

IMPACT OF THE BILL ON NEW ZEALAND LAW

1. The End of Life Choice Bill will have serious implications for the state of New Zealand law.

Impact of Bill on advance directives, enduring powers of attorney and welfare guardians

2. The End of Life Choice Bill does not address how its proposed regime for euthanasia and assisted suicide is intended to fit with the existing regimes for enduring powers of attorney and welfare guardians appointed under the Protection of Personal and Property Rights Act 1988, or with advance directives, which are permitted under the Code of Health and Disability Consumers' Rights. A number of concerns arise.

Enduring Powers of Attorney and Welfare Guardians

2.1 The role of people appointed to make care and welfare decisions on behalf of incapacitated persons as attorneys or welfare guardians under the Protection of Personal and Property Rights Act ("PPRA") 1988 is not addressed at all by the End of Life Choice Bill. A critical issue has been overlooked or ignored: whether a person with an enduring power of attorney ("EPA") or a welfare guardian will have the ability to have the life of the person for whom they have been appointed ended by euthanasia if the Bill becomes law.

2.2 PPRA grants to a person (a "Personal Care and Welfare Attorney / PCW Attorney") an enduring power of attorney in respect of the care and welfare of an incapacitated person (the "donor"), "to act in relation to the donor's personal care and welfare, either generally or in relation to specific matters, and in either case such authorisation may be given subject to conditions and restrictions".¹ It states further:²

(3) The attorney—

(a) must not act in respect of a significant matter relating to the donor's personal care and welfare unless a relevant health practitioner has certified, or the court has determined, that the donor is mentally incapable; and

(b) must not act in respect of any other matter relating to the donor's personal care and welfare unless the attorney believes on reasonable grounds that the donor is mentally incapable.

...

(6) In subsection (3)(a), **a significant matter relating to the donor's personal care and welfare** means a matter that has, or is likely to have, a significant effect on the health, well-being, or enjoyment of life of the donor (for example, a permanent change in the donor's residence, entering residential care, or undergoing a major medical procedure).

2.3 The PPRA states that "any action taken by the attorney in relation to the donor's personal care and welfare shall have the same effect as it would have had if it had been taken by the donor and the donor had had full capacity to take it".³ Further,

¹ Section 98(1).

² Sections 98(3) and 98(6).

³ Section 98(5).

when acting pursuant to an EPA in respect of a donor’s personal care and welfare, “the paramount consideration of the attorney is the promotion and protection of the welfare and best interests of the donor”.⁴ These powers are subject to the same restrictions that apply in respect of the powers of welfare guardians, who are restricted from:⁵

- (a) refuse consent to the administering to that person of any standard medical treatment or procedure intended to save that person’s life or to prevent serious damage to that person’s health;
- (b) consenting to the administering to that person of electro-convulsive treatment;
- (c) consenting to the performance on that person of any surgery or other treatment designed to destroy any part of the brain or any brain function for the purpose of changing that person’s behaviour;
- (d) consenting to that person’s taking part in any medical experiment other than one to be conducted for the purpose of saving that person’s life or of preventing serious damage to that person’s health.

2.4 The PPPRA does not expressly prohibit welfare guardians or PCW Attorneys from consenting to the euthanised death of a donor who is under their care. If the End of Life Choice Bill passes into law, it is unclear whether this statutory provision will be amended to extend the prohibition to EAS, or to explicitly permit EAS.

2.5 A number of important issues arise in the case of EPAs granted under the PPPRA:

- (a) If a person makes, and is granted, a request for euthanasia or assisted suicide under cl 4 and cl 8 and then grants another person an EPA to make decisions for their personal care and welfare if they become mentally incapable, will their PCW Attorney legally be permitted to decide to proceed with euthanasia under clauses 15 and 16 of the End of Life Choice Bill on the basis that they believe it is for the “welfare and best interests” of the donor?
- (b) If a person has made an advance directive to receive EAS in the event of a future medical event that meets the criteria of cl 4 of the End of Life Choice Bill and in which they lose their competence, and later grants another person an EPA, will their PCW Attorney legally be permitted to:
 - make a decision on their behalf to request EAS under cl 8 of the End of Life Choice Bill, or
 - make a decision on their behalf to proceed with EAS under cl 15 and 16 of the End of Life Choice Bill,on the basis of their belief that it is for the “welfare and best interests” of the donor?
- (c) Could a PCW Attorney who is granted an EPA in respect of a donor who has never requested EAS, legally be permitted to:

⁴ Section 98A(2).

⁵ Sections 18 and 98(4)

- make a decision on their behalf to request EAS under cl 8 of the End of Life Choice Bill, or
- make a decision on their behalf to proceed with EAS under cl 15 and 16 of the End of Life Choice Bill,

on the basis of their belief that it is for the “welfare and best interests” of the donor?

- (d) Can the “relevant health practitioner” who certifies that a donor is “mentally incapable” under s 98(3)(a) be the first attending medical practitioner in cl 8 of the End of Life Choice Bill or the second (SCENZ appointed) medical practitioner in cl 11?

2.6 Further complexities may arise in the case of court-appointed welfare guardians. The PPPRA allows a court to appoint a welfare guardian for an incapacitated person in relation to such aspect or aspects of their personal care and welfare as the court specifies.⁶ As with persons holding an EPA, the Act states that every decision and act of a welfare guardian in respect of that person “shall have the same effect as it would have had if it had been made or done by the person for whom the welfare guardian is acting and that person had had full capacity to make or do it”.⁷ However, as discussed above, the powers of welfare guardians are limited in respect of a number of medical procedures.⁸

2.7 The impact of the End of Life Choice Bill on the powers of welfare guardians making decisions for the personal care and welfare of incapacitated / incompetent persons under their care is also unclear, in situations where those persons:

- (a) may have previously made a request for euthanasia or assisted suicide under cl 8; or
- (b) may have previously made an advance directive to receive euthanasia or assisted suicide if a future medical event occurs that meets the criteria of cl 4 of the End of Life Choice Bill and have lost their competence; or
- (c) may not have made any such request or directive but otherwise now meet all of the criteria for EAS under cl 4 of the End of Life Choice Bill, and the welfare guardian believes that EAS would be in the “welfare and best interests” of the person.

Advance Directives

2.8 The 2003 “Death with Dignity Bill” facilitated the use of advance directives.⁹ In her 2003 report to Parliament on the Death with Dignity Bill, former Attorney-General Margaret Wilson found that the Bill was inconsistent with the right to life under s 8 of the New Zealand Bill of Rights Act, noting in particular that its procedural safeguards surrounding advance directives were inadequate to ensure protection of that right.¹⁰

⁶ Section 12.

⁷ Section 19.

⁸ Section 18.

⁹ Death with Dignity Bill 2003 (37-1), cl 5(2) and sch 2.

¹⁰ Margaret Wilson *Report of the Attorney-General under the New Zealand Bill of Rights Act 1990 on the Death with Dignity Bill 2003* (16 June 2003) at 4.

- 2.9 There is a conspicuous absence of any reference to advance directives in the End of Life Choice Bill. However, the right of a person to make an advance directive in New Zealand is guaranteed in the Code of Health and Disability Services Consumers' Rights ("Code"), which states that "every consumer may use an advance directive in accordance with the common law".¹¹
- 2.10 Under the Code, an "advance directive" is defined as:¹²
- a written or oral directive:
 - (a) by which a consumer makes a choice about a possible future health care procedure; and
 - (b) that is intended to be effective only when he or she is not competent.
- 2.11 The Code defines "choice" as a decision:¹³
- (a) to receive services;
 - (b) to refuse services;
 - (c) to withdraw consent to services.
- 2.12 The Code does not require people to make an advance directive only when they are terminally ill. It can be made at any time.
- 2.13 As New Zealanders already enjoy a common law right to draft and use an advance directive there is arguably no legal obstacle to excluding "eligible" New Zealanders from being able to plan their "end of life care" accordingly, by making an advance directive to receive EAS services at the arrival of a certain future event in their condition. Advance directives are already a regular practice in other jurisdictions where euthanasia and assisted suicide is practised, such as the Netherlands and Belgium.¹⁴ In Canada, the Council of Canadian Academies reported back to Parliament on the issue of advance directives in December 2018, and the issue will likely come up for consideration during Canada's parliamentary review of its euthanasia legislation in 2021.¹⁵
- 2.14 The issue becomes how far in advance of the future event (and the consequent administration of the lethal medication) a person with a terminal illness or a grievous and irremediable medical condition can request EAS, and what happens if competence is lost during the interim. The New Zealand Law Society's submission to the Justice Select Committee on the End of Life Choice Bill asks, in that event:¹⁶
- (a) Can the request still be acted on?
 - (b) Must the request still be acted on?

¹¹ Health and Disability Commissioner (Code of Health and Disability Services Consumers' Rights) Regulations 1996, sch 1 Right 7(5).

¹² Section 4.

¹³ Section 4.

¹⁴ Wet toetsing levensbeëindiging op verzoek en hulp bij zelfdoding (WtI) [Termination of Life on Request and Assisted Suicide (Review Procedures) Act 2002], Stb 2001, 194 (NL), art 2(2); and Loi relative à l' euthanasie [Euthanasia Act] of 28 May 2002, Moniteur Belge [MB] [Official Gazette of Belgium], 22 June 2002, 28515, art 4.

¹⁵ Government of Canada "Medical assistance in dying" (26 October 2018) <www.canada.ca>.

¹⁶ New Zealand Law Society "Submission on the End of Life Choice Bill" at [7].

(c) Can the request be overridden by a person appointed under an enduring power of attorney whose powers have become exercisable during that interval or a welfare guardian appointed under the Protection of Personal and Property Rights Act 1988?

2.15 In addition, there does not appear to be any legal barrier to New Zealanders who are **not** terminally ill or do not have a grievous and irremediable medical condition to make advance directives stipulating that they wish to access EAS if a certain future medical event occurs that meets the criteria of Cl 4 of the End of Life Choice Bill and in which they lose their competence. The same questions as those posed by the Law Society must be asked as to what could / should occur if the anticipated event eventuates.

2.16 In light of the above discussion, it would not appear to be necessary for a welfare guardian or a PCW Attorney to have any express advance directive in order to have a person under their care euthanized pursuant to the End of Life Choice Bill. That said, the presence of an advance directive may strengthen the hand of a welfare guardian or PCW Attorney in their decision to proceed with a request. Its existence would also likely place considerable pressure on any welfare guardian or PCW Attorney to proceed if they were undecided or unwilling.

2.17 In recent years this issue has become more problematic in the Netherlands where advance EAS directives are lawful, and where increasing numbers of patients suffering from incurable brain diseases such as dementia are being euthanized by doctors. Many such euthanasia deaths take place on the basis of a patient's advance directive stipulating that if their mental state later deteriorates beyond a certain point (for example, if they can no longer recognise family members) they are to be euthanised regardless of whether they later dissent from their original wishes. "The underlying problem with the advance directives", a reporter from The Guardian recently commented, "is that they imply the subordination of an irrational human being to their rational former self, essentially splitting a single person into two mutually opposed ones. Many doctors, having watched patients adapt to circumstances they had once expected to find intolerable, doubt whether anyone can accurately predict what they will want after their condition worsens".¹⁷

2.18 In an open letter published in June 2017, the prominent Dutch pro-euthanasia advocate Boudewijn Chabot declared that in the Netherlands "euthanasia practice is running amok because the legal requirements which doctors can reasonably apply in the context of physically ill people, are being declared equally applicable without limitation in the context of vulnerable patients with incurable brain diseases". He noted that in that context what worries him is "the increase in the number of times euthanasia was performed on dementia patients, from 12 in 2009 to 141 in 2016, and on chronic psychiatric patients, from 0 to 60." He went on to say:¹⁸

In psychiatry, an essential limitation disappeared when the existence of a treatment relationship was no longer required. In the case of dementia, such a restriction disappeared by making the written advance request equivalent to an actual oral request. And lastly, it really went off the tracks when the review committee concealed that incapacitated people were surreptitiously killed.

¹⁷ C de Bellaigue, "Death on Demand: Has euthanasia gone too far?", The Guardian, 18 January 2019

¹⁸ Boudewijn Chabot "Worrisome Culture Shift in the Context of Self-Selected Death" (19 June 2017) TrudoLemmens <<https://trudolemmens.wordpress.com>>.

2.19 In relation to dementia patients, Chabot added:

With dementia there is another concern. The Euthanasia Law has added that a written letter of intent may replace an oral request, while the other due care criteria remain applicable. According to ethicist Den Hartogh, this implies that for a demented patient, two of the three due care criteria disappear – the requirement of a well-considered request and the requirement that reasonable alternatives have to be tried – because they cannot be applicable. What remains is the requirement that there should be unbearable suffering that cannot be alleviated. But it is often very hard to determine whether there is unbearable suffering in advanced dementia, as five professors of geriatric medicine recently stated in NRC.

2.20 The same problem also recently forced medical ethicist Berna van Baarsen to resign from a Dutch regional assessment committee for euthanasia who stated: “I do not believe that a written declaration of intent can replace an oral request for incapacitated patients with advanced dementia”.¹⁹

Medical practitioners taking matters into their own hands

2.21 Ultimately, there is a possibility that it could be the final "attending medical practitioner" scheduling and/or administering euthanasia who decides whether or not a patient should be euthanised. The Code of Health and Disability Services Consumers' Rights states that if a patient is not competent to make an informed choice and give informed consent, and no person entitled to consent on behalf of the patient is available, a doctor "may provide services" without obtaining the informed consent of the patient when:²⁰

- (a) it is in the best interests of the patient;
- (b) reasonable steps have been taken to ascertain the views of the patient; and
- (c) either the provider believes, on reasonable grounds, that the provision of the service is consistent with the informed choice that the patient would have made if he or she were competent;
- (d) or if the patient's views have not been ascertained, the provider takes into account the views of other suitable people who are interested in the welfare of the patient and available to advise the provider.

2.22 The New Zealand Medical Council reiterates this:²¹

"In some circumstances it may not be possible to obtain the patient's informed consent. For example, the patient may be a young child, be unconscious, suffer dementia or have an intellectual disability. In such cases you should try to contact a legal guardian or an appropriate person who is in the position to grant consent on behalf of the patient. The only individuals who are entitled to grant consent on behalf of a patient are legal guardians (welfare guardians under the Protection of Personal Property Rights Act, or parents/ guardians under the Guardianship Act), or someone with enduring powers of attorney. **In certain circumstances you may provide a service in the best interests of a patient without receiving consent...**"

¹⁹ Eva Nyst “‘Een wilsverklaring kan een mondeling verzoek niet vervangen’” [‘An advance directive cannot replace an oral request’] *Medisch Contact* (online ed, Netherlands, 10 January 2018).

²⁰ Health and Disability Commissioner (Code of Health and Disability Services Consumers' Rights) Regulations 1996, sch 1 Right 7(4).

²¹ Medical Council of New Zealand *Information, choice of treatment, and informed consent* (10 January 2012) at [21].

Falsification of death certificates in Bill

3. The End of Life Choice Bill is possibly the first bill before the House that proposes to legislate the falsification of public records. Clause 28 stipulates that in all cases involving euthanasia or assisted suicide under the Bill the cause of death is to be falsified on the person's death certificate. It achieves this by way of amendments to the Births, Deaths, Marriages, and Relationships Registration (Prescribed Information) Regulations 1995, requiring that for a person who is euthanised or helped to commit suicide under the End of Life Choice Act 2017 regulation 7(1)(a)(xiii) must state:
 - 3.1 the cause or causes of death as if assisted dying had not been provided;
 - 3.2 the fact that the person died as a result of the provision of assisted dying under the End of Life Choice Act 2017.
4. It is difficult to see how a death certificate could record that a person "died as a result of the provision of assisted dying" when cl 25 of the End of Life Choice Bill stipulates that "a person who dies as a result of the provision of assisted dying is taken for all purposes to have died as if assisted dying had not been provided". As discussed below, this provision is also likely to be problematic in situations where a medical professional is prosecuted or faces civil or disciplinary action in relation to their acts or omissions in EAS, an event which cl 25 deems not to have happened.

Offences and immunity from prosecution in Bill

5. It will be an offence, punishable by a term of imprisonment for up to 3 months or a fine of up to \$10,000, for a person to wilfully fail to comply with a requirement of the End of Life Act.²²
6. The End of Life Choice Bill does not explicitly make it an offence for any person to coerce another into requesting euthanasia or assisted suicide. Even if coercion is detected, the bill provides no practical means for protecting a person against it.
7. The Bill also provides for immunity from criminal prosecution or civil liability for any person who provides or intends to provide EAS, if their acts or omissions occur "in good faith and without negligence".²³ This immunity -
 - 7.1 extends to the first and second doctor,²⁴ the third practitioner called in to assess competence,²⁵ the doctor who prepares and administers the lethal medication,²⁶ and the pharmacist who prepares the lethal medication;²⁷
 - 7.2 applies whether or not a doctor or pharmacist has made any attempt to comply with the requirements in the Act.²⁸

²² End of Life Choice Bill, cl 27.

²³ Clause 26.

²⁴ Clauses 9–11

²⁵ Clause 12

²⁶ Clauses 15–16

²⁷ Clause 15

²⁸ Clauses 26 and 27.

8. It follows that if any of the above practitioners carelessly fails to comply with the legislation, they will not commit an offence under cl 27 of the End of Life Choice Bill (which requires a “wilful” failure). They may also be immune from criminal or civil liability under cl 26 if they can show they acted “*in good faith and without negligence*”.
9. As above, cl 25 of the Bill also provides that a person who dies as a result of assisted suicide or euthanasia “*is taken for all purposes*” to have died as if assisted suicide or euthanasia had not been provided.
10. Read together, the deeming provision in cl 25, the offence provision in cl 27, the immunity provision in cl 26, and the death certificate falsification provision in cl 28 seem oxymoronic. If, as a matter of law, assisted suicide or euthanasia are “taken for all purposes” as not being the cause of a person’s death under the End of Life Choice Bill:
 - 10.1 the cl 27 offence of “wilfully fail[ing] to comply with a requirement of the Act” is potentially unenforceable insofar as it relates to acts or omissions leading to a person’s death under the Act;
 - 10.2 any exclusion of a doctor or pharmacist from criminal or civil immunity under cl 26 may be difficult to establish (even if bad faith or negligence could be proven) if the act (“assisted dying”) for which they are liable is deemed by law not to have happened.
11. David Seymour has publicly claimed that those doctors involved in euthanizing patients or assisting them to commit suicide will act cautiously, under threat of prosecution. In an article in the New Zealand Herald, Mr Seymour “guaranteed” that doctors who facilitate a request for euthanasia or assisted suicide “will err on the side of caution, because the maximum penalty for getting it wrong is 14 years in prison”.²⁹ It is difficult to see how a doctor who facilitates or participates in euthanasia or assisted suicide could be prosecuted for “getting it wrong”, however, if, as a matter of law, euthanasia or assisted suicide is deemed **not** to be the cause of a person’s death under the End of Life Choice Bill.

Impact of Bill on Crimes Act 1961 and Harmful Digital Communications Act 2015

12. The End of Life Choice Bill makes no reference to amending or repealing important provisions of the Crimes Act, even though its primary intent is to override the crimes of assisted suicide and euthanasia (murder / manslaughter).³⁰ It also contains no reference to the Harmful Digital Communications Act 2015.
13. Instead, as discussed above, cl 26 give medical practitioners an immunity from criminal or civil liability, stating:

"A person is immune from liability in civil or criminal proceedings for acts or omissions in good faith and without negligence in providing or intending to provide assisted dying."
14. The Bill offers no guidance as to which party in any such anticipated civil or criminal proceedings would bear the burden of proof in establishing whether the actions were undertaken in good faith and without negligence.

²⁹ David Seymour “End of Life Choice Bill has safeguards” *The New Zealand Herald* (online ed, New Zealand, 5 February 2018).

³⁰ EOLC Bill (explanatory note) at 1–2.

15. The immunity provision in cl 26 creates exceptions to a number of fundamental provisions of the Crimes Act 1961:
- (a) Murder or manslaughter;³¹
 - (b) Aiding and abetting suicide;³²
 - (c) Consent to death;³³
 - (d) Acceleration of death;³⁴
 - (e) Assault;³⁵
 - (f) Poisoning with intent;³⁶
 - (g) Omitting without lawful excuse to discharge duty of using reasonable knowledge, skill and care in doing dangerous acts in the administration of surgical or medical treatment;³⁷
 - (h) Prevention of suicide or certain offences;³⁸
16. The End of Life Choice Bill does not provide a definition of who a ‘person’ is for the purposes of cl 26. This makes it unclear whether the immunity in that provision extends to other people such as other practitioners, family members, carers or friends who may counsel and encourage someone through the EAS process under the Act. As it reads, cl 26 should absolve any person ("a person") who is involved in the process of facilitating a person's death by euthanasia or assisted suicide under the Act. It would be illogical, for example, that a doctor could claim immunity for facilitating a person's assisted suicide under the Act while a supportive family member of the person is prosecuted under the Crimes Act for aiding and abetting their suicide.
17. The immunity would also prevent actions that might have been pursued under the Harmful Digital Communications Act 2015 (“Harmful DC Act”) against digital communications inciting or encouraging a person to be euthanized or helped to commit suicide under the End of Life Choice Act. The Harmful DC Act states:
- 17.1 A digital communication should not incite or encourage anyone to send a message to an individual for the purpose of causing harm to the individual³⁹; and
 - 17.2 A digital communication should not incite or encourage an individual to commit suicide.⁴⁰
18. These principles would no longer apply to doctors who participate in EAS. It is unclear whether the Harmful DC Act would still apply to other practitioners or family members, whanau, friends or carers who counsel, encourage or otherwise assist a person through the process of euthanasia or assisted suicide.

³¹ Crimes Act 1961, ss 158–177.

³² Section 179.

³³ Section 63.

³⁴ Section 164.

³⁵ Section 196.

³⁶ Section 200.

³⁷ Section 155.

³⁸ Section 41.

³⁹ Harmful Digital Communications Act 2015, s 6(1) Principle 8.

⁴⁰ Section 6(1) Principle 9.

19. The potential impact of the End of Life Choice Bill on s 41 of the Crimes Act requires consideration:

19.1 The End of Life Choice Bill's predecessor Bill, Maryan Street's "End of Life Choices Bill", had proposed to make it an offence (punishable by imprisonment of up to 3 months or a fine not exceeding \$10,000 or both) for any person "*who ... frustrates the expressed wishes of a terminally ill person, or a mentally incompetent person who has a registered End of Life Directive, or any person who chooses to end his or her life in a manner that fulfils the requirements of this Act*".⁴¹

19.2 The offence of "frustrating the expressed wishes" of a person requesting EAS does not appear in the End of Life Choice Bill. However, a person's statutory entitlement to being euthanised or assisted to commit suicide in the End of Life Choice Bill is plainly at odds with s 41 of the Crimes Act, which states:

Prevention of suicide or certain offences

Every one is justified in using such force as may be reasonably necessary in order to prevent the commission of suicide, or the commission of an offence which would be likely to cause immediate and serious injury to the person or property of any one, or in order to prevent any act being done which he or she believes, on reasonable grounds, would, if committed, amount to suicide or to any such offence.

19.3 If the End of Life Choice Bill passes into law, s 41 will almost certainly require amendment in order to protect a person who requests EAS from being forcefully thwarted in achieving the desired end. Any such amendment would likely result in the prohibition of the use of force by any person (whether a spouse, family member, friend or other) seeking to prevent a person from being euthanised or assisted to commit suicide by physically assaulting the person or the administering doctor.

Impact of Bill on investigative and prosecutorial functions of Police

20. The foregoing analysis - in particular the decriminalising impact of the cl 26 immunity on numerous acts that presently are criminal offences - raises the question of how the New Zealand Police might practically investigate or prosecute a potential abuse of the legislation. By way of example, were the Police to receive a credible complaint that coercive pressure had been applied to a vulnerable person by a family member to request euthanasia or assisted suicide under the End of Life Choice Act, how could the Police intervene prior to death taking place to prevent what ordinarily would be an offence under s 179 Crimes Act? How could the Police investigate or prosecute after death had occurred? With the medicalisation of euthanasia and assisted suicide, how willing might the Police be to investigate doctors, family members or caregivers of patients to ascertain whether they had coerced them into requesting EAS? The Bill does not explicitly make it an offence for any person to coerce another into requesting euthanasia or assisted suicide. If coercing a person to undergo EAS is not a crime, how could it be investigated?

21. From a practical point of view, the Police may be very reluctant to intervene given the likely uncertainties there will be around the legal parameters of "assisted dying". Recently the Police were publicly criticised (and censured by the Independent Police Conduct Authority) for stopping attendees at a checkpoint outside a pro-euthanasia meeting. As a law enforcement agency, the Police tend to be reluctant to involve themselves in "politically

⁴¹ Maryan Street *Draft for Consultation: End of Life Choice Bill* (2013), cl 30.

sensitive” issues, and that reluctance will likely be heightened in situations where once-criminal acts have been decriminalised and become standard medical practice. The passing of the End of Life Choice Bill into law could therefore lead to a chilling effect in terms of how the Police approach the issue.

Impact of Bill on Privacy Act and other information issues

22. The End of Life Choice Bill contains no express provisions addressing what are likely to be very complex privacy issues for people who are engaged in its processes. For example, the following issues arise:
 - 22.1 The reports to the Registrar and the Review Committee will contain a significant amount of personal information. Tensions will inevitably arise over striking the appropriate balance between protecting that information and:
 - the strong public interest in a high level of transparency in the EAS process;
 - the interests and concerns of family members or carers or other health professionals who had been otherwise involved in the patient’s care;
 - researchers or commentators requiring a high level of detail to undertake a meaningful analysis of the operation of the regime.
 - 22.2 It is unclear whether the SCENZ list of co-operating medical practitioners and pharmacists will be published, or whether there will be obligations of secrecy imposed on those with access to the list;
 - 22.3 It is unclear whether persons who conscientiously object to participating in euthanasia or assisted suicide can or cannot be named in public;
 - 22.4 It is unclear whether the names of practitioners on the SCENZ list or those who conscientiously object will be required to be disclosed to a potential employer, or to patients or potential patients.