

DEFICIENCIES IN THE BILL'S PROCESSES FOR FACILITATING EUTHANASIA OR ASSISTED SUICIDE

Deficiencies in starting point for a request for euthanasia or assisted suicide (Cl 8)

1. Clause 8 of the End of Life Choice Bill initiates the euthanasia and assisted suicide process. That provision states:

Request made

- (1) A person who wishes to have the option of receiving assisted dying must tell the attending medical practitioner of his or her wish.
 - (2) The attending medical practitioner must—
 - (a) give the person the following information:
 - (i) the prognosis for the terminal illness or grievous and irremediable medical condition; and
 - (ii) the irreversible nature of assisted dying; and
 - (iii) the anticipated impacts of assisted dying; and
 - (b) talk with the person about his or her wish at intervals determined by the progress of his or her terminal illness or medical condition; and
 - (c) ensure that the person understands his or her other options for end of life care; and
 - (d) ensure that the person knows that he or she can change his or her mind at any time; and
 - (e) encourage the person to talk about his or her wish with others such as family, friends, and counsellors; and
 - (f) ensure that the person knows that he or she is not obliged to talk to anyone; and
 - (g) ensure that the person has had the opportunity to talk about his or her wish with those whom he or she chooses; and
 - (h) do his or her best to ensure that the person expresses his or her wish free from pressure from any other person by—
 - (i) talking with other health practitioners who are in regular contact with the person; and
 - (ii) talking with members of the person's family approved by the person; and
 - (a) complete the first part of the prescribed form requesting the option of assisted dying by recording the actions he or she took to comply with paragraphs (a) to (h).
2. Unusually, cl 8 *requires* patients, as a matter of law, to inform their doctor if they wish to have the option of euthanasia or assisted suicide.¹ This in turn triggers a legal obligation on the doctor to talk with the person about that wish from time to time as their condition progresses, and for the doctor to initiate the process for making a formal request.²
 3. As a starting point, the End of Life Choice Bill contemplates the commencement of the euthanasia and assisted suicide process with a "request" by a patient. However, it is silent on what conduct may precede or pre-empt that request, in particular -
 - 3.1 whether or when a medical practitioner or others may raise (or be required to raise) the prospect of accessing euthanasia or assisted suicide with a patient;

¹ Clause 8(1).

² Cl 8(2)(b) and (i).

- 3.2 whether or when a medical practitioner or others may counsel or encourage a patient to access it;
- 3.3 whether EAS services may be advertised or publicly promoted, and where they may be advertised.
4. In its present form the End of Life Choice Bill does not prohibit a doctor from counselling or encouraging a patient with a terminal illness or irremediable medical condition to request euthanasia or assisted suicide (or, at the very least, encouraging the patient to do so under the guise of providing them "information").
5. The End of Life Choice Bill does not address the question of whether doctors may, or will be required to, inform patients of their "right" to euthanasia or assisted suicide at the time of diagnosing a grievous or irremediable condition or terminal condition. Canada's equivalent enactment, Bill C-14 ("Medical Aid in Dying"), prohibits counselling or abetting a person to die by suicide but permits health care professionals to "provide information to a person on the lawful provision of medical assistance in dying". Victoria's legislation prohibits health practitioners from initiating discussion with a patient about euthanasia or suggesting it to a patient, but permits the practitioner "providing information" about euthanasia if the patient asks for it.
6. In Canada, Ontario patient Roger Foley recently initiated litigation against his Ontario hospital, several health agencies, the Ontario government and the federal government, alleging that hospital health officials denied him the medical option of assisted home care, instead offering him euthanasia or assisted suicide.³ Foley, who has an incurable neurological disease, has published audio recordings of hospital staff to that effect and has stated:⁴
- I have not received the care that I need to relieve my suffering and have only been offered assisted dying. I have many severe disabilities and I am fully dependent. With the remaining time I have left, I want to live with dignity and live as independently as possible.
7. In Oregon and California, state and private insurance companies have denied terminally-ill citizens coverage for their chemotherapy or drug treatment, instead offering to pay for them to kill themselves under laws permitting physician-assisted suicide.⁵ A California woman with scleroderma was told by her insurers that instead of funding her chemotherapy they would fund her suicide, "and you would only have to pay \$1.20 for the medication".⁶
8. The End of Life Choice Bill also does not address whether it will be lawful to advertise or publicly promote euthanasia or assisted suicide as valid healthcare services, an issue discussed in a separate analysis (see "Lack of protection in Bill against coercion or pressure").
9. In summary, the End of Life Choice Bill's failure to address these critical issues could result in the introduction of an unacceptable risk of suggestibility or coercion into New Zealand's health

³ *Foley v Victoria Hospital London Health Sciences Centre* Ontario SCJ CV-18-592072, 14 February 2018 (Statement of Claim).

⁴ "Chronically ill man releases audio of hospital staff offering assisted death" *CTV* (online ed, Canada, 2 August 2018).

⁵ Bradford Richardson "Insurance companies denied treatment to patients, offered to pay for assisted suicide, doctor claims" *The Washington Times* (online ed, United States, 31 May 2017); and Susan Donaldson James "Death Drugs Cause Uproar in Oregon" *ABC News* (online ed, United States, 6 August 2008).

⁶ Bradford Richardson "Assisted-suicide law prompts insurance company to deny coverage to terminally ill California woman" *The Washington Times* (online ed, United States, 20 October 2016).

system, thereby threatening to undermine the treatment-focused nature of the medical profession and calling into question the underlying notion of “choice” implicit in the Bill.

Deficiencies in processing of EAS request (Clauses 8–14)

10. Two doctors will be involved in processing a request for euthanasia or assisted suicide until a “positive decision is made” on the request.

The first doctor

10.1 The **first doctor**, who initially approves the request for euthanasia or assisted suicide –

- (a) does not need to have met the person before;
- (b) does not need to be involved in that person’s care;
- (c) is not required to have any expertise or experience in the person’s condition, or in mental health care, or in palliative care. The absence of this safeguard is particularly concerning, given that it is a well-documented fact that there is an inequitable spread of palliative care services around New Zealand and our health system is not currently able to deliver universal access to quality services of this nature to all locations or regions.⁷ It could have the effect of forcing some New Zealanders who are unable to access requisite levels of medical care and support in their regions to opt for euthanasia or assisted suicide because of a lack of availability of proper care;
- (d) is not required to ensure that the person 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;
- (e) may assess the person outside the scope of their expertise or practice (albeit with immunity), in apparent contravention of the Code of Rights and the Health Practitioners Competence Assurance Act 2003;⁸
- (f) does not need to see the person more than once before approving their request for euthanasia or assisted suicide;
- (g) is not required to recommend alternative treatment options to the person;⁹
- (h) may counsel or encourage the person *into* choosing to be euthanised or helped to commit suicide, and will be immune from prosecution for doing so unless it can be proved that they acted in bad faith; the medical practitioner only needs to “*do their best*” to ensure that the person is free from coercion;¹⁰
- (i) only needs to “*encourage*” the person to talk about their request for EAS with others such as family, friends, and counsellors, not to ensure that they do (to the

⁷ NZ - Ministry of Health. Review of Palliative Care Services in New Zealand [internet], 30 March 2017 Available from <https://www.health.govt.nz/publication/review-adult-palliative-care-services-new-zealand>

⁸ Section 8.

⁹ Clause 8(2)(c) only requires the doctor to “ensure that the person *understands* his or her other options for end of life care”, not to recommend them. The phrase “end of life care” is undefined and vague. On a plain, ordinary meaning it could only encompass terminally ill patients who are at the end of their lives and for whom there are other (eg palliative) “end of life care” options available. Logically it could not include *non*-terminally ill patients, yet cl 8(1) and cl 8(2)(i) clearly contemplate the inclusion of non-terminally ill patients with irremediable medical conditions (such as disabilities, mental illnesses etc). No explanation is given as to what the “other options for end of life care” for these groups are.

¹⁰ Clause 8(2)(h) (emphasis added); see separate analysis “Lack of protection in Bill against coercion or pressure”.

contrary, they must ensure that the person understands they don't have to talk to anyone);¹¹

- (j) must commence the process of facilitating the person's death, regardless of whether or not they conscientiously object to doing so;¹²
- (k) "must" comply with the requirements in cl 8, regardless of the serious deficiencies noted above, and of the services, treatments and support that ought to be considered in order for the person to be fully informed; and
- (l) is not required or authorised to consult with other practitioners who may be more familiar with the patient or their condition or care options (except in relation to assessing whether that patient is being coerced, separately from their assessment of whether the patient is eligible for EAS).¹³

10.2 Once approved, the request for euthanasia or assisted suicide lasts forever and does not need to be renewed. The first doctor is thereafter required to *"talk with the person about his or her wish at intervals determined by the progress of his or her terminal illness or medical condition"*.¹⁴

The second doctor

10.3 The **second doctor**, an *"independent"* SCENZ doctor who is *"willing to participate"*¹⁵ in euthanising eligible New Zealanders or helping them to kill themselves –

- (a) does not need to have a relationship with the person beyond conducting a medical examination and reaching an opinion as to whether that person meets the eligibility criteria for euthanasia or assisted suicide under cl 4;
- (b) is not required to have any expertise or experience in the person's condition, or in mental health care, or in palliative care, or to have any particular skills, experience or expertise;
- (c) is not required or permitted to consider whether the request for euthanasia or assisted suicide has been freely made without any coercion (cl 11);
- (d) is not required or permitted to consult with other practitioners, or to engage the person with any other specialists or services that might be more experienced in the person's condition or which could better assist the person in dealing with their condition and/or the symptoms that are causing them unbearable suffering.

11. A **third practitioner** (a psychiatrist or psychologist) is only called into the processing of a request for euthanasia or assisted suicide if there is doubt amongst the first or second doctor over whether the person understands what euthanasia or assisted suicide is, and that the consequence of being euthanized or helped to kill themselves is that they will die.¹⁶ That is the only issue the third practitioner is permitted to consider and opine on.

12. The End of Life Choice Bill is silent on the question of who is responsible for an "eligible" patient's continuing care once they have been referred to the SCENZ practitioner. It is not

¹¹ Clause 8(2)(e)–(f).

¹² Clause 7(2); see paragraphs 114–128 for further discussion of the Bill's impact on conscientious objections.

¹³ Clause 8(2)(h)(i).

¹⁴ Clause 8(2)(b) (emphasis added).

¹⁵ EOLC Bill (explanatory note) at 3 (emphasis added).

¹⁶ Clauses 3, 4(f) and 12(3)(c).

specified whether the SCENZ practitioner becomes responsible for the patient's on-going care or only for facilitating their death by euthanasia or assisted suicide.

Deficiencies in execution of EAS request (Clauses 15 - 16)

13. Once approved for EAS, the request process under the End of Life Choice Bill culminates in a patient deciding with an attending medical practitioner (referred to in this analysis as the “**scheduling doctor**”) on a date to be euthanised or assisted in committing suicide, being given several options for the delivery of death to them, and then selecting one of those options namely:¹⁷
 - 13.1 ingestion of lethal medication, triggered by the person;
 - 13.2 intravenous delivery of lethal medication, triggered by the person;
 - 13.3 ingestion of lethal medication through a tube;
 - 13.4 injection of lethal medication (by a doctor).
14. On the date of their death, the patient who is approved for EAS then meets an “attending medical practitioner” (referred to in this analysis as “the **administering doctor**”). The administering doctor must ask the patient if they wish to receive the medication and, if yes, the practitioner must then administer the lethal medication to the patient.¹⁸
15. There is no requirement that the scheduling doctor or the administering doctor be the first or second doctor who processed the patient's request for euthanasia or assisted suicide, or that they know anything about the patient.
16. There is no requirement that the scheduling doctor or the administering doctor assess the patient's competence, mental state or freedom from pressure or coercion at the time the lethal dose is selected or administered. The only question the administering doctor must ask the person at that time is whether they choose to receive the lethal medication.¹⁹

Other deficiencies in process

17. The EAS process provides no flexibility to either the first, second or third doctor, or for the scheduling or administering doctors, to exercise their independent clinical judgement as to what they consider the patient's best care might be, or to take appropriate interim steps, such as *instead* referring the patient to other specialists or support services (including mental health services), for undertaking more tests or assessment, or for seeking advice or input from a different specialist. In fact, doing so could arguably constitute an offence under cl 27 of the End of Life Choice Bill by amounting to a "wilful failure" to comply with the mandatory steps that each doctor “must” take under cls 8–16.
18. This lack of flexibility is not patient-centred and appears to be in conflict with the patient's reasonable expectations of care based on their individual needs under the Code of Health and Disability Consumers' Rights.²⁰ In contrast, for example, to the District Inspectors provided for in the Mental Health (Compulsory Assessment and Treatment) Act 1992, there is no independent person appointed by the Minister of Health to oversee the euthanasia or assisted

¹⁷ Clause 15(3).

¹⁸ Clause 16.

¹⁹ Clause 16(2).

²⁰ See Health and Disability Commissioner (Code of Health and Disability Services Consumers' Rights) Regulations 1996, sch 1 Rights 4, 5 and 6.

suicide process as it occurs.²¹ The End of Life Choice Bill also has no specific provisions that would ensure patients are provided with culturally appropriate care and no provisions that address broader kaupapa Māori considerations.

19. The End of Life Choice Bill does not prescribe any timeframes, other than the 48 hours within which the Registrar must approve the issue of a prescription of the lethal drug on receipt of the appropriate form from the scheduling doctor (cl 15). There is no mandatory “cooling off” period. Theoretically it is possible for the entire process from request to death to be completed in a matter of days.
20. The EAS process contemplated under the End of Life Choice Bill contains no mechanisms to ensure that family members / whanau of eligible patients requesting euthanasia or assisted suicide are made aware of their request. The first doctor can do no more than merely "encourage" the patient "to talk about his/her wish with ... family, friends and counsellors", and is prohibited from talking to any family member whom the patient does not permit them to talk to, even if they are concerned that the patient may be acting under pressure or coercion.²² If a doctor, acting out of concern that a requesting patient is being coerced, contacts a family member whom the patient has not authorised them to contact they commit an offence punishable by imprisonment or a fine, or both.²³ In Belgium in 2012, university lecturer Tom Mortier's mother was euthanised without his knowledge on the grounds of chronic depression. In an article to the Belgian medical journal *Artsenkrant*, he wrote:²⁴

I was not involved in the decision-making process and the doctor who gave her the injection never contacted me. Since then, my life has changed considerably. Up until now, I am still trying to understand how it is possible for euthanasia to be performed on physically healthy people without even contacting their children. The spokesman of the university hospital told me that everything happened according to my mother's "free choice". After my mother's death, I talked to the doctor who gave her the injection and he told me that he was "absolutely certain" my mother didn't want to live anymore. The death of my mother has triggered a lot of questions. How is it possible that people can be euthanised in Belgium without close family or friends being contacted? Why does my country give medical doctors the exclusive power to decide over life and death? How do we judge what "unbearable suffering" is? What are the criteria to decide what "unbearable suffering" is? Can we rely on such a judgment for a mentally ill person?

21. Effectively, therefore, family / whanau could be shut out of the EAS process under the End of Life Choice Bill by various means:
 - 21.1 if the requesting patient does not want any of their family members to be notified;
 - 21.2 if the requesting patient is vulnerable to coercion by one or more family members, those exerting the coercive influence could manipulate the requester to ensure that other family members are excluded from consultation;
 - 21.3 if the requesting patient is vulnerable to coercion by a medical professional (eg a doctor or a nurse), the medical professional could talk them out of contacting any family / whanau or friends.²⁵

²¹ Mental Health (Compulsory Assessment and Treatment) Act 1992, ss 94–98A.

²² Cl 8(e), (h)

²³ Cl 27(1)(a); the requirement being breached is Cl 8(e).

²⁴ Tom Mortier, "How my mother died", *Artsenkrant*; reprinted in MercatorNet, 4 February 2013, http://www.mercatornet.com/articles/view/how_my_mother_died

²⁵ Cl 8(e) and (f) require the doctor to "encourage the person to talk about his or her wish with others such as family, friends, and counsellors" but also to "ensure that the person knows that he or she is not obliged to talk to anyone". It is not difficult to see how a doctor could manipulate these clauses against vulnerable patients.

Conclusion on process for facilitating EAS

22. In conclusion, the process in the End of Life Choice Bill:
 - 22.1 contains no safeguards preventing those many thousands of vulnerable New Zealand patients with terminal illnesses or grievous medical conditions who are captured by the Bill's eligibility criteria from being counselled or encouraged by doctors, family members or caregivers to be euthanized or assisted in committing suicide;
 - 22.2 facilitates the euthanasia or suicide deaths of vulnerable New Zealand patients by doctors who may not know them, or have any prior knowledge of or expertise in their condition, or have any mental health or palliative care knowledge, and whose eligibility assessments are checked only by SCENZ doctors who may also be lacking in that knowledge and expertise but are nonetheless willing to participate in euthanizing them or helping them commit suicide;
 - 22.3 enables euthanasia or assisted suicide potentially to occur within a matter of days after a request;
 - 22.4 could facilitate the death of a person by euthanasia or assisted suicide without their family members or friends knowing;
 - 22.5 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. Given regional variations in the availability of these services, New Zealanders unable to access quality medical care in their regions could opt for euthanasia or assisted suicide for that very reason. This casts doubt on the underlying concept of "choice" reflected in the title of the End of Life Choice Bill.