FATAL FLAWS IN THE END OF LIFE CHOICE ACT

If it comes into force following the 2020 referendum, the End of Life Choice Act 2019 ("the Act") would make it lawful in New Zealand for medical and nurse practitioners, overseen by the Ministry of Health, to end the lives of eligible patients through lethal ingestion or injection upon a request to a medical practitioner (known as euthanasia), or provide them with a lethal dose of medication to ingest or receive intravenously (known as assisted suicide). This development would signify the most profound shift in New Zealand law in our nation’s history since the abolition of the death penalty.

Numerous concerns over the dangerous impact of the Act on vulnerable New Zealanders were voiced by some 35,000 New Zealand organisations, experts and citizens to the Parliamentary Justice Select Committee during its passage through Parliament. The Act 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. More than 1700 doctors have also openly voiced their strong opposition to it. Even those who in theory support euthanasia have raised concerns about the Act and in particular the impact it would have on weak and vulnerable New Zealanders.

The Act’s drafters claim that it would be targeted at a "small but significant group of competent adults who are not vulnerable and who wish to die without unbearable suffering and pain". This claim is patently false because anyone who is eligible is necessarily vulnerable. In fact the Act would place many vulnerable, terminally ill members of our community at greater risk of premature death, as a result of neglect, coercion and other forms of abuse, as well as misdiagnosis or prognostic error and uncertainty. Its claimed "protections" fall a long way short of protecting these vulnerable people from these harms. Claims by the Act's supporters that it is "watertight" and the "safest" euthanasia law in the world are simply wrong.

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

Flaws in claimed “protections” against coercion and pressure

The Act’s claimed “protections” against coercion, pressure or abuse are completely inadequate to protect vulnerable New Zealanders from these very real dangers:

1. It does not impose any general obligation on a doctor or any other person to assess whether a requesting patient is being pressured into requesting euthanasia or assisted suicide (s 11(h)). Instead, it only requires one doctor to take two specific steps to try to ensure that the patient is

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3 The New Zealand Human Rights Commission Best practice guidelines for the prioritisation of vulnerable customers (Margaret MacDonald and Sally Carlton, New Zealand Human Rights Commission, 2016) at 3 contains an exhaustive list of persons whom it defines as ‘vulnerable’. The list includes a person who “has been diagnosed with a chronic illness or a terminal illness.”
not being pressured into the process (section 11). Neither step requires any kind of assessment. Once those two steps have been taken (or if they cannot be taken) the doctor’s role is at an end unless something arises that triggers s 24. Aside from those two steps, the Act contains no other mechanisms for detecting whether vulnerable New Zealanders are being pressured into requesting euthanasia.

2. The requirement that only one doctor (the first attending medical practitioner) “do their best to ensure” a requesting patient is not being pressured into the process (s 11) sets a hopelessly inadequate standard of compliance:

2.1 Courts in the United Kingdom have 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 pressure or coercion or provide a complete safeguard against it. Thus the Act requires just one person to try and achieve what an entire judicial system cannot accomplish in all cases.

2.2 Even those legal standards protecting New Zealanders from the loss of their chattels or property through coercion set the bar higher than this requirement.

2.3 The Royal New Zealand College of General Practitioners, the very doctors who would be on the front-line of the euthanasia process, has stated that under that requirement, “coercion of patients will be impossible to discern in every request for assisted death” and wrongful deaths would result.

3. Doctors would be significantly impeded in “doing their best to ensure” that a requesting patient is not being pressured into requesting euthanasia or assisted suicide, in that -

3.1 they would only be permitted to make enquiries of those family members whom the requesting patient allows them to speak to (s 11(2)(h)(ii)). Doctors could easily find themselves impeded in those efforts in situations where patients are being manipulated by abusive relatives and consequently refuse to allow the doctor to talk to them;

3.2 although they are required to try to talk with other health practitioners “who are in regular contact with” the requesting patient (s 11(2)(h)(i)) –

(a) those practitioners may not exist. The first doctor may very well be the patient’s only health practitioner;

(b) 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 pressure being exerted on them;

(c) given the large percentage of New Zealand doctors who are strongly opposed to euthanasia and assisted suicide, many health practitioners who might be

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4 Contrary to claims made by the Act’s supporters, only the first attending medical practitioner is required to “do their best to ensure” that a requesting patient is not being pressured. The second (“independent”) medical practitioner is only required to reach an opinion as to whether the patient is eligible or not. They are not required to do anything to determine whether there might be pressure on the patient.

5 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).

6 RNZCGP Submission to Justice Select Committee on End of Life Choice Bill, 6 March 2018.

7 Above note 7.
approached would also likely be unwilling to assist in that exercise due to their own conscientious objections.

4. The Act does not require the doctor “doing their best to ensure” the patient is not being pressured to have had any prior relationship with that patient (s 11). Many doctors are likely to find themselves having to try and detect pressure or manipulation 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 are opposed to euthanasia and assisted suicide. That would very likely lead to large numbers of requesting patients whose doctors have expressed conscientious objections instead being handed over to a SCENZ Group “replacement medical practitioner” who –

4.1 joined the SCENZ Group as a doctor who was “willing to participate” in the patient’s death by euthanasia or assisted suicide;  

4.2 will not know the patient or have met them before;  

4.3 will not be required to meet the patient in person;  

4.4 will not be required to carry out any kind of assessment of whether the patient is being pressured into requesting euthanasia, and will only need to undertake the two steps mentioned above.

5. The doctor required to “do their best to ensure” the patient is not being pressured into the process may choose to do so through telephone or electronic communications with the patient (s 11(2)(b)). They are not required to meet the requesting patient in person.

6. The doctor is only required to ensure a requesting patient is “free from pressure from any other person” (s 11(2)(h)). There are no protections in the Act against wider and more subtle coercive forces acting upon the patient such as –

6.1 their inability to access quality palliative care services;  

6.2 their inability to access PHARMAC-funded, life-prolonging medications or treatments due to budgetary decisions or government economic policies;

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8 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 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.

9 As per its original Explanatory Note, the Act 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.
6.3 advertising and promotion of euthanasia and assisted suicide services.

This undermines the entire underlying premise of “choice” upon which the Act purports to be based.

7. The doctor could be the person pressuring a patient to request euthanasia or assisted suicide, and no one may ever know.

8. Its prohibition (s 10) against a health practitioner initiating “any discussion” with or making “any suggestion” to a terminally ill patient about euthanasia could very easily be either ignored or otherwise circumvented by unscrupulous or disdainful health practitioners through unchallengeable means, such as:

8.1 initiating the discussion about euthanasia with a patient's family members;¹¹

8.2 arranging for non-health practitioner staff to initiate the discussion with a patient;

8.3 asking a patient to relay to them what they understand their options to be, and (if assisted dying is mentioned) then asking the patient whether they would like to initiate a discussion about those options.

In any event, it would be extremely difficult for any breach by a non-compliant practitioner to be proven before a disciplinary tribunal or a court, especially if the patient is dead. There will in most cases be no witness to what was said and no written or oral record of what was said. There will be no opportunity for concerned friends or relatives to make a complaint merely because they have suspicions but lack evidence.

9. It permits another person to sign a euthanasia request form on behalf of a requesting patient, but does not require that person to provide any evidence demonstrating that they do not stand to benefit from that patient's death (s 12(4)).

10. Unlike assisted dying laws in the US, Canada and Australia (Victoria and Western Australia), it does not require two independent witnesses to be present when a patient confirms their request in writing in the presence of the attending medical practitioner (ss 11, 12). Unlike assisted dying laws in Victoria and Western Australia, it does not require two independent witnesses to be present when the patient is given the lethal dose (s 20).

11. It does not require nurse practitioners, who are authorized to administer a lethal dose to a requesting eligible patient, to provide any evidence or declaration that they were authorised by an attending medical practitioner to do so (s 20).

12. A person could be euthanised or helped to commit suicide under the Act without the knowledge of any of their family or friends (s 11(2)(e) and (f)).

13. Family members who object to their loved ones being euthanized or assisted in suicide by doctors would be powerless to stop their deaths, and could be liable to prosecution if they intervene with the use of force to try and stop the process (s 37(4)).

¹¹ As happened in the case of Canadian Roger Foley despite a similar prohibition under Canada’s euthanasia law; see “Chronically ill man releases audio of hospital staff offering assisted death”, CTVNews, 2 August 2018

¹² As happened in the case of Canadian Candice Lewis despite a similar prohibition under Canada’s euthanasia law; see G Bartlett: “Mother says doctor brought up assisted suicide option as sick daughter was within earshot”, CBC News 24 July 2017.
14. A person could potentially have their life ended hastily under the Act, within just days of making a request for euthanasia or assisted suicide. Unlike other jurisdictions, there is no mandatory “cooling-off” period between a request and the lethal prescription (in their respective assisted dying laws Oregon has a 15 day cooling-off period, Hawaii a 20 day cooling-off period, Canada a 10 day cooling-off period and Victoria a 9 day cooling-off period). The Act’s only mandatory delay is just 48 hours between the time that a medical practitioner advises the Registrar of the method and of the date and time chosen for the administration of the lethal dose and that actual date.

15. It creates significant coercive risks to terminally ill, elderly New Zealanders, who would find themselves eligible for euthanasia and assisted suicide at a time when:

15.1 they would primarily be those persons most likely to be euthanized or helped to commit suicide under the Act, seeing that this is overwhelmingly the case in those jurisdictions where these practices are lawful;\(^\text{12}\)

15.2 New Zealand’s under-funded and over-burdened health system is already failing to meet their needs;\(^\text{13}\)

15.3 their numbers are growing rapidly. Up to 20-22% of New Zealanders (around 1.1 million) are projected to be aged over 65 years by 2032, 27% by 2050 and up to 33% by 2068;\(^\text{14}\)

15.4 New Zealand’s rapidly aging population is placing increasing pressure on its overburdened health system;\(^\text{15}\)

15.5 medical reports have found that the introduction of euthanasia and assisted suicide practices can lead to a significant reduction in health spending;\(^\text{16}\)

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\(^\text{12}\) In Canada in 2019, 4342 out of 5,389 represented euthanasia / assisted suicide deaths were of elderly persons aged 65 years or over (80.5%); see Health Canada: First Annual Report on Medical Assistance in Dying 2019, 23, at https://www.canada.ca/en/health-canada/services/medical-assistance-dying-annual-report-2019.html. In Oregon, 80% of those who died as a result of assisted suicide in 2017 were 65 or over, see Public Health Division Oregon Death with Dignity Act: 2017 Data Summary, 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>. In Victoria (Australia), the average age of persons euthanized during the past year was 71 years, according to the Voluntary Assisted Dying Review Board Report of Operations (June – Dec 2019, Jan – June 2020); at <https://d3n8a8pro7vhmx.cloudfront.net/australiancarealliance/pages/264/attachments/original/1598933513/VADRB_Report_of_operations_August_2020_FINAL_0.pdf?1598933513>.

\(^\text{13}\) 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).


\(^\text{15}\) 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.

\(^\text{16}\) Canadian researchers have cautiously estimated that legalising EAS could save Canada between $34.7 million and $138.8 million on annual health care expenditure, see Aaron J Trachtenberg and Braden Manns” “Cost analysis of medical assistance in dying in Canada” (2017) 189 CMAJ E101 at E104.
one in five elderly New Zealanders identify as being extremely lonely;\(^\text{17}\)

in Canada in 2019, 13.7% of those Canadians euthanised or assisted in their suicide under its Bill C-14 (Medical Assistance in Dying or “MAID”) law reported “isolation or loneliness” as one of their main reasons underlying their request;\(^\text{18}\)

10 per cent of elderly New Zealanders suffer some form of abuse, either physically, sexually, psychologically, financially or through neglect;\(^\text{19}\)

isolation and loneliness are common denominators in many cases of elder abuse;\(^\text{20}\)

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 are family / whānau members and 20% are staff of the facility;\(^\text{21}\)

financial and psychological abuse are the most common forms of elder abuse and neglect. Both forms are increasing in New Zealand's population;\(^\text{22}\)

on average there are 313 inheritance dispute cases each year in New Zealand's Family Courts and High Courts;\(^\text{23}\)

some 59% of those assisted in suicide under Oregon’s Death With Dignity Act in 2019 stated that being a “burden on family, friends or caregivers” was one of their main reasons for requesting assisted suicide. In Canada during 2019, 34% of those who were euthanised under the Bill C-14 MAID law cited “perceived burden on family, friends or caregivers” as one of their main reasons for requesting MAID;\(^\text{34}\)

the United Kingdom Supreme Court has found that elderly people would be particularly susceptible to real or perceived pressure to end their lives under an assisted dying law.\(^\text{24}\)

These various coercive factors, already prevalent amongst elderly New Zealanders, would work to undermine the “choice” that is purportedly being made available to them by the Act.

It creates significant coercive risks to terminally ill Māori at a time when:

Māori are disproportionately represented in New Zealand's suicide, terminal illness and sickness rates, and in the areas of mental health and disability;

\(^{17}\) 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.


\(^{20}\) Cherie Sivignon “Elder abuse often linked to loneliness and isolation: Age Concern Nelson Tasman” Stuff (online ed, New Zealand, 13 June 2018).

\(^{21}\) 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.

\(^{22}\) Ibid, 2.


16.2 older Māori face higher rates of elder abuse.\textsuperscript{25}

16.3 Māori constitute a significant proportion of New Zealand’s burgeoning older population who are poor and sick. The number of older Māori needing care on a more than daily basis could increase by more than 200 per cent by 2026;\textsuperscript{26}

16.4 Māori are already being failed by New Zealand’s health system, as a recent Waitangi Tribunal claim has argued.\textsuperscript{27}

**Flaws in eligibility criteria**

The Act’s eligibility criteria (s 5) would expose vulnerable, terminally ill New Zealanders to a risk of premature death through misdiagnosis, prognostic error, and institutional, familial or societal neglect:

17. Its “*terminal illness*” eligibility criterion is undefined, subjective, and is not even a term used any longer in medical or palliative terminology (s 5(1)(c)). Medical diagnosis is a matter of probability, not certainty, and practitioners frequently refer to it as an “art not a science”. Consequently medical misdiagnoses occur in New Zealand every year and include diagnoses of terminal illnesses that are later found to be misdiagnoses.\textsuperscript{28}

18. The eligibility criterion “a terminal illness likely to end the person’s life within 6 months” (s 5(1)(c)) is fraught with uncertainty, given that it is difficult ever to accurately predict life expectancy in cases of terminal illness. New Zealander Lecretia Seales was diagnosed in March 2011 with brain cancer by her doctors and at that time was given “weeks to live”.\textsuperscript{29} She lived for more than four years, until June 2015.\textsuperscript{30} Similarly, New Zealander Vicki Walsh was diagnosed with brain cancer in June 2011 and told she only had 12 to 14 months to live. She is still alive today, nine years later.\textsuperscript{31}

19. Its “*unbearable suffering*” eligibility criterion (s 5(1)(e)) is overly broad and subjective. Physical pain would very unlikely to be the primary cause of the “unbearable suffering” in requesting patients in New Zealand. Statistical data from those jurisdictions that have legalized euthanasia

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\textsuperscript{25} Office for Senior Citizens *Towards gaining a greater understanding of Elder Abuse and Neglect in New Zealand* (June 2015) at 5.

\textsuperscript{26} Ngaire Kense and others *Intervals of care need: need for care and support in advanced age* (The University of Auckland, 21 April 2017) at 11.

\textsuperscript{27} Carmen Parahi “Waitangi Tribunal investigates sick, racist health system that ‘fails Māori’” Stuff (online ed, New Zealand, 15 October 2018).

\textsuperscript{28} For example, there were 20 reported cases from July 2016 till June 2017 where initial assessments and diagnoses failed to find the key clinical issue; see Health Quality & Safety Commission Learning from adverse events: Adverse events reported to the Health Quality & Safety Commission 1 July 2016 to 30 June 2017 (2017) at 40; see also Eileen Goodwin “Dunedin Hospital’s cancer misdiagnosis” HealthCentral.nz (online ed, New Zealand, 21 December 2017); <healthcentral.nz/dunedin-hospitals-cancer-misdiagnosis>.

\textsuperscript{29} Rebecca Macfie “Dying Wishes” Noted (online ed, New Zealand, 8 January 2015).

\textsuperscript{30} NZME “Right to die: Lecretia Seales dies hours after judgment” NZ Herald (online ed, New Zealand, 5 June 2015).

or assisted suicide (Canada, Oregon, the Netherlands and Belgium) reveals that instead of physical pain –

19.1 psychological sufferings such as depression, loneliness and isolation, being a burden on family or caregivers, fears of being dependent, and loss of dignity and 

19.2 socioeconomic pressures such as low-income levels, prohibitive financial implications of treatment, a lack of access to quality palliative care, other health system failures, or insurance cover refusals –

would very likely become the “unbearable sufferings” that would compel terminally ill New Zealanders to request euthanasia and assisted suicide under the Act.

20. Its restriction of euthanasia eligibility only to New Zealanders “aged 18 years and over” with a “terminal illness” (s 5(1)(a) and (c)) is susceptible to legal challenge in our courts on the grounds of discrimination, which in turn would lead to mounting judicial pressure on Parliament to expand euthanasia and assisted suicide eligibility to younger New Zealanders and to non-terminal medical conditions including disabilities, chronic illnesses and mental illnesses.


34 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) and 2018 Data Summary (Oregon Health Authority, 15 February 2019), 11.


36 In Oregon between 63.3% and 66.9% of all assisted suicides during the past five years were of people on low incomes who were accessing state health care insurance through the Oregon Health Plan; see eg Oregon Public Health Division, Oregon Death With Dignity Act: Data Summary 2018, 6: “The proportions of patients who had private insurance (32.4%) and Medicare or Medicaid insurance (66.9%) in 2018 were similar to those reported during the past five years (35.8% and 63.3%, respectively)”. Medicaid Insurance is a federal program managed by the State of Oregon through the Oregon Health Plan which provides health insurance for low-income individuals.


39 In the case of Barbara Wagner, a 64-year-old Oregon woman with lung cancer who was prescribed a $4,000-a-month life-saving drug by her doctor, the Oregon Health Plan refused to pay for the drug, instead offering to cover her doctor-assisted suicide for around $50; see Susan Donaldson James “Death Drugs Cause Upheaval in Oregon” ABC News (online ed, United States, 6 August 2008).

40 The former New Zealand Attorney-General’s section 7 Report to Parliament on the End of Life Choice Bill stated that the Bill’s age limit of 18 years discriminates against eligible 16 and 17 year old New Zealanders who may also wish to be euthanised or be assisted to commit suicide: “I think the Bill appears to be inconsistent with the right to be free from discrimination on the grounds of age affirmed in s 19(1) of the Bill of Rights Act”.

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21. It provides no safeguards in a situation where a requesting patient who was initially assessed as competent and eligible later loses that competence, thereby ceasing to be eligible for euthanasia or assisted suicide prior to the time that the lethal dose is administered to them. It does not require any formal test for competence or for the presence of pressure or coercion to be carried out at the time a doctor ends a patient’s life by administering a lethal dose to them (s 20). Nor does it provide for the involvement of a psychiatrist if the attending medical practitioner or nurse practitioner are uncertain of the patient’s competence at the time that their life is ended (ss 15, 18, 19, 20).

22. It does not require screening of requesting patients for treatable depression (ss 5, 8, 15). An otherwise eligible terminally ill person who suffers from depression or another mental illness would not be excluded, unless their mental illness is such they are deemed not competent to make an informed decision about assisted dying. Depressed people regularly qualify for euthanasia in other jurisdictions where euthanasia is practiced (including the Netherlands, Belgium and Canada), while international “right to die” advocates argue that depressed people can be capable of consenting to euthanasia.41

23. It does not require assisted dying to be a last resort. An eligible person is not required to have tried any other treatments first and does not need to have unmanageable physical pain to qualify (s 5). The person does not need to have had a prior consultation with a palliative care specialist or a pain specialist, or be receiving or even have available to them appropriate medical, psychiatric, or palliative care for their terminal illness or disability as a pre-condition for establishing their eligibility (ss 5, 11).

Criminality, impunity and concealment

The Act 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:

24. It would not necessarily be an offence for someone to manipulate, pressure, counsel or otherwise encourage or persuade a person into requesting euthanasia or being euthanised under the Act (s 37(5) and s 179 Crimes Act 1961).

25. It would be extremely difficult for the Police to investigate or prosecute criminal or other abuses of the euthanasia and assisted suicide process.

26. It provides no contemporaneous oversight mechanism to monitor the efficacy of the euthanasia process as it occurs.

27. It does not require the Registrar (Assisted Dying) to follow up on any missing assisted death reports (s 21).

28. 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 (s 26).

29. It does not prohibit individuals being current or former members of both the SCENZ Group and the End of Life Review Committee. Nor does it prohibit the two health practitioners on the End of Life Review Committee from reviewing the cases of dead patients whom they may personally have assessed as eligible or have assisted in their dying (s 26).

30. It contains no appeal process for challenging medical decisions.

31. It impedes the likelihood of any form of judicial intervention occurring (whether by way of judicial review, injunction or otherwise). The decision to declare a patient eligible for euthanasia or assisted suicide or to administer a lethal dose would always be based on some form of medical judgment, and in previous cases New Zealand courts have shown considerable reluctance to second-guess the judgments of medical professionals.

32. 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 ever knowing, in the case of those people who have been euthanised or assisted in suicide (s 21):

32.1 their clinical information;
32.2 the reasons why doctors assessed them eligible for euthanasia or assisted suicide;
32.3 their ethnicity;
32.4 their personal or socio-economic circumstances;
32.5 what steps a doctor took in “doing their best” to detect coercion or pressure;
32.6 the nature of the “unbearable suffering” that led the person to request euthanasia or assisted suicide.

33. The New Zealand public would be deprived of even knowing the name of the institutions where people were euthanised or assisted in suicide (s 36). Effectively this means a media ban that could prevent reporters from bringing to light the details of individual institutions (such as DHBs, rest homes, retirement villages) that may experience an unusual upsurge in assisted dying cases through internal policies designed to promote it amongst their patients by lawful or unlawful means.

Other flaws in the Act

34. A key part in the process that must be followed by doctors is illogical. The Act stipulates a checklist of some 14 tasks which a doctor must complete once a patient has requested euthanasia (ss 11 and 12), yet the doctor is required to complete each of those tasks before they have even assessed whether the patient is eligible to be euthanized or assisted in their suicide (s 13). A refusal or failure by a doctor to complete these steps in this order would amount to an offence (s 39).

35. It is predicated on factually inaccurate or questionable claims in its original Explanatory Note, such as:

35.1 the claim that the practice of euthanasia overseas is safe ("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 “[t]he state of the law in New Zealand is out of step … with developments overseas…” In fact, attempts to legalise assisted suicide/ euthanasia have recently been rejected by a number of jurisdictions including -

- The United Kingdom Parliament, which rejected an assisted dying Bill by 330 votes to 118 in September 2015.42
- The Scottish Parliament, which rejected an assisted dying Bill by 82 votes to 36 in May 2015 and an earlier Bill introduced in 2010 by 85 votes to 16.43
- The National Assembly for Wales, which rejected an assisted dying Bill by 21 votes to 12 in December 2014.44
- The Guernsey Parliament, which rejected an assisted dying Bill by 24 votes to 14 in May 2018.45
- The Isle of Man Parliament, which rejected an assisted dying Bill by 17 votes to 5 in February 2015.46
- Parliaments in a number of Australian states and territories, which over the last few decades have rejected nearly 50 euthanasia and assisted suicide Bills, including the New South Wales Parliament in November 2017.47
- Legislatures across 39 states of the United States, where since 1994 some 260 attempts to legalise assisted suicide have failed and only 8 have succeeded.48 Euthanasia remains illegal in every state in the US.49

Undermining of suicide prevention measures

36. It would confuse and undermine suicide prevention efforts in New Zealand. For the first time in our nation’s history, our Ministry of Health would be actively facilitating the “right” of some suffering citizens to end their own lives while at the same time trying to dissuade other suffering citizens from doing the same.

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42 Rowena Mason “Assisted dying bill overwhelmingly rejected by MPs” The Guardian (online ed, United Kingdom, 12 September 2015).
44 Although this was not a devolved issue and the results were therefore not legally binding. See J Mildred, “Welsh Assembly soundly rejects Assisted Dying Bill, CARE UK, 11 December 2014.
46 E Vannin, “Assisted dying bill rejected by Isle of Man politicians”, BBC News (online ed, United Kingdom, 3 January 2015).
48 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.patientsrights council.org/site/failed-attempts-usa/>