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Health Select Committee
Parliament Buildings
Wellington 6160
New Zealand

Forch, 30 January 2016

Health Select Committee
Investigation into ending one's life in New Zealand
Petition no. 2014/18 of Hon Maryan Street and 8,974 others

Submission by DIGNITAS - To live with dignity -
To die with dignity, Forch, Switzerland

for and on behalf of DIGNITAS' members in New Zealand
submitted in electronic format to www.parliament.nz
DIGNITAS is happy to give oral evidence if the Committee would wish so

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1) Introduction

"The best thing which eternal law ever ordained was that it allowed us one entrance into life, but many exits. Must I await the cruelty either of disease or of man, when I can depart through the midst of torture, and shake off my troubles? . . . Are you content? Then live! Not content? You may return to where you came from"[1]. These are not the words by a protagonist of the many organisations around the world representing the interests of people who wish for freedom of choice in ending one's suffering and life self-determinedly today, but the words of Roman philosopher LUCIUS ANNAEUS SENECA who lived 2000 years ago, in his letters dealing with moral issues to Lucilius.

In recent years, questions dealing with the subject of end of life choices, including assisted suicide and voluntary euthanasia, have arisen again and are now discussed in the public, in parliaments and courts.

Of the many reasons for this development, one is the progress in medical science which leads to a significant prolonging of life expectancy. During the congress of the Swiss General Practitioners in 2011[2] it was emphasised that a sudden death, for example due to a 'simple' heart attack or a stroke is nearly unthinkable today, due to possibilities of modern intensive care.

Obviously, this progress is a blessing for the majority of people. Who would not want to live as long as possible if one's quality of life, which includes health, is good by one's personal point of view? However, medical advances have led to a vastly increased capacity to keep people alive without, in many cases, providing any real benefit to their health[3] – prolonging life to a point much further in the future than some patients would want to bear an illness. But, more and more people wish to add life to their years – not years to their life. Consequently, people who have decided not to carry on living but rather to self-determinedly put an end to their suffering started looking for ways to do so. This development has gone hand in hand with tighter controls on the supply of barbiturates and progress in the composition of pharmaceuticals which led to the situation that those wishing to put an end to their life could not use this particular option anymore for their purpose and started to choose more violent methods. A further, parallel, development was the rise of associations focusing on patient's rights, the right to a self-determined end of life and the prevention of the negative effects resulting from the narrowing of options.

In Switzerland, over 30 years ago, EXIT (German part of Switzerland) was founded, in the same year as EXIT-A.D.M.D. (French part of Switzerland), and shortly afterwards the first association to offer the option of an accompanied suicide to its members. Further not-for-profit member's societies like EX INTERNATIONAL, DIGNITAS, and LIFECIRCLE followed, the only difference between

1 In: Epistulae morales LXX ad Lucilium
2 Congress of Swiss General Practitioners in Arosa, March 31st - April 2nd, 2011
3 British Medical Journal 2012, http://www.bmj.com/content/bmj/345/bmj.e4637.full.pdf

these organisations being mainly the acceptance or not of members residing in countries other than Switzerland. As a result of the above-indicated aspects and other developments in modern society, the focus of all associations has widened to include working on suicide preventive issues directly or indirectly, especially suicide attempt prevention, palliative care and the implementation of advance directives (living will).

Today, EXIT has 92,000 members and EXIT-A.D.M.D. 22,000. DIGNITAS, together with its independent German partner association DIGNITAS-Germany in Hannover, counts 7,291 members worldwide of whom 7 reside in New land[4].

In the almost 18 years of DIGNITAS' existence, one person from New Zealand has made use of the option of a self-determined self-enacted ending of suffering and life with DIGNITAS in Switzerland[5]. For all DIGNITAS-members, being assisted and accompanied through the final stage of their life towards their self-determined end was and is an issue of major importance. DIGNITAS always encourages members to have their next-of-kin and friends at their side during the entire process, including the final days.

Whilst it has to be acknowledged that the legal system in New Zealand permits for palliative care, in some cases if need be applied in the ultimate form of terminal sedation, which provides an essential option for the dying, the option of choosing a safe and dignified self-enacted death, which is ending one's suffering in the frame of assisted/accompanied suicide, is not possible.

This leads to residents of New Zealand having to travel 18,771 kilometres (which is the air-line distance Wellington to Zürich) when all that he or she wishes is to have a self-determined and self-enacted end of suffering. Furthermore, the present legal situation in New Zealand has the additional appalling effect that the very important support towards the end of life by next-of-kin and friends must take place shadowed by the fear of prosecution. Sometimes, this even leads patients to decide to travel to DIGNITAS only with very few loved ones or even alone.

This is approached differently under Swiss law: whilst in Switzerland, like in New Zealand, palliative care is established and suicide as such is not a crime, article 115 of the Swiss Criminal Code states:

> "Whoever, from selfish motives, induces another person to commit suicide or aids him in it, shall be imprisoned for up to five years or pay a fine, provided that the suicide has either been completed or attempted."

The obvious difference is the 'selfish motives': whilst in New Zealand the law basically threatens to punish assistance in suicide whatever the motive, Swiss law makes a clear distinction of motives, permitting assistance in self-enacted

[4] http://www.dignitas.ch/images/stories/pdf/statistik-mitglieder-wohnsitzstaat-31122015.pdf
[5] http://www.dignitas.ch/images/stories/pdf/statistik-ftb-jahr-wohnsitz-1998-2015.pdf

ending of life out of non-selfish motives, and thus gives a basis for assisted/accompanied suicide for competent patients – made possible by associations like DIGNITAS and others.

DIGNITAS very much welcomes the 'Investigation into ending one's life in New Zealand' by the Health Select Committee: it brings the issue of end-of-life-questions to the level where it should be addressed, the legislation.

2) Who is DIGNITAS and why does DIGNITAS write this submission?

DIGNITAS is a Swiss not-for-profit members' society, a help-to-life and right-to-die dignity advocacy group, founded in 1998 by Swiss human rights attorney-at-law Ludwig A. Minelli. Many years earlier, in 1977, he had already founded SGEMKO, the Swiss Society for the European Convention on Human Rights, a not-for-profit members' society spreading information about the European Convention for the Protection of Human Rights and Fundamental Freedom (ECHR). At an early stage, Mr. Minelli and his colleagues have been convinced that where there is the individual's right to life as enshrined in article 2 of the ECHR, there also must be the individual's right to die – the right to end his or her own life. Many years later, in 2011, the European Court of Human Rights confirmed this opinion in the case of HAAS v. Switzerland, application no. 31322/07 (see further in this submission).

DIGNITAS being a human rights orientated organisation posed the question: if in Switzerland, why not in other countries? Isn't it discriminatory, if access to a dignified end of life depends on domicile/residence and citizenship? The ECHR condemns such discrimination in article 14[6]. Therefore, the logic consequence for DIGNITAS was 1) to allow non-Swiss residents and non-Swiss citizens to access the possibility of an assisted suicide in Switzerland, and 2) to advocate for implementation of 'the last human right', the practice of Switzerland, in other countries too. In its almost 18 years of operation, DIGNITAS has been involved in several leading legal cases dealing with the 'right to die' at the European Court of Human Rights and others more and DIGNITAS has been consulted by committees, panels and representatives of parliaments, from England, Scotland, Sweden, Australia, Canada and others more, with an aim of implementing laws to introduce assisted/accompanied suicide as an additional end-of-life-choice.

For DIGNITAS, when it comes to making use of freedom at life's end, it is understood that the discrimination of a New Zealander or any other citizen against a Swiss citizen is inacceptable and such discrimination should be abolished.

Clearly, the public is in favour of freedom of choice in these 'last issues'[7].

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6 http://www.echr.coe.int/Documents/Convention_ENG.pdf page 13

7 See for example the Horizon Research report in July 2012 http://www.horizonpoll.co.nz/attachments/docs/horizon-research-end-of-life-choices-survey--1.pdf , the First Report of the UK Select Committee on Assisted Dying for the Terminally Ill Bill: http://www.parliament.the-

No New Zealander should be forced to travel to Switzerland in order to have a self-determined, self-enacted, safe and accompanied ending of his or her suffering. Everyone should have access to such option at his or her home, as an additional choice besides palliative care. In consequence, DIGNITAS writes this submission in the name of its New Zealand members and for all other people who would like to have such freedom of choice now or in the future, so they won't need DIGNITAS.

3) The freedom to choose time and manner of one's own end from an European Human Rights perspective

All European states (with the exception of Belarus and the Vatican) have adhered to the European Convention for the Protection of Human Rights and Fundamental Freedoms (ECHR)[8]. In specific cases, set legal situations may be questioned whether they would be in line with the basic human rights enshrined in the ECHR. The European Court of Human Rights[9] has developed a valuable jurisdiction on basic human rights, including the issue of the right to choose a voluntary death. According to its preamble, this international treaty is not only a fixed instrument, "securing the universal and effective recognition and observance of the rights therein declared" but also aiming at "the achievement of greater unity between its members and that one of the methods by which that aim is to be pursued is the maintenance and further realisation of human rights and fundamental freedoms"[10]. The ECHR' text and case law may serve as an example and could be taken into consideration in legislation in New Zealand, which is why DIGNITAS herewith outlines some of its most important rulings in relation to a self-determined and self-enacted end of suffering and life.

In the judgment of the European Court of Human Rights in the case of DIANE PRETTY v. the United Kingdom dated April 29th, 2002[11], at the end of paragraph 61, the Court expressed the following:

> "Although no previous case has established as such any right to self-determination as being contained in Article 8 of the Convention, the Court considers that the notion of personal autonomy is an important principle underlying the interpretation of its guarantees."

Furthermore, in paragraph 65 of the mentioned judgment DIANE PRETTY, the Court expressed:

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stationery-office.co.uk/pa/ld200405/ldselect/ldasdy/86/8609.htm , the ISOPUBLIC/GALLUP Poll http://www.medizinalrecht.org/wp-content/uploads/2013/03/Results_opinion_poll_self-determination_at_the_end_of_life.pdf and others more.

8 The Convention: http://www.echr.coe.int/Documents/Convention_ENG.pdf
Member States: http://www.coe.int/en/web/conventions/full-list/-/conventions/treaty/005/signatures

9 http://www.echr.coe.int/Pages/home.aspx?p=home

10 http://www.echr.coe.int/Documents/Convention_ENG.pdf page 5

11 Application no. 2346/02; Judgment of a Chamber of the Fourth Section: http://hudoc.echr.coe.int/sites/eng/pages/search.aspx?i=001-60448

> "The very essence of the Convention is respect for human dignity and human freedom. Without in any way negating the principle of sanctity of life protected under the Convention, the Court considers that it is under Article 8 that notions of the quality of life take on significance. In an era of growing medical sophistication combined with longer life expectancies, many people are concerned that they should not be forced to linger on in old age or in states of advanced physical or mental decrepitude which conflict with strongly held ideas of self and personal identity."

On November 3rd, 2006, the Swiss Federal Supreme Court recognized that someone's decision to determine the way of ending his/her life is part of the right to self-determination protected by article 8 § 1 of the Convention stating:

> "The right of self-determination in the sense of article 8 § 1 ECHR includes the right to decide on the way and the point in time of ending one's own life; providing the affected person is able to form his/her will freely and act thereafter."[12]

In that decision, the Swiss Federal Supreme Court had to deal with the case of a man suffering not from a physical but a psychiatric/mental ailment. It further recognized:

> "It cannot be denied that an incurable, long-lasting, severe mental impairment similar to a somatic one, can create a suffering out of which a patient would find his/her life in the long run not worth living anymore. Based on more recent ethical, juridical and medical statements, a possible prescription of Sodium Pentobarbital is not necessarily contra-indicated and thus no longer generally a violation of medical duty of care . . . However, utmost restraint needs to be exercised: it has to be distinguished between the wish to die that is expression of a curable psychic distortion and which calls for treatment, and the wish to die that bases on a self-determined, carefully considered and lasting decision of a lucid person ('balance suicide') which possibly needs to be respected. If the wish to die bases on an autonomous, the general situation comprising decision, under certain circumstances even mentally ill may be prescribed Sodium Pentobarbital and thus be granted help to commit suicide."

And furthermore:

> "Whether the prerequisites for this are given, cannot be judged on separated from medical – especially psychiatric – special knowledge and proves to be difficult in practice; therefore, the appropriate assessment requires the presentation of a special in-depth psychiatric opinion…"

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[12] BGE 133 I 58, page 67, consideration 6.1: http://relevancy.bger.ch/php/clir/http/index.php?lang=de&type=show_document&page=1&from_date=&to_date=&from_year=1954&to_year=2014&sort=relevance&insertion_date=&from_date_push=&top_subcollection_clir=bge&query_words=&part=all&de_fr=&de_it=&fr_de=&fr_it=&it_de=&it_fr=&orig=&translation=&rank=0&highlight_docid=atf%3A%2F%2F133-I-58%3Ade&number_of_ranks=0&azaclir=clir#page240

Based on this decision, the applicant made efforts to obtain an appropriate assessment, writing to 170 psychiatrists – yet he failed to succeed. Seeing that the Swiss Federal Supreme Court had obviously set up a condition which in practice could not be fulfilled, he took the issue to the European Court of Human Rights.

On January 20th, 2011, the European Court of Human Rights rendered the judgement[13] HAAS v. Switzerland and stated in paragraph 51:

> "In the light of this jurisdiction, the Court finds that the right of an individual to decide how and when to end his life, provided that said individual was in a position to make up his own mind in that respect and to take the appropriate action, was one aspect of the right to respect for private life under Article 8 of the Convention"

In this, the Court adhered to the Swiss Federal Supreme Court and acknowledged that the freedom to choose time and manner of one's own end is indeed a basic human right protected by the European Convention of Human Rights.

In a further case, ULRICH KOCH against Germany, the applicant's wife, suffering from total quadriplegia after falling in front of her doorstep, demanded that she should have been granted authorisation to obtain 15 grams of pentobarbital of sodium, a lethal dose of medication that would have enabled her to end her ordeal by committing suicide at her home. In its decision of July 19th, 2012, the European Court of Human Rights declared the applicant's complaint about a violation of his wife's Convention rights inadmissible, however, the Court held that there had been a violation of Article 8 of the Convention in that the [German] domestic courts had refused to examine the merits of the applicant's motion[14]. The case is about to be taken to the Federal Constitutional Court, and depending on their decision, the case might well continue, once more, on to the European Court of Human Rights.

In the case of GROSS v. Switzerland, the European Court of Human Rights further developed its jurisdiction. The case concerned a Swiss woman born in 1931, who, for many years, had expressed the wish to end her life, as she felt that she was becoming more and more frail and was unwilling to continue suffering the decline of her physical and mental faculties. After a failed suicide attempt followed by inpatient treatment for six months in a psychiatric hospital which did not alter her wish to die, she tried to obtain a prescription for sodium pentobarbital by Swiss medical practitioners. However, they all rejected her wish, one felt prevented by the code of professional medical conduct being that the woman was not suffering from any life-threatening illness, another was afraid of being drawn into lengthy judicial proceedings. Attempts by the applicant to obtain the medication to end her life from the Health Board were also to no avail.

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[13] Application no. 31322/07; Judgment of a Chamber of the First Section (in French): http://hudoc.echr.coe.int/sites/eng/pages/search.aspx?i=001-102939

[14] Application no. 479/09, Judgment of the Former Fifth Section: http://hudoc.echr.coe.int/sites/eng/pages/search.aspx?i=001-112282

In its judgment[15] of May 14th, 2013, the European Court of Human Rights held in paragraph 66:

> "The Court considers that the uncertainty as to the outcome of her request in a situation concerning a particularly important aspect of her life must have caused the applicant a considerable degree of anguish. The Court concludes that the applicant must have found herself in a state of anguish and uncertainty regarding the extent of her right to end her life which would not have occurred if there had been clear, State-approved guidelines defining the circumstances under which medical practitioners are authorised to issue the requested prescription in cases where an individual has come to a serious decision, in the exercise of his or her free will, to end his or her life, but where death is not imminent as a result of a specific medical condition. The Court acknowledges that there may be difficulties in finding the necessary political consensus on such controversial questions with a profound ethical and moral impact. However, these difficulties are inherent in any democratic process and cannot absolve the authorities from fulfilling their task therein."

In conclusion, the Court held that Swiss law, while providing the possibility of obtaining a lethal dose of sodium pentobarbital on medical prescription, did not provide sufficient guidelines ensuring clarity as to the extent of this right and that there had been a violation of Article 8 of the Convention. However, unfortunately, the case was referred to the Grand Chamber and shortly prior to a public hearing on the case, it became known that the applicant had passed away in the meantime, which led to the case not being pursued.

In light of these judgments and because of respect for human personal autonomy, which the Court acknowledges as an important principle in order to interpret the guarantees of the Convention, further legal developments are to be expected.

We would like to emphasize that in this context, since the case of ARTICO v. Italy (judgment of May 13th, 1980, series A no. 37, no. 6694/74[16]), the developed practice (so-called ARTICO-jurisdiction) is of major importance. In paragraph 33 of said judgment the Court explained:

> "The Court recalls that the Convention is intended to guarantee not rights that are theoretical or illusory but rights that are practical and effective; . . ."

Dignity and freedom of humans mainly consists of acknowledging the right of someone with full capacity of discernment to decide even on existential questions for him- or herself, without outside interference. Everything else would be paternalism compromising said dignity and freedom. In the judgment DIANE PRETTY v. the United Kingdom, the Court correctly recognized that this issue will present itself increasingly – not only within the Convention's jurisdiction,

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[15] Application no. 67810/10; Judgment of a Chamber of the Second Section: http://hudoc.echr.coe.int/sites/eng/pages/search.aspx?i=001-119703

[16] http://hudoc.echr.coe.int/sites/eng/pages/search.aspx?i=001-57424

but internationally – due to demographic developments and progress of medical science.

Authorities' restrictions and prohibitions in connection with assisted dying also raise the question of violation of the prohibition of torture, such as enshrined in article 3 of the European Convention of Human Rights, which states that no one shall be subjected to torture or to inhuman or degrading treatment or punishment.[17] A violation could occur for example if a palliative treatment is made with insufficient effect; if physical and emotional suffering and pain of a certain minimum level are given, such approach could possibly fulfill the notion of an inhumane treatment.

As the Convention, in the frame of the guarantee of article 8 § 1, comprises the right or the freedom to suicide, then everyone who wishes to make use of this right or freedom has a claim that he or she shall be enabled to do this in a dignified and humane way. Such individuals should not be left to rely on methods which are painful, which comprise a considerable risk of failure and/or endanger third parties. The available method has to enable the individual to pass away in a risk-free, painless manner and within a relatively short time. Such a method must also consider aesthetic aspects in order to enable relatives and friends to attend the process without being traumatized.

4) The protection of life and the general problem of suicide

In the judgment DIANE PRETTY v. the United Kingdom mentioned earlier, the European Court of Human Rights rightly paid great attention to the question of the influence of the right to life, especially the aspects of protection for the weak and vulnerable. In the meantime, the 18 years of experience of the US-American state of Oregon derived from its 'Death With Dignity Act' shows that the question of the weak and vulnerable does not pose a problem in reality: neither the weak nor the vulnerable nor those with insufficient (or even without) health insurance would choose the option of physician assisted suicide, but in fact the self-confident, the above-average educated, the strong ones.[18]

Yet, the principle of protection of life cannot be seen only in the light of the individual life of a single person who wishes a self-determined end to his or her suffering and life; it must also be applied in questions regarding public health, the well-being, the quality of life of the entire society.

Until now, national and international debates on assisted suicide and/or euthanasia hardly realized that, apart from the small number of individuals who wish to end their life due to severe suffering with one of the few available methods (palliative care, assisted suicide, rejection of treatment and refusal of food and drink,

[17] http://www.echr.coe.int/Documents/Convention_ENG.pdf
[18] See the Death with Dignity Act annual reports of the Department of Human Services of the US State of Oregon: http://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Pages/ar-index.aspx

etc.), there is a problem on a much larger scale which questions the sanctity of life: the general problem of suicide and suicide attempts.

In the year 2013, there were in New Zealand – a provisional figure – 508 registered suicides (deaths determined by the coroner as intentionally self-inflicted following a coroner's inquiry)[19]. This signifies that on average almost ten individuals die every week in New Zealand as a result of a suicide attempt. Many other states, like Switzerland, show a high number of suicides and even higher counts of failed suicide attempts. In response to the request regarding information on suicide and suicide attempts in Switzerland from Andreas Gross, a former member of the Swiss National Council, the Swiss government rendered its comments to the parliament on January 9th 2002[20]: it explained that, based on scientific research (National Institute of Mental Health in Washington), Switzerland might have up to 67,000 suicide attempts annually – that is 50 times the number of 1,350 of fulfilled (and registered) suicides of that year. Thus, the risk of failure of an individual suicide attempt is up to 49:1!

In New Zealand, there are approximately 10 times more hospitalisations for intentional self-harm (suicide attempts) than actual suicides[21]. However, the number is quite likely even higher as records are only kept on those who are admitted to hospital as inpatients or day patients and no data is collected nationally on people treated in Accident and Emergency (A&E) as outpatients, nor people treated by GPs, nor those who do not seek medical treatment[22].

Given the results of the scientific research mentioned before, suicide attempts in New Zealand, based on the 2013 figure, must be estimated to be up to 25,400 per year. Even if a much lower ratio, based on the hospitalisations, that is 10 attempts for every completed suicide is applied – also in line with assumption by psychiatrist, therapists and coroners assume (according to the afore mentioned comments of the Swiss government), there would still be 5,080 suicide attempts in New Zealand of which 4,572 fail. In any case, as the WHO states, for every suicide there are many more people who attempt suicide every year[23].

Quite a number of commonly heard phrases – like "a suicide attempt is normally just a cry for help", "80 % of people who have survived a suicide attempt would not like to repeat it", "someone who talks about suicide will not do it" – are simply 'thought savers'[24]. 'Thought savers' are a way to stop thinking about a particular problem without solving it. It is quite significant that such 'thought savers' are very common in relation to the suicide problem. With a 'thought saver', one may get rid of the problem, belittling it so that it appears no longer worth thinking about. Hardly anyone asks, for instance, when speaking of a 'cry

[19] http://www.health.govt.nz/publication/suicide-facts-2013-data
[20] Online (in German): http://www.parlament.ch/d/suche/seiten/geschaefte.aspx?gesch_id=20011105
[21] http://www.health.govt.nz/system/files/documents/publications/nz-suicide-prevention-evidence-mar08.pdf
[22] http://www.life.org.nz/suicide/suicidekeyissues/nz-statistics-on-attempted-suicide
[23] http://www.who.int/mediacentre/factsheets/fs398/en
[24] An expression created by the American journalist Lincoln Steffens, a friend of President Theodore Roosevelt, see: The Autobiography of Lincoln Steffens.

for help': why does this person feel the need to undertake the risk of a suicide attempt in order to find help, instead of talking to other people and saying that they need help? In the special case of a suicidal situation, the reason for the 'cry for help' without words is the risk of losing one's liberty (due to being put in a psychiatric clinic) or the risk of not being taken seriously or being rejected (deprived of affection) if one talks to someone else about suicidal ideas.

Referring to the previously mentioned ARTICO-jurisdiction of the ECHR: no matter whether the risk is 49:1 or 'only' 9:1, it indicates that an individual can only make use of the right to end his or her life self-determinedly by accepting such a high risk of failure and therefore an unbearable (further) deterioration of his or her state of health. This signifies however, that the right to end ones life self-determinedly and self-enacted under the conditions currently found in New Zealand is neither practical nor efficient.

The negative and tragic result of 'clandestine' suicides is diverse:

- enormous costs for the public health care system, especially costs arising from caring for the invalid, costs for the public sector (rescue teams, police, coroner, etc.) and costs for a country's economy[25];
- high risk of severe physical and mental injuries for the person who attempts suicide;
- psychological problems for those unintentionally but directly getting involved in the suicide attempt such as train conductors;
- psychological problems for next-of-kin and friends of a suicidal person after their attempt and their death;
- personal risks and psychological problems for rescue teams, the police, etc., who have to attend to the scene at or after a suicide attempt;

In the light of the enormous number of committed/fulfilled and failed suicide attempts and their negative effects, governmental measures towards an improved suicide and suicide attempt prevention are now taking momentum. Some programs seem to focus very much on narrowing access to the means of suicide and a lot of money is spent on constructing fences and nets on bridges and along railway lines. However, the starting point of effective suicide attempt prevention is looking at the root of the problem: the taboo surrounding the issue, the stigmatization, the wall of fear of embarrassment, rejection and losing one's independence. More discussion of suicide and the provision of more accurate information about suicide in New Zealand can only be for the better[26].

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[25] See the study of PETER HOLENSTEIN: http://www.dignitas.ch/images/stories/pdf/studie-ph-der-preis-der-verzweiflung.pdf . In Switzerland, in the year 1999, there were 1'269 registered suicides leading to estimated costs of 65,2 Million Swiss Francs; given that the estimated number of suicide attempts is considerably higher (based on information provided by forensic psychiatrists, coroners, etc., the study calculates with a suicide attempt rate that is 10 to 50 times higher than the registered suicides), these costs could well be around 2'431,2 Million Swiss Francs. In New Zealand, the report 'The Cost of Suicide to Society' estimates the costs in connection with suicide to be NZ$ 206.2 million and the costs with suicide attempts to be NZ$ 32,3 million https://www.health.govt.nz/system/files/documents/publications/thecostofsuicidetosociety.pdf

[26] Judge Neil Maclean, Chief Coroner of New Zealand, http://www.justice.govt.nz/courts/coroners-court/suicide-in-new-zealand/message-from-the-coroner

5) Palliative Care

Palliative care is an approach that improves the quality of life of patients and their families facing the problems associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual[27]. Palliative care is widely accepted and practiced. It is one of the means of choice if the suffering of the individual is intolerable (in the personal view of the patient, of course) and the life expectancy is only a matter of a few days or weeks. It is certainly humanitarian and good practice in the sense of 'the Good Samaritan' to give a suffering, dying patient all the end of life care necessary and requested by the patient in order to soothe his or her ordeal.

However, voices claiming that palliative care "can solve anything" and "soothes any suffering" are not in touch with reality and try to mislead the public. Based on experience drawn from almost 18 years of operating, DIGNITAS very much adheres to Richard Glynn Owens, Professor of Psychology at the University of Auckland that palliative care, for all its significant benefits, is not always trouble-free, can be insufficient to meet the needs of some patients and not an answer for those for whom there is no relief from unendurable suffering[28]. There are sufferings for which medical science has still no cure, yet, for which palliative treatment is not an option or possibly only applicable in a very advanced late stage of that illness, given that these illnesses are not terminal as such, at least not in the short run. Patients suffering from neurological illnesses such as Amyotrophic Lateral Sclerosis (Motor Neurone Disease), Multiple Sclerosis, etc., or even more so quadriplegics[29] or patients suffering from a multitude of ailments related to old age[30] are generally not *per se* eligible for palliative care and terminal sedation because they are not suffering from excruciating pain and/or a life-threatening illness as such. Long-time degenerative neurological disease are, alongside cancer, the 'typical diagnosis' why patient would seek (and in Switzerland usually obtain access to) the option of an assisted / accompanied suicide. Certainly, these patients also receive medical treatment for pain relief, but that cannot be compared with the dosages applied in end-of-life palliative care. Without doubt, such patients are experiencing severe suffering which can lead them to wish to end their suffering and life self-determinedly. In such cases, the wish for an assisted/accompanied suicide and/or voluntary euthanasia is a personal choice which must be respected.

Palliative care and a patient's rational decision to self-enacted end suffering and life are not two practices in conflict but in fact they have a complementary relationship even though sometimes the opposite is claimed, usually by opponents

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[27] Definition by the World Health Organisation: http://www.who.int/cancer/palliative/definition/en

[28] http://lecretia.org/wp-content/uploads/2015/10/reply_affidavit_of_richard_glynn_owens.pdf

[29] Such as for example the British rugby-player Daniel James who was left paralysed with no function of his limbs, pain in his fingers, spasms, incontinence and needing 24 hour care after a sports accident.

[30] Such as for example the well-known British conductor Sir Edward Downes

of freedom of choice in assisted dying options. Almost every day DIGNITAS receives calls for help from patients stricken by the final stage of terminal cancer as well as their relatives and friends. As the administrative proceedings involved with the preparation of an assisted/accompanied suicide take quite some time, usually several weeks if not months, terminally ill patients are always recommended to also pursue palliative treatment possibly leading to continuous deep sedation (sometimes also called terminal sedation). Thus, DIGNITAS has directed uncountable patients towards palliative care, has given advice how to access the support of specialist doctors, how to implement Health Care Advance Directives in a way that it would give safety to the patient and also to the doctors practising palliative care, etc.

In the judgment DIANE PRETTY v. the United Kingdom mentioned before, the European Court of Human Rights avoided to look into the aspect of the states' positive duty to protect individuals from inhumane treatment in cases of assisted dying, but there is room to look into this aspect more closely in future cases[31].

6) Suicide attempt prevention – experience of DIGNITAS

Everyone should be able to discuss the issue of suicide openly with their general practitioner, psychiatrist, carers, teacher, priest, etc. The taboo which surrounds the topic must be lifted. The possibility of – anonymously as well as openly – using a help-line is a very important service provided by some institutions[32]. However, for many people 'talking about it' does not suffice: they seek the concrete option of a painless, risk-free, dignified and self-determined death, to put an end to their suffering.

DIGNITAS' experience with all people – no matter whether they suffer from a severe physical ailment or other impairment, or wish to end their life due to a personal crisis – shows that giving them the possibility to talk to someone openly and without fear of being put in a psychiatric clinic, has a very positive effect: they are – and feel that they are – being taken seriously (often for the first time in their life); through this, they are offered the possibility of discussing solutions to the problem(s) which led them to feeling suicidal in the first place[33]. They are not left to themselves and rejected like suicidal individuals who such cannot discuss their suicidal ideas with others through fear of being ostracized or deprived of their freedom in a mental institution for some time.

Furthermore, through their contact with DIGNITAS, not only are their suicidal ideas taken seriously but they also know that they are talking to an institution

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[31] See: STEPHAN BREITENMOSER, The right to assisted dying in the light of the ECHR (Das Recht auf Sterbehilfe im Lichte der EMRK), in: Frank Th. Petermann, Assisted Dying – Basic and practical questions (Sterbehilfe – Grundsätzliche und praktische Fragen), p. 184 ff, St. Gallen, 2006.

[32] In New Zealand provided for example by Lifeline http://www.lifeline.org.nz or the Samaritans http://samaritans.org.nz

[33] See 'The counselling concept of DIGNITAS', http://www.dignitas.ch/images/stories/pdf/diginpublic/referat-how-dignitas-safeguards-eth-21072014.pdf page 10 ff.

which could in fact, under certain conditions, arrange for a 'real way out'. This aspect of authenticity cannot be underestimated.

This 'talking openly' unlocks the door to looking at all thinkable options. These include advising the individuals in a personal crisis to visit a crisis intervention centre, referring severely suffering terminally ill to the palliative ward of an appropriately equipped clinic, suggesting alternative treatments, directing patients who feel ill treated by their general practitioner to other clinicians, and so on; always depending on the individual's needs. Over one third of DIGNITAS' daily 'telephone-work' is counselling individuals who are not even members of the association who thus receive an 'open ear' and initial advice free of charge.[34]

The experience of DIGNITAS, drawn from almost 18 years of working in the field of suicide prophylaxis and suicide attempt prevention, shows that the option of an assisted/accompanied suicide without having to face the severe risks inherent in commonly-known suicide attempts is one of the best methods of preventing suicide attempts and suicide. It may sound paradoxical: in order to prevent suicide attempts, one needs to say 'yes' to suicide. Only if suicide as a fact is acknowledged, accepting it generally to be a means given all humans to withdraw from life and also accepting and respecting the individual's request for an end in life, the door can be opened to 'talk about it' and tackle the root of the problem which made the individual suicidal in the first place.

A 'real' option, that is access to an accompanied suicide when someone rationally decides to die, will deter many from attempting/committing suicide through insufficient, undignified means. Furthermore, at DIGNITAS, in the preparation of an assisted/accompanied suicide, next-of-kin and friends are involved in the preparation process and encouraged to be present during the last hours: this gives them a chance to prepare for the departure of a loved one and thus give their support and affection to the suicidal person until the very end of life.

7) Arguments of 'vulnerable individuals' and a 'slippery slope'

At this point, we need to take a look at the two main arguments of opponents to legislation of any form of assisted dying: they argue that this could pressure 'vulnerable' individuals to end their life, for example because they would be pushed by loved ones not to be a burden on them anymore. And it is suggested that legalisation would create a 'slippery slope', an unstoppable increase in numbers. The general understanding may be that individuals under the age of 18 or 16, people who are dependent on medical care and those who suffer from a loss of capacity to consent (for example due to dementia) would be classified as vulnerable. However, it is acknowledged – especially in the annual reports of the

[34] http://www.dignitas.ch/images/stories/pdf/statistik-beratungsgespraeche-2607-30092010.pdf

Health Authority of the US-American State of Oregon[35] – that assisted suicide has nothing to do with 'vulnerable' individuals. Besides, the 'vulnerable' argument is another 'thought saver' and a pretext argument which distracts from further looking into the pressing social issue: the issue that those who become suicidal are often facing barriers. This, because there is still a taboo surrounding the topic of suicide, the fear of being put in a psychiatric clinic and thus being deprived of freedom and the fear of having his or her suicidal thoughts denounced, belittled, ignored or dismissed. In fact, these individuals are the really vulnerable ones and their situation will certainly not be improved by thought savers, pretext arguments and upholding the taboo.

The Journal of Medical Ethics carried the article "Legal physician-assisted dying in Oregon and the Netherlands: evidence concerning the impact on patients in vulnerable groups"[36]. The topic-related relevant part of the abstract of this article states as follows:

> "Background: Debates over legalisation of physician-assisted suicide (PAS) or euthanasia often warn of a 'slippery slope', predicting abuse of people in vulnerable groups. To assess this concern, the authors examined data from Oregon and the Netherlands, the two principal jurisdictions in which physician-assisted dying is legal and data have been collected over a substantial period.
>
> Methods: The data from Oregon (where PAS, now called death under the Oregon 'Death with Dignity Act', is legal) comprised all annual and cumulative Department of Human Services reports 1998–2006 and three independent studies; the data from the Netherlands (where both PAS and euthanasia are now legal) comprised all four government-commissioned nationwide studies of end-of-life decision making (1990, 1995, 2001 and 2005) and specialised studies. Evidence of any disproportionate impact on 10 groups of potentially vulnerable patients was sought.
>
> Results: Rates of assisted dying in Oregon and in the Netherlands showed no evidence of heightened risk for the elderly, women, the uninsured (inapplicable in the Netherlands, where all are insured), people with low educational status, the poor, the physically disabled or chronically ill, minors, people with psychiatric illnesses including depression, or racial or ethnic minorities, compared with background populations. The only group with a heightened risk was people with AIDS. While extralegal cases were not the focus of this study, none have been uncovered in Oregon; among extralegal cases in the Netherlands, there was no evidence of higher rates in vulnerable groups.

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[35] Death with Dignity Act annual reports of the Health Authority of the US State of Oregon: http://public.health.oregon.gov/providerpartnerresources/evaluationresearch/deathwithdignityact/pages/ar-index.aspx

[36] Journal of Medical Ethics 2007;33:591-597; doi:10.1136/jme. 2007.022335: http://jme.bmj.com/content/33/10/591.abstract

> Conclusions: Where assisted dying is already legal, there is no current evidence for the claim that legalised PAS or euthanasia will have disproportionate impact on patients in vulnerable groups. Those who received physician-assisted dying in the jurisdictions studied appeared to enjoy comparative social, economic, educational, professional and other privileges."

Furthermore, not every individual who may be seen by third parties as vulnerable would personally share this view. One needs to bear in mind: there is a fine line where protection turns into undesired paternalism. Such paternalism very much applies to psychiatry, which has a long-standing view that a desire to die is a manifestation of mental illness, whilst in fact patients who secure and utilise a lethal prescription are generally exercising an autonomous choice unencumbered by clinical depression or other forms of incapacitating mental illness[37].

As to the 'slippery-slope' argument, DIGNITAS adheres to a statement of the full professor ('Ordinarius') for law ethics at the University of Hamburg, Germany, Dr. iur. REINHARD MERKEL, who looked into this argument in his report "Das Dammbruch-Argument in der Sterbehilfe-Debatte" ("The slippery-slope argument in the euthanasia debate")[38]: in this report he emphasized that arguments of this nature have always been the most misused instruments of persuasion in public debates on controversial subjects. They have always been the probate residuum of ideologists and demagogues.

Furthermore, based on the experience of the Zürich City Council, we now know that allowing assisted/accompanied suicide even in nursing homes for the elderly does not lead to any rise of such end-of-life choice: of the 16,000 residents in Zürich homes for the elderly, only zero to three assisted/accompanied suicides per year have taken place since the authorities allowed associations like DIGNITAS, EXIT and others to access such homes in 2002[39].

The issue is not whether someone would make use of assisted/accompanied suicide: in fact, the majority of members of DIGNITAS who have requested the preparation of an accompanied suicide and who have been granted the 'provisional green light'[40] do not make use of the option after all. Based on a study on our work, research into 387 files of members of DIGNITAS, who – through the given procedure in our organisation – received a basic approval from a Swiss physician, a 'provisional green light', that he or she would issue the necessary prescription for an assisted suicide, 70 % did not contact DIGNITAS again after such notification. Only 14 % made use of the option of an assisted/accompanied

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[37] Cambridge Quarterly of Healthcare Ethics 2014, http://journals.cambridge.org/action/displayAbstract?fromPage=online&aid=9333247&fileId=S0963180114000085

[38] in: FRANK TH. PETERMANN, (ed.), Sicherheitsfragen der Sterbehilfe (Safety questions in assisted dying), St. Gallen 2008, p. 125-146

[39] See the interview with Dr. med. Albert Wettstein, former Chief of the Zürich City Health Service (available in German) online: http://www.derbund.ch/schweiz/standard/Natuerlicher-als-mit-Schlaeuchen-im-Koerper-auf-den-Tod-zu-warten/story/13685292?track

[40] For an explanation, see 'How DIGNITAS works', chapter 1.6, page 8 ff: http://www.dignitas.ch/images/stories/pdf/so-funktioniert-dignitas-e.pdf

suicide, some after quite a long time[41]. For many, the prospect of such a prescription signifies a return to personal choice at a time when their fate is very much governed by their suffering. It enables many to calmly wait for the future development of their illness and not to prematurely make use of an accompanied suicide, let alone take to a 'clandestine' suicide attempt with all its risks and dire consequences.

This shows that a liberal solution, which entirely respects the individual who wishes to end his or her suffering, offers more sophisticated results than action which in such situations deprive individuals of their dignity, personal freedom and responsibility for themselves.

8) The 'Swiss model' of freedom of choice

Switzerland has a liberal tradition. After decriminalisation of suicide during enlightenment in the 17th - 18th century, in the 19th century expert committee and parliament discussed the issue of assistance in suicide and found that a gentleman who would have lost his good reputation/dignity due to some incident should be able to ask a friend, who is officer in the army, to let him a gun and to show him how to use it so that he could properly end his misery. It was considered to be a 'Freundestat', an 'act of friendship', an assistance which should not be punished. In those days, there was not one criminal code for Switzerland, but each Canton (each Swiss State) had its own criminal code.

This aspect of assistance/help which should not be punished was also taken into consideration when discussions started about a criminal code for all of Switzerland. In 1918, in its comment (a so-called federal council dispatch) accompanying the proposal for a Federal Criminal Code, the Federal Council (which is the Swiss government, consisting of 7 members, each head of one department) stated that if the aforementioned assistance was done with selfish motives, it should be punished. As examples for such selfish motives the Federal Council referred to situations such as if someone greedily intended to inherit 'earlier' or if someone intended 'to get rid' of having to support a family member. Thus, the initial aim/purpose of the regulation was upheld and additionally specified. It took many more years for the Swiss Federal Criminal Code to be finalised in 1937 and to come into force on 1 January 1942. The legal consequence (in the sense of 'e contrario') of the specific article 115 in the Swiss Criminal Code is: anyone can help (assist) any person to commit suicide as long as (s)he who helps does not have selfish motives in the sense of the examples stated above. Of course, in these specific circumstances of being assisted, the person self-determinedly end-

[41] Extract of the study (available in German) online: http://www.dignitas.ch/images/stories/pdf/studie-mr-weisse-dossier-prozentsatz-ftb.pdf

ing his or her life must have legal capacity of judgment, in plain words: must be competent[42].

Up until today, Switzerland has not set up a specific law, a specific act/bill, regulating the procedure of assisted/accompanied suicide. However, with the development of modern medicine and consequently the founding of the two EXIT members' societies in 1982, followed by DIGNITAS, a practice developed which today enjoys acceptance with the authorities and the public.

Common denominator and in legal practice accepted is that a Swiss medical doctor can prescribe the psychotropic substance (barbiturate) Sodium Pentobarbital for the purpose of an assisted suicide, if he/she 1) checked the medical file = found that there is some medical diagnosis/suffering, 2) has seen/spoken the patient and found that he/she really wants to self-determinedly end his or her own life and 3) found that the patient does not lack mental competence to make a rational decision to do so. In practice, the medical doctor would prescribe 15 grams of Sodium Pentobarbital powder and give the prescription to an employee of DIGNITAS or EXIT. The employee would fetch the medication from a pharmacy. The medication is then used in the frame of an assisted/accompanied suicide, usually at the home of the patient (living anywhere within Switzerland), in the presence of one or more employees of the organisation. Family and friends are always encouraged and welcomed to attend the proceedings. Generally, the patient never receives the prescription or the medication to take home, such as it is the case in the US-State of Oregon. If the patient does not make use of the medication on that particular day, the employee of the organisation brings it back to the pharmacy.

There is also the possibility that a medical doctor prescribes the Sodium Pentobarbital and does the assistance himself/herself. However, Swiss general practicioners respecting the patient's rational decision to die by assisted suicide would usually reach out to an organisation such as DIGNITAS.

In all cases, the patient must do ingestion himself/herself, which is drinking it, or opening the valve of a drip, or activating a pain-pump which pushes down the rod of a syringe-container filled with the Pentobarbital and thus pumps the medication via a tube into the vein.

Details of the preparation and the actual course of an assisted/accompanied suicide can be found in the booklet 'How DIGNITAS works'[43].

At this point, it is important to stress that all this is about the personal decision of a competent individual assuming responsibility for his or her own life – not about a third person making decisions on behalf of this individual. It is always

[42] Swiss law bases on the assumption that up front everybody is assumed to have capacity of judgment; this, unless there are clear signs that such is not the case (such as the person being delirious due to drugs or having hallucinations due to a psychiatric ailment) – article 16 of the Swiss Civil Code https://www.admin.ch/opc/en/classified-compilation/19070042/index.html#a16 This matches common law which recognises – as a 'long cherished' right – that all adults must be presumed to have capacity until the contrary is proved.

[43] http://www.dignitas.ch/index.php?option=com_content&view=article&id=23&Itemid=84&lang=en

the patient who is in charge, who decides which steps will be taken – until the very last moment.

Despite such non-state-regulated practice, there is no misuse and even after more than 30 years of such assisted dying practice being an option to choose, numbers of Swiss patients making use of this are at a rate of under 1 % of all deaths per year; the most recent available figures, of the year 2013: 64,961 deaths – 587 assisted suicides[44].

The Swiss practice did not lead to a 'one-track solution': over these 30 years, a system developed, promoted by all Swiss 'right-do-die' organisations, which combines advocating and counselling for palliative care, suicide attempt prevention, advance directives and the right to choose in life and at life's end. In other words: 'right-to-die' organisations have developed into information centres on *all* options to soothe and/or end suffering. To little surprise, in its publication "National Strategy Palliative Care 2013 - 2015", referring to the Federal Council report "Palliative Care, Suicide prevention and organised assistance with suicide" of June 2011, the Federal Office of Public Health FOPH acknowledged that "*nowadays, in society primarily suicide assistance organisations are seen to be a possibility to ensure self-determination at the end of life*".

This public attitude was made very clear, for example, in votes in the Canton of Zürich, Switzerland, on 15 May 2011: two fundamental-religious political groups brought two initiatives to the people's vote, of which one initiative aimed to prohibit the current legal possibility of assisted suicide entirely whilst the other aimed to prohibit access for non-Swiss citizens and non-residents of the Canton of Zürich. The result was a clear message: the public voted by an impressive majority of 85:15 and 78:22 against any narrowing of the current legal status quo[45]. This result is even more notable in the light of the fact that a large part of the media had tried for years to scandalise the work of DIGNITAS and other such organisations through inaccurate, tabloid-style press coverage.

In this context one needs to remember that part of the media – especially the tabloids – are notorious for spreading nonsense such as there being the option of (voluntary) "euthanasia" at a "DIGNITAS-clinic" where people would take "poison" or a "lethal cocktail", etc., thus showing their irresponsibility towards their actual task of informing the public in an accurate, balanced way. Questions of life and death have always been subject to sensationalism. Deliberately or unintentionally generating life just as well as ending life can be well considered as the primary sensation to which the media has related to for centuries. Today's media – and even some politicians – draw their existence from offering their consumers a daily motive for emotional outrage. The late Zürich full professor in sociology, KURT IMHOF, pointed this out in an interview that he granted the

[44] http://www.bfs.admin.ch/bfs/portal/de/index/themen/14/02/04/key/01.html

[45] For links to the official statistics and a choice of media coverage on the results of the votes see online: http://www.dignitas.ch/index.php?option=com_content&view=article&id=26&Itemid=6&lang=en (on the website, scroll down to the comment/entry of 16 May 2011).

"Neue Zürcher Zeitung" (NZZ) on December 8th, 2007, stating that the result of such media coverage lies much further within the field of fiction than fact[46].

DIGNITAS favours the option of assisted/accompanied suicide such as Swiss law allows to practice and which the Swiss 'right-to-die' associations have been offering to their members for over 30 years now. In summary, assisted/accompanied suicide implies the following:

- The individual is respected in his or her request to have an end to his or her suffering.
- This request is explicitly expressed by the individual, not only once but several times during the process of preparation and re-confirmed even in the final minute prior to the assistance. (In the case of accompanied suicide in Switzerland, this is the moment prior to handing over the lethal drug to the individual).
- The individual expresses his or her desire to end his or her life not only verbally but undertakes the last act in his or her life him- or herself. (In the case of accompanied suicide in Switzerland, this is the action of the individual actually drinking the lethal drug or ingesting it in another form such as feeding it him- or herself through a PEG-tube or intravenous).
- All actions are based exclusively on the explicit will and rational decision to die of the individual.
- With assisted/accompanied suicide, the individual always has to do the last act himself or herself; without such final act of the individual, there will be no ending of life. Thus, the taboo of ending someone's life actively (on request by the patient, which would be voluntary euthanasia or even without such request which would be non-voluntary, active euthanasia) does not have to be broken.
- Access to the option of an assisted/accompanied suicide has a very important suicide attempt preventative effect, as already outlined earlier in this submission.

However, these aspects cannot hide the fact that with assisted/accompanied suicide 'only', some individuals could be excluded from assistance in dying: there are cases of patients who have lost all control over their bodily functions, including the ability to swallow, so that they would not be able to self-administer the lethal drug in any way and therefore voluntary euthanasia would be the only option. Furthermore, an individual in a coma or suffering from advanced dementia would not be able to express his or her will, would not have sufficient capacity to consent and/or simply would not be able to do the last act which brings about the end of suffering and life him- or herself. However, for these situations, a different approach is already in place to some extent at least: the strengthening and implementation of the already wide-spread and widely accepted Advance Directives (sometimes also called Advance Decisions or Living Will).

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[46] Article (in German) online: http://www.nzz.ch/aktuell/startseite/medienpopulismus-schadet-der-aufklaerung-1.595885

Based on DIGNITAS' experience, the large majority of requests for an individual's dignified end in life can be covered by assisted/accompanied suicide. Implementing a scheme for assisted/accompanied suicide would add a choice for New Zealanders, to have a real option helping to shake off despair and regain some control, dignity and hope when faced with severe suffering – something that all people wish for.

One needs to be clear about the fact that only a very small minority of individuals would actually make use of an assisted/accompanied suicide. First of all, for many, medical science offers relief, and second – as late Member of the Scottish Parliament Margo MacDonald's rightly put it in her first proposal for an Assisted Suicide Bill for Scotland – for some people the legal right to seek assistance to end life before nature decrees is irrelevant due to their faith or credo[47]; yet there is another important reason why in fact only a minority of patients would 'go all the way' and make use of an assisted/accompanied suicide: it's the fact that 'having the option gives peace of mind'. Having no hope, no prospect, not even the slightest chance of something to cling on is what all humans dislike most. Everyone would like to have at least a feeling of being in control of things. Faced with a severe illness, patients usually ask their doctor: "will I get better?" or: "how much more time do I have?" but an exact medical prognosis is generally difficult if not impossible as the course of disease is different with each individual. In this situation, having options, including the option of a self-determined ending of suffering and life in the sense of an 'emergency exit', can lift the feeling of 'losing control'. This is what members of DIGNITAS state again and again. Legalising assisted/accompanied suicide and voluntary euthanasia is not about 'doing it' but about 'having the option of doing it', having a choice. End-of-life choice means having the right to choose to die well with medical assistance[48].

In the light of all these considerations, DIGNITAS has drafted an Act to introduce assisted dying in New Zealand based on the 'Swiss system' of physician-supported accompanied suicide: an "Act to Provide for Accompanied Suicide with Assistance by Registered Charitable Not-for-Profit Organisations (Accompanied Suicide Act – ASA)", which is submitted in the Appendix as part of this submission.

9) Conclusion

No one should be forced to leave his or her home in order to make use of the basic human right of deciding on the time and manner of the end of his or her life. The current legal status of assisted dying in New Zealand and in many other countries is indeed "inadequate and incoherent" as the UK Commission on As-

[47] http://www.scottish.parliament.uk/S4_MembersBills/Final_version_as_lodged.pdf
[48] http://www.ves.org.nz/about

sisted Dying put it on the front side of its final report[49]. It forces citizens to travel abroad in order to have freedom of choice. In this context it should be pointed out that only individuals with at least a minimum of financial resources – something that certainly not everyone in New Zealand has – can afford to travel to Switzerland in order to make use of the option of a self-determined and self-enacted end of suffering and life, which is an unacceptable discrimination against those who are not so well off. DIGNITAS' articles of association / statutes allow for reduction or even total exemption of paying costs to DIGNITAS[50], however, the person still would have to bear the burden of a long journey which is even more strenuous in a deplorable state of health.

No one shall set upon a long journey without having thoroughly said goodbye to loved ones and no one shall set upon such journey without careful preparation. At a time in which lonely suicides among older people, in particular, are increasing – as a result of the significant increase in life expectancy and the associated health and social problems of many men and women who have become old, sick and lonely – careful and considered advice in matters concerning the voluntary ending of one's own life is gaining relevance. There are individuals who explicitly would like to add life to their years – not years to their life.

New Zealand's laws are not yet adequately meeting people's expectations regarding options available at the end of their life because there are New Zealanders who turn to DIGNITAS in Switzerland for help. The legal framework that operates at the end of life in New Zealand needs to be reformed.

DIGNITAS calls on New Zealand to implement a law which allows a competent individual to have a safe, dignified, self-determined and accompanied end in life at their own home – full choice on time an manner of one's end of suffering –, which is in fact what New Zealanders wish for. If this is implemented, as a side-effect the very goal of the DIGNITAS-organisation is closer in reach: to become obsolete. Because, if people in New Zealand (and other countries too) have real and legal choice, no citizen of New Zealand needs to travel to Switzerland and become a 'freedom-tourist' (which is a term certainly more appropriate than 'suicide-tourist') and thus DIGNITAS is not necessary anymore for them.

Legal certainty is the base for the functioning of a (democratic) society. DIGNITAS supports projects to implement freedom of choice in 'last matters', as these lead to less suffering, especially to smaller numbers of failed suicide attempts, with all their dire consequences. In this context, we refer to the philosophical and political principles guiding the activities of DIGNITAS[51] which we feel may well serve as a basis for any consideration of end-of-life-issues.

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[49] http://www.demos.co.uk/project/the-commission-on-assisted-dying
[50] http://www.dignitas.ch/index.php?option=com_content&view=article&id=11&Itemid=52&lang=en
[51] See 'How DIGNITAS works' chapter 2, page 20: http://www.dignitas.ch/images/stories/pdf/so-funktioniert-dignitas-e.pdf

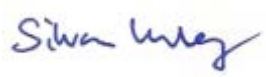
We close this submission with words by DAVID HUME, one of the most famous philosophers of the last 300 years[52]:

> „If Suicide be supposed a crime, 'tis only cowardice can impel us to it. If it be no crime, both prudence and courage should engage us to rid ourselves at once of existence, when it becomes a burthen. 'Tis the only way, that we can then be useful to society, by setting an example, which, if imitated, would preserve to every one his chance for happiness in life, and would effectually free him from all danger of misery."

Yours sincerely

DIGNITAS
To live with dignity - To die with dignity

Ludwig A. Minelli



Silvan Luley

[52] DAVID HUME, Of Suicide, http://ebooks.adelaide.edu.au/h/hume/david/suicide , in fine.

Note: all internet links in foot notes (re-)accessed 29 January 2016

Draft Act to introduce Assisted Dying in New Zealand
Based on the "Swiss system" of physician-supported accompanied suicide

Act

Draft Act to Provide for Accompanied Suicide with Assistance by Registered Charitable Not-for-Profit Organisations (Accompanied Suicide Act – ASA)

A. Issue

"Without in any way negating the principle of sanctity of life protected under the Convention, the Court considers that it is under Article 8 [of the European Convention on Human Rights] that notions of the quality of life take on significance. In an era of growing medical sophistication combined with longer life expectancies, many people are concerned that they should not be forced to linger on in old age or in states of advanced physical or mental decrepitude which conflict with strongly held ideas of self and personal identity..."

This view was expressed by the European Court of Human Rights (ECHR) in its decision in the case of Diane Pretty v. the United Kingdom of 29 April 2002. In doing so, the Court touched upon the question of whether the desire of some people for facilitating "assisted dying" might be a matter that falls under Article 8 of the European Convention on Human Rights (ECHR), "Right to respect for private and family life".

Since then, the ECHR has dealt with a series of other cases presenting similar issues. In its decision in one of these cases, Haas v. Switzerland, it recognised the right of a person to decide how and when he or she wishes to die as constituting an aspect of Article 8 ECHR and thus falling within the application of the European Convention on Human Rights as a basic right.

In the public debate on these issues, there has long been a divide between the opinion of a large section of the public and the stance of policymakers. For many years, surveys have shown that in many countries, also in New Zealand, a clear majority of the public is in favour of making assisted dying possible.

It must become possible for those residents of New Zealand who want to put an end to their life for justifiable reasons to do so in a dignified and safe manner of their own choosing and in the presence of their family and friends, in the privacy of their own homes and to be able to have access to professional, competent assistance.

B. Solution

In Switzerland, physician-assisted dying in the form of physician-supported assisted/accompanied suicide by private organisations such as DIGNITAS has been a practice of more than 30 years, even though there has never been a specific Law/Act regulating it. Despite there not being a specific Law/Act, this "Swiss scheme" notably, has been functioning without any of the typical but unfounded pretext arguments having been realised, such as abuse of such system, risks for certain less privileged social groups, "vulnerable people" such as elderly or disabled being pushed to end their days, or a "slippery slope" in the direction of increasing physician-assisted dying. Even after more than 30 years,

only about one per cent of all deaths in the Swiss population are attributable to assisted/accompanied suicide.

The solution lies in the New Zealand legal system enacting a law enabling the requirements to be established under which charitable not-for-profit organisations in the territory of New Zealand are allowed to provide and perform accompanied suicide in a professional manner. The law should enable assisted dying using the gentlest and safest method available, while ensuring that specific quality criteria are being met.

The following two aspects in particular are definitive:

Accompanied suicide should not be provided by commercial businesses that act as "market players";

and

Accompanied suicide needs to be embedded in charitable not-for-profit work premised on suicide as a legitimate act under some circumstances.

These aspects are taken into account by creating a law which sets conditions allowing only charitable not-for-profit organisations in the form of registered membership societies (associations in the sense of Swiss Civil Code article 60 ff) to act. This condition does away with the incentive to offer assisted dying in a commercial manner.

Switzerland's experience with this system has been very positive. The Swiss Federal Council (Swiss Government) and the Government of the Canton of Zurich (where DIGNITAS and EXIT have their seat, the latter being Switzerland's biggest help-to-live-and-right-to-die membership society with 92,000 members) – in line with both chambers of the Swiss parliament – have established that this system does not require any statutory measures to prevent abuse. This might be surprising in light of the fact that, as mentioned, Swiss law does not specifically regulate assisted/accompanied suicide by organisations. This example shows that "dare to live free!" in seeking a solution to difficult issues may be an eminently reasonable approach. There are no reasons to believe that this approach will be less successful in New Zealand than in Switzerland.

The Swiss system, which is based on freedom, personal autonomy, and responsibility, is also suited to providing valuable services to society in the area of suicide attempt prevention. This system strives to embody the principle "as many suicides as justified, as few suicide attempts as possible" and in doing so makes a significant contribution to preventing suicide attempts.

In light of the fact that there is obviously a "system that works", notably for more than 30 years now and this even without a specific Law/Act, the New Zealand Government – just like representatives of the UK House of Lords, parliamentarians of Sweden, Australia, Scotland and Canada, etc. – may be interested to see how this system could be put into law. For this reason, DIGNITAS has drafted an Act, basically a one-to-one image of the "Swiss system" which involves 1) a competent individual who wishes to terminate his or her suffering and life, 2) a public members' society (membership association) such as DIGNITAS, 3) counselling on alternatives to assisted/accompanied suicide and suicide attempt preventive work in general, 4) medical doctors, 5) a safe medication such as sodium pentobarbital, and 6) state authorities reviewing the accompanied suicide.

C. Alternatives

There are no viable alternatives to providing safe, reliable physician-supported assisted dying. The legitimate need and desire for such assistance is justifiable and the public support and demand, to have at least such option is great – even though only a small number of people would actually make use of it. Any intention to keep professionally assisted dying prohibited or to narrow access to such option will lead to the issue not being solved but the situation made worse. All through history, suicide and assistance in suicide have been reality. No criminal law and no making it a "sin" by religious dogmas have changed anything in this. In fact, by criminalising and banning self-determinedly ending one's suffering and life, the situation remains bad and/or becomes worse: either assistance takes place secretly or people take to drastic measures alone such as jumping off a high building, going in front of a train, shooting themselves, and so on. All this with the well-known high risk of failure and dire conse-

quences for the person and also for third persons (train drivers, emergency rescue teams, etc.), not to mention the costs for the country's healthcare system and the public in general. Furthermore, prohibiting or narrowing access to assisted/accompanied suicide will lead to unlawful discrimination: those who have the means and/or those who are able to travel abroad may find help elsewhere whilst others are forced to put up with what there is or, rather, what there isn't.

From a European legal perspective: a law that sets out medical requirements for the admissibility of assisted dying on a professional basis must ultimately be at odds with Article 8(1) in conjunction with Article 14 of the European Convention on Human Rights (ECHR): since the right to die has been recognised by the European Court of Human Rights as a human right, the imposition of any medical requirement would result in discrimination against persons who do not satisfy this requirement.

D. Costs

This draft Act, in Section 14, provides for the creation of a Central Supervisory and Documentation Agency collecting data of the activities of the organisations providing accompanied suicide and forwarding complaints to appropriate entities. It could be set up, for example, within the New Zealand Ministry of Justice. It is assumed that this agency can easily be integrated in the ministry's organisation. The resulting additional expense should be by far outweighed by a significant reduction in the costs incurred by the country of New Zealand associated with "common" suicides and attempted suicides with all their well-known serious health consequences and costs to society as a whole.

Draft Act to Provide for Accompanied Suicide with Assistance by Registered Charitable Not-for-Profit Organisations (Accompanied Suicide Act – ASA)

The New Zealand Parliament has adopted the following Act:

Article 1

Law on Accompanied Suicide with Assistance by Registered Charitable Not-for-Profit Organisations

Section 1

Purpose of the Act

This Act creates the conditions under which charitable not-for-profit organisations may prepare and provide an accompanied suicide as part of the charitable mission of the organisation.

Section 2

Definitions of the terms used

The terms used in this Act are defined as follows:

Organisation: Membership association (members' society) registered as a charitable not-for-profit organisation.

Member: Person who has been admitted as a member of an organisation, as defined in this section.

Request: Written expression of a member to an organisation in which the member seeks preparation for an accompanied suicide.

Preparation for an accompanied suicide: Consideration and clarification of whether the self-determined death intended by a member can be justified for health or other reasons.

Provisional green light: Declaration of a medical doctor to an organisation that he or she is in principle willing to issue a prescription for the medication for a member, based on that member's request and the result of the preparation for that member's accompanied suicide, provided that the medical doctor sees the member wishing to die before issuing the prescription and has no doubts concerning the member's mental capacity.

Accompanied suicide: Rendering of assistance to a member wishing to die with the goal of enabling this member to have a dignified, safe and painless self-determined death in the presence of his or her close ones of personal choice.

Assisting person: Persons who on behalf of the organisation assist a member wishing to die in their self-determined death.

Medication: Pharmaceutical preparations, such as narcotic drugs, individually or combined, in a dosage sufficient to reliably result in death.

Aid: Devices, instruments, equipment or release mechanisms that enable a member wishing to die who is not physically able to take the lethal medication without assistance to self-administer the medication, for example, by way of a previously inserted gastric tube or intravenous drip.

Self-determined death: Death by way of self-administration, with or without aid, of a lethal dose of medication prescribed by a licensed medical doctor for use by the member who has requested it.

Medical doctor: a physician, such as a general practicioner, clinician, etc.

Licensed pharmacy: any pharmacy or drug store which is licenced to sell psychotropic substances / barbiturates / sedatives.

Examination of the corpse: Inspection of the corpse of a deceased member to determine whether actions of a third party can be ruled out and therefore self-determined death can be certified.

Medical examiner: public medical doctor officer, a forensic medical doctor (coroner) or a specially trained medical doctor for performing examinations of corpses.

Section 3

Organisation

(1) It is lawful to found an organisation to counsel people considering suicide without a view to any specific outcome, to show them options enabling them to rethink their intention or, if justified, to aid them in realising their wish to die by providing an accompanied suicide. As soon as the organisation is entered in the register for registered associations, it shall be entitled to engage in accompanied suicide in its professional capacity.

(2) Rendering assistance in an accompanied suicide may not be the organisation's only purpose.

(3) The organisation's articles of association (bylaws / statute / charter) must be drafted in a way that the organisation can be lawfully recognised as being charitable / not-for-profit.

(4) In its articles of association, the organisation must set out the amount of ordinary members' dues and any the additional members' dues for preparing

and conducting an accompanied suicide, if additional dues are to be charged.

(5) The organisation may establish lump-sum fees for other services which may frequently occur in connection with rendering assistance in an accompanied suicide.

(6) The organisation shall ensure that these fees may be reduced or waived for members living in modest economic circumstances.

(7) The organisation shall refrain from aggressive promotion for providing accompanied suicide.

Section 4
Counselling / Advisory service

(1) The organisation shall counsel all persons who are considering suicide in an open-outcome manner.

(2) The organisation shall refrain from making any value judgement in respect of a person's wish to die.

(3) The organisation shall discuss with persons considering suicide the problem(s) that has(have) led to their wish to die and shall make suggestions for solutions that enable them to continue living where these suggestions appear useful and feasible.

(4) When it appears that such solutions do not exist or they are rejected by the person considering suicide, the organisation shall be entitled to engage in preparation for assisting the person, after they have become a member, in their self-determined death.

(5) The organisation shall keep, at least, summarised records of such counselling sessions. These records shall enable, at least, statistical data to be collected on the effectiveness of the organisation's work. Individual privacy shall be protected.

(6) The organisation shall provide this counselling to everyone free of charge.

Section 5
Preparation for accompanied suicide

(1) The requirements to be satisfied for the preparation of accompanied suicide are:

a) The person considering suicide has become a member of the organisation;

b) The organisation has received a request from the member specifically asking for preparation in that member's self-determined death;

c) If the member's request is being made for health reasons, the request must be supplemented with documents which provide information on the member's current health status;

d) If the member's request is being made for other reasons, these shall be set out in detail and, where possible, supported by documentation;

e) The request shall include a short biographical sketch providing information about the member's life history, what has occurred to date, and their family situation;

(2) Where the above requirements are satisfied in the opinion of the organisation, it shall forward the request to a medical doctor who is prepared to cooperate with such organisations. After examining the request including any attached documents, the medical doctor shall inform the organisation whether he or she:

a) can give the member wishing to die a provisional green light; or

b) needs additional information to arrive at a decision; or

c) is not able to give a provisional green light.

(3) Where a medical doctor states that he or she is not able to give a provisional green light, the organisation may submit the request to another medical doctor.

(4) The organisation may at any time notify the member wishing to die that the organisation is not able or willing to assist the member in an accompanied suicide.

Section 6
Arranging to provide accompanied suicide

(1) After a member has been given a provisional green light,

a) the member may wait for an indefinite period of time to set an appointment with a medical doctor so that the medical doctor may make a final decision regarding issuing the lethal dose prescription for the qualified member's use;

b) the member may express the desire to consult a medical doctor immediately so that the medical doctor may make a final decision regarding issuing the prescription for the medication, however the member may wait to apply for arrangements with the organisation to have an accompanied suicide;

c) the member may express the desire to consult a medical doctor immediately with regard to a definitive decision and also may apply immediately to the organisation for an appointed time for their accompanied suicide.

(2) The organisation shall comply with the desire of a member within the framework of the possibilities available to it and the medical doctor. The organisation shall ask the member whether the member has discussed the decision with next of kin and/or friends and shall encourage the member to do this, where reasonable. The organisation shall also ask the member whether anybody of the member's choosing is to be present at the accompanied suicide and if so, who.

(3) During the consultation with a member who has received a provisional green light, the medical doctor shall evaluate:

a) whether in his or her opinion there are options for a solution enabling the member to continue to live, whether the member knows of these options and whether the member has decided to take advantage of them or not;

b) whether the member steadfastly maintains the wish for an accompanied suicide;

c) whether the member appears to be mentally competent;

d) whether there are other cogent reasons for deciding against going through with an accompanied suicide;

e) whether the member is physically able to self-administer the medication by oral means, such as drinking it or by way of another action;

f) if the member is not physically able to self-administer the medication by oral means, the medical doctor shall determine whether the member is capable of operating an aid for the purpose of self-administering the medication;

g) where there are absolutely no possibilities for the member, by any physical action on his or her own, to initiate the final act of ingesting the medication in any way, the medical doctor shall definitively refuse to issue the prescription.

(4) Where the medical doctor definitively consents to issuing a prescription for the medication, he or she shall forward the prescription to the organisation.

(5) The medical doctor shall document his or her findings in a report which is to be forwarded, together with the prescription, to the organisation.

(6) The organisation shall procure the medication from a licensed pharmacy. The organisation may not give the prescription or the medication to the member. The organisation shall store the medication in a safe place until it is used in the member's accompanied suicide. If the medication is not used, the organisation shall return it to the licensed pharmacy from which it was procured.

Section 7

Assisting persons

(1) The organisation shall ensure that the assisting persons engaged by it possess the necessary training to prevent foreseeable problems arising during an accompanied suicide.

Section 8

Place and participants during an accompanied suicide

(1) As a general rule, an accompanied suicide shall take place at the residence of the member.

(2) Where this is not possible and the member does not designate another appropriate location, the location shall be designated by the organisation.

(3) The member shall determine whether, apart from the assisting persons, other persons are to be present during the member's accompanied suicide.

(4) When the accompanied suicide does not take place at the residence of the member, the organisation shall ensure that the member provides for what is to be done with personal property remaining at the place of the accompanied suicide subsequent to his or her death.

Section 9

Conducting an accompanied suicide

(1) To conduct an accompanied suicide, the organisation arranges for the medication and documentation and at least two assisting persons to be present at the agreed place at the agreed time.

(2) The assisting persons shall ensure that the person they are to assist is identical to the member for whom the medication has been procured.

(3) The assisting persons shall also ask the member whether he or she continues to wish to die or whether he or she would prefer to revoke the decision. In doing so, the assisting persons shall expressly indicate to the member that they would perceive such a change of mind to be positive, as would the organisation. No other persons may be present in the room while these questions are being asked and answered. If other persons have been sent out of the room before these questions are asked and if they then return to the room, these questions shall be posed to the member once more. If any doubts arise with the assisting persons as to the member's wish to die, or if there is any indication that the member might have affirmed the wish to die after being pressured to do so by any third party, the assisting persons shall discontinue the procedure of the accompanied suicide, indicate their reason for doing so, and make a written report to the organisation.

(4) If the member abides by his or her wish to die, they shall sign the relevant document in which they state this wish, the document also indicating who is present at the member's accompanied suicide.

(5) If the member abides by his or her wish to die, the assisting persons shall ensure that the member is able to self-administer the medicine in the intended manner. If self-administration with the aid of a device is required, the assisting persons shall prepare the device with the utmost care.

(5) The following shall be said to the member before they are given the prepared medication or device enabling them to self-administer the medication: "If

you drink this medication (or, for example, push this release mechanism), you will die. Is that what you want?" If the member responds in the affirmative, the prepared medication or the release mechanism is given to the member so they can self-administer the medication.

Section 10

Obligations after the medication has been self-administered

(1) The assisting persons shall ensure that, after the member has drunk the medication or self-administered it with the aid of a device, he or she is continuously monitored.

(2) If there are signs which enable the assisting persons to establish with certainty that death has occurred, they shall report this case of accompanied suicide to the competent police authority and indicate the name of the organisation. The police authority shall notify the medical examiner and ensure that the examination of the corpse takes place without undue delay.

(3) After the assisting persons have determined that death has occurred, the scene with the deceased member shall not be altered by them or any other persons who might be present.

Section 11

Examination of the corpse

(1) The medical examiner shall establish death according to medical principles, ensure that the deceased is identical to the individual named in the documents for the accompanied suicide, and inquire whether the actions of a third party can be ruled out as the cause of death.

(2) If there are any doubts concerning this, the medical examiner shall ensure that the matter is investigated by the competent police authority.

(3) When there are no doubts or they have been ruled out, the corpse shall be released for funeral provided that the public prosecutor raises no objections.

(4) A medical doctor who issues a prescription for accompanied suicide may not act as the medical examiner in the same case.

Section 12

Ensuring proper arrangements for handling the deceased's remains

(1) Generally, the relatives of the deceased member or another person designated in advance by the deceased member shall ensure that the deceased's remains are appropriately taken care of.

(2) Before the organisation assists a member in his or her accompanied suicide, it shall confirm that arrangements have been made for the member's remains. The organisation may be tasked with these arrangements.

Section 13

Maintaining a journal

(1) The assisting persons shall maintain a journal chronicling the accompanied suicide by itemising each step of the protocol, the time each step occurs, and any incidents of particular note.

(2) The journal is to be put in the member's file maintained by the organisation; the medical examiner is to be sent a copy of the journal. The medical doctor who provided the prescription shall also receive a copy.

Section 14

Central Supervisory and Documentation Agency

(1) The medical examiner or the competent police authority shall forward the documentation provided by the organisation to a Central Supervisory and Documentation Agency to be designated by the Ministry of Justice.

(2) This agency shall review the documentation to ascertain whether the persons acting under this Act comply with its provisions.

(3) When the agency finds that shortcomings or errors have occurred, it shall contact the relevant persons and ensure that the shortcomings and errors are remedied and not likely to occur again.

(4) In the event of serious violations by medical doctors of the relevant provisions, the agency shall report them to the competent medical board for the purpose of examining whether proceedings are to be initiated against these doctors under the professional code of conduct.

(5) Serious violations repeatedly committed by an organisation shall be reported to the registration court competent at the organisation's registered office to examine whether legal action is to be taken against the organisation.

(6) The Central Supervisory and Documentation Agency shall publish annually a report on its findings in respect of its supervisory activities, including statistical figures on accompanied suicide.

Section 15

Legal classification of a death by accompanied suicide

A death that has been brought about by an accompanied suicide shall be deemed to constitute a natural

death in respect of population statistics and in terms of civil law.

Article 2
Amendment of the Medicines Act

Section 1

In the Medicines Act, the following shall be entered:

"Sodium pentobarbital, sodium salt of
(±)-5-ethyl-5-(1-methylbutyl)-barbituric acid
The sodium salt of pentobarbital may be prescribed by medical doctors for the purpose of an accompanied suicide in a dose of up to 20 grams; the prescription and the substance itself may not be made available to the member wishing to die themselves but only to the competent organisation. If sodium pentobarbital is or becomes shorted or unavailable for any reason, other substances with the same or similar effect may be prescribed for accompanied suicide"

Section 2

The Government amends the Medicines Act within three months of the promulgation of this Act

Entry into Force
Article 3

This Act shall enter into force on the day following its promulgation

Wellington, [date] **(signatories)**

Explanatory Memorandum

A. General Part

I.

The first organisation advocating for the right of people to decide when and where they wish to die was founded in England in the mid-1930s. It was later called "Exit" or "The Voluntary Euthanasia Society", which is today the members' society known as "Dignity in Dying". According to historical surveys, 60% of the British people favoured such a possibility at that time – and still do today.

On 17 January 1938, *The New York Times* wrote that a "Society for Voluntary Euthanasia" had been founded in the USA.

It is worth re-examining what circumstances led to these societies being founded. It is conceivable that this was a reaction to the introduction of antibiotics in medicine, Sir Alexander Fleming having discovered penicillin in 1928. Each major medical advance not only has a good but also a downside.

With Penicillin and other antibiotics developed in due course, life expectancy of humans could be extended significantly because medication was now available to eliminate the lethal effect of minor infections, infections which previously often led to the death of even young people. For example, the German dramatist Georg Büchner died in 1837 at the young age of 24 of a typhoid infection, an illness that no longer inspires abject terror since the advent of antibiotics.

Yet for the elderly or the seriously ill, minor infections that used to lead to a quick and painless death for the most part were sometimes felt to be like a welcomed relief. Thus, it comes as no surprise that in their advance health care directives today, many people stipulate that if they were to contract pneumonia, no antibiotics should be administered so that nature can take its course.

II.

The mid 1950s saw another revolutionary medical development which not only had a beneficial but

also a downside: the introduction of medical intensive care. This prompted Hermann Kesten (1900–1996), German author and principal literary figure of the New Objectivity movement, to exclaim: “Medical progress is terrific and terrifying. One can no longer be sure of one’s death.”

When in 1979 the gastric tube was invented which can be inserted directly through the abdominal wall so that artificial feeding became significantly easier to handle compared to tubes inserted through the nasal cavity, the possibility arose of keeping those alive who were actually in the process of dying, not only for weeks but for an almost unlimited period of time.

With intensive care it had thus become possible to biologically keep alive the bodies of people who would have previously died as the result of failure of essential biological systems. The saying of being “hooked up to machinery” became a common expression after this time.

Generally, since around 1970, a growing resistance can be observed in various countries with regard to “exaggerated life-sustaining measures”.

At about the same time, sleeping pills commonly based on barbiturates came to be replaced by benzodiazepines in many countries. Barbiturates, the gentlest method to end one’s life at that time, disappeared. This gave further boost to the movement in favour of implementation of a right to die.

III.

This development took place with a slight delay in German-speaking countries. 7 November 1980 saw the founding of the German Society for Dying with Dignity (DGHS) in Nuremberg. This was followed in April 1982 by the founding of EXIT (Swiss-German section) in Zurich, preceded by the founding of EXIT A.D.M.D. (Swiss-French section) in Geneva in February of the same year (A.D.M.D. = *Association pour le Droit de Mourir dans la Dignité*; English: Association for the Right to Die with Dignity).

During the first years after its founding, EXIT (Swiss-German section) provided its members (after at least three months’ membership) with a brochure depicting comparatively safe methods for committing suicide. Starting in the mid-1980s, the organisation began to directly provide accompanied suicide to its members: having assistance provided by someone who is knowledgeable is the best guarantee that a suicide attempt does not go wrong and fail. With the aid of medical doctors who provided prescriptions for a combination of medications, accompanied suicides could now take place in a way that those wishing to die could perform the last definitive actions leading to their death themselves whilst the assisting persons ensured that the risks due to lacking knowledge about a certain method would be avoided.

In the Netherlands, developments took place differently. In the Dutch health care system, general practicioners (GPs) had and continue to have an important position. Gradually, a practice established among doctors, illegal at that time, in which they helped severely ill patients to die, either by procuring medication to enable them to safely commit suicide on their own or by administering an injection containing a lethal dose of medication to patients who wished to put an end to their lives but were no longer able to do so, or for whom committing suicide was untenable.

IV.

The view ultimately prevailed in the Netherlands that it was not right that, although such an act was punishable under the law – even when performed by a medical doctor – the justice authorities did not intervene. It was considered better for assisted dying by medical doctors to be legalised and regulated under the law.

Consequently, Dutch legislator enacted a law on 1 April 2002 which permits Dutch medical doctors to aid patients with a specific illness status to end their lives either by assisted suicide or by voluntary euthanasia (“killing on request”). The law provides for special procedure for both.

Belgium, and then Luxembourg, later followed this example.

A similar law, for assisted suicide, the “Death with Dignity Act”, was approved in the US State of Oregon through ballots via people’s initiatives; attempts of the Federal Administration in Washington D.C. to reduce or even make impossible the use of the law by narrowing access to the necessary medication failed before the US Supreme Court. Neighbouring US-State Washington, also located in the American Northwest, followed the example of Oregon in 2008. In 2014, a similar law went into effect in the first State on the US east coast: Vermont. A few years earlier, in 2009, the Montana Supreme Court ruled in Baxter v. Montana that there was no public interest in prohibiting a medical doctor from providing assistance in suicide to one of his patients. On 5 October 2015, the US-State with the highest population followed when Governor Edmund G. Brown Jr. signed legislation to allow physician assisted suicide for terminally ill – the End of Life Option Act. "I do not know what I would do if I were dying in prolonged and excruciating pain. I am certain, however, that it would be a comfort to be able to consider the options afforded by this bill. And I wouldn't deny that right to others." he wrote in his signing message.

V.

Advances to permit assisted dying in various forms are to be noted throughout the world. The debates in the UK and France are commonly known throughout Europe. The British House of Lords has dealt with the matter several times. The right to a voluntary death was an election promise of the current French president François Hollande in his presidential election campaign. According to his statements in a press conference on 14 January 2014, a draft Act was to be tabled that same year.

A mostly liberal attitude abounds in Switzerland: Since the cantonal criminal codes were superseded by the Swiss Criminal Code of 1 January 1942, article 115 stipulates: "Any person who for selfish motives incites or assists another to commit or attempt to commit suicide is, if that other person thereafter commits or attempts to commit suicide, liable to a custodial sentence not exceeding five years or to a monetary penalty."

Therefore, inciting or assisting someone to commit suicide is not an offence in Switzerland as long as selfish motives are not the controlling motive. This enabled the service of assisted/accompanied suicide to be established, generally provided by membership associations / not-for-profit members' societies. EXIT (Swiss-German section), today the largest of a total of five associations, now counting some 92,000 members, which is equal in size to a medium-size political party represented in the Swiss Federal Parliament.

This account of the worldwide developments is far from complete, but it indicates increasing demand for implementing the possibility of assisted dying in many different countries.

VI.

This is quite regularly confirmed by the findings of scientific surveys. The figures of a representative FORSA survey were recently published, that was conducted on behalf of health insurance "DAK-Gesundheit" in Germany. According to the survey, more than two thirds of all Germans support assisted dying. The German magazine "*Der Spiegel"* reported on a survey in its issue dated 3 February 2014. According to the article, TNS Forschung, an opinion research institute, surveyed 1,000 persons over the age of 18 in January. 55% of those surveyed could imagine wanting to put an end to their life in old age if faced with the prospect of a serious illness, prolonged care dependency, or dementia.

The figures are similar throughout Europe. A survey conducted by Swiss pollster Isopublic in 2012 in twelve European countries revealed that even in Orthodox Catholic Greece, 52% were of the opinion that everyone should be allowed to determine when and how they die. In Germany this figure was as high as 87%.

All this is not different in New Zealand: According to a to a survey, nearly 7 out of 10 New Zealanders – across all demographics, including political party, religion, age, gender, geographic location and income level – support or strongly support an end-of-life choice, for those who qualify and who request it.

VII.

In view of the democratic principle, which forms the basis of public policy in New Zealand, it is not appropriate to rely on Switzerland to offer a way of responding to New Zealanders' desires and needs for assisted dying, preventing the pressure in New Zealand from becoming too high. New Zealanders should be able to implement this important decision in their home country, in their homes, and with friends and family nearby.

But there is another element besides respect for individual New Zealanders' right to receive assistance in dying in their home country. The experience gained from 30 years of assisted dying practice in Switzerland shows that the slippery slope feared by many critics in allowing assisted dying has not materialised. The number of Swiss residents who choose an accompanied suicide every year is still just about one per cent of all deaths. Furthermore, the possibility of an accompanied suicide in the municipal old-age and care homes of the City of Zurich, where this has been introduced as early as in 2002, proves the opposite of what was feared back then: that this could put pressure on the 16,000 elderly living there. In fact, since then the number of lonely, violent suicide attempts has declined and the number of people dying by accompanied suicide in these facilities has remained constant year on year, between zero and three cases.

Now, the New Zealand legislator is tasked with adapting a statutory instrument to its own situation in a meaningful manner, an instrument that has proven itself in a comparable European legal system.

This is the goal of this proposed Act.

VIII.

The proposed Act follows a liberal principle. The Act is designed to give individual legal subjects the possibility of asserting their human right to self-determination also, and in particular, at the end of their lives in a practical and efficient manner. At the same time, it ensures that the fears and reservations frequently voiced against this form of assisted dying will not materialise.

With a coherent, comprehensive legal structure in place, discussion can return to a matter-of-fact basis. For instance, the claims that were made in Germany in connection with a failed draft Act on prohibiting assistance in suicide, according to which Germany

would have to be "saved from the danger of a commercialised campaign promoting premature death by way of suicide", have not only been recognised as untrue but also called as such: there has not yet been any commercialised assisted dying in the territory of the Federal Republic of Germany. It also does not exist in Switzerland, nor does it exist in the Benelux countries, nor anywhere else. By grounding the lawful provision of assistance with dying in charitable not-for-profit organisations acting under clear guidelines, this Act ensures that commercial assisted dying will never come to pass.

The proposed Act contains provisions stipulating that organisations which provide for accompanied suicide in New Zealand are to be constituted as registered membership associations / members' societies, making them subject to New Zealand law and regulations for association, which permits associations to be regulated to a certain extent. The proposed Act also stipulates that these organisations must frame their articles of association in a way that they satisfy the requirements for recognition as a charitable not-for-profit organisation. Apart from the purpose of offering the service of counselling in end-of-life issues to anyone and, for members only, where justified, providing for a safe and dignified accompanied suicide, they must establish another purpose that pursues a charitable goal, such as for example suicide attempt prevention. The requirement of a charitable organisation status enables audits to be conducted by the tax authorities to monitor compliance. From the very outset this precludes organisations from taking in revenue other than as appropriate compensation for the work performed by them and not have such monies flow to members of the organisations' governing bodies (i.e. the board) or other members.

In setting out the accompanied suicide procedures of such organisations the Act is based on the established and proven procedures of the organisations in Switzerland. These procedures have been developed and fine-tuned over the course of thirty years. As a consequence, they have been recognised by all competent Swiss authorities as being properly organised, it being expressly stated that no special provisions going beyond article 115 of the Swiss Criminal Code are required in Swiss law. And, no irregularities existed that would require the intervention of the legislator.

The details of these procedures are discussed in Section B. Explanatory Notes below.

IX.

It might be asked why the proposed Act is silent on one question that could be theoretically posed: What should happen if private individuals, cooperative societies or even commercial enterprises were to come up with the idea of offering accompanied suicide in New Zealand?

Since the proposed Act permits the medication sodium pentobarbital to be dispensed only to organisations in line with this Act, there is no way for other parties to offer a similar service – meaning the question no longer arises.

The medication sodium pentobarbital enables a quantitatively comparatively small dose (up to approx. 20 g in approx. 50 cc of water) to be administered; other medication combinations which have been used to date in different countries in accompanied suicide consist of much larger quantities and always presuppose that the person wishing to die is capable of self-administering these quantities by swallowing and ingesting them.

X.

The proposed Act provides for another opportunity to make a significant contribution to resolving a major social problem that for the most part is not talked about: the issue of the high number of suicide attempts year after year that are almost entirely hidden from public awareness. Among the public at large, as well as policymakers and researchers, constant reference is made only to the high number of suicides that must be reduced.

There is no agreement on the dark figure, that is, the number of suicides which are not detected as such, and on the number of attempted suicides that have to be assumed. The literature on the subject generally indicates that in order to determine the total number of attempted suicides during a year, the number of committed suicides must be multiplied at minimum by a factor of 10.

In its response to an inquiry from the Swiss parliament of 9 January 2002, the Swiss government stated that, based on the research work of the National Institute for Mental Health in Washington D.C. done in the 1970s, a factor of up to 50 had to be applied in industrialised countries.

This means that the 508 suicides in 2013 in New Zealand translate into up to 25,400 attempted suicides of which no fewer than up to 24,892 fail.

Whether the number of attempted and failed suicides is 9 out of 10 or 49 out of 50: a failed suicide attempt has serious consequences not only for the person attempting it but also for others. Moreover, suicide attempts that are not seriously meant quite frequently inadvertently end fatally. In conclusion, prevention policy should actually focus on the vast field of suicide attempts, not just those actually committed and statistically registered as suicides.

Therefore, when employing societal resources to reduce the number of deaths by suicide – that is

suicide prevention – the question should be asked whether just as many resources should be added for making efforts to reduce the number of suicide attempts.

The experience of the "right-to-die"-organisations in Switzerland shows that the availability of people with whom someone who has become suicidal can talk without fearing loss of their freedom or reputation, and in whose presence they can voice an – objectively even nonsensical – wish to die, has a suicide-attempt-preventive effect.

This applies particularly to suicide among the elderly, which is on the rise throughout industrialised countries, and among younger people who find themselves in a personal crisis.

For this, the proposed Act stipulates that in such cases organisations must provide free of charge counselling to those seeking help. The funding for this work can be obtained by ordinary members' dues as well as special members' dues, the latter being payable by the member when an accompanied suicide is to be prepared or conducted.

The principal charitable / not-for-profit orientation of the articles of association of these organisations must also enable these services to be made available to persons who are of modest economic means and cannot afford to avail themselves of these services at the normal rates.

XI.

In summary, it can be established that by approving this Act, an issue in New Zealand that has remained unresolved for decades can be regulated in a favourable manner.

The Act deliberately refrains from touching upon the highly controversial issue of legalising voluntary euthanasia (act of killing a person on this competent persons' explicit request, sometimes called "mercy killing"), which always arises when a person wishing to die is physically totally incapable of performing an act of suicide, even if this only involves actuating a specially constructed aid/device to this end. Based on the Swiss experience, these cases are so rare in comparison to the others that this issue can remain open for now.

Specific Explanatory Notes

Article 1 (Enactment of an Accompanied Suicide Act)

Section 1

Section 1 sets out the purpose of the Act. The Act governs the requirements with which organisations that prepare and conduct accompanied suicide in a professional capacity must comply.

Section 2

Section 2 provides definitions of the specific terms used in the Act.

Section 3

Section 3 contains provisions stipulating how an organisation – registered membership associations (members' societies) according to Section 2 – can draft their articles of association so that they are entitled to perform accompanied suicide in a professional capacity for which the medication that is most suitable – which is sodium pentobarbital – is made available.

Subsection 1

Subsection 1 contains a description of the organisation's most important work. The organisation's primary purpose is to provide counselling to people who are thinking of suicide and end-of-life-options. Counselling is to be done open-outcome, that is, without a view to achieving a predetermined specific result. This means that the organisation itself has no preference for either of the two basic possibilities, which are that the person either continues to live or puts an end to their life.

Only if this condition is satisfied can the organisation be credible in the eyes of people who are thinking of suicide, and therefore effectively act as a help-point to counsel people for resolving the issue which brought them to consider suicide and therefor help them to regain quality in life.

This issue previously arose in another context, in abolishing the illegality of abortion. Only those counselling centres prescribed under the law which did not take an up-front disapproving stand on a decision for abortion could be perceived by pregnant women as being suitable for offering counselling.

Subsection 2

Subsection 2 stipulates that in its articles of association an organisation should not only include as its purpose advising, preparation and conducting with regard to accompanied suicide, but it should also include another purpose. Such as, for example, free-

of-charge counselling for suicide attempt prevention, advisory work on how to establish advance care directives, establishing a network of medical doctors specialising in palliative care, etc.

Subsection 3

Subsection 3 stipulates that the organisation's articles of association are to be framed so that it can be recognised as being charitable / not-for-profit.

Consequently, in selecting its second purpose, the organisation is limited to objectives that are deemed charitable. This also prevents the organisation from providing monies to natural persons from its funds for purposes other than appropriate compensation for work or services rendered or goods supplied.

This also averts the danger that an organisation may be used to establish a commercialised form of accompanied suicide. The regulatory supervision by the tax authorities to which charitable organisation must answer is a suitable means to this end.

Subsection 4

The organisation requires funding in order to finance its activities. That is why its articles of association must establish ordinary members' dues (such as a yearly membership subscription) as well as special dues / lump sum fees for the services routinely provided by the organisation in preparing and conducting accompanied suicide. The articles of association may also provide for the receipt of charitable donations from any person, to facilitate the fulfilment of the organisation's charitable mission.

Subsection 5

Apart from its usual services, the organisation also provides additional services that are more or less frequently associated with its usual services. For example, the organisation assumes liability vis-à-vis the medical doctors with whom it cooperates for the payment of their fees for their expert opinions and consultation with members. For this, as with subsection 4, the organisation may set up special dues / lump-sum frees that are collected in advance from a member going through the process of preparing his or her accompanied suicide. Only in this way can amounts payable to the organisation to meet its operating expenses and obligations to various providers be acquired without the risk of having to sue a deceased's estate.

Subsection 6

A key principle for an organisation that provides these services is showing solidarity with people of modest economic means. Consequently, the articles of association are to contain provisions that permit these persons to pay reduced ordinary and special fees or for these fees even to be waived entirely where these people are destitute. It would be discriminatory to enable only those who have the financial means to pay fees in full to assert the human right and freedom to determine time and manner of one's own end in life.

Subsection 7

In the debate to date, the demand has been sometimes made to prohibit intrusive promotion of (accompanied) suicide as an easy way out of a personal crisis. Even though there has never been such advertising, the demand is theoretically still justified. This subsection is designed to satisfy this demand.

Section 4

Section 4 governs the organisation's counselling work.

Subsection 1

This subsection governs the principle of open-outcome counselling offered to persons who are thinking of suicide. Whoever is thinking of suicide normally has hardly any possibility to access counselling; they must fear being confronted with someone who does not take them seriously, who seeks to deter them of their wish to die in an intrusive manner, or they must fear that an attempt will be made to subject them to therapy – if need be, even against their express will. Only with open-outcome counselling can someone feel that he or she is being taken seriously in a situation which may arise from a crisis just as much as it may arise after long and careful reflection, and thus will be able to open up after establishing trust with the counsellor. This is an indispensable base for a genuine chance to reach the decision to go on living, provided that the objective conditions for this actually exist.

Subsection 2

Subsection 2 also serves this idea; whoever provides counselling in such cases should refrain from making any value judgement with regard to the person's wish to die.

Subsection 3

This subsection describes how counselling is to take place. First, the cause for the person's wish to die is to be ascertained. Then, a discussion should follow to determine whether there are solutions enabling the person to go on living.

Subsection 4

However, it is conceivable that, although solutions may exist, they are not accepted. In this case the organisation is to be entitled, but not obligated, to engage in preparation for an accompanied suicide.

Subsection 5

This subsection governs the minimum obligations

regarding record keeping in respect of the counselling services.

Subsection 6

Counselling of this type, which is generally provided to persons who are not (yet) members of the organisation, is to be done free of charge. This is intended to create the basis for the effective prevention of potentially ill-considered suicide attempts.

Section 5

Section 5 governs the preparation of accompanied suicide. In a carefully drafted procedure it is determined whether accompanied suicide can be viewed as justified in a specific case.

Subsection 1

Subsection 1 sets out the requirements that must be satisfied for the preparation of an accompanied suicide. Paragraphs a and b set out two formal requirements: first, the person must be a member of the organisation so that a special personal relationship develops between the person and the organisation; then the person – now a member – must submit to the organisation an explicit request for the preparation of an accompanied suicide. Paragraphs c to e set out material requirements; the result of satisfying them is that the organisation is actually able to examine such a request based on the documents submitted.

Subsection 2

Subsection 2 governs the procedure from the point in time at which the requirements of subsection 1 are satisfied. If in the view of the organisation these requirements are satisfied, it is to forward the request including documents to a medical doctor who has expressed a willingness to cooperate with the organisation.

The medical doctor reviews the request and then informs the organisation of his or her decision. Three alternatives are open to the doctor: the doctor can either approve of the request; the doctor can request supplementary information; or the doctor can reject the request.

If the medical doctor approves the request, this only means a provisional consent to issue the prescription for the member wishing to die; a definitive approval is not possible until the medical doctor has seen and talked to the member. That is why the provisional approval is referred to as the provisional green light in the definitions in section 2. The medical doctor always remains free in respect of the final decision.

Subsection 3

Subsection 3 enables the organisation to submit a member's request to another medical doctor if it is turned down by the first medical doctor. Experience shows that medical doctors do not all share the same views with regard to questions of life and death. This option also makes it easier for medical doctors to come to a decision free of any constraints.

Subsection 4

This subsection establishes the organisation's option of notifying a member wishing to die at any time that it is not able or willing to assist them in an accompanied suicide. This follows from respect for the right to self-determination on the part of the persons who act on behalf of the organisation. Reasons for not being able or willing could be, for example, if the member wishing to die causes personal frictions such as threatening or harassing the persons who act on behalf of the organisation. In case of such dissolution of the relation between the member wishing to die and the organisation, monies received by the organisation for the service of an accompanied suicide that will not take place must be refunded.

Section 6

Section 6 governs the procedure after the provisional green light has been given by the medical doctor. The member then has various options.

Subsection 1

In paragraphs a to c, this subsection outlines the three available options:

The first one is that upon being notified of the provisional green light, the member simply waits and perhaps later on makes application for proceeding towards an accompanied suicide.

The second option enables the member to swiftly have the provisional green light become definitive by consulting the medical doctor right away and having the medical doctor make his final decision. Then, the member can wait to make an application for further proceedings towards an accompanied suicide. However, it is understood that in order for an accompanied suicide to actually take place, the condition must be satisfied that the member is mentally competent at the time that the medication is actually prescribed and also at the time of ingestion of the medication.

The third option is for the member to consult the medical doctor, followed swiftly by applying for and agreeing on an accompanied suicide to take place as soon as possible.

Subsection 2

As a general rule, the organisation complies with a member's wishes; however, this is limited by the constraints imposed by virtue of the possibilities and capacity with regard to the medical doctor. Furthermore, the organisation should discuss with the member whether he or she has talked about their plans for an accompanied suicide with relatives

and/or friends. If this is not the case, the organisation should try to persuade the member to do this. This is in the best interest of the wellbeing of relatives and friends so that after the member has passed away these individuals need not ask themselves questions that no one is any longer able to answer. However, the member cannot be compelled to inform these third parties; unfortunately there are many dysfunctional families in which it is not possible to talk objectively about serious issues.

Subsection 3 sets out the tasks of the medical doctor to be performed during the consultation with the member.

As to paragraph a, the medical doctor should discuss options with the member that the medical doctor thinks would enable the member to go on living, after which the member can make his or her decision.

Paragraph b requires the medical doctor to verify once again that the member still wishes to die. If the member's wish to die falters during the consultation with the medical doctor, the member cannot be considered to have the required clear and settled wish to end his or her own life.

Paragraph c requires the medical doctor to determine whether the member still appears to be mentally competent. In principle, people who are of age are assumed to be mentally competent unless there are indications that their mental capacity is limited or no longer present. This matches common law which recognises – as a 'long cherished' right – that all adults must be presumed to have capacity until the contrary is proved. An indication that mental competence might not be given is the situation that the person is suffering from a serious psychiatric illness. However, a psychiatric illness may impact a person's mental capacity but it need not. This is why it is the task of the medical doctor – and of the assisting persons immediately prior to accompanied suicide – to look for such signs and properly interpret them.
As a rule, this takes place by virtue of an appropriate conversation.

Paragraph d sets out other conceivable reasons that militate against going through with an accompanied suicide in a specific case.

A special case of this question is covered in paragraph e: It deals with the situation of a member being physically unable to drink the medication. It must be determined whether he or she can ingest the medication by way of an aiding device.

Paragraph f stipulates that in the absence thereof, no accompanied suicide can lawfully take place.

Subsection 4

This subsection stipulates that the medical doctor must forward the prescription for the medication to the organisation. The doctor may not give it to the member.

Subsection 5

Subsection 5 stipulates that the medical doctor must document his or her findings. The doctor must forward the resulting report to the organisation. By examining this report, the organisation can determine, if it has not already looked into this matter through direct contact with the member wishing to die, whether the use of an aid is required for the accompanied suicide.

Subsection 6

Subsection 6 stipulates that the organisation (and not the member) is to procure the medication using the prescription provided to it by the medical doctor. If the medical doctor has prescribed a narcotic, a controlled substance, this provision grants the organisation the authorisation to procure it in the prescribed dose for the member and to transport and store it. The organisation is obligated to store the medication in a safe place until it is used. The Act also requires return of any unused medication to the licenced pharmacy from which it was procured.

Section 7

Section 7 covers the topic of those persons assisting in accompanied suicide. They are to be trained by the organisation so that they are able to safely conduct accompanied suicide, even in difficult circumstances. Subsection 1 stipulates in particular that the care is to be taken to prevent foreseeable problems potentially arising during the accompanied suicide. Such foreseeable problems, for example, can be that a member, due to vigorous tremor caused by his or her illnesses (typical for example with Parkinson's disease), would spill the medication.

Section 8

Section 8 concerns the place of and the people present at an accompanied suicide.

Subsection 1

It is the goal to have an accompanied suicide take place at the member's residence, that is within their own four walls: this is the standard location. The goal of the Act is for someone to be able to die at home, which is what most people want. This enables dying to take place in the protection of privacy and in the bosom of the person's family.

Subsection 2

Where this is not possible, the member wishing to die will normally designate the location. If this location should not be appropriate, a location will be designated by the organisation.

Subsection 3

It is also up to the member to determine whether any other persons are to be present at his or her death.

Subsection 4

This provision is relevant if the place of death is not the member's home. If someone dies at home, their personal belongings are not in a foreign place. The purpose of this provision is for the organisation to know what is to be done with the deceased member's personal belongings (clothing, shoes, jewellery, wallet, etc.) when the accompanied suicide has taken place at a location that is not the deceased's home.

Section 9

Section 9 establishes how an accompanied suicide is to take place.

Subsection 1

Accompanied suicide could actually be performed by one assisting person without further ado. However, practice has shown that it is useful when at least two assisting persons are present. This ensures a two-way supervision. It also has the advantage that at all times and especially after the member has passed away, one assisting person can attend to the member's relatives and friends, and the other can attend to the work involving the member and later the work involving the authorities.

Subsection 2

Subsection 2 specifically stipulates that the assisting persons verify whether the individual who declares to be the member wishing to die is identical to the person indicated in the documents. In other words, an identity check should be performed.

Subsection 3

Subsection 3 stipulates that once more it has to be verified whether the member really wants to die. By including the provision that no other persons should be present in the room, it is ensured that the member can respond freely. When the relatives and/or friends return to the room, the questioning is to be repeated. If there are any doubts whatsoever, the accompanied suicide proceedings are to be stopped. Signs indicating that the member's decision was brought about under pressure exerted by a third party should also lead to the accompanied suicide proceedings being stopped. In these cases, the Act requires that a written report must be submitted by the assisting persons to the organisation.

In this penultimate questioning to determine the member's wish to die – the last and final clarification takes place immediately before the medication is ingested (see Subsection 5 below) – the member is expressly told that he or she is free to revoke their decision to die and that this would be viewed in a positive light by the assisting persons and the organisation. The member's reaction to this clarification is an important indicator enabling the assisting persons to determine whether the member actually has a clear and settled wish to die. By experience, such questioning and insisting by the assisting person that the member may well rather revoke their wish to go through with the accompanied suicide, leads to a reaction of annoyance from the member, they will object to this "impertinence" as such clarification is sometimes perceived – which is a clear sign that the member's wish to die is clear and settled.

Subsection 4

Subsection 4 stipulates that the member should establish a written suicide declaration, which is a document in which they state that they wish to end his or her own life. Following the firm oral declaration by the member that he or she now wishes to die, this is such confirmed by the member in a written document. The document also lists the persons who are present at the member's accompanied suicide.

Subsection 5

The medication is prepared once the member's wish to die is unequivocally confirmed. The medication is normally drunk as a liquid. If the member is unable to drink the medication, the aid indicated in the medical doctor's report is to be used. The aid is prepared by the assisting persons.

Subsection 6

Subsection 6 stipulates a last and final clarification to determine the member's wish to die. This is done by showing the member the prepared medication, or the release mechanism when an aid is used, and explaining that if the member drinks this medication or actuates the release mechanism they will die, followed by asking them if they want this. The member is not given the medication or the release mechanism until he or she has answered this question in the affirmative so that he or she can then perform this last act in their lives on their own. The actions taken by the member then lead to his or her death.

Section 10

Section 10 governs the duties of the assisting persons after the member has self-administered the medication.

Subsection 1

Since the medication, sodium pentobarbital, generally acts quickly – in the vast majority of cases it causes the member to fall asleep within two to five minutes – the member is to be monitored continuously. The sleep onset phase, which causes the member to lose consciousness completely, is fol-

lowed by the dying phase. The assisting persons' duty to monitor the member also continues during this phase.

Subsection 2

When there is subsequently sufficient indication that death has occurred – during their training the assisting persons learn what they must look for – they notify the police, reporting that the death is the result of an accompanied suicide provided by their organisation.

It is then up to the police to ensure that an official examination of the corpse takes place without undue delay; the police notify the medical examiner / coroner.

Subsection 3

Subsection 3 ensures that the scene resulting after the preliminary establishment of death is not changed by the assisting persons.

Section 11

Section 11 deals with the examination of the corpse to be performed after an accompanied suicide. The purpose of the examination is to determine whether death resulted from actions taken by the deceased or whether there is evidence that death might be due to the intervention of a third party.

Subsection 1

The medical examiner, who according to the definitions of Section 1 must be a public medical doctor officer, a forensic medical doctor or a specially trained medical doctor for performing examinations of corpses, first verifies the identity of the deceased person. The medical examiner then certifies the death of the deceased person according to medical principles. This includes determining whether death might have been brought about by the intervention of a third party.

Subsection 2

If there are any doubts in this respect, subsection 2 stipulates that the medical examiner calls in the police authorities, who must then determine how death actually occurred. This Act need not set out how the police authorities are to proceed further in the matter; the police have their own standard operating procedures for such matters.

Subsection 3

However, if there are no doubts that death has come about as a result of actions taken by the decedent, subsection 3 stipulates that the decedent's remains are to be released for funeral. The final decision on this is made by the legally competent public prosecutor.

Subsection 4

Subsection 4 precludes a medical doctor who has issued the prescription in a specific accompanied suicide from acting as the medical examiner in the same case.

This provision is one of the rules ensuring that the risk of any abuse is kept to an absolute minimum. A system of reciprocal control is also ensured by virtue of the fact that an entire group of people is involved in an accompanied suicide prior and subsequent to the death.

Section 12

Section 12 ensures that proper funeral arrangements are made after the accompanied suicide.

Subsection 1

Since accompanied suicide normally takes place in a member's home, funeral arrangements are assumed by the member's next of kin such as in the case of a death by natural cause. Frequently, the deceased member has made arrangements in advance by designating someone or a funeral home to attend to this task.

Subsection 2

In cases in which the organisation performs accompanied suicide for a member who is alone and has no family, the organisation has discussed this matter with the member during the preparation phase. If the organisation has been tasked with making the necessary arrangements, it assumes this task in place of the (absent) family.

Section 13

Section 13 stipulates that the assisting persons are to maintain a journal. The journal is intended to enable the process of an accompanied suicide to be reconstructed.

Subsection 1

Each individual step in the course of the accompanied suicide, with the respective time, is to be noted in this journal.

Subsection 2

Subsection 2 establishes that the original of this journal is to be stored in the member's file maintained by the organisation; the medical examiner is to be given a copy of the journal. A further copy is to be sent to the medical doctor who issued the prescription, so that he or she is informed of the decease of the member.

Section 14

Section 14 provides for a central supervisory and documentation agency for all of New Zealand to be

designated by the Ministry of Justice. This agency is of key importance in collecting data and forwarding complaints to appropriate entities, and through this monitoring the activities of the organisations.

Subsection 1

The documents that are furnished by the assisting persons to the medical examiner or the police after an accompanied suicide are forwarded by the latter to the central agency.

Subsection 2

Subsection 2 stipulates that the central agency is to check the file forwarded to it to determine whether the persons who have acted have complied with the provisions of this Act.

Subsection 3

Subsection 3 stipulates that where shortcomings or errors are detected by the central agency, it will contact the relevant and responsible persons and ensure that the shortcomings are remedied and that the errors are not repeated.

Subsection 4

Subsection 4 stipulates that in the event that the central agency discovers serious violations on the part of acting medical doctors, serious violations are to be reported to the competent medical board. This board must then examine whether profession-legal proceedings are to be initiated against this medical doctor.

Subsection 5

Subsection 5 deals with serious violations that are repeatedly committed by an organisation. In these cases, the central agency must report misconduct to the registration court, which then examines whether legal action is to be taken against the organisation.

Subsection 6

Subsection 6 provides for a significant task of the central agency: it is charged with collecting sufficient statistical data on accompanied suicides, analysing the data, arriving at findings and publishing them. This ensures that this area can be subjected to public scrutiny, while members' privacy is protected.

Section 15

Section 15 stipulates the legal construction of a death that has been brought about by accompanied suicide: that it is to be considered to constitute a natural death in respect of population statistics and in terms of civil law.

This distinction as compared to a "common suicide" is not only significant but also essential. Frequently, common suicides can be subsequently unequivocally established as being justified only with great difficulty and uncertainty. An accompanied suicide in line with this Act is a completely different matter. For the most part, the justification results from the deceased member's illness or other health impairment and lack of physical integrity. In the case of the elderly it can also consist of being profoundly tired of living or an unremitting profound sense of loneliness and loss.

Article 2 (Amendment of the Medicines Act)

Section 1

Section 1 stipulates that the Medicines Act is to be amended such that the medication sodium pentobarbital is entered in the alphabetical list which contains substances which have been approved for marketing and prescription. It is explicitly established that this medication may be prescribed by medical doctors in a dosage of up to 20 g for the purpose of accompanied suicide by organisations. It is also stipulated that neither the prescription nor the medication should be made available to an individual but only to a competent organisation. Additionally, the section leaves room for other substances than sodium pentobarbital, with similar effect, to be used, if sodium pentobarbital becomes shorted or unavailable for any reason. This is necessary because pharmaceutical companies could, on purpose or for any other reason, stop supplying sodium pentobarbital.

Section 2

Section 2 imposes upon the New Zeeland Government the task of accordingly amending the Regulations for the Prescription of Narcotics / Psychotropic substances within three months of the promulgation of this Act.

Article 3 (Entry into Force)

Article 3 provides for the entry into force of the Act on the day following its promulgation since there are no grounds for having the Act go into effect at a later point in time.