

## “UNBEARABLE SUFFERING” – WHAT DOES IT MEAN AND WHO COULD QUALIFY?

1. The next eligibility criterion requires that the applicant “experiences unbearable suffering that cannot be relieved in a manner that he or she considers tolerable”.<sup>1</sup> The term “unbearable suffering” is neither defined within the Bill nor is it an objectively assessable criterion for a doctor. Further, it is not limited to physical suffering. The Explanatory Note to the End of Life Choice Bill makes it clear that the Bill's focus is on personal autonomy and choice, and its references to the High Court decision in *Seales v Attorney General* support the view that unless otherwise expressly stated, it will be the patient’s own perception of whether their condition is “grievous” and whether they are experiencing “unbearable suffering” that will be determinative.<sup>2</sup>
2. A patient is unlikely to differentiate between psychological and emotional suffering and physical suffering, and so “unbearable suffering” will incorporate elements of both. This was an important feature in *Seales*.<sup>3</sup> In the 2015 Belgian study cited above, all of the 100 psychiatric patients who requested euthanasia considered their psychological / emotional suffering to be “chronic, constant and unbearable”.<sup>4</sup>

### “Unbearable suffering”: physical or psychological suffering?

3. Contrary to a widespread belief that physical pain is the main reason underlying requests for euthanasia or assisted suicide, research evidence indicates that requests are less for reasons of inadequate pain relief and far more for reasons related to psychological and social concerns.<sup>5</sup> These include depression,<sup>6</sup> feelings of hopelessness,<sup>7</sup> of disintegration and loss of community,<sup>8</sup> loss of autonomy and ability to participate in activities that made life enjoyable,<sup>9</sup> loss of dignity,<sup>10</sup> and of being a burden on others.<sup>11</sup>

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<sup>1</sup> EOLC Bill, cl 4(e).

<sup>2</sup> EOLC Bill (explanatory note) at 1 and 2.

<sup>3</sup> *Seales v Attorney General* [2015] NZHC 1239, [2015] 3 NZLR 556, at [29]–[30], [46], [48], [54], [71] and [81].

<sup>4</sup> Dr Lieve Thienpont and others “Euthanasia requests, procedures and outcomes for 100 Belgian patients suffering from psychiatric disorders: a retrospective, descriptive study” (2015) 5 *BMJ Open* 1, at 5.

<sup>5</sup> *Seales v Attorney-General* HC Wellington CIV-2015-485-235, May 2015 (Affidavit of Dr John Kleinsman) at [80]–[81].

<sup>6</sup> William Breitbart and others “Depression, hopelessness, and desire for hastened death in terminally ill patients with cancer” (2000) 284 *JAMA* 2907; Ezekiel J Emanuel and others “Euthanasia and physician-assisted suicide: attitudes and experiences of oncology patients, oncologists, and the public” (1996) 347 *Lancet* 1805 at 1808; Keith G Wilson and others “Desire for Euthanasia or Physician-Assisted Suicide in Palliative Cancer Care” (2007) 26 *Health Psychology* 314 at 321; Marije L van der Lee and others “Euthanasia and Depression: A Prospective Cohort Study Among Terminally Ill Cancer Patients” (2005) 23 *Journal of Clinical Oncology* 6607 at 6611; Linda Ganzini, Elizabeth R Goy and Steven K Dobscha “Prevalence of depression and anxiety in patients requesting physicians’ aid in dying: cross sectional survey” (2008) 337 *BMJ* 1682; Kathryn A Smith and others “Predictors of Pursuit of Physician-Assisted Death” (2015) 49 *Journal of Pain and Symptom Management* 555 at 557.

<sup>7</sup> Linda Ganzini and others “Attitudes of Patients with Amyotrophic Lateral Sclerosis and their Care Givers Towards Assisted Suicide” (1998) 339 *New Eng J Med* 967 at 969; Harvey Max Chochinov and others “Depression, Hopelessness, and Suicide Ideation in the Terminally Ill” (1998) 39 *Psychosomatics* 366 at 369; Breitbart “Depression, hopelessness, and desire for hastened death in terminally ill patients with cancer”, at 2910.

<sup>8</sup> James V Lavery and others “Origins of the desire for euthanasia and assisted suicide in people with HIV-1 or AIDS: a qualitative study” (2001) 358 *Lancet* 362 at 363.

<sup>9</sup> Public Health Division *Oregon Death with Dignity Act: 2017 Data Summary* (Oregon Health Authority, 9 February 2018) at 10.

<sup>10</sup> Harvey Max Chochinov “Dignity in the terminally ill: a developing empirical model” (2002) 54 *Social Science & Medicine* 433 at 438.

<sup>11</sup> Wilson “Desire for Euthanasia or Physician-Assisted Suicide in Palliative Cancer Care” (2007) 26 *Health Psychology* 314 at 321; and Public Health Division *Oregon Death with Dignity Act: 2017 Data Summary* (Oregon Health Authority, 9 February 2018) at 10.

4. This was also the conclusion of a qualitative study conducted by the University of Auckland in 2012:<sup>12</sup>

An important finding of this study indicates that some healthy, older individuals who support medical practices that hasten death have serious concerns about their (perceived) future incapacities and dependency on others, as well as their fears around becoming a burden. We also found that fear of future pain was not a dominant reason to support medical assistance to die.

5. In Oregon, where assisted suicide has been legal since 1998, the Public Health Division is entrusted with preparing an annual report analysing the administration of the Act. Its report from 2018 confirms that, in practice, and over the entire period the law has been in operation, **psychological concerns** far outweigh any concerns related to physical pain amongst those patients who are assisted in their suicides.<sup>13</sup> According to the report, during 2018 the four most frequently reported end-of-life concerns and reasons for seeking assisted suicide were loss of autonomy (91.7%), decreasing ability to participate in activities that make life enjoyable (90.5%), loss of dignity (66.7%), and being a “burden on family, friends or caregivers” (63.6%). Nine other people who were helped in their suicides during 2018 cited the “financial implications of treatment” as a reason for seeking assisted suicide.<sup>14</sup>
6. Annual reports on the assisted suicide regime in Washington are no different. In 2017, the four most frequently reported end-of-life concerns of those in Washington who were assisted in their suicides were loss of autonomy (90%), decreasing ability to participate in activities that make life enjoyable (87%), loss of dignity (73%), and being a “burden on family, friends / caregivers” (56%).<sup>15</sup>
7. None of this knowledge is contentious. Even the pro-euthanasia advocate, Dr Rob Jonquiere, who toured New Zealand in 2015 and whom the Voluntary Euthanasia Society describes as a "world expert" and a "principal architect of the Dutch euthanasia legislation", has stated that those elderly who choose euthanasia or assisted suicide are more likely to do so for psychological / social reasons rather than out of fear of physical pain:<sup>16</sup>

Research found that, for the elderly person, the loss of personal dignity is often a more important reason for the self-chosen end of life than unbearable suffering in the narrower sense ... Here the problem is not so much physical, but social and emotional; with a severe loss of self-reliance and any direction over personal life ... The elderly have feelings of detachment and stillness ... The elderly have feelings of isolation and loss of meaning. The elderly are tired of life – they are no longer able to do things that are meaningful to them. Their days are experienced as useless repetitions. The elderly become largely dependent on the help of others, they have no control over their personal situation and the direction of their own lives ... Loss of personal dignity appears in many instances to be the deciding factor for the conclusion that their lives are complete.

8. In both logical and practical terms, the inescapable conclusion is that instead of being a remedy for physical pain, assisted suicide and euthanasia will be made available under the End of Life Choice Bill to those "eligible" New Zealanders whose sufferings include loneliness, the worry of being a burden on family, friends and caregivers, loss of autonomy, loss of dignity, financial concerns, and the fear of being or becoming disabled, so long as these subjective

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<sup>12</sup> Phillipa J Malpas, Kay Mitchell and Malcolm H Johnson “‘I wouldn’t want to become a nuisance under any circumstances’ – a qualitative study of the reasons some healthy older individuals support medical practices that hasten death” (2012) 125 NZMJ 9 at 15.

<sup>13</sup> Oregon Public Health Division *Oregon Death with Dignity Act: 2018 Data Summary*, at 12.

<sup>14</sup> *Ibid* at 12

<sup>15</sup> Washington State, *Death with Dignity Act Report 2017*, 8.

<sup>16</sup> Rob Jonquiere “Dying Assistance for the Elderly in the Netherlands” (Fourth Annual SOARS Lecture, London, 20 September 2013).

feelings are present alongside a recognised condition. Clearly this has been the experience in those few jurisdictions which have legalised EAS to date. Under cl 4(e) of the End of Life Choice Bill, the first and second medical practitioner's only task will be to confirm that a person considers their situation constitutes "unbearable suffering".

### Impact of End of Life Choice Bill on New Zealand's elderly

9. This conclusion is particularly unsettling when it is viewed against the plight of many elderly New Zealanders, amongst whom the primary sufferings discussed above predominate. In countries where euthanasia and assisted suicide are lawful, the elderly comprise by far the largest proportion of those people who are euthanized or helped to commit suicide.<sup>17</sup> Serious consideration must therefore be given to the impact that the End of Life Choice Bill could have on many elderly New Zealanders, at a time when:
  - 9.1 across the board, New Zealand's health care system is already at near breaking point as a result of underfunding and population growth,<sup>18</sup>
  - 9.2 elderly New Zealanders consume 42 per cent (\$983 million) of the health services budget of the Ministry of Health, the same government department that will bear responsibility for overseeing and administering euthanasia and assisted suicide under the End of Life Choice Bill;<sup>19</sup>
  - 9.3 the Ministry of Health reports that "[p]opulation ageing without health improvement will cause this [42%] share to increase";<sup>20</sup>
  - 9.4 New Zealand's population is aging rapidly. By 2032, some 20-22% of New Zealanders (around 1.1 million) will be aged over 65 years. That is expected to reach up to 27% by 2050 and up to 33% by 2068.<sup>21</sup>
  - 9.5 the number of superannuitants in New Zealand is may almost double over the next 20 years;<sup>22</sup>
  - 9.6 Māori constitute a significant proportion of New Zealand's burgeoning older population who are poor and sick. The absolute number of this older Māori population is projected to almost treble between 2001–2021;<sup>23</sup>

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<sup>17</sup> In Oregon, 80 per cent of those who died as a result of assisted suicide in 2017 were 65 or over, Public Health Division *Oregon Death with Dignity Act: 2017 Data Summary*, above n 84, at 6; In Belgium, 83.5 per cent of those who received EAS were 60 or over, Sigrid Dierickx and others "Euthanasia in Belgium: trends in reported cases between 2003 and 2013" (2016) 188 CMAJ at E407 at E410; and in the Netherlands, 78 per cent of those who received EAS were 65 or over, Centraal Bureau voor de Statistiek [Statistics Netherlands] "Overledenen naar medische beslissing rond levenseinde; behandelaar,leeftijd" [Dead people to medical decision about end of life; practitioner, age] (42 May 2017) StatLine <<https://opendata.cbs.nl>>.

<sup>18</sup> Audrey Young "Huge demand for services in Auckland stretches health system to the limit say bosses" *The New Zealand Herald* (online ed, New Zealand, 22 February 2018); and 1 News "'The system is so overstretched' – Andrew Little says health system underfunded by \$2.3 billion" 1 News Now (online ed, New Zealand, 7 June 2017).

<sup>19</sup> Ministry of Health "DHB spending on services for older people" (13 July 2016) <[www.health.govt.nz](http://www.health.govt.nz)>.

<sup>20</sup> Ministry of Health, above n 93.

<sup>21</sup> Statistics New Zealand "National Population Projections" (8 March 2017) Stats NZ <<http://archive.stats.govt.nz/>>.

<sup>22</sup> Ministry of Social Development *Briefing for Incoming Minister 2017: Social Development* (2017) at 20.

<sup>23</sup> Statistics New Zealand *Demographic Aspects of New Zealand's Ageing Population* (March 2006) at 21.

- 9.7 by 2026 the number of older Māori needing care on a more than daily basis could increase by more than 200 per cent;<sup>24</sup>
- 9.8 New Zealand's aging population will place increasing pressure on our already-stretched health system and lead to a substantial increase in the need to provide daily and weekly care for the elderly;<sup>25</sup>
- 9.9 the introduction of euthanasia and assisted suicide practices can lead to a significant reduction in health spending;<sup>26</sup>
- 9.10 one in five elderly, frail New Zealanders identify as being "lonely";<sup>27</sup>
- 9.11 a major study found that 10 per cent of elderly New Zealanders have suffered some form of abuse, either physically, sexually, psychologically, financially or via neglect. However, the study was limited by the fact that elder abuse tends to be hidden and not reported, so the study may have underestimated the extent of abuse.<sup>28</sup>
- 9.12 projections indicate that the number of older New Zealanders experiencing elder abuse and neglect will increase significantly in the next 20 years;<sup>29</sup>
- 9.13 loneliness and isolation are common denominators in many cases of elder abuse;<sup>30</sup>
- 9.14 older Māori, women, and New Zealanders who are separated, divorced or widowed face higher rates of elder abuse;<sup>31</sup>
- 9.15 79% of elderly abusers are family / whānau members, and children are the most common category of abuser (48%). In elder abuse cases involving older people living in residential care, 67% of abusers were family / whānau members and 20% were staff of the facility;<sup>32</sup>
- 9.16 close family members are the most common perpetrators of elder abuse; their victims are often very old people in poor health, especially women;<sup>33</sup>

<sup>24</sup> Ngaire Kerse and others *Intervals of care need: need for care and support in advanced age* (The University of Auckland, 21 April 2017) at 11.

<sup>25</sup> Helen Harvey "Aging population puts pressure on health system" *Stuff* (online ed, New Zealand, 20 September 2015); and Lyndon Keene and others "Funding New Zealand's public healthcare system: time for an honest appraisal and public debate" (2016) 129 NZMJ 10 at 14.

<sup>26</sup> Canadian research estimated that legalising EAS could save Canada between \$34.7 million and \$138.8 million on annual health care expenditure, Aaron J Trachtenberg and Braden Manns "Cost analysis of medical assistance in dying in Canada" (2017) 189 CMAJ E101 at E104.

<sup>27</sup> Hamish A Jamieson and others "Profile of ethnicity, living arrangements and loneliness amongst older adults in Aotearoa New Zealand" A national cross-sectional study" (2017) 37 Australasian Journal on Ageing 68 at 71.

<sup>28</sup> Charles Waldegrave *Measuring Elder Abuse in New Zealand: Findings from the New Zealand Longitudinal Study of Ageing (NZLSA)* (Family Centre Social Policy Research Unit, 2015) at 12; but see Kathy Glasgow and Janet Fanslow *Family Violence Intervention Guidelines: Elder Abuse and Neglect* (Ministry of Health, 2 August 2007) at 14–15.

<sup>29</sup> Office for Senior Citizens *Towards gaining a greater understanding of Elder Abuse and Neglect in New Zealand* (June 2015) at 5.

<sup>30</sup> Cherie Sivignon "Elder abuse often linked to loneliness and isolation: Age Concern Nelson Tasman" *Stuff* (online ed, New Zealand, 13 June 2018).

<sup>31</sup> Office for Senior Citizens *Towards gaining a greater understanding of Elder Abuse and Neglect in New Zealand* (June 2015) at 5.

<sup>32</sup> Penny Brander, Judith A Davey and Jayne McKendry *Elder Abuse and Neglect Prevention: Challenges for the Future* (Age Concern New Zealand, 1 October 2007) at 27 and 37.

<sup>33</sup> Judith A Davey and Jayne McKendry *Financial abuse of older people in New Zealand* (Institute of Policy Studies, Working Paper 11/10, November 2011) at 2.

- 9.17 financial and psychological abuse are the most common forms of elder abuse and neglect, and both forms are increasing with the ageing and increased longevity of New Zealand's population.<sup>34</sup>
- 9.18 in recent years, there has been an average of 313 inheritance dispute cases per year in New Zealand's Family Courts and High Courts, as a recent article in the Otago Daily Times reported.<sup>35</sup> According to the article, "inheritances are becoming increasingly important as stagnant incomes and unaffordable housing continue to bite deep....[as] highlighted in a report released last year by the Organisation for Economic Co-operation and Development.... The world's leading economic think-tank said the wealth of cash-strapped younger generations now depends more on how much they inherit."

### Impact of End of Life Choice Bill on New Zealand's disabled

10. As assisted suicide and euthanasia is more likely to be accessed by "eligible" New Zealanders on the basis of the psychological and social discussed above (loss of autonomy, loss of dignity, loneliness, the worry of being a burden on family, friends and caregivers, financial concerns etc), consideration must also be given to the End of Life Choice Bill's potential impact on those New Zealanders living with disabilities. The Disability Commissioner's Submission to the Select Committee on the End of Life Choice Bill has examined this impact in some detail, noting that:<sup>36</sup>

- 10.1. Disabled New Zealanders experience loss of autonomy:<sup>37</sup>

Statistics indicate that disabled people are currently unable to participate in society on an equal basis with non-disabled people. ... This extends from limitations as to where and with whom they live – due to a lack of appropriate housing, support services, and low income – through to every day decision-making about what they eat, wear and where they spend their time.

- 10.2. Disabled New Zealanders experience stigmatisation:<sup>38</sup>

Anecdotal evidence (such as the portrayal of disability in the media, and peoples' response to those stories) suggests that many people see disabilities, particularly in more severe forms, as tragic or even 'a fate worse than death'. As with other marginalised groups in history, disabled people are often perceived as an 'other' (ie someone not like "you" or "me") to be pitied or avoided.

- 10.3. Disabled New Zealanders must deal with societal perceptions that their conditions are undignified:<sup>39</sup>

Many disabled people rely on others for basic daily living tasks, some of which such as showering and toileting, may be perceived to be undignified.

<sup>34</sup> At 2.

<sup>35</sup> B Munro: "A troubling inheritance", Otago Daily Times, 11 February 2019.

<sup>36</sup> Paula Tesoriero "Submission of The Disability Rights Commissioner on the End of Life Choice Bill"; see also *Seales v Attorney-General* HC Wellington CIV-2015-485-235, 8 May 2015 (Affidavit of Dr Huhana Hickey); and *Seales v Attorney-General* HC Wellington CIV-2015-485-235, 8 May 2015 (Joint Affirmation of Wendi Alison Wicks and Robyn Mary Hunt Filed on Behalf of the Care Alliance).

<sup>37</sup> Paula Tesoriero at [13].

<sup>38</sup> At [17].

<sup>39</sup> At [22].

10.4. Disabled New Zealanders may be made to feel they are a burden:<sup>40</sup>

There is social and historical context associated with how society values and treats disabled people. Community attitudes to people with a disability and concepts such as “quality of life” affect the way that disability is perceived and the way in which disabled people value themselves and form their own identity. Fear of becoming disabled, or of becoming a “burden”, on family members and others can have an impact on the decisions that disabled people might make around end of life choices.

10.5. Disabled New Zealanders experience difficulties in accessing support services (in contrast to the ease with which they could access EAS services):<sup>41</sup>

There are well known and acknowledged limitations and constraints with clinical and support service provision in relation to many physical and mental illnesses in New Zealand.

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These types of limitations could effectively result in a “Clayton’s choice” for disabled people, whereby an inability to access the services, medication or supports that would improve quality or length of life mean that an individual might feel that there is no option but to access assisted dying procedures. The lower cost and relative ease with which an assisted dying process could be accessed, as compared with the difficulties and obstacles (both practical and financial) of trying to obtain adequate social, medical and practical supports for chronic conditions, is a matter of considerable concern.

11. Authors from "Not Dead Yet", a group of disabled people set up to oppose euthanasia and assisted suicide, stated similarly:<sup>42</sup>

In a society that prizes physical ability and stigmatizes impairments, it’s no surprise that previously able-bodied people may tend to equate disability with loss of dignity. This reflects the prevalent but insulting societal judgment that people who deal with incontinence and other losses in bodily function are lacking dignity. People with disabilities are concerned that these psycho-social disability-related factors have become widely accepted as sufficient justification for assisted suicide.

### Impact of End of Life Choice Bill on New Zealand Māori

12. Special consideration must also be given to the potential implications of the “unbearable suffering” criterion for elderly, sick or disabled Māori, who could suddenly find themselves eligible for euthanasia or assisted suicide under the End of Life Choice Bill at a time when there are mounting concerns that the New Zealand health system has already failed them due to institutional racism within the health sector and "silence, inaction, denial and resistance" on the part of the Crown.

13. Māori are disproportionately represented in New Zealand's suicide, terminal illness and sickness rates, and in the areas of mental health and disability. In December 2018 the overall state of Māori health prompted the Waitangi Tribunal to commence an investigation into more than 200 claims that the Crown is operating a “sick, racist system that fails Māori”, leading to Māori dying earlier and suffering the worst health outcomes.<sup>43</sup> Negative health outcomes for Māori include:

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<sup>40</sup> At [40].

<sup>41</sup> At [24]–[25].

<sup>42</sup> Not Dead Yet “Disability Rights Toolkit for Advocacy Against Legalization of Assisted Suicide” <<http://notdeadyet.org/>>.

<sup>43</sup> Carmen Parahi “Waitangi Tribunal investigates sick, racist health system that ‘fails Māori’” *Stuff* (online ed, New Zealand, 15 October 2018).

- 13.1. the fact the suicide rate amongst Māori is at its highest level since records began (97 died by suicide in the year ending June 2018, 12 per cent more than the previous year), and that Māori men continue to be disproportionately represented in suicide statistics;<sup>44</sup>
  - 13.2. the fact that Māori are more likely to die prematurely from avoidable diseases or injuries;<sup>45</sup>
  - 13.3. the fact there are significant disparities between Māori and non-Māori across a number serious health conditions including cardiovascular disease and heart failure (mortality rates in Māori are twice as high), strokes (Māori mortality is one and a half times higher), rheumatic heart disease (Māori deaths are five times higher), cancer (total Maori mortality is over one and a half times higher than non-Māori), cervical cancer (mortality rate is two and a half times higher for Māori women) and lung and liver cancer (male Māori mortality rates are nearly three to three and a half times higher than non-Māori men).<sup>46</sup>
  - 13.4. According to the Waitangi Tribunal, "Many of these illnesses and problems are practically at epidemic levels".
14. Additionally, as already noted above, the older Māori population is projected to almost treble between 2001–2021,<sup>47</sup> Māori comprise a significant proportion of New Zealand's burgeoning older population who are poor and sick, and older Māori experience higher rates of elder abuse.<sup>48</sup>

#### **Impact of a euthanasia regime on Government cost-cutting in health sector**

15. It is difficult not to see how significant fiscal pressures generated by an overburdened health system, and by the growing numbers of elderly, disabled, terminally ill, chronically ill and mentally ill New Zealanders, might impact future government policy around the provision of euthanasia and assisted suicide as an acceptable healthcare service (and, indeed, as a "right") if the End of Life Choice Bill passes into law. In the 1990s, the New Zealand Government secretly considered eliminating certain categories of patients from accessing life-saving health care. After the then-Minister of Health Jenny Shipley created the Core Health Services Committee to find new cost-cutting measures in an effort to reduce the Health budgets, investigative journalist Selwyn Manning exposed a secret Core Health Services Committee plan, approved by the Minister of Health, to draw up thresholds that would prevent some patients with renal failure from seeking life-saving care because of the cost. In a 2016 editorial "Be Aware and Beware of What You Demand – A Case Against State-Backed Euthanasia", Manning wrote:<sup>49</sup>

"In August 1994, I became aware that the Core Health Services Committee had been evaluating the most costly procedures, including renal dialysis treatment for people with end-stage renal failure. I was told by sources that the CHSC had drafted a document that included a framework for how

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<sup>44</sup> Brad Flahive "Māori suicide rate the highest it's ever been. What are we missing?" *Stuff* (online ed, New Zealand, 24 August 2018).

<sup>45</sup> Waitangi Tribunal: "Age Standardised Amenable Mortality Rates", cited in Carmen Parahi article, above n 120.

<sup>46</sup> Carmen Parahi "Waitangi Tribunal investigates sick, racist health system that 'fails Māori'", above n 120.

<sup>47</sup> Statistics New Zealand *Demographic Aspects of New Zealand's Ageing Population*, above n 101 at 21.

<sup>48</sup> Office for Senior Citizens *Towards gaining a greater understanding of Elder Abuse and Neglect in New Zealand*, above n 29 at 5.

<sup>49</sup> Manning, S: "Be Aware and Beware of What You Demand – A Case Against State-Backed Euthanasia", Evening Report, 4 October 2016.

expensive treatments would be handled, and that the Minister of Health had approved the plan..... What this meant was people who presented with end stage renal failure, and who required dialysis to stay alive, would be excluded from getting this life-saving treatment if they were deemed:

- \* to be blind
- \* to have an intellectual disability
- \* had a history of mental illness
- \* exhibited or expressed anti-social behaviour
- \* had a history of imprisonment
- \* had an unrelated health condition that may cause complications
- \* were over the age of 65-years...

The set of exclusion criteria continued on.”

### **Conclusion on impact of “unbearable suffering” criterion**

16. Into the intolerable situation that growing numbers of vulnerable New Zealanders with terminal illnesses or irremediable medical conditions may find themselves in over coming decades, as a result of a serious lack of state funding for services, poor public policies, neglect, institutional racism, ageism, abuse, ignorance, or – worst of all – a growing lack of will to care from family and / or society, the End of Life Choice Bill promises to deliver an easy way of helping those victims of these failures in care, and who suffer psychologically as a result, to dispose of themselves. In such circumstances, it is difficult to see how the personal “choice” promised to these New Zealanders in the End of Life Choice Bill could be anything other than a Clayton’s choice – a choice in name alone. As euthanasia and assisted suicide practices develop into valid healthcare options for New Zealand’s most vulnerable groups at a time when New Zealand’s health system is unable to cope with the demands of meeting their needs, our governing State may well find itself both complicit in their intolerable condition and complicit in their premature death by suicide or euthanasia.<sup>50</sup>

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<sup>50</sup> *Seales v Attorney-General* HC Wellington CIV-2015-485-235, May 2015 (Affidavit of Dr John Kleinsman) at [84].