Lack of protection in Bill against coercion or pressure

1. The End of Life Choice Bill's Explanatory Note claims that eligible New Zealanders wishing to be euthanised or assisted to commit suicide will be protected by a "*comprehensive set of provisions to ensure this is a free choice, made without coercion*."[1]

2. In fact, there are no adequate protections in the End of Life Choice Bill to prevent a person from being coerced into being euthanised or helped to commit suicide, or to protect a person against the many and varied forms of family, societal or financial pressure that might prompt them to request either form of death:

   2.1 Clause 8 of the Bill, which contains its only purported protection against coercion, states that the first doctor to whom a request for euthanasia or assisted suicide is made is only required to *"do his or her best"* to ensure that the person expresses his/her wish "*free from pressure*" by "*any other person*".[2] "Doing their best" is expressly limited to, at most, talking to other health professionals who are in contact with the person, and talking to members of the person's family that they expressly approve the doctor speaking to;[3]

   2.2 The requirement that the first doctor "*do their best*" to ensure a person is "*free from* pressure" is not part of the Bill's "eligibility criteria" in cl 4. It is merely one of a number of free-standing additional requirements that the first doctor must follow, separately from their assessment of eligibility for EAS. Therefore, a conclusion by the first doctor that the person may be acting under coercion does not render that person ineligible for EAS;

   2.3 There is no provision requiring or allowing the first doctor to refuse to proceed with a request if they have concerns that the person is not free from pressure. That is, the process provides *no* safeguard to prevent the killing or assisted suicide of a person whom a doctor believes is being coerced or otherwise pressured into requesting it;

   2.4 The first doctor does not need to be the person's usual medical practitioner, or even have to know the person. Doctors may therefore find themselves having to try and detect coercion or pressure against a patient they know nothing about. In fact, given that between 52 – 58% of New Zealand general practitioners and 80% of New Zealand palliative care doctors oppose the practice of euthanasia and assisted suicide,[4] it is more

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1 EOLC Bill (explanatory note) at 1 (emphasis added).

2 Clause 8 (emphasis added).

3 Clause 8 states that the first medical practitioner must:
(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.

4 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 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

likely that it will be a SCENZ replacement practitioner who is completely unknown to a requesting patient who will have the task of assessing whether or not that patient is acting under coercion.

2.5 As it reads, the first doctor may interpret the phrase "*do his or her best to ensure that the* person *expresses his or her wish free from pressure from any other person*" in cl 8(2)(h) as meaning that the doctor may either:

(a) do their best to ensure the person is not being coerced or pressured into *choosing* euthanasia or assisted suicide; or

(b) do their best to ensure the person is not being coerced or pressured into *declining* the option of euthanasia or assisted suicide,

and may act accordingly;

2.6 Other than talking to other health professionals and/or members of the person's family whom they expressly approve the first doctor speaking to, there is no provision allowing the first doctor to make any other inquiries in order to satisfy themselves that the person is free from pressure;[5]

2.7 Only the first doctor, who may not even know the person, is required to "do their best" to detect coercion. The second doctor (ie the SCENZ appointed doctor) is neither required nor permitted to do anything to ensure the person has made their request "free from pressure";[6]

2.8 There is no requirement that either the scheduling doctor or the administering doctor "*do* their best" to ensure a patient is free from coercion at the time of scheduling their death or administering the lethal medication to them;

2.9 In practical terms, the "do their best" coercion test will likely prove unworkable in the view of the professional body regulating those doctors who will most likely be involved in its operation. The Royal New Zealand College of General Practitioners gave the following submission to the Justice Select Committee over the "coercion" test in cl 8:

> The College also considers clause (h) where the medical practitioner is required to 'do his or her best to ensure that the person expresses his or her wish free from pressure' is problematic. As one member wrote: "It will prove impossible to determine if a patient is 'free from coercion'. What criteria will doctors use to determine whether or not coercion exists? If patients request assisted death, there is no provision in the Bill as to what a doctor should do if she or he thinks that coercion is actually present. Coercion of patients will be impossible to discern in every request for assisted death. Doctors will not be 100% correct in their assessments of coercion. Wrongful deaths will be the result of this proposed new law." Again, we question the practicalities of medical practitioners being able to consult with other health practitioners. In cases where some medical professionals and health

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.

5 See clauses 8–10.

6 See clause 11.

> professionals have a conscientious objection to euthanasia, in sharing their medical opinion they may feel complicit in the process of enabling euthanasia.

2.10 The "*do their best*" obligation is hardly a high threshold safeguard. It is lower, for example, than requiring the medical practitioner to be *satisfied* that the person is acting freely. The restricted power of inquiry also supports an interpretation that the medical practitioner is neither required nor authorised to undertake further inquiries than those set out in the Bill. The Bill is silent as to what the medical practitioner should do if they harbour some misgivings about the person's free choice that fall short of proof of actual "*pressure from another person*". The Bill is also silent on the risks of 'practitioner shopping' by carers or family members, although the provision for the SCENZ list of practitioners who are willing to facilitate assisted suicide is likely to have the practical effect of supporting that.

3. Ultimately, the End of Life Choice Bill could effectively prevent its overseeing bodies (the Registrar and Review Committee) and, consequently, the New Zealand public, from ever finding out whether a particular patient was coerced into electing euthanasia or assisted suicide:

3.1 The only doctor required to "do his or her best" to detect coercion in a patient is then only required to send the registrar a record (not necessarily the *results*) of "the actions he or she took" in that regard.[7] Those "actions" only involve the doctor talking with other health practitioners of the patient (who may know nothing about their personal or family situation, or who may refuse to speak with them because of a conscientious objection), and those family members whom the patient permits them to talk to (which could exclude conversations with family members who believe the patient is being coerced). The doctor is not required to record any concerns they may have had arising out of those conversations. The doctor is not required to talk to any friends of the patient.

3.2 The first doctor themselves could be the person exerting a coercive influence on a patient. There is no safeguard against that risk in the Bill.

4. As a result, some New Zealanders could be pressured into choosing euthanasia or assisted suicide under the End of Life Choice Bill and no one would ever know.

Comparative analyses - inadequacies of bill's "safeguard" against coercion

5. The inadequacy of the End of Life Choice Bill's "*do their best*" safeguard is highlighted by a recent analysis by the High Court of England and Wales of a much more stringent proposal: that **the Court itself** be involved in each case to assess and determine capacity and the absence of pressure or duress. The High Court considered that **even that** rigorous process would be inadequate, stating (emphasis added):[8]

> [100] … the involvement of the High Court to check capacity and absence of pressure or duress does not meet the real gravamen of the case regarding the protection of the weak and vulnerable. Persons with serious debilitating terminal illnesses may be prone to feelings of despair and low self-esteem and consider themselves a burden to others, which make them wish for death. They may be isolated and lonely, particularly if they are old, and that may reinforce

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7 Clause 8(2)(i).

8 *R (Conway) v Secretary of State for Justice* [2017] EWHC 2447, [2018] 2 All ER 250 at [100]–[104] (emphasis added).

such feelings and undermine their resilience. All this may be true while they retain full legal capacity and are not subject to improper pressure by others.

[101] As Lord Sumption put it in *Nicklinson*:[9]

> '**The vulnerability to pressure of the old or terminally ill is a … formidable problem** … The real difficulty is that even the mentally competent may have reasons for deciding to kill themselves which reflect either overt pressure upon them by others or their own assumption about what others may think or expect. … The great majority of people contemplating suicide for health-related reasons, are likely to be acutely conscious that their disabilities make them dependent on others. These disabilities may arise from illness or injury, or indeed (a much larger category) from the advancing infirmity of old age. People in this position are vulnerable. They are often afraid that their lives have become a burden to those around them. The fear may be the result of overt pressure, but may equally arise from a spontaneous tendency to place a low value on their own lives and assume others do so too. … **The legalisation of assisted suicide would be followed by its progressive normalisation, at any rate among the very old or very ill. In a world where suicide was regarded as just another optional end-of-life choice, the pressures which I have described are likely to become more powerful**. It is one thing to assess some one's mental ability to form a judgment, but another to discover their true reasons for the decision which they have made and to assess the quality of those reasons … **There is a good deal of evidence that this problem exists, that it is significant, and that it is aggravated by modern attitudes to old age and sickness-related disability**.'

…

> [104] Moreover, in relation to external pressure exerted by others on the person concerned, the process of seeking **approval from the High Court would not be a complete safeguard**. The court would have to proceed on the evidence placed before it. External pressures might be very subtle and not visible to the court … it might be difficult to disentangle factors of external pressure from the individual's own thought processes and difficult to tell when external pressure is illegitimate or such as to invalidate the individual's own choice to die. **Data from surveys in Oregon** of people seeking physician assisted suicide showed that of those responding 48.9% cited "Burden on family, friends/caregivers" as one reason for their decision. **The risk that individuals will feel such pressures is clearly a real one**. Also, the court would look at the position at a particular point in time and would not pick up cases where the individual concerned had doubts or their mood changed later on, but might come under pressure to proceed despite this.

6. The End of Life Choice Bill does not currently provide any safeguards against the more indirect pressures of the nature discussed by the courts in *Conway* and *Nicklinson*. As currently drafted, it restricts its focus to direct one-on-one coercion by an identifiable person only.

7. The "do his/her best" formulation also sets a lower standard for protection from coercion leading to the loss of human life in EAS cases than the legal standard protecting from coercion leading to the loss of chattels and property. The task of establishing whether a person is acting "free from pressure from any other person" or coercion has for long been a complex legal question (generally in the context of contract law but also in relation to fair trading, wills and testamentary promises) which has challenged experienced Judges even after lengthy examination of witnesses, arguments by well-prepared counsel and deliberation consistent with past legal precedent.

8. Under contract law, the issue of whether an illegitimate threat constitutes duress is generally determined by its coercive effect (other formulations relate to undue influence and duress but the End of Life Choice Bill has specifically referred to protection from "coercion"), and was

[9] *R (Nicklinson) v Ministry of Justice* [2014] UKSC 38, [2015] AC 657 at [228] (emphasis added).

originally based on the fact that the will of the victim was overborne so as to invalidate any contractual consent.[10] The "overbearing of the will" requirement has however been criticized, and it has been doubted whether it is helpful to speak of a person's will having been coerced in that a person who is subject to duress usually knows what he or she is doing. In the case of *Crescendo Management Pty Ltd v Westpac Banking Corp,* the court held:[11]

> The proper approach in my opinion is to ask whether any applied pressure induced the victim to enter into the contract and then ask whether that pressure went beyond what the law is prepared to countenance as legitimate.

9. New Zealand Courts consider whether the pressure under which the person was acting should be regarded as legitimate or illegitimate (namely, has the person been put under pressure to an extent that free choice is negated) and, in that respect, the nature of any alternatives reasonably open to the person will be of major importance.[12]

10. In short, full responsibility for detecting "pressure from any other person" under the End of Life Choice Bill rests solely with *one* doctor, who may not even know the patient. That responsibility is to be contrasted with commercial and property law cases (where the Courts bring considerable analysis to bear in attempting to establish if a person has acted "free from pressure" or coercion from any other person) and with recent findings by the High Court of England and Wales that even a court-based inquiry into questions of capacity and coercion in end-of-life cases cannot provide a complete safeguard against abuse. It is difficult to see how medical practitioners (or, in the case of this Bill, merely the first doctor assessing a person's request for EAS) are in any way qualified or equipped to carry out similar deliberations in cases involving a request for EAS, without the extensive powers of enquiry and evidence that the courts possess.

Advertising and promotion of euthanasia and assisted suicide services

11. The End of Life Choice Bill is also silent on another potentially coercive force, namely whether it will be lawful for any person, group or government department (such as the Ministry of Health) to advertise or publicly promote euthanasia and assisted suicide services, or drug choices, or even publish information about these services and their availability. There are significant policy issues that have not been addressed in this context in the Bill: for example, whether it is considered appropriate or not appropriate for advertising, promotional or "information" material regarding euthanasia and assisted suicide to appear in:

    (a) the media;
    (b) hospitals;
    (c) rest homes;
    (d) hospices;
    (e) facilities providing support for those with mental illness or physical or intellectual disabilities;
    (f) medical clinics.

12. Advertising of euthanasia and assisted suicide in one form or another is very likely. The Bill appears to create immunities under the Harmful Digital Communications Act 2015 for digital

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10 *Pao On v Lau Yiu Long* [1980] AC 614, [1979] 3 All ER 65 at 79.
11 *Crescendo Management Pty Ltd v Westpac Banking Corp* (1988) 19 NSWLR 40 at 46.
12 *R v Her Majesty's Attorney-General for England and Wales* [2003] UKPC 22; [2004] 2 NZLR 577 at [15]–[16].

communications that incite or encourage a person to be euthanized or helped to commit suicide, a point which is discussed in a separate analysis (see “Impact of the Bill on New Zealand Law”). Given the Explanatory Note's claimed motivations: "The motivation for this Bill is compassion. It allows people who so choose, and are eligible under this Bill, to end their lives in peace and dignity, surrounded by loved ones”[13] and the promotion of the End of Life Choice Bill in the media and public sphere under the ‘my life, my choice’ mantra,[14] there would not seem to be any impediment to advertising and other public promotions of the "rights" of individuals to elect euthanasia or assisted suicide as a desirable, social good.

[13] EOLC Bill (explanatory note) at 1.

[14] “‘Stay out of my life and my choice' - euthanasia advocate” *Newshub* (online ed, New Zealand, 20 February 2018).