Lawyers for Vulnerable New Zealanders

35 FATAL FLAWS IN THE END OF LIFE CHOICE BILL

If passed into law, David Seymour's End of Life Choice Bill will make it lawful in New Zealand for medical professionals, overseen by the Ministry of Health, to end the lives of their patients through lethal injection upon request (euthanasia), or to assist them in committing suicide through the ingestion or intravenous delivery of lethal medication. Arguably this development would signify the most seismic shift in New Zealand law and medical practice in our nation's history.

Numerous concerns over the Bill's dangerous impact have been voiced by some 34,932 New Zealand organisations, experts and citizens to the Parliamentary Justice Select Committee. The Bill is opposed by a number of leading individuals and organisations assisting the vulnerable, including the New Zealand Disability Rights Commissioner, the New Zealand Medical Association, the Australian and New Zealand Society of Palliative Medicine, the Australia New Zealand Society for Geriatric Medicine, Palliative Care Nurses New Zealand, Hospice New Zealand, and the Salvation Army. Even those who in theory support euthanasia and assisted suicide have raised concerns about the Bill and in particular the impact it will have on weak and vulnerable New Zealanders.

There is a fundamental inconsistency between the End of Life Choice Bill's stated purpose and its actual effect. For a proposed law that purports to be targeted to helping only a "small" group of New Zealanders who are "not vulnerable",[1] the effect of the Bill's eligibility criteria and claimed safeguards in fact will be to place many terminally or chronically ill, disabled and mentally ill New Zealanders who are in vulnerable situations at risk of death though coercion, abuse, neglect, misdiagnosis, or prognostic error.

The Bill presents a danger to New Zealand's most vulnerable citizens for the following reasons:

1. **It will confuse and undermine suicide prevention efforts in New Zealand.**
   (Explanatory Note; clauses 19, 21)

Eligibility Criteria

2. **Its terminal illness eligibility clause exposes vulnerable New Zealanders to premature death through misdiagnosis, prognostic error, and institutional, familial or societal neglect.**
   (Clause 4)

3. **Its 'grievous and irremediable medical conditions' eligibility clause is dangerously vague, subjective, likely to be arbitrarily applied, and could extend to tens or hundreds of thousands of New Zealanders with these conditions.**
   (Clause 4)

4. **It poses significant risks to groups of vulnerable elderly, terminally ill, chronically ill, mentally ill and disabled New Zealanders who could find themselves potentially eligible for euthanasia and assisted suicide at a time when New Zealand's under-funded and over-burdened health system is failing to cope with meeting their needs.**
   (Clause 4)

[1] The Explanatory Note to the End of Life Choice Bill claims it is targeted to a "*small but significant group of competent adults who are not vulnerable and who wish to die without unbearable suffering and pain*"

5. **It poses a particular danger to Māori who are elderly, sick, disabled or mentally ill at a time when New Zealand's health system is already failing Māori.**
(Clause 4)

6. **Its "unbearable suffering" eligibility criterion is overly broad and subjective. Statistical data from those jurisdictions that have legalized euthanasia or assisted suicide reveals that instead of unbearable physical pain –**

   (a) psychological sufferings such as fears of being dependent, being a burden on family or caregivers and loss of dignity, and
   (b) socioeconomic pressures such as low-income levels, prohibitive financial implications of treatment, health system failures or insurance cover refusals –

   will likely be the reasons why those vulnerable New Zealanders mentioned above will request euthanasia and assisted suicide under this criterion.
   (Clause 4; see also empirical data from Oregon, Netherlands and Belgium)

7. **It sets an unacceptably low standard of competency and is inconsistent with the informed consent obligations in the Code of Health and Disability Services Consumer's Rights.**
(Clause 4)

8. **Even a more restrictive "terminal illness only" Bill that excludes disability and mental illness as grounds for eligibility could be susceptible to legal or legislative challenge and could lead to an expansion of euthanasia and assisted suicide to these and other non-terminal conditions.**
(Clause 4; see also recent legal challenges to Canada's Bill C-14)

Coercion "safeguards"

The Bill's claimed "safeguards" are completely inadequate in protecting vulnerable New Zealanders from coercion and abuse:
(Clause 8)

9. **It places the entire burden of assessing whether a patient is being pressured or coerced into requesting euthanasia and assisted suicide onto a single doctor, who may not even know the requesting patient. Courts in the United Kingdom recently found that not even a lengthy court-based inquiry, relying on legal precedent and extensive powers of enquiry, evidence and cross examination, can accurately detect coercion or provide a complete safeguard against it.[2] The Bill will require one doctor to achieve what an entire judicial system cannot accomplish.**

10. **It does not require the doctor who assesses whether a requesting patient is being pressured or coerced into requesting euthanasia and assisted suicide to have had any prior relationship with that patient. Doctors could find themselves having to try and detect coercion in patients whom they know nothing about. That likelihood is exacerbated by the fact that 52-58% of New Zealand's GPs and 80% of New Zealand's Palliative Care physicians oppose euthanasia and assisted suicide,[3] which will result in large numbers of**

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[2] *R (Conway) v Secretary of State for Justice* [2017] EWHC 2447, [2018] 2 All ER 250 at [100]–[104], in a decision that was upheld by the UK Court of Appeal (27 June 2018) and the UK Supreme Court (27 November 2018).

[3] In **April 2018** a *New Zealand Doctor* magazine-commissioned survey by Horizon Research reported its findings from a survey of 1,540 General Practitioners and registrars, for which 545 responded, and found that 52% of doctors totally opposed assisted dying if death was imminent, while 32% supported it. 56% opposed and 31% were in favour if the patient's condition was irreversible but death was not imminent. In **2017** the NZMJ published the findings of a survey of 969 New Zealand-registered doctors and nurses taken in October to November 2015. The survey found that 58% of doctors "strongly" or "mostly" disagreed (on a 5-point scale from 'strongly agree' to 'strongly disagree' or 'not sure') that assisted dying should be legalised in New Zealand, assuming provision of

requesting patients whose doctors have expressed conscientious objections instead being assessed for coercion by a SCENZ "replacement medical practitioner" who has never met them before, but who will be "willing to participate" in euthanizing them or assisting their suicide. [4]

11. Its only requirement of the doctor assessing whether a requesting patient is being coerced or pressured into requesting euthanasia and assisted suicide is that they "*do [*their*] best*" to detect it. Even those legal standards protecting New Zealanders from the loss of their chattels or property through coercion set the bar higher than this.

12. In "*doing their best*", the doctor is only permitted by the Bill to make enquiries of those family members whom the requesting patient allows them to speak to.

13. While the doctor must also talk with other health practitioners "who are in regular contact with" the requesting patient, many health practitioners know little or nothing of a patient's family situation, let alone of the complex dynamics within their patients' families that could lead to coercion or pressure.

14. Aside from one doctor, the Bill contains no other oversight mechanisms for detecting or preventing euthanasia or assisted suicide through coercion.

15. The doctor him/herself may be the person exerting a coercive influence on a patient, and no one would ever know.

16. It is not an offence under the Bill for a person to counsel or encourage another into requesting euthanasia or assisted suicide.

17. A person could be euthanised or assisted to commit suicide under the Bill without the knowledge of family or friends.

18. Family members who object to their loved ones being euthanized or assisted in suicide by their doctors will be powerless to stop their deaths, and could be liable to prosecution if they use force to try and stop the process.

19. A person could potentially have their life ended hastily under the Bill, within just days of making a request for euthanasia or assisted suicide.

20. It does not require the doctor who administers the lethal dose to assess whether a requesting patient is competent or free from pressure or coercion before administering the dose.

21. It contains no protections against wider and more subtle coercive forces such as advertising and promotion of euthanasia and assisted suicide services, or societal attitudes towards those vulnerable New Zealanders mentioned above.

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appropriate guidelines and protocols. In contrast 37% of doctors "strongly" or "mostly" agreed with legalising AD. See https://www.parliament.nz/media/5372/assisted-dying-new-zealand-december-2018.pdf
A **2016 study** found very low support for legalising euthanasia (7.1%) and assisted dying (8.9%) among Australasian palliative care specialists and GPs with palliative care practice interests: 80.1% were opposed and 15.9% were undecided about euthanasia; 75.2% were opposed and 15.9% were undecided about assisted dying. The study also found that very few palliative care specialists were willing to participate in euthanasia (2%) or assisted dying (4.5%); see Sheahan L. 2016, "Exploring the interface between 'physician-assisted death' and palliative care: cross-sectional data from Australasian palliative care specialists", Internal Medicine Journal.

[4] The Bill's Explanatory Note proposes the creation of a Support and Consultation for End of Life in New Zealand ("SCENZ") Group, which will be serviced by the Ministry of Health and which will maintain a list of replacement medical practitioners who are "willing to participate" in assisted dying.

Concealment and impunity

It contains no effective oversight mechanisms for ensuring the accountability of doctors or other actors in the euthanasia and assisted suicide process, or for detecting, preventing or punishing coercion or abuse:

22. **There is no appeal process for challenging medical decisions.**

23. **There is no contemporaneous mechanism overseeing the euthanasia process as it occurs.**

24. **Its proposed registrar-based "procedure to deal with complaints about breaches" is silent on whether that process comes into play before or after a person has died.**

25. **Its post-death review process is undertaken by an "End of Life Review Committee" which has no power to review the exercise of clinical judgment by doctors and no powers of inquiry or response beyond reporting back to the registrar and making recommendations.**

26. **There is very little likelihood of any form of judicial intervention whether by way of judicial review, injunction or otherwise. This is so because the decision to declare a patient eligible for euthanasia or assisted suicide or to administer a lethal injection will always be based on some form of medical judgment, and in previous cases New Zealand courts have shown an extreme reluctance to second-guess the judgments of medical professionals.**

27. **It shrouds the euthanasia and assisted suicide in secrecy by depriving its only oversight body (the "End of Life Review Committee") and thus the New Zealand public from knowing, in the case of a person who has been euthanized or assisted in suicide:**

    27.1 their clinical information;

    27.2 the reasons why doctors assessed them eligible for euthanasia or assisted suicide;

    27.3 their ethnicity;

    27.4 their personal or socio-economic circumstances such as family situation, income status,

    27.5 what steps a doctor took in "doing their best" to detect coercion or pressure;

    27.6 the nature of the "unbearable suffering" that led the person to request euthanasia or assisted suicide.

    (Clause 17 – "Death Reported", listing the information which doctors must provide the Registrar who then provides it to the Review Committee)

28. **It deems that patients who are euthanised or assisted to commit suicide under its provisions were not euthanized or assisted to commit suicide, and requires death certificates to falsify the cause of death.**

29. **It makes it extremely difficult for the Police to investigate or prosecute criminal or other abuses of the euthanasia and assisted suicide process.**

Other flaws in the Bill

30. It is silent on the issue of how it would fit within New Zealand's existing regime of enduring powers of attorney, welfare guardianship and advance directives.

31. It does not require either of the two doctors who will assess a euthanasia or assisted suicide request to have any expertise or experience in that patient's condition, or in mental health care, or in palliative care.
(Clauses 8 – 11)

32. It contains no safeguards to ensure that a person requesting euthanasia or assisted suicide be receiving or even have available to them appropriate medical, psychiatric, or palliative care for their chronic or terminal illness or disability as a pre-condition for establishing their eligibility.
(Clauses 4, 8)

33. It overrides the exercise by doctors of any independent clinical judgment of the best care options for requesting patients who meet its eligibility criteria for euthanasia or assisted suicide, and instead forces doctors to comply with and facilitate a patient's request.
(Clauses 8–16 - mandatory process which "must" be followed by doctors)

34. It requires all doctors, hospices and palliative care practitioners to facilitate euthanasia and assisted suicide, regardless of their conscientious or ethical objections.
(Clause 7(2)(b))

Purpose of Bill

35. The Bill is premised on an Explanatory Note which contains a number of factually incorrect or questionable claims, such as:

35.1 The claim that "analysis from overseas jurisdictions where assisted dying is permitted demonstrates that concerns, including concerns about the abuse of the vulnerable, have not materialised and that risks can be properly managed through appropriate legislative safeguards…"

This claim is false, as analyses of abuses in overseas jurisdictions posted on the Lawyers for Vulnerable New Zealanders website shows.

35.2 The claim that "the risks can be managed and the law targeted to the small but significant group of competent adults who are not vulnerable…"

The effect of the Bill is at odds with its stated purpose. It does not define a person who is "not vulnerable". It does not define a "vulnerable" person. In fact, large numbers of vulnerable New Zealanders across a range of illnesses and conditions are likely to find themselves eligible for euthanasia or assisted suicide under its eligibility criteria.

35.3 The claim that "[t]he state of the law in New Zealand is out of step … with developments overseas…"

If developments overseas are to be considered precedential then the Bill should be rejected. Proposals to legalise assisted suicide/ euthanasia have recently been

considered and rejected by the UK Parliament,[5] **the Scottish Parliament** [6] **and the Portugese Parliament**,[7] **while cases similar to the *Seales'* case have been rejected by the Irish courts**,[8] **the UK Supreme Court** [9] **and the European Court of Human Rights**.[10] **With the exception of Victoria** (**and, for a brief time in 1996, Northern Territory) nearly 50 euthanasia and assisted suicide bills have been rejected across Australia over the last few decades**.[11] **In the United States, since 1994 there have been 269 legislative attempts in 39 states to legalise assisted suicide. With the exception of only 8 jurisdictions, all have failed**,[12] **and euthanasia remains illegal in every state in the US.**[13]

5 Rowena Mason "Assisted dying bill overwhelmingly rejected by MPs" *The Guardian* (online ed, United Kingdom, 12 September 2015).

6 Libby Brooks "Scottish parliament rejects assisted dying law" *The Guardian* (online ed, United Kingdom, 27 May 2015).

7 "Portugal parliament rejects euthanasia decriminalisation" *BBC* (online ed, United Kingdom, 29 May 2018).

8 Mary Carolan "Marie Fleming appeal on assisted suicide rejected" *The Irish Times* (online ed, Ireland, 29 April 2014); and *Fleming v Ireland,* above n 252, at [166].

9 John Bingham "Supreme Court rejects right to die bid but challenges Parliament to review law" *The Telegraph* (online ed, United Kingdom, 25 June 2014); and *R (Nicklinson) v Minister of Justice,* above n 164, at [149], [195], [206], [257], [289], [293], [298] and [366].

10 See AFFAIRE HAAS c. SUISSE (*Haas v Switzerland*, Application No. 31322/07, 20 January 2011). See also "Right-to-die campaigners' case rejected in Europe" *BBC* (online ed, United Kingdom, 16 July 2015).

11 G Alcorn, Crossing the threshold: how Victoria's assisted dying law finally made history, The Guardian,23 November 2017.

12 Assisted dying bills in the US have either been defeated, tabled for the session, withdrawn by sponsors, or have languished with no action taken; see "Attempts to Legalize Euthanasia/Assisted-Suicide in the United States", Patient Rights Council, <www.patientsrightscouncil.org/site/failed-attempts-usa/>

13 CNN Library "Physician-Assisted Suicide Fast Facts" *CNN* (online ed, United States, 13 August 2018).