁰. More recently, in 2015, the Assisted Dying Bill, a private members bill which sought to introduce physician assisted dying for terminal patients and included judicial oversight mechanisms for individual cases, was defeated in the House of Commons⁴¹.

Conclusions and recommendations

48. The Commission is of the view that a legal framework permitting assistance to be given to a competent terminally ill adult to end his or her life (if he or she freely and autonomously chose to do so), could potentially be implemented if:

- a. It is developed in a manner consistent with core human rights principles; and
- b. Is accompanied by adequate legal and procedural safeguards to protect vulnerable members of society; and
- c. Appropriate palliative care services are available and remain accessible for all.

49. The following are matters that the Commission believes require careful consideration and which would be essential minimum components of any legal framework that might be considered. These matters clearly require detailed examination and further investigation if any legal change is to be contemplated. These are not exhaustive and are noted by way of example only.

a. Need for high thresholds. Clear and sensible thresholds are necessary. A minimum age of 18 and likely death within 12 months would be essential.

b. Decisions must be free from any indication of coercion or influence and must be competently made. Systems would be required to ensure that decisions are competently and freely made. A framework that permits,

⁴⁰ Government Response to the Report of the Select Committee on Medical Ethics, Presented to Parliament by Command of Her Majesty, May 1994, Cm 2553

⁴¹ <http://services.parliament.uk/bills/2015-16/assisteddyingno2.html>

or requires, self-administration of lethal medication may be preferable to one that provides for administration by a third party medical practitioner.

c. Need for supporting medical review/and perhaps psychiatric screen.

Appropriate medical evidence must be available to confirm prognosis and to ensure absence of a treatable/remediable physical or mental health condition that may impact on any decision-making ability.

d. Cooling off period. A “cooling off period” would be essential to prevent hasty and reactive decisions, particularly in the face of recent diagnosis and to ensure an enduring and consistent wish to proceed.

e. Need for ongoing monitoring and independent review of the system.

Independent oversight of any system would be essential to prevent abuse or misuse, to ensure public transparency about what is occurring and to assist early identification of any potential problems.

f. Judicial /expert oversight. Judicial level consideration as to whether relevant prerequisites and thresholds have been met in each particular case would be desirable and could assist in the identification of irregularities or concerns not obvious to those directly involved. This input could be provided through direct review/inquiry and confirmation that requirements have been met similar to Protection of Personal and Property Rights proceedings in the Family Court. Alternatively, it could be achieved via a less intrusive “paper based” review system. Input from independent ethicists and others with specialist knowledge or skills in relevant areas (such as those with lived experience of disability) would also be highly desirable.

g. Participation by medical professionals and others in the process must be voluntary – ie an “opt out” conscience clause. There will be medical practitioners and pharmacists who would not want to participate in any manner in the deliberate bringing about of death even if this were permitted by the law. Such views ought to be respected and any proposed legal change should contain “conscientious objection” provisions similar to the current abortion legislation. Participation by health professionals should be on a voluntary basis only and not compelled.

h. Cultural considerations. Cultural considerations need to be taken into account and reflected in any framework and process that might be developed. This includes appropriate account being taken of the cultural diversity of the New Zealand population, including those for whom English is a second language.

i. Need to ensure access to and standard of palliative care is not compromised and remains a viable and “first choice” option. It is essential that high quality palliative care is provided, and remains, accessible to all. Palliative care is an essential component of the health system and diligent and dedicated palliative care providers throughout the country play a key role in assisting New Zealanders to die peacefully and with dignity in the vast majority of cases. Assisted death should not become a “default option” or a choice that is made because of an absence of alternatives.

j. Importance of advanced care planning. It is important not to lose sight of advance directives and other components of advance care planning that can also help give effect to autonomous decisions at the end of life, irrespective of any direct clinical intervention that might be available.

50. This submission does not purport to be an exhaustive or definitive overview of the human rights components of the matters that the Committee is inquiring into. The Commission is cognisant of the complexity of the matters under consideration and the likely volume of submissions that the Committee will receive. This document is only intended to highlight some key points of importance to the Commission and the Commission’s agreed overall approach to the issue of assisted dying. The Commission seeks an opportunity to meet with Committee to discuss these matters further.

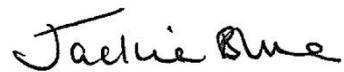
51. In closing, the Commission would like to note the importance of these issues to all New Zealanders and the desirability of the matters being debated in an open, robust and non-partisan manner.

A handwritten signature in black ink, appearing to read 'D. Rutherford'.

David Rutherford – Chief Commissioner

A handwritten signature in black ink, appearing to read 'Susan Devoy'.

Dame Susan Devoy – Race Relations Commissioner

A handwritten signature in black ink, appearing to read 'Jackie Blue'.

Dr Jackie Blue – Equal Employment Opportunities Commissioner

A handwritten signature in black ink, appearing to read 'Paul Gibson'.

Paul Gibson – Disability Rights Commissioner

A handwritten signature in black ink, appearing to read 'K Johansen', written in a cursive style.

Karen Johansen – Human Rights Commissioner

A handwritten signature in black ink, appearing to read 'R Tankersley', written in a cursive style.

Richard Tankersley – Human Rights Commissioner