

End of Life Choice Bill

Member's Bill

As reported from the Justice Committee

Commentary

Recommendation

The Justice Committee has examined the End of Life Choice Bill and the Report of the Attorney-General under the New Zealand Bill of Rights Act 1990 on the End of Life Choice Bill. We recommend that the amendments set out below be passed.

We were unable to agree that the bill be passed.

Conscience vote

This bill is expected to result in conscience votes by members in the House. In previous situations where a bill was expected to result in conscience votes, committees have recommended amendments that left the policy content of the bill largely intact, while trying to ensure that the bill was a coherent and workable piece of legislation—particularly regarding consequential amendments and amendments to related legislation.¹

The eight members of this committee hold diverse views. We decided to report the bill back with minor, technical, and consequential amendments only. We leave it to the full membership of the House to resolve the broader policy matters.

For clarity, some members would prefer to refer to assisted dying as “suicide and euthanasia” throughout this commentary.

Structure of this report

This report sets out:

- descriptions of the bill and the Attorney-General's report

¹ See Speaker's Ruling 104/3.

- a description of the minor and technical changes that we would recommend if the bill were to be passed
- a summary of the submissions that we received on the bill
- a summary of similar laws in overseas jurisdictions
- a revision-tracked version of the bill showing our recommended minor and technical changes.

1. About the bill as introduced

The End of Life Choice Bill is a member’s bill in the name of David Seymour MP. It seeks to allow people to request assisted dying if they have a terminal illness or a grievous and irremediable medical condition. The bill defines assisted dying as “the administration by a medical practitioner of a lethal dose of medication to a person to relieve his or her suffering by hastening death”.

Eligibility criteria

A person would be eligible for assisted dying if they:

- were aged 18 years or over
- were a New Zealand citizen or permanent resident
- suffered from:
 - a terminal illness that was likely to end their life within 6 months or
 - a grievous and irremediable medical condition
- were in an advanced state of irreversible decline in capability
- experienced unbearable suffering that could not be relieved in a manner they considered tolerable
- were able to understand the nature and consequences of assisted dying.

Bill proposes a process for “assisted dying”

Part 2 of the bill outlines what would happen if a person asked for assisted dying.

Any medical practitioner could conscientiously object to participating in assisted dying. However, doctors who conscientiously objected would have to tell a person about this objection and refer them to the SCENZ Group (described below) for help to find a replacement doctor.

When a person told a doctor that they wish to receive assisted dying, the doctor would have to undertake a process to ensure a person understands the requirements of the legislation and consents to assisted dying.

The bill would require two people—the attending medical practitioner and an independent medical practitioner—to decide whether a person was eligible for assisted dying. If either of them was unsure whether a person was competent—that is, able to understand the nature and consequences of their request for assisted dying—they would have to ask the SCENZ Group for the details of a specialist (psychiatrist or

psychologist). The specialist would then examine the person and their files and decide whether the person was competent.

When this process was complete, the attending medical practitioner would have to tell the patient whether they were eligible for assisted dying. If the patient was not eligible, the medical practitioner would have to explain the reasons for the decisions.

At each step of the process, prescribed forms would be sent to the registrar (assisted dying) so that they had a complete record of the decisions.

If a person was eligible for assisted dying, the attending medical practitioner would have to discuss the progress of their illness or condition and the likely timing of the assisted dying, and make provisional arrangements to administer the medication.

When a person was ready to opt for assisted dying, they would choose a method for receiving the medication—ingestion or intravenous delivery triggered by the person, ingestion through a tube, or injection. The doctor would have to ask the person to choose a time for the medication to be administered and ensure that the person knew that they could change their mind at any time.

At least 48 hours before the chosen time of administration, the doctor would have to write the prescription for the person, advise the registrar about the time and method chosen, and give the registrar the prescription. The registrar would have to ensure that the required steps have been complied with before co-signing the prescription.

At the chosen time of administration, the attending medical practitioner would have to ask the person whether they chose to receive the medication. If the answer was yes, the medication would be administered using the chosen method and the medical practitioner would remain available until the person died. The medical practitioner would have to report the death to the registrar within 14 days.

Administrative bodies that the bill would create

The bill would create three administrative bodies: a Support and Consultation for End of Life in New Zealand (SCENZ) Group, a registrar (assisted dying), and an end of life review committee.

The SCENZ Group, consisting of medical practitioners, would:

- make and maintain a list of medical practitioners, specialists in mental health, and pharmacists willing to participate in assisted dying
- provide contact details of replacement medical practitioners, independent medical practitioners, and specialists for when an assessment of a person's competence was required
- prepare standards of care, advise about the required medical and legal procedures, and, if required, provide practical assistance in relation to the administration of medication.

The registrar would receive prescribed forms submitted by medical practitioners and specialists. They would be responsible for maintaining a register of forms, co-signing

prescriptions, establishing a procedure to deal with complaints, and reporting to the Minister and the review committee.

The review committee would consider reports about assisted deaths, report to the registrar whether it was satisfied with the cases, and recommend follow-up actions where it was not satisfied.

Other matters

Clause 22 would require a review of how the legislation was operating to begin 3 years after the bill's commencement. The review would have to be completed within 6 months. Subsequent reviews would be required every 5 years. The reviews would have to consider whether any amendments to the legislation were needed or desirable.

Under clause 25, a patient who died as a result of assisted dying would be taken to have died as if assisted dying had not been provided.

Clause 26 would protect doctors from civil or criminal liability as long as they were acting in good faith and without negligence. Clause 27 would create offences for failing to comply with requirements in the legislation and for completing, altering, or destroying prescribed forms without consent. A person who was convicted of any of these offences would be liable for up to 3 months' imprisonment and/or a fine of up to \$10,000.

Attorney-General's report under the New Zealand Bill of Rights Act

The Attorney-General made a report on the End of Life Choice Bill under the New Zealand Bill of Rights Act 1990. That report was presented to the House under section 7 of the Bill of Rights Act and was referred to us. We considered it in conjunction with the bill.

The Attorney-General concluded that the bill is inconsistent with section 19 of the Bill of Rights Act, which provides that everyone has the right to freedom from discrimination on the basis of age, starting at the age of 16 years. Under clause 4 of the bill, only those aged 18 and over would be eligible for assisted dying. The Attorney-General found that the age limit was not a justified limitation under section 5 of the Bill of Rights Act. He said that the inconsistency could be resolved by either reducing the age of eligibility to 16 or removing the age criterion altogether and relying on the other criteria and safeguards to ensure that the patient is competent.

The Attorney-General did not find the bill to be inconsistent with sections 8, 13, or 14 of the Bill of Rights Act. These are about, respectively, the right not to be deprived of life, freedom of conscience, and freedom of expression.

2. Amendments to the bill

On many of the substantial issues, we did not decide. However, we do agree that the bill is not workable in its present state. If the House were to decide that the bill should proceed, we recommend making the following minor or technical amendments. These

proposed amendments are shown in the revised bill that is attached to this commentary.

Commencement date

We recommend amending clause 2 to change the commencement date from 6 months to 12 months after the bill receives the Royal assent. This would allow time for the Ministry of Health to establish the new processes and roles in the bill and to consider developing and delivering guidance and training on the bill. It would also allow time for regulations to be made for the prescribed forms and the Department of Internal Affairs to make changes to the death certificates regime.

Definition of “assisted dying”

The definition of “assisted dying” in clause 3 refers to administration by a medical practitioner of a lethal dose of medication. We recommend amending it to include the self-administering of medication.

Aligning the bill with other legislation

We recommend amending the definitions of “medical practitioner”, “pharmacist”, and “psychologist” to align with other legislation. We also recommend other amendments to align the bill with existing legislation, including:

- the Burial and Cremation Act 1964
- the Health Act 1956
- the Health and Disability Commissioner Act 1994.

We propose setting out these amendments in a new Schedule to the bill.

In our view, people who asked for assisted dying should have the same protections as others in the health system. They should have the same rights as other patients, and doctors providing assisted dying services should be subject to the same duties as when providing other types of services. We recommend amending the Health and Disability Commissioner Act and the Health and Disability Commissioner (Code of Health and Disability Services Consumers’ Rights) Regulations 1996 to allow complaints to be made to the Health and Disability Commissioner about an assisted death.

We also recommend amending the Health (Retention of Health Information) Regulations 1996 to ensure that providers of assisted dying would be subject to the same requirements to retain health information as providers of other health services.

Eligibility for assisted dying

Attorney-General’s report under the Bill of Rights Act

Clause 4(a) would exclude 16- and 17-year-olds from eligibility for assisted dying. We acknowledge the Attorney-General’s conclusion that this provision is inconsistent with section 19 of the Bill of Rights Act. Consistent with our approach to not recom-

mend changes to the substantial policies in the bill, we do not make any recommendations in relation to the age limit in clause 4(a).

Conscientious objections

Under clause 6(1), a person would not have to do anything to which they had a conscientious objection. This provision is not clear enough. We recommend making it clear that it would apply only to medical practitioners when somebody informs them that they wish to receive assisted dying.

Process for assisted dying

If the bill were to proceed, we recommend amending clause 8(2)(b) which would require the doctor to talk to the patient at intervals about their wish for assisted dying. We recommend replacing “talk” in clause 8(2)(b) with “personally communicate by any means”. This would cover all means of personal communication, not just talking face-to-face. It would also make clear that the communication could be by social media or video-conferencing.

Clause 8(2)(h), which is about coercion, would require the doctor to do their best to ensure that the patient expresses their wish free from the pressure of others.

If coercion was found, a patient should no longer be eligible for assisted dying. We recommend inserting new clause 22A to require a medical practitioner to halt the assisted dying process if they had reasonable grounds to suspect that a person was subject to coercion.

We recommend replacing the phrase “mental disability” in subparagraph (iv) of clause 9(4)(d) with “mental incapacity”.

Lethal dose of medication chosen

We recommend changing the headings to clauses 15 and 16 to make it clear that they are referring to lethal doses of medication.

Clause 15(6) would require the registrar to co-sign the prescription. We do not believe that there is any merit in this process. We recommend amending clause 15(6) so that the registrar would simply notify the attending medical practitioner when he or she was satisfied that the process in clauses 8 to 14 had been complied with. As a consequence of this recommendation, clause 18(3) should be removed. It relates to what happens if the registrar had the prescription when the person dies.

Unused medication

Clause 18 deals with unused medication. We consider that it is too prescriptive. It also overlaps with established legislative requirements, guidelines, and protocols for storing and disposing of medicines, including the requirements in the Medicines Act 1981 and the Misuse of Drugs Act 1975. We recommend removing subclauses (4) and (5), which are about unused prescriptions.

Review committee

The proposed status and purpose of the end of life review committee is not clear. We recommend amending clause 20(2) to require the review committee to report on compliance with the requirements of the bill.

Registrar's role

We recommend amending clause 21 to make it clear that the registrar's function in dealing with complaints under subclause (4) would be a triage role: deciding where complaints should be referred.

To enable the registrar to report on complaints under clause 21(5)(c) and (d), we recommend inserting new clause 21A to require public bodies receiving complaints to reasonably assist the registrar by providing the relevant information.

We also recommend inserting new subclause (4A) into clause 21 to require the registrar to take any action that the review committee recommended under clause 20(2)(c). We also recommend amending clause 20(2)(c) to make it clear that the review committee could direct the registrar to take actions to follow up unsatisfactory compliance.

Further, we recommend inserting new clause 21B to require the Minister to table the registrar's report in the House.

Reviews of the legislation's operation

Under clause 22 as introduced, the Ministry of Health would have to begin a review of the operation of the legislation 3 years after its commencement. The review would have to be completed within 6 months. Further reviews would be conducted every 5 years.

We believe that 6 months to fully evaluate the operation of an Act is rigid timing that could affect the review's quality. We recommend amending clause 22 so that it specifies only the timeframe for completing, not starting, reviews.

Regulation-making powers

Clause 23 would allow regulations to be made setting out details of the forms that would be used. The bill proposes eight forms (in clauses 9 to 13 and 16 to 18). If the bill were to proceed, we propose two new forms:

- We recommend inserting new subclause (3) into clause 14 to provide a form to record the actions taken when a doctor advised a person that they were eligible for assisted dying.
- We also recommend providing for a new form in proposed new clause 22A, to record the actions taken when coercion was suspected.

Effect of death on contracts

Under clause 25, a patient who died as a result of assisted dying would be taken to have died as if assisted dying had not been provided. The effect of this clause would

be that assisted dying would not void a contract or prevent a payment or other benefit being made to the estate of the person who had died.

We consider that clause 25 should be clearer and more specific. We recommend amending it to make clear that assisted dying would not affect any contractual arrangements of the person who had died.

Immunity

Clause 26 seeks to provide people with immunity from civil or criminal prosecution for acts or omissions in good faith and without negligence in providing, or intending to provide, assisted dying. This clause would protect doctors from liability if they were acting in good faith and without negligence.

We recommend amending clause 26 to set out more clearly the criminal immunity from prosecution.

We believe that the civil immunity provision in clause 26 of the bill as introduced should exclude complaints to the Health and Disability Commissioner and complaints under the Health Practitioners Competence Assurance Act. We do not consider that these complaint processes should be affected by the bill. Health practitioners who breach standards of practice should be subject to appropriate investigation and disciplinary action. We recommend inserting new clause 26A to set out the proposed limitations on civil immunity.

Offences under the Crimes Act

Section 41 of the Crimes Act 1961 justifies the use of force to prevent suicide (and certain other things). Section 48 justifies using force in the defence of yourself or another. Under these provisions, a family member who did not want their loved one to go ahead with assisted dying would have a defence if they assaulted staff or other supporters of the patient.

If the bill were to proceed, we recommend making it clear that the defences under these sections could not be used to avoid prosecution for using force against doctors or others who were providing or supporting a person with assisted dying.

Offences created by the bill

Clause 27(1) sets out the three new offences that the bill would create.

We note that clause 27(1) is very wide. It would apply to every actor mentioned in the bill, including the patient, the various health professionals, and administrative bodies including the registrar, the Director-General of Health, and the Minister of Health. This is unusual for an offence provision. We do not consider it necessary to make all of these people liable for failing to comply with a requirement in the bill. We recommend narrowing clause 27(1)(a) so that it would cover only the attending medical practitioner, the independent medical practitioner, and the specialist.

Referral to the coroner

Under existing legislation, bodies may only be buried or cremated after authorisation by a coroner, or the provision of a certificate of cause of death. The cause of death certificate can only be provided if a doctor or a nurse practitioner is satisfied that the person's death was a natural consequence of their illness or when a person aged 70 years or over dies after an accident. Neither of these causes of death would apply in the case of an assisted death. This means that an assisted death would have to be referred to the coroner before a burial or cremation could take place.

We consider that, if the bill were to be passed, assisted deaths should not be referred to the coroner as a matter of course. We recommend:

- amending the Burial and Cremation Act to authorise the attending medical practitioner to give a cause of death certificate for an assisted death
- amending the Coroners Act 2006 to ensure that assisted deaths would not all have to be reported to the Police and therefore to a coroner
- amending the Cremation Regulations 1973 so that the cremation certificate could be used for an assisted death.

Amendments to death certificate

Clause 28 is about the information that would go on the death certificate of a person who died as a result of assisted dying. The death certificate would have to include the fact that the person died as a result of assisted dying. Under clause 28(2), new regulation 7(1)(a)(xiiiia), it would also have to include the cause or causes of death as if assisted dying had not been provided.

For consistency with other legislation, we recommend moving the contents of clause 28 into the proposed new Schedule. We also propose making new subparagraph (xiiiia) clearer. We recommend amending it so that the death certificate would have to state the terminal illness or medical condition that gave rise to the person's eligibility for assisted dying.

Other proposed amendments

Other amendments were proposed by submitters but involved substantive policy changes. Consistent with our approach not to consider substantive policy issues on a conscience bill, these amendments were not considered by the committee. They are listed in Appendix C.

3. Submissions on the bill

We received and considered 39,159 submissions from interested groups and individuals. We heard oral evidence from 1,350 submitters (77 organisations and 1,273 individuals) at hearings in Whangarei, Auckland, Tauranga, Rotorua, Hamilton, New Plymouth, Whanganui, Napier, Palmerston North, Wellington, Nelson, Christchurch, Dunedin, and Invercargill. We would like to thank the people who shared their views and stories with us—both in written submissions and at oral hearings.

We heard from a very wide variety of submitters including individuals, families, groups of individuals, and organisations. Some submissions came from overseas. About 200 submissions came from organisations.² Submitters included health service users, doctors, nurses, health practitioner professional colleges, hospices, disability organisations, and other health sector providers, church and religious groups, scientific groups, not-for-profit organisations, lobby groups, and legal organisations. Many individuals shared personal stories with us about themselves or a loved one.

About 36,700 of the written submissions contained a discernible view. Of these, about 90 percent opposed the bill and about 8.5 percent supported it. We note that the majority of written submissions discussed only whether assisted dying should be allowed in principle.

We summarise submitters' views below. They include views on assisted dying generally and, where applicable, on specific clauses in the bill.

We noticed a variety of language used by submitters when talking about concepts in the bill. For example, many submitters preferred to use the terms "suicide" or "euthanasia" over "assisted death". Many submitters took issue with the bill's use of the word "medication". They felt that medication intrinsically means something is therapeutic rather than lethal. Alternatives included "lethal drug", "toxin", and "poison". To help emphasise the messages that we heard from submitters, we have sometimes in this commentary used their words rather than the terms in the bill.

Views from various groups of submitters

As noted earlier, we heard from a wide variety of submitters. We have grouped below some of our observations on submissions by the type of submitter. As mentioned earlier, about 90 percent of submissions were opposed to the bill. However, we did not conduct a detailed analysis of submissions by type of submitter, so we cannot assign proportions to the views held within each of the groups.

Health professionals

Health professionals held a wide range of views on the bill.

Doctors

Many doctors submitted that they do not support the bill in principle because they believe that doctors have an obligation to preserve life. The New Zealand Medical Association considers assisted dying unethical. However, it acknowledged that the medical community has a range of opinions on the bill.

We heard concerns from doctors about the risk of complications in the administration of assisted dying. For example, some doctors doubted doctors' abilities to predict trajectories and timeframes of conditions to an acceptably accurate degree. Those who raised this issue were troubled by the weight of responsibility that might be placed on

² Organisational submitters are listed in Appendix B of this report.

doctors, and the potential impact on people's trust in doctors. Others had confidence in doctors' abilities to make the necessary judgments about conditions.

Some doctors support the bill on the grounds of compassion. They told us they have seen patients in terrible pain and have known there is nothing more they can do for those patients. We also heard the sentiment that some doctors themselves would never want to live with certain conditions, knowing what those illnesses can involve.

Some GPs, including the Royal New Zealand College of General Practitioners, were concerned that the definition of "medical practitioner" was too broad, and could include branches of medicine ill-suited to assisted dying. Some of the college's members supported GPs having a role in assisted dying, while others considered it should remain outside of general practice.

The college also argued that there should be a requirement for a medical practitioner to have practiced medicine for a minimum amount of time before being eligible to perform euthanasia. Some GPs also raised concerns over potentially having to refer a patient to a participating medical practitioner. They questioned how this requirement would interact with the right to conscientious objection to participating in assisted dying.

Some medical professionals were concerned about the impact of the bill on mental health and suicide. The New Zealand Medical Council submitted that legal euthanasia could contribute to normalising suicide.

Psychiatrists and psychologists

We heard concerns about the requirement for a psychiatrist or psychologist to assess whether a person requesting assisted dying could understand the nature of assisted dying and the consequences of it. The New Zealand Psychologists Board submitted that not all practising psychologists would be sufficiently qualified and experienced to assess competence in the context of assisted dying.

Some psychologists and psychiatrists believe the bill should include a mandatory role for them to assess all candidates for assisted dying, to ensure that mental competence is properly assessed.

The Royal Australian and New Zealand College of Psychiatrists said that the bill should specifically exclude people with mental illness from being eligible for assisted dying.

Nurses

Nurses held a diverse range of personal and professional views on the bill. We heard that nurses were disappointed that the bill is silent on the roles and responsibilities of nurses. They said that they will inevitably be involved with providing services for people who seek assisted suicide if the bill is passed. Nurses submitted that the bill should include nurse practitioners by referring to "health practitioners" instead of "medical practitioners".

Palliative care workers

Some palliative care professionals acknowledged the complex boundaries between current palliative practices and assisted dying. We heard from palliative care professionals who believe that assisted dying is in conflict with the basic principle of palliative care, which is to “neither hasten nor postpone” death. However, some palliative care professionals who support the bill said that some conditions cannot be alleviated with palliative care and assisted dying should be an option in these cases. At the same time, some palliative care professionals who acknowledged untreatable suffering said that this affects a minority of cases and an assisted dying law should not be created to cater for these cases. Some palliative care professionals shared stories of patients spending time with loved ones at the end of their lives, describing this as a special experience that they would not want to see compromised by assisted dying. Many people submitted that palliative care should be better resourced and more accessible, and that if this were to happen, demand for assisted dying would decrease.

Aged care professionals

We heard from aged care workers who were concerned about family members manipulating and coercing elderly people. Submitters were concerned that people who could gain from an elderly family member’s death might pressure them into asking for assisted dying.

We also heard that elderly and sick people can often feel they are a “burden” to their family, and could feel pressured to choose assisted dying.

Some aged care professionals expressed the preference that if the bill were to pass into law, they would not want assisted dying taking place on the premises of their workplace.

Hospices

We heard from many hospices around New Zealand that opposed this bill. They argued that it was inconsistent with the hospice philosophy of palliative care. They supported patients’ choice in focussing on a quality of life that included ending treatment, but believed good care and properly administered medication ensured people did not suffer. They believed euthanasia would detrimentally affect their relationship with patients and families and did not believe it would be compatible with their work to provide euthanasia at a hospice.

Disabled people

We heard several submissions that it might not be possible to identify and implement safeguards to sufficiently protect disabled people from harm. The Disability Rights Commissioner submitted that making people with non-terminal illnesses eligible for assisted dying is not consistent with a human rights approach to legislation. We also heard that disabled people could be more vulnerable to coercion.

Some disabled people held the view that their lives would be devalued if the bill was interpreted to mean that they would be eligible for assisted dying because of a condi-

tion that causes them to be disabled. Others, particularly those with degenerative disabilities, submitted the contrasting argument that being excluded because they are disabled is discriminatory.

Some disabled people were particularly concerned about being classified as a person suffering from a “grievous and irremediable medical condition”, and therefore automatically being eligible for assisted dying under clause 4 of the bill.

Seriously ill people and their families

Some seriously ill people support the bill for a number of reasons. Some consider that assisted dying could prolong their lives. These seriously ill people told us that they already planned to commit suicide to prevent future suffering, but would have to do this when they were still relatively healthy in order to still have the physical capacity to carry out the act. They submitted that, with legal assisted dying, they would be alive for longer, because of the option of having someone assist them to die. This would also mean they could die more peacefully and with family around.

Other people with conditions who expected to become seriously ill in the future supported the bill because they did not wish to experience intense suffering. Some of these included individuals who were not yet sick but had serious genetic conditions that would make them sick in the future. These submitters expressed fear of the future that awaits them.

Others described the experience of being seriously ill and then recovering unexpectedly. These submitters were concerned that they may have chosen assisted dying if it were available at the time.

Some individuals who had experienced serious illness submitted that suffering is an important part of the human experience, which would be compromised by assisted dying.

We heard from individuals who had family members who were seriously ill or who had died from serious illness. Some of these submitters were opposed to assisted dying, arguing that it would have shortened their time with their loved ones. On the other hand, some submitters supported assisted dying after having witnessed the suffering of their loved ones.

The submissions from seriously ill people and their family members, both those for and against the bill, were heart-felt and often very moving. We thank these submitters in particular for sharing their experiences with the committee.

Faith-based submitters

As mentioned earlier, several groups were opposed to the bill for religious reasons. Many of these submissions referred to the sanctity of life, the view that only God should decide the timing of life and death, and the concern that euthanasia and suicide are morally wrong and contrary to religious teachings.

Common beliefs expressed about assisted dying

Many views about whether assisted dying should be allowed were motivated by submitters' beliefs about maintaining life, autonomy, dignity, and compassion. We discuss these views below.

Attitudes towards maintaining life

Some submitters who oppose the bill and the principle of assisted dying believe that life is sacred and should be protected in all cases. Conversely, many supporters of the bill consider that the quality of a person's life may be more important than its length. They argue that each individual should determine whether their life has quality.

Supporters of the bill consider that assisting in the death of another person is justified when it is for altruistic reasons and a person has given free and informed consent. Many who oppose the bill believe that it is always wrong to assist in the death of another person, including in the situations listed in the bill.

Many submitters who opposed the bill on religious grounds told us that God should decide the timing of life and death. We were often referred to theological and biblical quotes, including the commandment "thou shall not kill", to show that assisted dying is incompatible with a submitter's religion. Many of these submitters believe that taking a person's life or helping them to commit suicide is a sin. They were concerned about the spiritual repercussions for those involved.

Submitters have contrasting views about what is meant by a natural death. Some submitters consider that assisted dying is unnatural and that people should live their life until death naturally occurs. However, others believe there is little difference between assisted dying and other ways of dying, such as palliative sedation.³ Others observe that, because modern medical treatment extends people's lives, most deaths could no longer be considered natural, regardless of whether assisted dying was used.

Autonomy

Most supporters of the bill consider that assisted dying provides personal choice and autonomy for the end of a person's life. Many supporters believe that individual autonomy and self-determination are the foundations of modern New Zealand society. They maintain that people should be free to make their own choices about how they die. Some supporters argue that this choice is a human right.

Some supporters consider that having access to assisted dying does not necessarily mean that people will choose to use it. Rather, they state that it can ease people's fears about death by letting them know that a legal option to end their life is available should their pain and suffering become intolerable.

³ The Australian and New Zealand Society of Palliative Medicine defines Palliative Sedation Therapy as "the monitored use of medications to lower a patient's awareness in order to provide relief of symptoms that are refractory to usual measures, are distressing, and result in considerable suffering if unrelieved".

However, many submitters consider that personal autonomy must be balanced with the needs of other people and the wider community. They submit that, because humans do not live in isolation, it is necessary to restrict an individual's autonomy to ensure the safety and wellbeing of the community. We often heard that the bill should not be passed because it would benefit only a few people while being detrimental to many.

Dignity

Submitters have different views about the meaning of dignity and what a dignified death means. Many supporters of the bill consider that people should not have to die in a way that they deem undignified. They believe that assisted dying is a way of achieving this. Supporters of the bill often linked dignity with maintaining their independence, choice, and control.

Some submitters who oppose the bill believe that all deaths are dignified, irrespective of a person's circumstances or their perceived quality of life. Many of these submitters are offended by the concept of an undignified death, particularly when articulated as a loss of independence, control, or choice.

Other opponents of the bill believe that deaths are always undignified. They consider that the stated purpose of the bill—allowing people to end their life in peace and dignity—cannot be achieved.

Compassion

Despite their differences in opinion, many submitters acknowledged that the views of both sides are motivated by compassion.

Some supporters consider that assisted dying is compassionate when people live with unbearable suffering or indignity. They often described it as inhumane, and the equivalent of torture, when a person has to continue living under these conditions. Submitters frequently provided examples of witnessing loved ones experiencing unbearable suffering or indignity.

In contrast, submitters who oppose the bill consider that euthanasia is not a compassionate response to a person's suffering. Instead, they advocate treating, caring, and supporting people with love. These submitters often discussed their experiences of caring for a loved one.

Some supporters of the bill used animal euthanasia as an example of society accepting that it is compassionate to assist in another's death in some cases. We heard many submitters' experiences of euthanising a pet, and they asked why their family and friends who were suffering did not have the same option. However, submitters who oppose the bill do not consider that animals are a valid comparison. Many of these submitters view animals as property, with different considerations involved in deciding about euthanasia. Further, many submitters with faith-based beliefs believe that, because humans were created in the image of God, they have more inherent value than animals.

Several opponents of the bill consider that the bill is contradictory. They believe that its eligibility criteria, which determine who could receive assisted dying, undermine the bill's compassionate intent. They queried why the criteria exclude certain people, even if they were experiencing unbearable suffering, such as those under the age of 18.

Attitudes towards the current framework

Belief that the current framework is sufficient

Most opponents of the bill consider that it is not needed because the existing medical and legal framework is working well. Those submitters said that the existing framework does provide for people choosing to decline treatment, and pain relief medication being administered, even if doing so brings forward the time of death.

Some submitters maintain that people do not need to experience unbearable suffering because modern medicine, which is constantly improving, provides adequate pain relief. Others acknowledge that there are still some cases of unbearable suffering. However, they consider there are too few of them to justify legislative change.

Many submitters argue that unbearable suffering can be alleviated in different ways. For example, a doctor can legally withdraw futile treatments, turn off life support, or administer palliative sedation. They can also give pain relief, such as morphine, when the primary aim is to relieve a patient's distress, even though it may also hasten death.

Some submitters consider that a person already has the autonomy to end their life by refusing medical treatment, nutrition, or hydration or by using a "do not resuscitate" directive.⁴

Others note that a person can already end their life when they choose to do so because suicide is not illegal. Many of these submitters believe that it is inappropriate to have other people assist in their death. However, some opponents of the bill consider that the law is sufficiently lenient for people who do assist in the death of another person for compassionate reasons.

Belief that the current framework is inadequate

Most supporters of the bill believe that people are suffering under the existing framework. Some of these supporters consider that current pain relief is inadequate and that people should not have to suffer because of this.

Supporters of the bill acknowledge that ways already exist for people to end their own life should they wish to do so. However, they expressed concern that these methods often force people to die alone. They can also be painful and may take time. Further, some submitters believe that some terminally ill people are ending their life while

⁴ Section 11 of the New Zealand Bill of Rights Act 1990 provides that everyone has the right to refuse medical treatment.

they are still physically able to do so. These submitters expressed their dismay and grief about the consequent loss of time with their loved one.

Several supporters of the bill consider that assisted dying already occurs in New Zealand through the use of palliative sedation treatment and pain relief. Some of these submitters are concerned that these practices lack legal guidance. They believe that the bill would regulate assisted dying and require doctors' actions to be accountable and transparent.

Some supporters consider it inappropriate that a person who compassionately assists another person's death should have to go through the court system. They believe that relying on lenient sentencing is not an appropriate way of dealing with these issues.

Attitudes towards the state allowing assisted dying

Many opponents of the bill consider that allowing euthanasia is against the purpose and role of the state, which they perceive to be the protection of citizens and enhancement of their lives. However, some supporters maintain that the state and its laws are designed to respond to the needs and wants of citizens. They believe that people are suffering under the current framework, and therefore the state has a duty to ease this harm.

Many submitters argue that legislation should reflect the opinion of the majority. Whether for or against the bill, many submitters expressed the view that the majority of the New Zealand public favours their own position. Opponents of the bill often interpreted Petition 2014/18 of Hon Maryan Street and 8,974 others as demonstrating that the majority of the public opposes assisted dying.⁵ Supporters of the bill often cited public opinion polls as showing that that majority supports the bill or the principle of assisted dying.

Some submitters claim that Parliament does not have the right to decide whether the bill should pass. They believe a binding referendum should be held. Other submitters disagree with a referendum. They believe that the New Zealand public does not appreciate what the bill entails and that a referendum would not be able to capture their true views.

Some supporters of the bill view assisted dying as a natural step towards New Zealand becoming a more modern and liberal state. Some of them consider that this would align New Zealand with other modern, liberal states, such as the Netherlands and Belgium. However, other submitters believe that it is unnecessary to follow these jurisdictions because New Zealand is different from them.

⁵ That report can be found on Parliament's website at www.parliament.nz/en/pb/sc/reports/document/SCR_74759/petition-20140018-of-hon-maryan-street-and-8-974-others.

Palliative care

Palliative care is currently available for people of any age with a progressive, life-limiting condition. It aims to:

- neither hasten nor postpone death
- optimise a patient's quality of life by addressing their physical, psychosocial, spiritual, and cultural needs
- support their family, whānau, and other caregivers, both during the illness and after their death.

In New Zealand, district health boards (DHBs) and hospices provide palliative care in hospitals, aged residential care, private homes, and hospices. It is paid for by a combination of Government funding and charitable donations. In 2018, DHBs funded about half of hospice costs, with the remainder coming from public donations and hospice shops.

Many opponents of the bill consider that euthanasia and assisted suicide are unnecessary because palliative and hospice care is available for people at the end of their lives. Submitters frequently commented that they believe that New Zealand has one of the best palliative care systems in the world. However, many other submitters believe that sometimes the severity of a person's illness or condition means that no care is sufficient to relieve their pain.

Submitters expressed concern that access to palliative care and hospice services is inequitable across the country, particularly in rural areas, and services are underfunded and rely on the generosity of communities. Many submitters agreed that funding for palliative care should be increased and the services improved. Some submitters also proposed better education about the benefits of palliative care to encourage the public to use these services.

We were advised that the Ministry of Health's Palliative Care Action Plan 2017 aims to manage future demand and achieve the overarching goals in adult palliative care. A short-term goal is to better understand what palliative care is needed nationally. The ministry acknowledged that recent work has indicated shortfalls. It said that projected need will continue to exceed current service levels, access to palliative care is inequitable, and the quality of care varies across settings and regions. The ministry is developing indicative options to address these challenges.

Suicide

In New Zealand, suicide is defined as a death where there is evidence that the person deliberately brought about their own death. A coronial verdict is required for a death to be classified as suicide. More than 500 people die by suicide in New Zealand each year.

Submitters regard New Zealand's suicide rate as too high. Regardless of their views on the bill, many submitters believe that initiatives to prevent suicide should receive more funding and public education.

A major concern for some opponents of the bill is that legalising assisted dying validates suicide. If assisted dying becomes available, some submitters are concerned that suicide will be validated because death will be seen as an acceptable response when people are faced with suffering or hardship. They believe that suicide rates will increase and programmes aimed at suicide prevention will be undermined. Further, many opponents of the bill do not recognise a distinction between assisted dying and suicide.

Opponents of the bill are particularly concerned that the bill will negatively affect the suicide rates for Māori and Pasifika—who are disproportionately represented in suicide statistics—and for young people. Some submitters shared stories of people they know who had committed suicide and the emotional effect the deaths had.

Some supporters of the bill consider that assisted dying would reduce the suicide rate, particularly for people who are terminally ill or have a degenerative condition. This is because people will be able to choose the timing of their death, rather than being forced to commit suicide prematurely due to the fear of pain and losing the physical ability to end their life. We also heard that there has been no discernible reduction in suicide in jurisdictions that have introduced euthanasia.

Cultural considerations

Many submitters are concerned that the bill is based on a Western philosophy of valuing individual autonomy. Some opponents consider that the bill is ignorant or dismissive of other cultures and their values. In particular, some submitters are concerned that the bill is inconsistent with the values of non-Pākehā cultural groups within New Zealand. Submitters described these groups as being more collective, with an emphasis on family, community, and valuing life.

Māori tikanga

Although not all submitters who identified as Māori oppose the bill or consider it inconsistent with Māori tikanga (values), others have several concerns. Submitters described a Māori worldview where people are part of their whānau, hapū, and iwi, where care, respect, and reverence are shown for the elderly and terminally ill, and life and wairua (spirituality) are valued. Some believe that assisted dying would breach the tapu (sacredness) of the person and have spiritual consequences for those involved.

Some submitters consider that the bill would breach the Treaty of Waitangi. In particular, they cited the Treaty's underlying principle of tiaki (protection) of Māori values and, under Article 2, the concept of the taonga (treasure) of life.

Other submitters consider that the bill would contravene holistic models of Māori health, such as Te Whare Tapa Whā, which sets out four equally balanced foundations of Māori health: physical, spiritual, family, and mental.

Belief that the bill would contribute to discrimination in the health system

Some submitters believe that assisted dying would further contribute to discrimination and prejudice that already exists in the health system. They consider that Māori and Pasifika are less likely to be able to pay for health care, and that they receive lower standards of care and have less access to palliative care. Therefore, they believe these groups will be disproportionately more likely to request assisted dying than other groups.

Submitters also believe that these groups are less likely to be treated by health practitioners of their own culture or those who understand their world view. They regard it as important that health practitioners understand the correct procedures for tāngata māuiui (sick people), their transition to death, and the treatment of tūpāpaku (the deceased).

Consulting with non-Western cultures

Many submitters recommended that leaders of non-Western cultures be consulted about the bill and its potential effect on members of these groups. They noted that a written submission process may not obtain fully representative views from these groups. Some submitters observed that Māori tikanga concerning life and death will vary across the country, so wide-ranging consultation is important.

Eligibility criteria

Clause 4 of the bill describes the six criteria a person would have to meet to be eligible for assisted dying. Submitters commented extensively on whether the criteria are appropriate. Many opponents of the bill consider the criteria too wide and vague, while supporters believe they are adequate.

Age

Clause 4(a) provides that a person would have to be aged 18 years or over to be eligible for assisted dying. Submitters have different views on whether the age limit is appropriate, or even necessary.

Some submitters said that teenagers cannot accurately make informed judgements, often experience fluctuating emotions, and can be impulsive and subject to peer pressure. Other submitters expressed concern that parents or guardians, rather than the child, would make decisions about assisted dying if the age limit was lowered.

Some medical organisations and many other submitters maintain that, at 18, a person has not yet reached full cognitive maturity. They observed that this may not be until the age of 25, particularly for males. Other submitters suggested that the age limit should be even higher, with recommendations ranging from 30 years to 50 years.

In contrast, some submitters propose that the age limit should be lowered. They consider that a person under the age of 18 should not be excluded from assisted dying because their suffering is no less valid. Ages suggested by submitters included 16 years (with or without parental consent) or under the age of 18 with support or independent representation.

Some submitters do not believe an age limit is needed. They consider that the other criteria in the bill would be sufficient to ensure that a person was capable of deciding whether to access assisted dying.

We note the Attorney-General's view that the age limit is inconsistent with section 19 of the Bill of Rights Act, under which everyone aged 16 or over has the right to freedom from age-based discrimination. The Attorney-General said that the inconsistency with the Bill of Rights Act would be resolved by reducing the age of eligibility to 16 or removing the age criterion from clause 4 and relying on the other criteria and safeguards in the bill.

Citizenship and residency

Under clause 4(b), only New Zealand citizens and permanent residents would be eligible for assisted dying.

Few submitters commented on this clause. Those who did consider it necessary to limit "euthanasia tourism". Some submitters believe the requirement is sensible but others consider it to be discriminatory and irrational. Other submitters would like more restrictions, such as continuously living in New Zealand for a certain period.

Condition of a person wishing to access assisted dying

Clauses 4(c) to 4(e) are about the state of a person who wished to access assisted dying. They would have to meet all of the following criteria:

- suffer from a terminal illness that is likely to end their life within 6 months or have a grievous and irremediable medical condition
- be in an advanced state of irreversible decline in capability
- experience unbearable suffering that cannot be relieved in a manner they consider tolerable.

Many submitters consider that the terms used in these clauses are vague, subjective, and open to interpretation.⁶ To ensure that the criteria are consistently applied, many submitters recommended that definitions be included in the bill.

Terminal illness

Limiting eligibility to terminal illness

Some submitters consider that the term "grievous and irremediable" is a low threshold to meet. They submit that eligibility for assisted dying should be limited to people with a terminal illness. Some suggested that including grievous and irremediable conditions could be reconsidered when the legislation was reviewed 3 years after its commencement.

⁶ The terms commented on include "grievous and irremediable medical condition", "advanced state of irreversible decline in capability", "unbearable suffering", and "relief that is not considered tolerable".

However, other submitters believe it would be inadequate and cruel to limit assisted dying to those with terminal illnesses. They gave examples of conditions, such as motor neurone disease, which may not be terminal but can cause intolerable suffering.

Six-month prognosis

We heard several concerns about the provision in clause 4(c) that would require a person seeking assisted dying to be suffering from a terminal illness that is likely to end their life within 6 months.

Some submitters consider that it can be difficult for medical practitioners and specialists to accurately estimate life expectancy. They said that this could be due to errors or the nature of a medical condition. Submitters shared stories about themselves or people that they knew who had survived for longer than their initial medical prognosis. Some submitters suggested that prognoses would be more accurate within a three-month timeframe.

We also heard concerns about doctors misdiagnosing conditions. Some submitters said that this could lead to incorrect decisions about treatment, or people being euthanised or assisted to commit suicide unnecessarily. These people may have had more time to live, or could even recover. Submitters consider that these would be wrongful deaths and some queried whether medical practitioners would, or should, be liable in these cases.

Other submitters consider that easing a person's suffering should be prioritised and a specified life expectancy of 6 months could prolong avoidable suffering. They believe a fixed time limit does not acknowledge that many diseases and illnesses are unpredictable.

Grievous and irremediable conditions

Submitters are particularly concerned about what conditions might be considered grievous and irremediable under the bill. Some submitted that many common conditions would be covered because people would be eligible if they had a condition that was incurable and painful but not terminal. Examples of these include rheumatoid arthritis, chronic pain syndromes, cerebral palsy, and heart disease.

Examples of other conditions that some submitters also believe would be covered include asthma, diabetes, dementia, incontinence, gluten intolerance, grief, and loneliness. Some submitters believe that the Netherlands and Belgium have expanded their eligibility criteria to include such conditions.

We were advised that the Canadian legislation defines a person as having a grievous and irremediable condition if they meet several criteria. The criteria are listed later in this commentary, in our description of the Canadian legislation.

Concerns that bill would allow people with disabilities to access assisted dying

Numerous submitters expressed concern that people with disabilities and degenerative or chronic conditions would be eligible for euthanasia or assisted suicide under

this bill. They believe that this promotes a message that the lives of these people are less valuable and not worth living.

Some submitters who represent disability groups reported that some people already view the lives of people with disabilities as being undignified. If the bill was passed, they anticipate that society's attitudes towards people with disabilities would deteriorate. Submitters are concerned that society may begin to consider these people a burden and coerce them into asking for euthanasia or assisted suicide.

Further, some submitters believe that fewer resources would be allocated to people with disabilities or degenerative or chronic conditions. Some submitters are concerned that the state would use assisted dying to save money on health costs. They were also concerned at the possibility of losing funding for research aimed at improving the quality of life for people with disabilities and curing conditions.

Some submitters consider that a person with a disability should never be able to access assisted dying. Other submitters suggested that the bill use the provisions in the Voluntary Assisted Dying Act 2017 (Victoria, Australia). Section 9(3) of that Act provides that a person is not eligible for voluntary assisted dying only because they have a disability.⁷

Conversely, other submitters consider that people with disabilities should have the same autonomy as able-bodied people to make decisions and choose assisted dying if they are eligible. We heard that any person who is suffering should not have to continue to live their life in pain if they do not wish to do so, and that it is inconsequential whether the person has a disability or a degenerative or chronic condition.

These submitters consider that knowing there is an alternative to suffering would be a huge relief. They note that people who are suffering would not have to use assisted dying but they would have it available to them as an option.

Concerns about people with mental illness accessing assisted dying

Submitters noted that suffering is not limited to physical pain and can include other pain, such as psychological, social, and spiritual. Most submitters consider that only physical pain should constitute suffering.

Many opponents of the bill are concerned that people who suffer from mental illness would be eligible to access assisted dying. Depression was the condition most frequently mentioned. Submitters said that mental illnesses may only be temporary, and can be easy to hide and difficult to diagnose. They also argue that people with mental illness lack the competence to make decisions about suicide.

Most submitters consider that mental illness is not a legitimate reason for allowing assisted suicide or euthanasia. Many submitters suggested that, if the bill progresses, it should be made clear that mental illness on its own is not a criterion. Some submit-

⁷ We provide a summary of the Victorian law later in this commentary.

ters believe that people suffering from, or with a history of, mental illness should not be able to ask for assisted suicide or euthanasia.

Instead, these submitters believe that people suffering from mental illness should be supported and cared for. Submitters often shared stories about how they, or a loved one, had wished to end their life by suicide while suffering from a depressive episode. These submitters told us that they are now grateful that they, or the person, did not end their life.

However, other submitters maintain that people who meet the other eligibility criteria should not be prevented from accessing assisted dying if they suffer from a mental illness. Many of these submitters believe that unbearable suffering often makes people depressed and mentally ill. They consider that preventing people with mental illness from accessing assisted dying would exclude the people who need it the most.

Some supporters of the bill argue that people with mental illness should be eligible for assisted dying. They consider that excluding those with mental illness is discriminatory and diminishes the pain people with mental illness have.

Expanding the eligibility criteria at a later date

Many submitters are concerned that, if the bill were passed, the eligibility criteria would later be expanded to include people not eligible under the current bill. They are particularly concerned that assisted suicide and euthanasia could become available for those with a mental illness or psychiatric condition and children under the age of 18.

Other submitters support the criteria being expanded over time. These submitters believe that all people who are suffering should be able to access assisted dying, regardless of their age or whether the suffering was physical or mental.

Submitters who oppose the bill commonly referred to the Netherlands and Belgium as examples of other countries that have wider eligibility criteria. However, many supporters of the bill view the experiences of overseas jurisdictions positively. They believe that other jurisdictions demonstrate that the criteria and application of the legislation could only be expanded by democratic process.

Opponents of the bill are concerned that euthanasia would be normalised and the eligibility criteria relaxed in practice. These submitters commonly give the Contraception, Sterilisation, and Abortion Act 1977 as an example of legislation that they consider has expanded in scope.

Many submitters also consider that, in the future, the legislation could be interpreted to allow the killing of patients without their consent. In particular, they expressed concern for people who are incapacitated or those who are unable to communicate due to a disability or medical condition. However, some supporters believe that the bill does not propose, and would never provide for, assisted dying without a person's consent.

Competence

To be eligible for assisted dying, clause 4(f) of the bill would require a person to be able to understand the nature of assisted dying and the consequences for them of assisted dying.

Submitters who commented on this clause agree that it would be important to assess a person's competence before they were eligible for assisted dying. However, some noted that this clause would exclude only a small group of people who were unable to understand that assisted dying would cause their own death.

Submitters, including doctors, note that determining whether a person is competent is complex, challenging, and subject to error, and no absolute test for capacity is available. They said that a person's competence can vary daily, particularly if they are suffering from a terminal illness.

Some submitters are concerned that medical practitioners may not have the expertise or experience to assess whether a person is competent. We heard submissions, including from some medical practitioners, that an assessment of capacity often involves input from, and assessment by, other medical practitioners, such as geriatricians or psychiatrists.

Many submitters expressed concern that medical practitioners' usual obligation to assess whether a patient can make decisions about medical treatment would be replaced under the bill with a lower standard. They are particularly concerned that the clause would not require an assessment of informed consent. Several submitters believe that the clause is inconsistent with the Code of Health and Disability Services Consumers' Rights⁸, such as Right 6 (the right to be fully informed) or Right 7 (the right to make an informed choice and give informed consent). Submitters highlighted other jurisdictions, such as Canada, which include informed consent as part of their eligibility criteria.⁹

Some submitters questioned whether a person diagnosed with a terminal illness or serious condition would be competent to make decisions about assisted dying. Some submitters believe that a terminal diagnosis will always result in depression and suicidal thoughts, limiting a person's capacity to make decisions.

Others expressed concern that a person being treated for a disease may already be under the influence of pain medication, which could be mind-altering and lead to suicidal ideation. Many of these submitters believe that people who have suicidal thoughts may be, or appear to be, competent to make decisions.

However, some submitters disagree with these arguments. Some submitters with terminal illnesses were uncomfortable with the idea that they could be unable to make their own decisions simply because they were ill.

⁸ The Code can be found at www.hdc.org.nz/your-rights/about-the-code/code-of-health-and-disability-services-consumers-rights/.

⁹ The relevant law in Canada is set out below, in our discussion on international jurisdictions.

Submitters identified two areas related to competence that they believe should be clarified in the bill. They commented that the bill is unclear about what would happen when a person is only competent to make decisions about some areas of their life. Submitters also said that the bill is unclear about what would happen when a person requesting assisted dying lost competency during the process. They suggested that a further test of competence before a person received the lethal dose of medication should be required.

Advance directives

The Code of Health and Disability Services Consumers' Rights defines an advance directive as a:

written or oral directive (a) by which a consumer makes a choice about a possible future health care procedure; and (b) that is intended to be effective only when he or she is not competent.

Right 7(5) of the Code provides that every consumer may use an advance directive in accordance with the common law.

Submitters queried whether advance directives could be used to give consent under clause 4(f). Some submitters support their use. They believe that advance directives would allow people to end their life with autonomy and choice, even where they were not competent or became incompetent during the process. Other submitters expressed concern that advance directives might undermine consent. This is because people might have changed their minds but would be forced to continue with the plan they made while they were competent.

Some submitters noted that, under the Protection of Personal and Property Rights Act 1988, an enduring power of attorney can be used to make decisions on behalf of people who are not competent to make decisions. They are concerned that, if the bill were passed, some decision-makers could abuse this process and decide that it was in a person's best interests to request euthanasia.

Role of health practitioners in assisted dying

Submitters had a range of views about which health practitioners should be involved in administering assisted dying. Most submitters believe that a medical practitioner (doctor) would perform the role of attending medical practitioner as defined in clause 3. However, some submitters claim that nurses could be the medical practitioner or assist in a person's death, regardless of what is stated in the bill.

Concerns that assisted dying will undermine medical practice

Many opponents of the bill are concerned at the prospect of doctors being involved in assisted dying. Many consider that the bill is medically unethical and incompatible with the Hippocratic Oath and the commitment to do no harm. These submitters often referenced statements from the World Medical Association, the New Zealand Medical Association, and other medical organisations to support their position.

Some submitters believe that assisted dying is not health care and that the role of a medical practitioner is to heal and care for patients. They consider that being involved in euthanasia or assisted suicide would undermine that role. However, some supporters of the bill suggested that assisted dying better respects patient autonomy and helps the health sector to reduce suffering.

Submitters believe that the bill would negatively affect a medical practitioner's relationship with their patients by reducing trust. We heard that people might fear that their medical practitioner would try to pressure them into assisted suicide or administer euthanasia without their consent.

Further, submitters said that medical practitioners might no longer act in the patient's best interest and their motivation to heal and care for patients would decrease. Some submitters argued that funding for, and research into, terminal illnesses, pain relief, and palliative care would be reduced and discouraged as euthanasia would become a cheaper way of easing suffering.

In contrast, some supporters of the bill maintain that assisted dying would enhance medical and palliative care. They believe patients would be able to discuss their views about end-of-life care and death more openly and honestly with medical practitioners.

Concerns about how the health workforce would be affected

Some opponents of the bill are concerned about the psychological effect on medical professionals who administered assisted dying. They believe their mental health could be affected both in the short and long term. Additionally, euthanasia and assisted suicide would add stress and an unwanted burden to what submitters view as an already over-burdened sector. Submitters often commented about the effect of euthanising animals on veterinarians' suicide rates.

Some submitters who oppose the bill are concerned that, if passed, it might divide the medical sector as people adopted strong positions on either side. They claim that it could become difficult to recruit and retain staff in the medical sector.

Many believe that most health practitioners would not want to assist in a person's death. Some submitters said that they, or people they know, would leave the medical profession or refuse to comply with the procedures if the bill was passed. Some submitters who identified as medical students maintain that they would reconsider entering the profession. Some of these submitters questioned whether the conscientious objection provisions in the bill would be effective. They are concerned that medical practitioners would be compelled to participate in assisted suicide and euthanasia by their patients, family and friends, or work places.

In contrast, other submitters consider that the conscientious objection provisions would be sufficient to allow medical practitioners who oppose assisted dying to remove themselves from the process. Further, some submitters who identify as health practitioners said that they would be willing to offer assisted dying if the bill were passed.

Alternatives to health practitioners being involved

Some submitters proposed organisations and positions as alternatives to health practitioners participating in assisted dying. They included lawyers, judges, members of Parliament, the Family Court, or establishing a special role. Several submitters also suggested that assisted dying should only be performed by a group of specially trained people.

Conscientious objection

Clauses 6 and 7 of the bill set out the mechanism that would allow a conscientious objection to be exercised. Clause 3 defines a conscientious objection as “an objection to doing anything authorised or requested by this Act”.

Many submitters support the intent of these provisions in the bill. Many others consider that the provisions are unsatisfactory.

Clause 7(2) would require the attending medical practitioner to tell the person that:

- (a) the medical practitioner has a conscientious objection; and
- (b) the person may ask the SCENZ Group for the name and contact details of a replacement medical practitioner.

Some submitters are concerned that a medical practitioner who conscientiously objected might be criminally liable or imprisoned if they did not comply with either, or both, of these provisions. They perceive this as coercive.

Some submitters consider that clauses 6 and 7 do not provide for true conscientious objection because a medical practitioner would still be required to participate in the person’s death. Submitters consider that some medical practitioners would be forced to choose between complying with the law and maintaining their own values.

Referring a person to the SCENZ Group

Some submitters firmly believe that a medical practitioner should not be obliged to refer the person to the SCENZ Group. This would be making them participate in a system they objected to. They recommend that clause 7(2)(b) be removed from the bill.

Other submitters proposed alternatives to clause 7(2)(b), including these options:

- The details of the SCENZ Group could be made publicly available—for example, on the medical practice website, or in pamphlets in medical waiting rooms.
- Medical practitioners who conscientiously objected could register their objection with a government body such as the SCENZ Group. A person wishing to request assisted dying would have access to the register.
- Medical practitioners willing to provide assisted dying services could opt in, rather than the proposed mechanism of opting out.

However, other submitters support the requirement for a medical practitioner to refer a person to the SCENZ Group for the name and details of a replacement. These sub-

mitters do not believe the onus should be on a person to find a suitable medical practitioner because it would add to their stress. Additionally, some people who were extremely unwell might not be strong enough to continue to seek help if a medical practitioner refused them without giving them a referral.

Submitters' other concerns about conscientious objection

Submitters raised numerous, often contrasting, concerns about the conscientious objection provisions. They contend that:

- The scope of the objection is too narrow and should include anyone who might be involved in the assisted dying process, such as nurses or healthcare assistants.
- Clause 6(1), which allows “a person” to object, is too broad. They believe it would allow people mentioned in the bill, such as the Minister responsible for the administration of the legislation or the Director-General of Health, to object to their roles.
- Conscientious objection should be extended to organisations, such as hospices. This would allow them to object to their premises being used for assisted dying.
- Conscientious objection should only be used by an individual and the provisions to this effect should be made clearer in the bill. This would prevent situations experienced overseas where faith-based institutions have banned their staff from participating in assisted dying.
- Medical practitioners should be assured that they could assert their right to conscientious objection at any stage of the process. This would acknowledge that a medical practitioner’s conscience could change during the process.

Submitters also noted the lack of a provision to prohibit discrimination against medical professionals who had a conscientious objection. They are concerned that these people could be screened out of medical school, not hired for medical roles, or pressured to provide information about euthanasia and assisted suicide. On the other hand, some submitters expressed concern that medical practitioners who support assisted dying could experience discrimination within their organisation.

Concerns that assisted dying might become commercialised

Some submitters are concerned that euthanasia and suicide would become commercialised. They consider that the bill would allow pharmaceutical companies or medical professionals to make money, which would act as a disincentive to preventing unnecessary deaths. These submitters do not believe that any person involved in assisted dying should receive any additional financial benefit for their services.

Others argue that people who are very sick should not be dependent on a system where companies profit from people experiencing slower deaths and suffering unbearably for longer.

Coercion

Some submitters interpret the bill as providing for euthanasia without consent. Many of these submitters believe that people could be killed with the consent of their family, medical practitioners, or the state. Other submitters interpret the bill as only requiring consent at the start of the process. They believe that people would not be able to change their minds during the process.

Many other opponents of the bill believe that the bill would clearly require the individual's consent. However, they are concerned that this consent might be coerced, either inadvertently or intentionally.

Fear of becoming a burden

Submitters expressed concern that people might choose euthanasia or suicide because they feared they were a burden to family, caregivers, the health system, or society. They maintain that when people realised they were eligible for the process, their self-worth could decrease and they might feel subliminally pressured to request it. Submitters often describe this as feeling a “duty to die”.

Other submitters believe that people might feel pressure to choose euthanasia to end the emotional suffering of loved ones who were watching them at the end of their life.

Submitters consider that these fears could easily be magnified by the actions and words of those around them. Submitters noted that this coercion can be subtle and often unintentional, making it impossible to detect.

Opponents of the bill are concerned that family, friends, and caregivers might intentionally coerce a person by encouraging them to access euthanasia or assisted suicide to eliminate the time, financial, or emotional burdens of caring for them. Submitters are particularly concerned about elderly people being coerced. Some shared personal stories and highlighted elder abuse statistics, which they expect would rise if the bill was passed.

Coercion for financial reasons

Some opponents of the bill are concerned that people would be coerced into requesting euthanasia or assisted suicide for financial reasons. They include:

- being unable to afford medication or treatment that might prevent or alleviate their suffering
- wanting to save their financial resources for family and friends
- unscrupulous family members encouraging a person to access an earlier death to gain inheritances or limit the money being spent on care.

Coercion from medical practitioners

Submitters had numerous concerns about the potential for medical practitioners to coerce people to access euthanasia or assisted suicide:

- Medical practitioners who volunteered to participate would be those biased towards allowing it.

- Over time, medical practitioners might take less care in completing the process because they became more relaxed or mentally affected by the process.
- A person would not question a medical practitioner's suggestion to access euthanasia or assisted suicide because of the high level of trust they place in their medical practitioner.
- Medical practitioners might not recommend, or make clear, that a person has other options available.
- A medical practitioner might encourage euthanasia or assisted suicide when they were unable to treat a patient's condition further, even though another practitioner might be able to do so. These submitters view a person's choice as depending heavily on the advice and expertise they receive from medical practitioners.
- The state might encourage assisted dying to lower health care costs, particularly in the future when submitters expect the health care system to face increased demand.
- Assisted dying might become commercialised and medical practitioners might start their own businesses providing it. Therefore, medical practitioners might encourage assisted dying for their own financial benefit.

Safeguards

Some opponents of the bill are concerned that New Zealand could become more tolerant of assisted suicide and euthanasia over time. They argue that non-compliance with the safeguards would increase. Many of these submitters referenced the Contraception, Sterilisation, and Abortion Act. They claim that the restrictions on accessing abortion that were expected when the legislation was introduced are no longer being complied with. Submitters stated that women can easily obtain an abortion by falsely claiming mental health issues.

Safeguards when a person initially requested assisted dying

Clause 8(2)(a) to (h) of the bill specifies the information that an attending medical practitioner would have to provide to a person who requested assisted dying.

Many submitters consider the safeguards in this clause inadequate, particularly for patients who may be vulnerable to coercion. Submitters are concerned that the requirements would become a "rubber-stamping exercise" with self-reporting by the medical practitioner being the only accountability. To strengthen the safeguards, submitters' suggestions include the following:

- A second independent medical practitioner should be involved at the time of the request.
- An independent body, such as the SCENZ Group, should manage the request process.
- The initial request should be made in writing or videoed.

- A person requesting assisted dying should immediately be referred to a counsellor, social worker, psychologist, or psychiatrist to exclude conditions such as mental illness and depression.
- Detailed guidance should be developed containing the information that an attending medical practitioner would have to provide to a person requesting assisted dying. Submitters suggested that the resources be disease-specific, evidence-based, and publicly available.

Submitters strongly support the requirements for the attending medical practitioner to ensure that a person understands their other options for end-of-life care and that they can change their minds at any time. However, some submitters note that these requirements all entail competence. They consider that the bill is unclear as to whether a person would be eligible for assisted dying if they did not understand them.

Ensuring a person was free from coercion

Under clause 8(2)(h), the medical practitioner would have to do their best to ensure that the person seeking assisted dying was free from pressure from anyone else. They would do this by talking with other health practitioners who are in regular contact with the person; and members of the person's family, with the person's approval.

Many submitters consider that this threshold is low, subjective, and would not ensure the absence of coercion, particularly for vulnerable people. They report that coercion can be difficult to recognise and subtle, and medical practitioners may not have the time or expertise to identify it. Although some submitters suggested that other medical professionals could be used to assess and protect against coercion, many others believe that no safeguards could ever be sufficient.

Submitters argue that if a person is being coerced by family members, the person is unlikely to give approval for the medical practitioner to talk with those family members. They also consider that the bill is unclear about what would happen if coercion was determined, and whether it would result in a person being ineligible for assisted dying.

Confirming the request

Under clause 9, the attending medical practitioner would have to give a prescribed form to a patient wishing to proceed with assisted dying. The patient would sign and date the second part of the form in the presence of the attending medical practitioner. If they could not write, the form could be signed and dated on their behalf and in their presence. The person signing on their behalf could not be:

- a health practitioner caring for the patient
- an individual who knows that they stand to benefit from the death of the patient
- a person under the age of 18 years
- a person with a mental disability.

Although some submitters support having the request confirmed in writing, others believe that the process could be easily abused. They suggested that someone could

sign on behalf of the patient without their consent or knowledge, and that it would be difficult to prove whether an attending medical practitioner was present.

To mitigate the risk of abuse or deception, some submitters suggested that a person should not be allowed to have a form signed on their behalf. Other submitters consider that the criteria are unclear about who would not be allowed to sign a form on a person's behalf—for example, “mental disability” is not defined. They also noted that it is difficult to prove whether an individual knows that they would benefit from the death of a person.

Medical opinions

Clauses 10 and 11 set out the two opinions that would have to be reached by the attending and independent medical practitioners. Clause 12 sets out the third opinion that a specialist (psychiatrist or psychologist) would have to reach if the attending or independent medical practitioners were unsure whether a patient was competent.

Submitters' views vary about how many medical opinions should be required. Some submitters consider it should be compulsory for a psychiatrist, psychologist, or mental health professional to assess whether a person was competent to make a decision about assisted dying. However, others said that a third opinion should only be required when there were clear signs that a person was not competent.

Several submitters commented that involving two medical practitioners would provide adequate safeguards, while a few submitters suggested that a second opinion would not even be needed.

However, many other submitters consider the safeguards inadequate. To strengthen them, some suggested that the independent medical practitioner should also complete the process outlined in clause 8.

Other suggestions from submitters included the following:

- A panel of medical practitioners with a range of specialties should provide the second opinion. Support could also be provided by a multi-disciplinary team that included palliative care specialists, chaplains, psychologists, and nurses.
- A process to appeal opinions should be created—for example, through the SCENZ Group or an independent appeal authority.
- A court should oversee or make decisions about whether a person was eligible for assisted dying.

Many submitters consider that it would be difficult to ensure the independence and impartiality of medical practitioners participating in assisted dying. This is because those participating would be those who support assisted dying and who might therefore be more inclined to make a positive decision.

Submitters also highlighted a potential risk for unethical practice and collaboration between attending and independent medical practitioners. To mitigate this risk, it was suggested that the SCENZ Group should not allow consecutive or repetitive pairings.

Many submitters maintain that the attending or independent medical practitioner should have a certain level of expertise or be a specialist—either in the condition of the person seeking assisted dying or in palliative care medicine. Other submitters proposed that the attending and independent medical practitioners should have different specialities and preferably be involved in the person’s care.

Some submitters had several concerns about the role of the specialist (psychiatrist or psychologist) providing the third opinion. We heard that the number of psychiatrists and psychologists in New Zealand is limited, and involving them in assisted dying would divert them from front-line mental health services. Submitters also noted that specialists are not often involved with dying patients and would need to be trained, and that the psychiatrist and psychologist roles are different. It was suggested that the third opinion should only be given by a psychiatrist with relevant experience, a psychogeriatrician, or a palliative care physician.

Effects on family and friends

Some supporters of the bill consider that assisted dying would be emotionally helpful for family and friends. Most of these submitters believe that family and friends often feel distressed when witnessing a loved one suffering unbearably or living in an undignified way. Submitters frequently told personal stories about watching someone close to them suffer at the end of their life. These submitters wished to alleviate the person’s suffering. Some submitters commented that they found it upsetting because they knew that their loved one wished to be assisted to die, but they were unable to fulfil that wish.

Supporters of the bill also consider that assisted dying helps family and friends grieve and feel a sense of closure, and allows them to be involved at the time of death. Several submitters described relatives who were terminally ill or suffering committing suicide alone. These submitters often experienced guilt and remorse for being unable to support their loved ones in their final moments.

In contrast, some opponents of the bill view the end of life as a valuable time for friends and family to spend with the person. They are concerned that euthanasia would shorten this time, thereby limiting a loved one’s time for grieving and closure. Submitters also noted that strained and distanced relationships are often healed during this time.

Others perceive that suffering can bring people closer to their religious or spiritual beliefs, which is an important part of the human experience. Some of them believe that suffering enhances a person’s life by teaching about hope, resilience, and gratitude. Submitters often gave examples about how they had changed as a person after spending time with somebody at the end of their life.

Concern about not being obliged to talk to anyone

Clause 8(2) of the bill would require the medical practitioner to:

- (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.

Many submitters strongly disagree with the proposal that a person would not be obliged to talk to anyone. They noted that family and loved ones often play an important role in caring for someone with a terminal illness. Submitters stated that if people understood what had motivated their loved one to request assisted dying, they might be able to offer additional or alternative support.

Submitters believe that those who would be affected by the death could be devastated if it was not discussed with them. They also noted that neighbours, social workers, district nurses, care providers, or extended family often raise concerns about coercion, influence, or psychological control.

Some submitters consider that meetings with family members, carers, and involved medical practitioners should be compulsory. However, other submitters disagree. They believe that the opinion of a person seeking assisted dying would be the only one that matters. Also, they suggested that a person can have more open discussions with their medical practitioner when family members are not involved.

Terminology used in the bill

Clause 3 defines several terms used in the bill. Several submitters commented specifically on the definitions.

Submitters often maintain that the term “assisted dying” is a euphemism and that the terms “suicide”, “assisted suicide”, “euthanasia”, or “killing” (or a similar term) are more appropriate. Some consider that the term “assisted dying” is inappropriate, offensive, or insulting to hospice palliative care workers whose role includes caring for someone who is dying.

Some said that the term “medication” in the definition is misleading. Alternative suggestions included “lethal drug”, “lethal dose” or “lethal quantity”, “toxin”, “poison”, “overdose”, and “death-dealing drug”.

Other submitters observed that the definition does not include the self-administration option set out in the bill. Some submitters recommend adopting the terminology of “assisted dying” and “euthanasia” used by the Health Committee in its 2017 report on Petition 2014/18 of Hon Maryan Street and 8,974 others.¹⁰

Although technically correct, submitters consider that the definition of “medical practitioner” is too broad. They believe that the bill should require a medical practitioner to have a minimum length of experience, be practising in specified areas of medicine, or have experience in the medical condition of the person seeking assisted dying.

¹⁰ That committee referred to “assisted dying” as “A patient receiving lethal drugs at their request, which they take by themselves” and “euthanasia” as “A patient being administered a lethal drug. This can be voluntary or involuntary”.

Process for assisted dying

Clauses 8 to 18 of the bill set out the process that medical practitioners would need to follow to give effect to a request for assisted dying. Below, we discuss submitters' views on the parts of the process that we have not discussed in previous sections.

Timeframes

Many submitters discussed the timing for the process in the bill. We note that most steps in the process do not have a set time frame and the whole process could take many months. The total time is mostly decided by the person requesting assisted dying, subject to the availability of the parties involved and the time they take to progress the steps.

Given that people seeking assisted dying are suffering, some submitters suggested that the processes should be followed with appropriate urgency and efficiency. Other submitters do not want a person to feel rushed or pressured into proceeding and want to minimise the chance of coercion. Some submitters suggested there should be cooling-off periods at various stages in the process.

Some submitters also suggested that the bill should specify that the process would be paused when a patient decided to stop at any time. This would prevent them having to begin the process anew each time. Submitters consider that this would maintain control and autonomy for the person and reduce any pressure to proceed in the process.

Requesting assisted dying

Under clause 8, the person wishing to have the option of assisted dying would have to tell their attending medical practitioner of that wish. Some submitters consider that the bill is unclear about whether a medical practitioner could initiate a discussion about assisted dying with a person. To protect against coercion by the medical practitioner, some submitters believe that only the patient should be allowed to suggest assisted dying.

Submitters noted a perceived conflict between the Crimes Act and the Code of Health and Disability Services Consumers' Rights. Section 179 of the Crimes Act criminalises inciting or counselling suicide. However, under the Code, a patient has the right to be fully informed, including receiving an explanation about their condition and of the options available. Submitters are concerned that a medical practitioner could breach the Crimes Act if they discussed assisted dying with a person. However, the medical practitioner could breach their obligations under the Code if they did not raise the option of assisted dying.

Negative decisions

Under clause 13, if the attending or independent medical practitioners determined that a person was ineligible for assisted dying, or the specialist determined that the person was not competent, they would need to explain their reasons to the person. This is called a negative decision and would end the process.

Most submitters agree that the reasons for a negative decision should be explained to a person. Some submitters believe that the explanation should be provided in writing for the person's reference and for the purposes of monitoring and review.

However, many submitters are concerned that people might visit different medical practitioners until they received a positive decision. Therefore, some argue that a person should not learn the reasons for a negative decision because it could give them information to manipulate another request.

Some submitters advocate including a minimum time frame for reapplying after a negative decision. Others believe there should be an appeal process for a negative decision.

Some submitters expressed concern that a person might be more likely to take their own life following a negative decision. Many submitters recommended that the attending medical practitioner should be obliged to arrange appropriate support after a negative decision. Examples suggested include palliative care, information about suicide prevention, psychological support, counselling, and other support services as appropriate.

Positive decisions

Clause 14 sets out the process that would be followed if a person was deemed eligible and competent for assisted dying. The attending medical practitioner would have to talk to the person about the likely timing for the assisted dying and make provisional arrangements to administer the medication.

Submitters are concerned that the bill does not clearly address who would be responsible for the patient's continuing care after a positive decision. Given the significance of the decision, submitters consider that the person should also receive psychological support. Some submitters suggested that such support also be available to family and friends.

Some submitters believe that family or close friends should be notified about a positive decision, with a written response required stating that they have no concerns with the process.

The assisted death

Clause 15 specifies the steps that would have to be followed for a person who was ready for an assisted death. They would have to tell the attending medical practitioner, who would have to inform them about the methods for the administration of a lethal dose of medication and ask them to choose a method—ingestion or intravenous delivery triggered by the person, ingestion through a tube, or injection. The medical practitioner would also have to ask the person to choose the time for the medication to be administered and ensure that the person knew that they could change their mind at any time.

At least 48 hours before the chosen time of administration, the medical practitioner would have to write the prescription for the medication, advise the registrar about the time and method chosen, and give the registrar the prescription. The registrar would

have to ensure that the steps in clauses 8 to 14 had been complied with before co-signing the prescription.

Clause 16 provides that, at the chosen time of administration, the attending medical practitioner would have to ask the person if they choose to receive the medication. If the person did not, the attending medical practitioner would have to remove the medication, return it to the pharmacist, and complete a prescribed form. If the person chose to receive the medication, the medical practitioner would have to provide it using the chosen method and remain available until the person died.

Some submitters support the options that the medicine could be either self-administered or administered by the doctor. They note that some people eligible for assisted dying would be unable to self-administer medication. Other submitters consider that self-administration is more ethically acceptable than a medical practitioner administering the medication.

Submitters are concerned that, when a person wished to receive the medication, the medical practitioner would not have to ensure that the person was competent and not being coerced. They contend that this undermines the other protections required in the bill. Submitters suggested that an impartial witness or second medical practitioner should be present to ensure the medication was administered at the request of the patient. Alternatively, the person could complete a form confirming their consent before they received or were administered the medication.

To minimise the risks from an adverse event, submitters suggested that a person with specialist training and expertise or an anaesthetist or palliative care medicine specialist should administer the medication. We also heard that clinical guidance would be needed to clarify the role of the medical practitioner in the event of a problem administering medication.

Some submitters who are employers believe there should be appropriate support to protect the mental health of medical practitioners participating in assisted dying. To reduce the emotional burden, submitters suggested that the medical practitioner administering the medication should not be the same practitioner who assessed the person.

The following other points were made in submissions on clause 15:

- The terms used in the clause are unclear. Examples include “administration”, “triggered by the person”, “providing it”, and “providing it to the person”.
- The definition of “available” should be narrowed to require the medical practitioner to be in the same room as the person to help if something went wrong.
- The requirement for the medical practitioner to be present might make a person feel pressured to complete the process.
- The 48 hours should be a maximum time frame and it would be impractical for a registrar to complete all the required steps within that time.
- The bill should require that the registrar’s approval to proceed be given expeditiously or within a specified time.

- The bill should allow a person to fill a prescription and store the medication until they decided whether they wished to use it.
- The bill should enable the medical practitioner to sedate the person before administering the medication if the person wished.

Reporting a death

Clause 17 would require the medical practitioner to send a report to the registrar within 14 days of the death. The registrar would have to send the report to the review committee.

Submitters consider it important to know what the information collected would be used for, who would have access to it and for what purposes, and whether it would be publicly available and subject to the Official Information Act 1982.

Some submitters would like additional demographic information to be collected. They provided examples including ethnicity, religion, usual residence, living situation, personal care services being delivered to the person, and primary health care provider.

Returning unused medication

If the person decided not to receive the medication, or died before the medication was used, clause 18 would require the prescription to be destroyed or the medication to be returned to the dispensing pharmacist for destruction.

Some submitters suggested that the medication should be dispensed, held, and administered under careful control to enable tracking at all times. Others said that the bill should specify the actual process for returning the medicine to the pharmacist and how they would dispose of it, particularly if the medicine was a controlled drug.

Administrative bodies

Clauses 19, 20, and 21 would establish three administrative bodies—the SCENZ Group, the review committee, and the registrar (assisted dying). Submitters who commented generally on the bill support oversight groups being established. They consider it important that the groups receive appropriate funding and resources.

However, other submitters are concerned that the checks and audits of the assisted dying process would only happen after a person had been assisted to die. They describe the accountability mechanisms as lacking detail and appearing weak.

Membership of the groups

Clause 19(1) of the bill would require the Director-General of Health to appoint the number of medical practitioners to the SCENZ Group that he or she considered appropriate. Some submitters agree with this provision but others argue that the number and composition of the group should be specified in the bill.

Many submitters believe that the SCENZ Group and review committee should consist of a range of health practitioners. Others suggested that the groups should include people with specific skills or knowledge, including those with cultural experience,

Māori, minority groups, and representatives of people with disabilities. Many also questioned why a medical ethicist would be compulsory on the review committee but not the SCENZ Group.

Some submitters consider that people who agreed to be on either group would be biased in favour of assisted dying. They are concerned that the groups might not be objective and could be inclined to broaden access to assisted dying. To balance the perceived bias, it was suggested that the group should contain some members who are opposed to assisted dying. Others suggested that the groups should be non-religious.

Other proposals about membership included establishing a pool of medical practitioners to approach to join the review committee to provide specialised advice, and setting time limits for membership.

Several submitters noted that the bill would not require the registrar to have any relevant experience or skills for the role, such as a medical background. Some submitters suggested that the registrar should be a judicial officer, at the level of District Court Judge or higher.

Powers and functions of the administrative bodies

Some submitters expressed concern that the bill lacks detail about how the administrative bodies would operate and what they would do. These submitters consider it unacceptable to have such uncertainty.

It was submitted that the administrative bodies would need more power. Submitters provided examples, including the power for the SCENZ Group to test, assess, and audit, and powers of inquiry or investigation for the review committee and registrar.

Some submitters would strongly support the SCENZ Group, or others, developing clinical guidelines for assisted dying. They consider that the guidelines should include information assessing an individual's competence, the main legal requirements, and expected standards of care for people seeking assisted dying. Submitters stated that the guidelines should be publicly available and only prepared after full consultation—for example, with the Medical Council of New Zealand, relevant vocational colleges, the Health and Disability Commissioner, and patient advocacy groups.

Some submitters consider that it would be more appropriate for the registrar to perform the administrative functions of the SCENZ Group.

Other matters related to administrative bodies

Submitters raised the following other matters:

- Many support establishing and maintaining a register of medical practitioners and pharmacists willing to act for the purpose of the bill. Some submitters suggested keeping lists of other health practitioners and people willing to address spiritual matters.
- Some submitters from the medical profession argue that the lists should be confidential to prevent medical practitioners coming under pressure to participate or not participate.

- Other submitters consider that the lists should be publicly available so people could make informed choices about who to consult.
- Many submitters believe that the annual report of the registrar to the Minister should be released publicly, and should include statistics and aggregated qualitative and quantitative information about how the bill was working.
- Rather than reporting to the registrar, some submitters suggested that the review committee should have to report annually about its overall activities and findings to the responsible Minister and the New Zealand public.
- Some submitters stated that the bill should specify the purpose of the registry of forms that would be established and maintained by the registrar. They also said the bill should allow for access to the registry and explain how the information would be used and shared.

Review of how the legislation was operating

Clause 22 would require the Ministry of Health to begin a review of the legislation's operation 3 years after its commencement. The review would have to be completed within 6 months. Subsequent reviews would begin every 5 years after the date of the last review.

Submitters suggested that the bill should contain more detail about the purpose of the reviews and what they should include. They believe that the reviews should:

- require public consultation
- involve the medical community
- include statistics and information about why people were requesting assisted dying so that targeted care could be introduced where possible
- be completed by an independent governance committee.

Submitters had different views about the timing of the reviews. Some submitters believe that the legislation should be first reviewed much sooner than 3 years after it commenced and more regularly than every 5 years. This is because the bill would have significant and irreversible effects. However, other submitters consider that specific timing should not be prescribed. They said that Ministers of the day may make decisions about priorities for officials and allocate resources to competing priorities.

Some submitters consider that 6 months might not be enough time for a full review and only the completion date should be prescribed.

Forms

Clause 23 would establish a form-based system to record compliance with the assisted dying process. These forms would be on a register administered by the registrar. The bill proposes eight forms (in clauses 9 to 13 and 16 to 18), the contents of which would be set out in regulations.

Few submitters commented on this clause. Some believe that the details of the forms should be included in legislation rather than regulations. Others consider that the

regulation-making power should also allow regulations prescribing the contents of annual reports of the administrative bodies that would be created by the bill.

Other submitters expressed concern about the amount of information that would be collected about a person. They believe there are privacy issues that should be considered by the Privacy Commissioner.

Effect of death

Clause 25 of the bill specifies that a person who died as a result of assisted dying would be taken for all purposes to have died as if assisted dying had not been provided. We were advised that this clause is similar to provisions for contractual and insurance purposes found in other jurisdictions that permit assisted dying. The intent of these provisions is to ensure that the assisted dying would not void a contract or prevent a payment or other benefit being made to the estate of the person.

Most submitters who commented on clause 25 strongly disagree with it being included. They consider that it is against principles of honesty, openness, and transparency and that its purpose is to hide the fact that a person was euthanised or assisted to commit suicide. Some submitters believe that it would allow or encourage these deaths to go unreported.

Some submitters focused on this clause's implications for insurance. They believe that having to pay out on a policy might give insurers an incentive to try to resist payment or otherwise try to circumvent the law. Other submitters consider that the bill could lead to increased insurance premiums, because payment on a life insurance policy would be more certain.

Death certificate

Submitters commented on how clause 25 would interact with clause 28, which would amend the information that must be recorded on a death certificate. The underlying medical condition, as if assisted dying had not been provided, would have to be recorded on the death certificate. The fact that the person died as a result of assisted dying would also have to be recorded on the death certificate.¹¹

Some submitters believe that clause 25 would override other clauses in the bill, including clause 28. They submitted that the death certificate should not state the cause of death as if assisted dying had not been provided. They believe that this would be fraudulent and would falsify the death certificate, and that it would result in incorrect reporting of deaths and inadequate review processes.

¹¹ Submitters' views on clause 28 are discussed in more detail later in this commentary.

Immunity in civil or criminal proceedings

Under clause 26, a person would be immune from liability in civil or criminal proceedings for acts or omissions in good faith and without negligence in providing or intending to provide assisted dying.

Some submitters are concerned that immunity from civil proceedings would override existing complaints and discipline regimes under the Code of Health and Disability Services Consumers' Rights and the Health Practitioners Competence Assurance Act 2003. These regimes allow complaints to the Health and Disability Commissioner about compliance with the code, and complaints to professional bodies to ensure competent practice under the Act.

Other submitters do not believe that the clause would override existing complaints and discipline regimes. Some argued that these regimes should be excluded from the bill so that they could not be used by relatives who were upset that their loved one had requested assisted dying and who wanted to criticise the medical practitioner involved.

Submitters expressed concern that clause 26 lacks clarity. For example, they questioned the meaning of "good faith" and the relationship between clause 26 and the offence provisions. They asked who would receive immunity and for what offences. They asked whether the immunity would apply to people who helped more generally in assisted dying, such as pharmacists, nurses, and families. Submitters are concerned that, if these people were not covered by clause 26, they could be considered to be aiding and abetting suicide.

It was also suggested that, rather than providing immunity, it would be clearer if the bill were to decriminalise assisted dying by repealing or amending the relevant provisions in the Crimes Act.

Offence provisions

Clause 27 of the bill would create three offences. They are:

- wilfully failing to comply with a requirement in the legislation
- completing or partially completing a prescribed form for a person without their consent
- altering or destroying a completed or partially completed prescribed form without the consent of the person who completed or partially completed it.

A person convicted of any of these offences could be imprisoned for up to 3 months and/or fined up to \$10,000.

Many submitters believe that the penalties for wrongful death in the bill are limited to those contained in clause 27. Submitters compared the penalties in the bill with the penalties in the Crimes Act for murder, manslaughter, and aiding and abetting suicide. They noted that the penalties proposed in the bill are far lower than the Crimes Act provisions.

Many submitters believe the proposed penalties are insufficient because the offences could result in the death of a person without their consent. However, other submitters believe that the penalties might not always be appropriate. Some interpret the offence as applying to all requirements and prescribed forms within the bill. They therefore expressed concern that people could be fined or imprisoned for administrative errors.

Others observed that the clause contains strict liability offences without defences. They believe that this might not be appropriate in all cases, particularly if family or friends carried out a prohibited action out of a sense of obligation to a loved one.

Some submitters argued that the clause does not cover all types of behaviour that would be of concern. They suggested additional offences such as coercing, threatening, or incentivising another person to access assisted dying, or helping a non-eligible person to access assisted dying.

Several submitters queried how offences would be investigated. In particular, they believe it would be difficult to prosecute a person for destroying or altering a document without consent. This is because the main witness (the person accessing assisted dying) would be dead.

Reporting the cause of death

Clause 28 relates to the information that would go on a death certificate of a person who died as a result of assisted dying. The death certificate would have to include the fact that the person died as a result of assisted dying. It would also have to include the person's underlying condition as if assisted dying had not been provided. Submitters who commented on clause 28 believe that it would entail death certificates being falsified and medical practitioners being asked to be dishonest. They frequently suggested that "assisted dying" or the method of assisted dying should be recorded as the cause of death, rather than the underlying condition.

We heard that it could be difficult to identify what the cause of death would have been if assisted dying had not been provided, particularly for those with a grievous or irremediable condition. Further, a person suffering from a terminal illness might die of an unanticipated event, such as pneumonia, an infection, or a stroke.

Some submitters are concerned that clause 28 could result in biased records about outcomes from conditions. This is because the records would show shorter survival rates over time. Gradually, people with those same conditions might be given poorer prognoses and might be more likely to seek an early death.

Other submitters support the intent of this clause. They often commented that the death certificate would also record that the person died of assisted dying.

4. Overseas jurisdictions

We received a large number of submissions commenting on the different jurisdictions that have euthanasia. We summarise the law, as interpreted by our officials, in each of those jurisdictions, in the order in which they were introduced:

- Switzerland—1940s

- Oregon, USA—1998
- Belgium—2002
- Netherlands—2002
- Canada—2017
- Victoria, Australia—2017 (yet to come into force)

Switzerland

The Swiss Criminal Code allows for assisted or accompanied suicide (not euthanasia) by making assistance with suicide an offence where it is conducted in self-interest.

Eligibility

There are no explicit provisions at the federal level on organised assisted suicide.

Private associations in Switzerland offer assistance to their members that wish to die. The main groups are Dignitas, Exit, Ex International and Lifecircle. The eligibility information below is from one of the largest organisations, Dignitas, which assists both Swiss residents and people who live in other countries.

To access Dignitas' assisted suicide service, a person must:

- be a member of Dignitas
- be of sound judgement
- possess a minimum level of physical mobility (sufficient to self-administer the drug)
- have a terminal illness, an unendurable incapacitating disability, or be in unbearable and uncontrollable pain.

Any person capable of judgement can resort to assisted suicide, regardless of age.

Process

The process to access assisted suicide is not set out in legislation.

Information on the processes followed by the associations that operate in Switzerland are available on their websites.

Oversight

People are liable for prosecution by the authorities for breach of the Swiss Criminal Code.

USA

The Oregon Death with Dignity Act 1997 allows terminally ill Oregon residents to end their lives through self-administration of lethal medications. Six other jurisdictions in the United States also allow patient-assisted suicide in legislation modelled on Oregon law: Washington, Vermont, California, Colorado, District of Columbia, and Hawaii.

In Montana, a 2009 decision, confirmed by the Montana Supreme Court, determined that terminally ill Montanans may request lethal medication from a physician under existing law.

Eligibility

For a person to be eligible to be prescribed lethal medication:

- two doctors must agree that a patient is terminally ill (6 months or less to live)
- the patient must be an Oregon resident and at least 18 years of age
- the patient must be able to self-administer the medication either by swallowing it or by self-administering it through their feeding tube
- the patient must be capable of making and communicating their own medical decisions.

Process

Residents of Oregon must make three requests in writing to their prescribing physician: two verbal requests and one written request that are at least 15 days apart.

The written form must be completed with two witnesses after the applicant has seen both the prescribing doctor and the consulting doctor. The requests cannot be made by anyone else, nor through an advanced directive.

Oversight

The Oregon Health Division must monitor compliance with the law, collect information about the patients and physicians who participate in it, and publish an annual statistical report.

When a prescription for lethal medication is written, the physician must submit specific information to the Oregon Health Division that documents compliance with the law. The Oregon Health Division reviews all physician reports and contacts physicians about any missing or discrepant data.

The Oregon Health Division must also review death certificates. All Oregon death certificates are screened by the Oregon Health Division. Death certificates of all recipients of prescriptions for lethal medications are reviewed by the Oregon Health Division and matched to the prescribing physician reports.

Definitions

Definitions in the legislation include attending physician, capable, consulting physician, informed decision, and terminal disease.

Belgium

The Belgian Act on Euthanasia (2002) was amended in 2014 to include terminally ill children (“emancipated minors”).

Eligibility

A doctor who performs euthanasia commits no criminal offence when they ensure that:

- the patient is aged over 18 years or an emancipated minor
- the patient is legally competent and conscious at the moment of making the request
- the request is voluntary, well-considered, and repeated, and is not the result of any external pressure
- the patient is in a medically futile condition of constant and unbearable physical or mental suffering that cannot be alleviated, resulting from a serious and incurable disorder caused by illness or accident.

Additional conditions for emancipated minors are:

- they have the capacity of discernment
- they are in a medically futile condition of constant and unbearable physical suffering that cannot be alleviated, that will result in death in the short term and that results from a serious and incurable disorder caused by illness or accident
- a child psychiatrist or psychologist must be consulted to assess the capacity of discernment
- the legal representatives of the minor must agree.

Process

The doctor must have several conversations with the person over time to be certain of the person's constant physical or mental suffering. Conversations must include life expectancy and possible palliative care options. Together the person and their doctor must come to the belief that the request is voluntary and there is no reasonable alternative to the person's situation.

People who must be consulted on the request include an independent physician (and sometimes a third), the person's nursing team (if there is one), and the person's relatives.

Advanced directives are permitted for patients aged over 18 years or emancipated minors.

Oversight

The Belgian legislation sets up a Federal Control and Evaluation Commission. The Commission studies completed registration forms (that must be filled in by the physician when they perform euthanasia) and makes an assessment as to whether each euthanasia was performed in accordance with the conditions and procedure in the Act.

If the Commission decides that the conditions have not been fulfilled they can turn the case over to the public prosecutor of the jurisdiction where the person died.

The Commission must draft reports every two years that include statistics on certain information from the registration form, an evaluation of the implementation of euthanasia law, and any recommendations.

Definitions

Euthanasia is defined in Belgium as “intentionally terminating life by someone other than the person concerned, at the latter’s request”.

Netherlands

The Dutch law on assisted dying has not changed since it came into force in 2002. It provides a ground for exemption from criminal liability for a physician who, with due observance of the requirements of due care, terminates a life on request or assists in a suicide of another person.

Eligibility

In the Netherlands, the physician must:

- hold the conviction that the request by the patient was voluntary and well-considered
- hold the conviction that the patient’s suffering was lasting and unbearable
- have informed the patient about their situation and prospects.

The patient must hold the conviction that there was no other reasonable solution for their situation.

At least one other independent physician must see the patient and provide a written opinion on the physician’s requirements above.

The physician must terminate a life or assist in a suicide with due care.

Age criteria

The following age criteria apply in the Netherlands:

If the patient is between 12 and 16 years old, they must have a reasonable understanding of their interests and the parent(s) and/or guardian must agree.

If the patient is between 16 and 18 years old, they must have a reasonable understanding of their interests and the parent(s) and/or guardian must have been involved in the decision process.

If the patient is over 16 and is not capable of expressing their will, but was previously deemed to have a reasonable understanding of their interests and made a written request (that is, an advance directive).

A patient over 18 years old must be capable of expressing their will.

The process

The process to access termination of life or assisted suicide is not set out in Dutch legislation. The Regional Review Euthanasia Committees have published a Code of Practice outlining the issues and considerations that they regard as relevant.

Oversight

There are five Regional Review Committees who review reported cases of termination of life on request or assisted suicide. The attending physician is referred to the Public Prosecution Service and the Regional Health Care Inspector if they are found not to have acted in accordance with the eligibility criteria.

Each committee is made up of an odd number of members appointed by Ministers, including at least a legal expert as the chair, a physician, and an expert on ethical or moral issues. Further legal experts are appointed as secretaries.

The committees report each year on their activities during the preceding calendar year.

Definitions

Definitions in the legislation include assisted suicide, attending physician, independent physician, and care providers.

Groningen Protocol

The Groningen Protocol is a medical protocol that sets out the requirements for a doctor in the Netherlands to meet before actively ending the life of a severely ill newborn.

Canada

Canada has a federal law amending the criminal code and Quebec has a provincial Act Respecting End-Of-Life Care. The legislation came into effect in 2017.

Eligibility

To be eligible for assisted dying under the federal law, a person must meet the following criteria:

- be eligible, or would be eligible, for health services funded by the Canadian government
- be at least 18 years of age and capable of making decisions with respect to their health
- have a grievous and irremediable medical condition
- have made a voluntary request for assisted dying that, in particular, was not made as a result of external pressure
- have given informed consent to receive medical assistance in dying, after having been informed of the means that are available to relieve their suffering, including palliative care.

The Quebec law has very similar eligibility criteria to federal law. Additionally, the person must be an insured person within the meaning of the Health Insurance Act.

Process

Under the federal law, a medical practitioner or nurse practitioner can only assist someone with dying after:

- ensuring that the request for medical assistance in dying was made in writing, and signed in front of two independent witnesses
- ensuring that the person has been informed that they may at any time, and in any manner, withdraw their request
- ensuring that another independent medical practitioner or nurse has provided a written opinion confirming that the person meets the eligibility criteria
- ensuring that there are 10 clear days between the day the request was signed and the day on which the medically assisted dying is provided (or shorter, if the person's death or their loss of capacity to provide informed consent is imminent)
- immediately before providing the medical assistance in dying, giving the person an opportunity to withdraw their request and ensure that the person gives express consent to receive medical assistance in dying.

The Colleges of Physicians and Surgeons in each province have issued guidelines for the provision of medical assistance in dying.

The Quebec process is very similar to federal law.

Oversight

The Canadian federal law does not establish an oversight committee, but reviews are required at set intervals:

- An independent review, due in December 2018, looking at:
 - medical assistance in dying requests by minors
 - advance requests
 - requests where mental illness is the sole underlying medical condition.
- No later than two years after the review, a report on the review must be produced and laid before each House of Parliament.
- Five years after the Act received Royal Assent, the Government must review the provisions in the Act. A report must be produced by whichever committee reviews the provisions, and must also include the state of palliative care in Canada. The report must include the findings and any proposed changes.

The Quebec law establishes a commission on end-of-life care. Its responsibility is to examine any matter relating to end-of-life care. Its duties include advising the Minister and evaluating the implementation of legislation regarding end-of-life care.

The Collège des Médecins du Québec must prepare a yearly report on the end-of-life care provided by physicians practising in private health facilities. The report must be sent to the commission.

Definitions

Definitions in the federal legislation include medical assistance in dying, medical practitioner, nurse practitioner and pharmacist.

“Grievous and irremediable medical condition” is defined as where a person meets all the following criteria:

- they have a serious and incurable illness, disease or disability
- they are in an advanced state of irreversible decline in capability
- that illness, disease or disability or that state of decline causes them enduring physical or psychological suffering that is intolerable to them and that cannot be relieved under conditions that they consider acceptable
- their natural death has become reasonably foreseeable, taking into account all of their medical circumstances, without a prognosis necessarily having been made as to the specific length of time that they have remaining.

The Quebec definitions include end-of-life care, palliative care, continuous palliative sedation, and medical aid in dying.

Victoria, Australia

Victoria’s Voluntary Assisted Dying Act 2017 is due to come into force on 19 June 2019.

The co-ordinating doctor has to be granted a voluntary assisted dying permit, either a self-administration permit or a practitioner administration permit.

Eligibility

The patient must:

- be 18 years or older
- be an Australian citizen or permanent resident who normally lives in Victoria
- have the capacity to decide on voluntary assisted dying
- be diagnosed with:
 - a disease, illness or medical condition that is incurable, advanced, progressive, and will cause death, and is expected to cause death within 6 months
 - a disease that is neurodegenerative, and is expected to cause death within 12 months
- be experiencing suffering that cannot be relieved in a manner that the person considers tolerable.

A person is not eligible for voluntary dying if they have a mental illness only, or if they have a disability only.

A person may not make a request for assisted dying via an advanced care directive.

If the co-ordinating and consulting practitioners cannot determine whether the patient has decision-making capacity or a disease that meets the eligibility requirements, they must refer the patient to a specialist in the relevant area who can make the determination.

If the medical practitioner determines that the patient suffers from a neurodegenerative condition that may cause death within 12 months, they must refer the patient to a specialist in that area for the specialist's determination.

Process

After the patient has made a first request for voluntary assisted dying, they are assessed as eligible for it by the co-ordinating medical practitioner and a consulting medical practitioner.

The person makes and signs a written declaration that they understand the nature and the effect of the decision. This is witnessed by certified witnesses in the presence of the co-ordinating practitioner. Another person may sign on their behalf if the person directs it.

The person makes a final request to the co-ordinating medical practitioner at least 9 days after the day of the first request, and at least one day after being assessed as eligible.

The person appoints a contact person. Then the co-ordinating practitioner certifies that the request and assessment process has been completed.

The person is then the subject of a voluntary assisted dying permit.

Oversight

The Act provides that the patient, their agent, or any other person who has a special interest in the medical treatment of the patient can apply to the Victorian Civil and Administrative Tribunal for the review of certain decisions of the co-ordinating or consulting practitioner.

The Act sets up a board to review the function of the Act and provide advice to relevant Ministers. Reports may make recommendations on any systemic voluntary assisted dying matter identified by the review board.

A person is eligible for membership if the Minister is satisfied that the person has appropriate knowledge and skills to perform all the duties and functions of a member of the Board.

Definitions

Definitions in the legislation include administration request, consulting assessment, consulting medical practitioner, contact person, co-ordinating medical practitioner,

decision-making capacity, mental illness, palliative care, psychiatrist, registered health practitioner, and voluntary assisted dying.

Appendix A: process, membership, evidence, and advice

Committee process

The End of Life Choice Bill was referred to the committee on 13 December 2017. The closing date for submissions was 6 March 2018. We received and considered 39,159 submissions from interested groups and individuals. The 199 organisations that made submissions are listed in Appendix B of this report.

We heard oral evidence from 1,350 submitters (77 organisations and 1,273 individuals) at hearings in Whangarei, Auckland, Tauranga, Rotorua, Hamilton, New Plymouth, Whanganui, Napier, Palmerston North, Wellington, Nelson, Christchurch, Dunedin, and Invercargill.

The Report of the Attorney-General under the New Zealand Bill of Rights Act 1990 on the End of Life Choice Bill was referred to the Government Administration Committee of the 51st Parliament on 10 August 2017. On 8 November 2017, it was reinstated with the Governance and Administration Committee of the 52nd Parliament. It was transferred to the Justice Committee on 31 January 2018. We considered it alongside our consideration of the End of Life Choice Bill.

We received advice from the Ministry of Justice and the Ministry of Health.

Committee membership

Raymond Huo (Chairperson)

Ginny Andersen

Hon Maggie Barry

Chris Bishop

Hon Mark Mitchell

Greg O'Connor

Hon Dr Nick Smith

Dr Duncan Webb

Advice and evidence received

The documents that we received as advice and evidence are available on the Parliament website, www.parliament.nz.

Appendix B: organisational submitters

Below is a list of organisations that made submissions to us on the End of Life Choice Bill.

- 1 24-7 YouthWork Trust
- 2 Alzheimers New Zealand
- 3 Amitabha Hospice Service, Auckland
- 4 Anglican Bishops of Dunedin, Christchurch, Te Waipounamu, Nelson, Wellington, Waiapu, Waikato & Taranaki, and Auckland
- 5 Anglican Care South Canterbury
- 6 Anglican Dioceses of Christchurch and Dunedin
- 7 Anglican Living, Christchurch
- 8 Arohanui Hospice Service Trust, Palmerston North
- 9 Association of Catholic Women New Zealand
- 10 Auckland Baptist Tabernacle
- 11 Auckland Vision Baptist Church
- 12 Australian and New Zealand College of Anaesthetists and Faculty of Pain Medicine
- 13 Avonhead Baptist Church, Christchurch
- 14 Baptist Churches of New Zealand
- 15 Brightwater Community Anglican Church, Nelson
- 16 Brooklyn Reformed Church, Wellington
- 17 Cancer Nurses College NZNO
- 18 Care Alliance NZ
- 19 Caritas Aotearoa New Zealand
- 20 Catholic Diocese of Auckland
- 21 Catholic Women's League of Aotearoa New Zealand
- 22 Chinese Methodist Church in New Zealand, Hamilton Mission Centre
- 23 Choice is an Illusion
- 24 Christchurch Hospital Palliative Care Service
- 25 Christian Alliance
- 26 Christian Medical Fellowship of New Zealand
- 27 Church of the Nazarene New Zealand
- 28 Clutha Valley Community Church
- 29 College of Nurses Aotearoa (NZ) Inc
- 30 Congregational Christian Church of Samoa, Mangere East

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- 31 Conservative Party of New Zealand
 - 32 Cromwell & Upper Clutha Catholic Parish
 - 33 Dignitas, Switzerland
 - 34 Disability Rights Commissioner, Human Rights Commission
 - 35 Disabled Persons Assembly NZ
 - 36 DLA Piper
 - 37 Elevate Christian Disability Trust
 - 38 Elim Church, Christchurch
 - 39 End-of-Life Choice Society New Zealand Inc.
 - 40 Epsom Baptist Church, Auckland
 - 41 European Institute of Bioethics
 - 42 Euthanasia Prevention Coalition—USA
 - 43 Euthanasia Free NZ
 - 44 Every Life Research Unit
 - 45 Faith Bible Church, New Plymouth
 - 46 Family First New Zealand
 - 47 Family Life International NZ
 - 48 Flaxmere Christian Fellowship, Hastings
 - 49 Focolare Movement, Women's Branch
 - 50 Godwit Films Limited
 - 51 Grace International, Auckland
 - 52 Grace Presbyterian Church of New Zealand
 - 53 Greymouth and Kumara Anglican Parish
 - 54 Hibiscus Coast Hospice
 - 55 Hikurangi Christian Fellowship Union Parish, Northland
 - 56 HOPE: Preventing Euthanasia & Assisted Suicide
 - 57 Hospice New Zealand
 - 58 Hospice North Shore
 - 59 Hospice Southland
 - 60 Hospital Palliative Care New Zealand
 - 61 Auckland City Hospital Palliative Care Team
 - 62 Humanist Society of New Zealand
 - 63 Impilo Family Practice, Whanganui
 - 64 Intercessors for New Zealand, Wellington
 - 65 InterChurch Bioethics Council

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- 66 Just Life, Palmerston North
 - 67 Justice and Peace Commission, Catholic Diocese of Auckland
 - 68 Kaitaia Union Parish Church
 - 69 King's Church, Wellington
 - 70 Kirk Session of the Auckland Congregation, Free Presbyterian Church of Scotland
 - 71 Kumeu Baptist Church
 - 72 Lamb of God Christian Community
 - 73 Legion of Mary Upper Hutt
 - 74 Legislation Design and Advisory Committee
 - 75 Liberty Christian Fellowship, Auckland
 - 76 Living and Dying Well
 - 77 Living Faith, Hibiscus Coast
 - 78 Lutheran Church of New Zealand
 - 79 Matua Community Baptist Church, Tauranga
 - 80 Maxim Institute
 - 81 Pacific Youth Leadership and Transformation Council, Christchurch
 - 82 Mercy Healthcare Auckland Limited
 - 83 Mission India Christian Centre
 - 84 Mornington Presbyterian Church, Dunedin
 - 85 Musselburgh Baptist Church, Dunedin
 - 86 National Council of Women of New Zealand
 - 87 Nazareth Community of Care, Christchurch
 - 88 ND Folaha Society of Development Inc, Auckland
 - 89 New Life Churches International
 - 90 New Plymouth Bible Chapel
 - 91 New Zealand Aged Care Association
 - 92 New Zealand Association of Rationalists and Humanists
 - 93 New Zealand Catholic Bishops Conference
 - 94 New Zealand Christian Network
 - 95 New Zealand Health Professionals Alliance Inc
 - 96 New Zealand Law Society
 - 97 New Zealand Medical Association
 - 98 New Zealand Nurses Organisation
 - 99 New Zealand Psychologists Board
 - 100 Not Dead Yet (USA)

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- 101 Not Dead Yet Aotearoa
 - 102 New Zealand Christian Network
 - 103 Oasis Family Church, Blenheim
 - 104 Office of the Privacy Commissioner
 - 105 Our Lady Star of the Sea Church, Auckland
 - 106 Oxford Terrace Baptist Church, Christchurch
 - 107 Pacific Child, Youth and Family Integrated Care Trust
 - 108 Pakuranga Chinese Baptist Church
 - 109 Palliative Care Nurses New Zealand
 - 110 Palmerston North Elder Care Group
 - 111 Pastoral Council of the Parish of St Francis of Assisi Parish, Wellington
 - 112 Pax Christi Aotearoa-New Zealand
 - 113 Perpetual Guardian
 - 114 Pharmacy Guild of New Zealand Inc
 - 115 Physicians for Compassionate Care Education Foundation
 - 116 Porirua Church
 - 117 Presbyterian Women Aotearoa New Zealand
 - 118 Prolife Foundation
 - 119 Prolife Massey
 - 120 Raukura Hauora o Tainui
 - 121 Regulatory Institute, Brussels & Lisbon
 - 122 Remote New Zealand Mission Project
 - 123 Right to Life New Zealand Inc
 - 124 Royal Australasian College of Physicians
 - 125 Royal Australian and New Zealand College of Psychiatrists
 - 126 Saving Downs
 - 127 St Barnabas Church, Porirua
 - 128 Sisters of Mercy, Wiri
 - 129 Skylight Trust
 - 130 Society of St Vincent de Paul, Papanui Conference
 - 131 Society of Saint Vincent de Paul, Ashburton
 - 132 Society of St Vincent de Paul, St Joseph's Conference, New Plymouth
 - 133 Society of St Vincent de Paul, Area Council Marlborough
 - 134 Society of St Vincent de Paul in New Zealand
 - 135 Society of St Vincent de Paul, Te Puke Conference

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- 136 Society of St Vincent de Paul, Feilding
 - 137 Society of St Vincent de Paul, Levin Conference
 - 138 Society of St Vincent de Paul, St Joseph's Conference Hawera
 - 139 Society of St Vincent de Paul, Stella Maris Ferrymead Conference
 - 140 Society of St Vincent de Paul, Wellington Area Council
 - 141 Society of St Vincent de Paul, Rangiora
 - 142 Society of St Vincent de Paul, Papakura
 - 143 Society of St Vincent de Paul, St Marys Conference Mt Albert
 - 144 South Canterbury Hospice Inc
 - 145 South West Baptist Church, Christchurch
 - 146 Speak Up Kōrerotia
 - 147 St Andrew's Parish, Inglewood
 - 148 St Andrew's Presbyterian Church Session, Invercargill
 - 149 St Anthony's Church
 - 150 St Christopher's Anglican Church, Christchurch
 - 151 St Dominic's College, Auckland
 - 152 St John of God Hauora Trust, Wellington
 - 153 St Mary's Parish, Papakura
 - 154 St Paul's Presbyterian Church, Invercargill
 - 155 St Peter Chanel Catholic Church
 - 156 St Theresa's Catholic Church, Plimmerton
 - 157 Stratford Catholic Mission Group
 - 158 Surfside Christian Life Centre, Raglan
 - 159 Synergy Cambridge Trust
 - 160 TalkLink Trust
 - 161 Te Hui Amorangi ki te Upoko o te Ika
 - 162 Te Runanga o Ngāti Whātua
 - 163 The Australian & New Zealand Society of Palliative Medicine Inc
 - 164 The Australian and New Zealand Society for Geriatric Medicine
 - 165 The Centre for Science & Citizenship Trust
 - 166 The Cranford Hospice Trust
 - 167 The House of Grace
 - 168 The Lucy Foundation
 - 169 The Motor Neurone Disease Association of New Zealand
 - 170 The Nathaniel Centre

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- 171 The New Zealand Council for Civil Liberties
 - 172 The Order of Malta—Wellington Group
 - 173 The Pharmaceutical Society of New Zealand Inc
 - 174 The Royal New Zealand College of General Practitioners
 - 175 The Salvation Army New Zealand, Fiji and Tonga Territory
 - 176 The Selwyn Foundation
 - 177 Third Age Health
 - 178 Tino Rangatiratanga Commission Hamilton Catholic Diocese
 - 179 Turangi Catholic Women's League
 - 180 Voice for Life Gore
 - 181 Voice for Life Hastings
 - 182 Voice for Life Waihi
 - 183 Voice for Life Wanganui
 - 184 Voice for Life Winton
 - 185 Voice of Life Gore
 - 186 Waihola Grace Presbyterian Church
 - 187 Waipu Presbyterian Church
 - 188 Waipuna Hospice Incorporated
 - 189 Waiuku Catholic Women's League
 - 190 WEC International
 - 191 Wellington Branch of Aotearoa New Zealand Association of Social Workers
 - 192 Wellington Chinese Methodist Church
 - 193 Wellington Interfaith Council
 - 194 Whangarei Central Baptist Church
 - 195 Whole Lotta Life Foundation
 - 196 Women's Forum Australia
 - 197 Working Together Group
 - 198 World Harvest Church Auckland
 - 199 Youth for Life

Appendix C: other proposed amendments

Below are some amendments that were proposed by submitters but that involved substantive policy changes. Consistent with our approach not to consider substantive policy issues on a conscience bill, these amendments were not considered by the committee.

Eligibility

Submitters recommended that we consider:

- whether assisted dying should be limited to only those with a terminal illness (and not those with a grievous and irremediable medical condition)
- whether the timeframe for likely life expectancy for those with a terminal illness should be shorter than 6 months or indefinite
- whether the timeframe for likely life expectancy should also apply to a grievous and irremediable medical condition
- whether to exclude people with disabilities and/or mental illness from eligibility
- whether a collection of more minor illnesses could be assessed as a whole in terms of whether the eligibility criteria are met
- whether the settings are correct for the assessment of the patient's competence to understand the nature of assisted dying and the consequences of it (clause 4(f)).

Assisted dying process

Submitters recommended that we consider:

- amending the bill to either allow or prohibit health professionals raising the option of assisted dying with the patient
- clarifying the following matters relating to clause 9(4)(d) (which provides for signing a request form on behalf of the patient):
 - the meaning of "benefit"
 - providing for a more overt, independent process for signing on behalf of the patient
 - providing consequences when the criteria for those signing on behalf of the patient are not met
- amending clause 15(3)(a) to reflect that the methods available for administering a lethal dose of medication are ingestion or injection, either by the patient or by somebody else.

Administration

Submitters recommended that we consider:

- clarifying the following matters relating to the SCENZ Group and the review committee:
 - their powers, duties and responsibilities
 - membership, including composition, length of tenure, re-appointment, remuneration, resignation, and removal of members
 - procedures, including quora and absences, chairpersons and deputy chairpersons, decision-making and voting, sub-groups or sub-committees, conflicts of interest, appointing experts, and timeframes
- amending the bill so that the normal rules about disclosure, retention, and protection of health information would apply to information under the bill.

SCENZ Group

Submitters recommended that we consider:

- setting out the purpose of the SCENZ Group
- clarifying whether SCENZ Group lists of willing practitioners should be publicly available or kept private.

Review committee

Submitters recommended that we consider:

- clarifying, in clause 20, the status of the review committee and prescribing a clear purpose to guide its work
- setting out details about the type of consideration and reporting the review committee would do, and the information and powers it would need to do its work
- providing for administrative assistance for the review committee.

Registrar

Submitters recommended that we consider:

- inserting a subclause into clause 21 to set out the registrar's general purpose and functions, and consolidate all their functions into one place in the bill
- clarifying the purpose of the register in clause 21(2) and its intended use and availability.

Immunity

Submitters recommended that we consider:

- providing immunity in clause 26 for people helping and supporting the doctor in providing or intending to provide assisting dying
- clarifying how clause 26 would work, including:
 - whether it would operate as a justificatory defence provision or an immunity to prosecution

-
- who would have the burden of proof
 - whether the civil or criminal burden of proof would apply
 - whether criminal liability should be available on the basis of “negligence”
 - making clear that the immunity clause should not apply to clause 27 (offences).

Offences

Submitters recommended that we consider:

- amending clauses of the bill to which 27(1) would apply to make the offences clear, so that people would be able to understand them
- amending clause 27(2) to stratify the penalties between the different seriousness of offences
- proposing a new offence, with an appropriate penalty, to capture those who intentionally caused another person to ask for assisted dying against their will.

Coroner involvement

Submitters recommended that we consider:

- whether there are any circumstances (such as suspicious or medically unusual assisted deaths) which could justify an assisted death being referred to a coroner.

Key to symbols used in reprinted bill

As reported from a select committee

text inserted unanimously

~~text deleted unanimously~~

David Seymour

End of Life Choice Bill

Member's Bill

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Schedule 20
Amendments to other enactments

The Parliament of New Zealand enacts as follows:

1 Title

This Act is the End of Life Choice Act **2017**.

2 Commencement

This Act comes into force ~~6~~ 12 months after the date on which it receives the Royal assent. 5

Part 1
Preliminary provisions

3 Interpretation

In this Act, unless the context requires another meaning,—

10

assisted dying, in relation to a person, means ~~the administration by a medical practitioner of a lethal dose of medication to a person to relieve his or her suffering by hastening death~~

- (a) the administration by a medical practitioner of a lethal dose of medication to the person to relieve the person's suffering by hastening death; or 5
- (b) the self-administration by the person of a lethal dose of medication to relieve their suffering by hastening death

attending medical practitioner means a person's medical practitioner

authority has the meaning given to it by section 5(1) of the Health Practitioners Competence Assurance Act 2003 10

competent means having the ability described in **section 4(f)**

~~**conscientious objection** means an objection to doing anything authorised or required by this Act~~

Director-General means the Director-General of Health

health practitioner has the meaning given to it by section 5(1) of the Health Practitioners Competence Assurance Act 2003 15

independent medical practitioner means a medical practitioner who is independent of an attending medical practitioner and the person

medical practitioner means a health practitioner who—

- (a) is, or is deemed to be, registered with the Medical Council of New Zealand continued by section 114(1)(a) of the Health Practitioners Competence Assurance Act 2003 as a practitioner of the profession of medicine or is deemed to be so registered; and 20
- (b) holds a current practising certificate

minister means the Minister of the Crown who is responsible for the administration of this Act— 25

- (a) under the authority of a warrant; or
- (b) under the authority of the Prime Minister

ministry means the Ministry of Health

person who is eligible for assisted dying has the meaning given to it in **section 4** 30

pharmacist means a health practitioner who—

- (a) is, or is deemed to be, registered with the Pharmacy Council established by section 114(5) of the Health Practitioners Competence Assurance Act 2003 as a practitioner of the profession of pharmacy or is deemed to be so registered; and 35
- (b) holds a current practising certificate

psychiatrist means a medical practitioner whose scope of practice includes psychiatry

psychologist means a health practitioner who—

(a) ~~is, or is deemed to be, registered with the Psychologists Board continued by section 114(a) of the Health Practitioners Competence Assurance Act 2003 as a practitioner of the profession of psychology or is deemed to be so registered;~~ and 5

(b) holds a current practising certificate

registrar means the registrar (assisted dying) nominated under **section 21**

review committee means the committee established under **section 20** 10

SCENZ means Support and Consultation for End of Life in New Zealand

SCENZ Group means the body established under **section 19**

specialist means a psychiatrist or a psychologist.

4 **Meaning of person who is eligible for assisted dying**

In this Act, **person who is eligible for assisted dying** means a person who— 15

(a) is aged 18 years or over; and

(b) is—

(i) a person who has New Zealand citizenship as provided in the Citizenship Act 1977; or

(ii) a permanent resident as defined in section 4 of the Immigration Act 2009; and 20

(c) suffers from—

(i) a terminal illness that is likely to end ~~his or her~~ the person's life within 6 months; or

(ii) a grievous and irremediable medical condition; and 25

(d) is in an advanced state of irreversible decline in capability; and

(e) experiences unbearable suffering that cannot be relieved in a manner that ~~he or she~~ the person considers tolerable; and

(f) has the ability to understand—

(i) the nature of assisted dying; and 30

(ii) the consequences for ~~him or her~~ them of assisted dying.

5 **Act binds the Crown**

This Act binds the Crown.

Part 2 Assisted dying

- 6 Conscientious objection**
- (1) ~~This Act does not require a person to do anything to which the person has a conscientious objection.~~ 5
- (2) **Subsection (1)**—
- (a) ~~applies despite any legal obligation to which the person is subject, however the obligation arises; and~~
- (b) ~~does not apply to the requirement in **section 7(2)**.~~
- 7 Effect of conscientious objection** 10
- (1) ~~This section applies when—~~
- (a) ~~a person tells the attending medical practitioner under **section 8(1)** that the person wishes to have the option of receiving assisted dying; and~~
- (b) ~~the attending medical practitioner has a conscientious objection.~~
- (2) ~~The attending medical practitioner must tell the person that—~~ 15
- (a) ~~the medical practitioner has a conscientious objection; and~~
- (b) ~~the person may ask the SCENZ Group for the name and contact details of a replacement medical practitioner.~~
- (3) ~~If the person chooses to have the replacement medical practitioner, references in this Act to the attending medical practitioner mean the person's replacement medical practitioner, except in **subsection (2) and section 8(1)**.~~ 20
- 6 Conscientious objection**
- (1) This section applies if—
- (a) a person informs the attending medical practitioner under **section 8(1)** that they wish to have the option of receiving assisted dying; and 25
- (b) the attending medical practitioner has an objection to providing that option to the person (a **conscientious objection**).
- (2) The attending medical practitioner must tell the person—
- (a) of their conscientious objection; and
- (b) of the person's right to ask the SCENZ Group for the name and contact details of a replacement medical practitioner. 30
- (3) If the person chooses to have a replacement medical practitioner, all subsequent references in this Act to the attending medical practitioner (except in **section 8(1)**) are to the person's replacement medical practitioner.

8 Request made

- (1) A person who wishes to have the option of receiving assisted dying must ~~tell~~ inform the attending medical practitioner of ~~his or her~~ their wish.
- (2) The attending medical practitioner must—
 - (a) give the person the following information: 5
 - (i) the prognosis for the person's 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~~ personally communicate by any means (for example, by telephone or using social media) with the person about the person's wish at intervals determined by the progress of ~~his or her~~ the person's terminal illness or medical condition; and 10
 - (c) ensure that the person understands ~~his or her~~ their other options for end-of-life care; and 15
 - (d) ensure that the person knows that ~~he or she~~ they can change ~~his or her~~ their mind at any time before the administration of the medication; and
 - (e) encourage the person to ~~talk about his or her~~ discuss their wish with others such as family, friends, and counsellors; and
 - (f) ensure that the person knows that ~~he or she is~~ they are not obliged to ~~talk~~ to discuss their wish with anyone; and 20
 - (g) ensure that the person has had the opportunity to ~~talk about his or her~~ discuss their wish with those whom ~~he or she~~ they chooses; and
 - (h) ~~do his or her~~ their best to ensure that the person expresses ~~his or her~~ their wish free from pressure from any other person by— 25
 - (i) ~~talking~~ conferring with other health practitioners who are in regular contact with the person; and
 - (ii) ~~talking~~ conferring with members of the person's family approved by the person; and
 - (i) complete the first part of the prescribed form requesting the option of assisted dying by recording the actions ~~he or she~~ the attending medical practitioner took to comply with **paragraphs (a) to (h)**. 30

9 Request confirmed

- (1) This section applies after **section 8** is complied with.
- (2) If the person wishes to proceed, the attending medical practitioner must give 35 the person the prescribed form requesting the option of assisted dying.
- (3) The person must—
 - (a) sign and date the second part of the form; or

- (b) be present when the second part of the form is signed and dated as described in **subsection (4)**.
- (4) The second part of the form may be signed and dated by a person other than the person to whom it relates if—
- (a) the person to whom it relates cannot write for any reason; and 5
 - (b) the person to whom it relates requests the other person to sign and date it; and
 - (c) the person who signs and dates the part notes on it that ~~he or she~~ they did so in the presence of the person to whom the form relates; and
 - (d) the person who signs and dates the part is not— 10
 - (i) a health practitioner caring for the person to whom the part relates; or
 - (ii) a person who knows that ~~he or she~~ they stands to benefit from the death of the person to whom the part relates; or
 - (iii) a person aged under 18 years; or 15
 - (iv) a person with a mental ~~disability~~ incapacity.
- (5) The attending medical practitioner must—
- (a) be present when—
 - (i) **subsection (3)(a)** is complied with; or
 - (ii) **subsections (3)(b) and (4)** are complied with; and 20
 - (b) collect the form; and
 - (c) send the completed form to the registrar.
- 10 First opinion reached**
- (1) This section applies after **section 9** is complied with.
- (2) The attending medical practitioner must reach the opinion that— 25
- (a) the person is a person who is eligible for assisted dying; or
 - (b) the person is not a person who is eligible for assisted dying; or
 - (c) the person would be a person who is eligible for assisted dying if the person's competence were established as described in **section 12**.
- (3) The attending medical practitioner must— 30
- (a) complete a prescribed form recording ~~his or her~~ their opinion; and
 - (b) send the completed form to the registrar.
- 11 Second opinion reached**
- (1) This section applies if the attending medical practitioner reaches the opinion described in **section 10(2)(a) or (c)**. 35
- (2) The attending medical practitioner must—

- (a) ask the SCENZ Group for the name and contact details of an independent medical practitioner; and
- (b) ask the independent medical practitioner for ~~his or her~~ their opinion on whether the person is a person who is eligible for assisted dying.
- (3) The independent medical practitioner must— 5
- (a) read the person’s medical files; and
- (b) examine the person; and
- (c) reach the opinion that—
- (i) the person is a person who is eligible for assisted dying; or
- (ii) the person is not a person who is eligible for assisted dying; or 10
- (iii) the person would be a person who is eligible for assisted dying if the person’s competence were established as described in **section 12**.
- (4) The independent medical practitioner must—
- (a) complete a prescribed form recording ~~his or her~~ their opinion; and 15
- (b) send the completed form to the registrar; and
- (c) send a copy of the completed form to the attending medical practitioner.
- 12 Third opinion reached, if necessary**
- (1) This section applies if—
- (a) the following situation exists: 20
- (i) the attending medical practitioner reaches the opinion described in **section 10(2)(a)**; and
- (ii) the independent medical practitioner reaches the opinion described in **section 11(3)(c)(iii)**; or
- (b) the following situation exists: 25
- (i) the attending medical practitioner reaches the opinion described in **section 10(2)(c)**; and
- (ii) the independent medical practitioner reaches the opinion described in **section 11(3)(c)(i)**; or
- (c) the following situation exists: 30
- (i) the attending medical practitioner reaches the opinion described in **section 10(2)(c)**; and
- (ii) the independent medical practitioner reaches the opinion described in **section 11(3)(c)(iii)**.
- (2) The medical practitioners must jointly— 35
- (a) ask the SCENZ Group for the name and contact details of a specialist; and

-
- (b) ask the specialist for ~~his or her~~ their opinion on whether the person is competent.
- (3) The specialist must—
- (a) read the person’s medical files; and
 - (b) examine the person; and 5
 - (c) reach the opinion that—
 - (i) the person is competent; or
 - (ii) the person is not competent.
- (4) The specialist must—
- (a) complete a prescribed form recording ~~his or her~~ their opinion; and 10
 - (b) send the completed form to the registrar; and
 - (c) send a copy of the completed form to—
 - (i) the attending medical practitioner; and
 - (ii) the independent medical practitioner.
- 13 Negative decision made on request 15**
- (1) **Subsection (2)** applies if the attending medical practitioner reaches the opinion described in **section 10(2)(b)**.
- (2) The attending medical practitioner must explain the reasons for ~~his or her~~ their opinion to the person.
- (3) **Subsection (4)** applies if— 20
- (a) the independent medical practitioner reaches the opinion described in **section 11(3)(c)(ii)**; or
 - (b) the following situation exists:
 - (i) a specialist is asked for ~~his or her~~ their opinion under **section 12(2)(b)**; and 25
 - (ii) the specialist reaches the opinion described in **section 12(3)(c)(ii)**.
- (4) The independent medical practitioner or the specialist, as appropriate, must attend meet the person with the attending medical practitioner to explain the reasons for ~~his or her~~ their opinion to the person. 30
- (5) The attending medical practitioner must—
- (a) complete a prescribed form recording the actions taken to comply with **subsection (2) or (4)**; and
 - (b) send the completed form to the registrar.
- 14 Positive decision made on request 35**
- (1) This section applies if—

- (a) the following situation exists:
- (i) the attending medical practitioner reaches the opinion described in **section 10(2)(a)**; and
 - (ii) the independent medical practitioner reaches the opinion described in **section 11(3)(c)(i)**; or
- (b) the following situation exists:
- (i) a specialist is asked for ~~his or her~~ their opinion under **section 12(2)(b)**; and
 - (ii) the specialist reaches the opinion described in **section 12(3)(c)(i)**.
- (2) The attending medical practitioner must—
- (a) ~~tell~~ advise the person that the person is a person who is eligible for assisted dying; and
 - (b) discuss with the person the progress of the person’s terminal illness or grievous and irremediable medical condition; and
 - (c) discuss with the person the likely timing of the assisted dying; and
 - (d) make provisional arrangements to be available to administer the medication at the time indicated.
- (3) The attending medical practitioner must—
- (a) complete a prescribed form recording the actions taken to comply with subsection (2); and
 - (b) send the completed form to the registrar.

15 Lethal dose of Mmedication chosen

- (1) This section applies after **section 14** is complied with.
- (2) When the person wishes to exercise the option of receiving assisted dying, ~~he or she~~ they must tell inform the attending medical practitioner.
- (3) The attending medical practitioner must—
- (a) ~~tell~~ advise the person about the following methods for the administration of a lethal dose of medication:
 - (i) ingestion, triggered by the person:
 - (ii) intravenous delivery, triggered by the person:
 - (iii) ingestion through a tube triggered by the attending medical practitioner:
 - (iv) injection administered by the attending medical practitioner; and
 - (b) ask the person to choose one of the methods; and
 - (c) ask the person to choose the time ~~at which he or she wishes for the administration of the medication~~ the medication to be administered; and

- (d) ensure that the person knows that ~~he or she~~ they can change ~~his or her~~ their mind at any time before the administration of the medication.
- (4) At least 48 hours before the chosen time of administration, the attending medical practitioner must—
- (a) write the appropriate prescription for the person; and 5
 - (b) advise the registrar of the method and time chosen; ~~and~~
 - (c) ~~provide the registrar with the prescription.~~
- (5) The registrar must check that the process in **sections 8 to 14** has been complied with.
- (6) If the registrar is satisfied that the process in **sections 8 to 14** has been complied with, the registrar must— notify the attending medical practitioner accordingly. 10
- (a) ~~co-sign the prescription for the person; and~~
 - (b) ~~provide the co-signed prescription to the attending medical practitioner.~~
- 16 Lethal dose of Mmedication administered** 15
- (1) This section applies after **section 15** is complied with.
- (2) At the chosen time of administration, the attending medical practitioner must ask the person if ~~he or she chooses~~ they choose to receive the medication.
- (3) If the person chooses not to receive the medication at the chosen time, the attending medical practitioner must— 20
- (a) immediately remove the medication from the room; and
 - (b) ~~return the medication to the pharmacist who dispensed it; and~~
 - (c) complete a prescribed form recording the actions taken to comply with **paragraphs (a) and (b)**; and
 - (d) send the completed form to the registrar. 25
- (4) If the person chooses to receive the medication, the attending medical practitioner must ~~administer it by—~~
- (a) ~~providing it~~ provide the medication to the person, for administration by either of the methods described in **section 15(3)(a)(i) and (ii)**; or
 - (b) ~~providing it, for~~ administer the medication by either of the methods described in **section 15(3)(a)(iii) and (iv)**. 30
- (5) The attending medical practitioner must—
- (a) be available to the person until the person dies; or
 - (b) arrange for another medical practitioner to be available to the person until the person dies. 35
- (6) For the purposes of **subsection (5)**, the medical practitioner **is available to the person** if the medical practitioner—

- (a) is in the same room as the person; or
- (b) is not in same room as the person but is in close proximity to the person.

17 **Death reported**

- (1) Within 14 working days of a ~~person dying~~ person's death as a result of the administration of medication under **section 16**, the attending medical practitioner must send the registrar a report in the prescribed form containing the information described in **subsection (2)**. 5
- (2) The information is—
 - (a) the attending medical practitioner's name; and
 - (b) the person's name; and 10
 - (c) the person's last known address; and
 - (d) the fact that the person has died; and
 - (e) ~~a description of how the attending medical practitioner complied with **section 14(2)**~~; and
 - (f) which of the methods described in **section 15(3)(a)** was used; and 15
 - (g) a description of the administration of the medication; and
 - (h) whether any problem arose in the administration of the medication and, if so, how it was dealt with; and
 - (i) the place where the person died; and
 - (j) the date and time when the person died; and 20
 - (k) the name of the medical practitioner who was available to the person until the person died; and
 - (l) the names of any other health practitioners who were present when the person died.
- (3) The registrar must send the report to the review committee. 25

18 ~~Unused medication returned~~Destruction of prescription if no longer required

- (1) ~~Subsection (2) or (3)~~ applies if—
 - (a) an attending medical practitioner holds a prescription is written under **section 15(4)(a)**; and 30
 - (b) ~~the medication is not dispensed before the person for whom the prescription was written dies~~ no longer required.
- (2) ~~If the~~ The attending medical practitioner holds the prescription when the person dies, he or she must—
 - (a) immediately destroy it ~~the~~ prescription; and 35
 - (b) complete a prescribed form recording the action taken to comply with **paragraph (a)**; and

- (c) send the completed form to the registrar.
- (3) ~~If the registrar holds the prescription when the person dies, he or she must—~~
- (a) ~~destroy it; and~~
- (b) ~~complete a prescribed form recording the action taken to comply with **paragraph (a)**.~~ 5
- (4) **Subsection (5)** applies if—
- (a) a prescription is written under **section 15(4)(a)**; and
- (b) the medication is dispensed but not used before the person for whom the prescription was written dies.
- (5) The attending medical practitioner must— 10
- (a) return the medication to the pharmacist who dispensed it; and
- (b) complete a prescribed form recording the action taken to comply with **paragraph (a)**; and
- (c) send the completed form to the registrar.

Part 3 15

Accountability

19 SCENZ Group

- (1) The Director-General must establish the SCENZ Group by appointing to it the number of medical practitioners that the Director-General considers appropriate. 20
- (2) The functions of the SCENZ Group are—
- (a) to make and maintain a list of medical practitioners who are willing to act for the purposes of this Act as—
- (i) replacement medical practitioners:
- (ii) independent medical practitioners: 25
- (b) to provide a name and contact details from the list maintained under **paragraph (a)**, when this Act requires the use of a replacement medical practitioner or independent medical practitioner, in such a way as to ensure that the attending medical practitioner does not choose the replacement medical practitioner or independent medical practitioner: 30
- (c) to make and maintain a list of health practitioners who are willing to act for the purposes of this Act as specialists:
- (d) to provide a name and contact details from the list maintained under **paragraph (c)**, when this Act requires the use of a specialist, in such a way as to ensure that neither the attending medical practitioner nor the independent medical practitioner chooses the specialist: 35

- (e) to make and maintain a list of pharmacists who are willing to dispense medication for the purposes of **section 16**;
- (f) to provide a name and contact details from the list maintained under paragraph (e) when **section 16** is to be applied;
- (g) in relation to the administration of medication under **section 16**,— 5
- (i) to prepare standards of care; and
 - (ii) to advise on the required medical and legal procedures; and
 - (iii) to provide practical assistance, if assistance is requested.
- (3) The ministry must service the SCENZ Group.
- 20 Review committee** 10
- (1) The minister must appoint an end-of-life review committee consisting of—
- (a) a medical ethicist; and
 - (b) a medical practitioner who practises in the area of end-of-life care; and
 - (c) another medical practitioner.
- (2) The review committee has the following functions: 15
- (a) to consider reports sent to it under **section 17(3) (attending medical practitioner reports)**; and
 - (b) to report to the registrar ~~about its satisfaction or otherwise with the cases reported whether it considers that the information contained in an attending medical practitioner report shows satisfactory compliance with the requirements of this Act;~~ and 20
 - (c) to ~~recommend actions that direct the registrar may take to follow up cases with which on any information contained in a medical practitioner report that the review committee considered did not show was not satisfied~~ satisfactory compliance with the requirements of this Act. 25
- 21 Registrar (assisted dying)**
- (1) The Director-General must nominate an employee of the ministry as the registrar (assisted dying).
- (2) The registrar must establish and maintain a register recording the following: 30
- (a) prescribed forms held by the registrar; and
 - (b) the review committee's reports to the registrar; and
 - (c) the registrar's reports to the minister.
- (3) The registrar must consult the Privacy Commissioner—
- (a) before establishing the register; and
 - (b) at regular intervals while maintaining the register. 35

- (4) ~~The registrar must establish and maintain a procedure to deal with complaints about breaches of this Act.~~
- (4) If the registrar receives a complaint about the conduct of any person under this Act that the registrar considers relates to a matter more properly within the jurisdiction of any of the following persons, the registrar must refer the complaint to that person: 5
- (a) to the Health and Disability Commissioner, if it appears that the complaint relates to a breach of the Code of Health and Disability Services Consumers' Rights; or
- (b) to the appropriate authority, if it appears that the complaint relates to a health practitioner's competence, fitness to practise, or conduct; or 10
- (c) to the New Zealand Police.
- (4A) If the registrar does not refer a complaint under **subsection (4)**, the registrar must notify the complainant of that fact and of the reason why a referral was not made. 15
- (4B) The registrar must take any action directed by the review committee under **section 20(2)(c)**.
- (5) The registrar must report to the minister by the end of 30 June each year on the following matters for the year:
- (a) the total number of deaths occurring under **section 16**: 20
- (b) the total broken down into deaths occurring through each of the methods described in **section 15(3)(a)**:
- (c) the number of complaints received about breaches of this Act:
- (d) how the complaints were dealt with:
- (e) any other matter relating to the operation of this Act that the registrar thinks appropriate. 25
- (6) The registrar must perform any other functions that this Act requires the registrar to perform.
- 21A Persons to provide information to registrar**
- (1) This section applies to— 30
- (a) the Health and Disability Commissioner; and
- (b) an authority; and
- (c) the New Zealand Police.
- (2) A person to whom this section applies must provide to the registrar each year any information that the registrar may require to enable the registrar to report to the minister on the matters referred to in **section 21(5)(c) and (d)**. 35
- (3) The information must be provided within the time and in the manner (which must be reasonable in the circumstances) specified by the registrar.

21B Minister must present to House of Representatives copy of report under section 21

As soon as practicable after receiving a report under **section 21(5)**, the minister must present a copy of the report to the House of Representatives.

22 Review of operation of Act

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~~(1) Three years after the commencement of this Act, the ministry must start a review of the operation of this Act and must complete it within 6 months of starting it.~~

~~(2) Every 5 years after the date of the last review, the ministry must start another review of the Act and must complete it within 6 months of starting it.~~

10

~~(3) Every review must consider whether any amendments to this Act are necessary or desirable.~~

~~(4) Every review must be the subject of a report to the minister.~~

~~(5) The minister must present every report to the House of Representatives as soon as practicable after receiving it.~~

15

The ministry must, within 3 years after the commencement of this Act and then at intervals of not more than 5 years,—

(a) review the operation of this Act; and

(b) consider whether any amendments to this Act or any other enactment are necessary or desirable; and

20

(c) report on its findings to the minister.

22A Attending medical practitioner to take no further action if coercion suspected

If at any time the attending medical practitioner has reasonable grounds to suspect that a person who has expressed the wish to exercise the option of assisted dying is not expressing their wish free from pressure from any other person, the medical practitioner must—

25

(a) take no further action under this Act to assist the person in exercising that option; and

(b) tell the person that they are taking no further action under this Act to provide assisted dying services to the person; and

30

(c) complete a prescribed form recording—

(i) that they are taking no further action under this Act to assist the person in exercising the option of assisted dying; and

(ii) the actions taken to comply with **paragraph (b)**; and

35

(d) send the form completed under **paragraph (c)** to the registrar.

Part 4 Related matters

- 23 Regulations prescribing forms**
The Governor-General may, by Order in Council, make regulations prescribing forms for the purposes of this Act. 5
- 24 Other rights and duties not affected**
- (1) Nothing in this Act affects a person's rights to—
- (a) refuse to receive nutrition:
 - (b) refuse to receive hydration:
 - (c) refuse to receive life-sustaining medical treatment. 10
- (2) Nothing in this Act affects a medical practitioner's duty to alleviate suffering in accordance with standard medical practice.
- 25 ~~Effect of death under this Act~~**
~~A person who dies as a result of the provision of assisted dying is taken for all purposes to have died as if assisted dying had not been provided.~~ 15
- 26 ~~Immunity in civil or criminal proceedings~~**
~~A person is immune from liability in civil or criminal proceedings for acts or omissions in good faith and without negligence in providing or intending to provide assisted dying.~~
- 25 Effect on contracts of death under this Act** 20
A person who dies as a result of the provision of assisted dying is, for the purposes of any life insurance contract, or any other contract,—
- (a) taken to have died as if assisted dying had not been provided; and
 - (b) taken to have died from—
 - (i) the terminal illness referred to in **section 4(c)(i)** from which they suffered; or 25
 - (ii) the grievous and irremediable medical condition referred to in **section 4(c)(ii)** from which they suffered.
- 26 Immunity from criminal liability**
- (1) A person (A) is immune from criminal liability if A, in good faith and believing on reasonable grounds that another person (B) wishes to exercise the option of assisted dying,— 30
- (a) takes any action that assists or facilitates the dying of B in accordance with the requirements of this Act; or

- (b) fails to take any action and that failure assists or facilitates the dying of B in accordance with the requirements of this Act.
- (2) **Subsection (1)** applies even if that the doing of that thing, or the failure to do that thing, would constitute an offence under any other enactment.
- 26A Immunity from civil liability** 5
- (1) A person (A) is immune from civil liability if A, in good faith and believing on reasonable grounds that another person (B) wishes to exercise the option of assisted dying,—
- (a) takes any action that assists or facilitates the dying of B in accordance with the requirements of this Act; or 10
- (b) fails to take any action and that failure assists or facilitates the dying of B in accordance with the requirements of this Act.
- (2) Nothing in this section affects the right of any person to—
- (a) bring disciplinary proceedings against a health practitioner under the Health Practitioners Competence Assurance Act 2003; or 15
- (b) bring proceedings under section 50 or 51 of the Health and Disability Commissioner Act 1994; or
- (c) apply for judicial review.
- 27 Offences**
- (1) A person commits an offence who— 20
- (a) wilfully fails to comply with a requirement in this Act; or
- (b) completes or partially completes a prescribed form for a person without the person's consent; or
- (c) alters or destroys a completed or partially completed prescribed form without the consent of the person who completed or partially completed it. 25
- (2) The person is liable on conviction to either of both of—
- (a) a term of imprisonment not exceeding 3 months;
- (b) a fine not exceeding \$10,000.
- (1) A person who is a medical practitioner or specialist commits an offence if the medical practitioner or specialist wilfully fails to comply with any requirement of this Act. 30
- (2) A person commits an offence if the person, without lawful excuse,—
- (a) completes or partially completes a prescribed form for any other person without that other person's consent; or 35
- (b) alters or destroys a completed or partially completed prescribed form without the consent of the person who completed or partially completed the form.

- (3) A person who commits an offence under this section is liable on conviction to either or both of the following:
- (a) imprisonment for a term not exceeding 3 months:
- (b) a fine not exceeding \$10,000.

28 Amendments to Births, Deaths, Marriages, and Relationships Registration (Prescribed Information) Regulations 1995 5

- (1) ~~This section amends the Births, Deaths, Marriages, and Relationships Registration (Prescribed Information) Regulations 1995.~~

- (2) Replace regulation 7(1)(a)(xiii) with:

~~(xiii) the cause or causes of the person's death, subject to **subparagraph (xiiia)**:~~ 10

~~(xiiia) in respect of a person who died as a result of the provision of assisted dying under the End of Life Choice Act **2017**, the cause or causes of death as if assisted dying had not been provided:~~

~~(xiiib) in respect of a person who died as a result of the provision of assisted dying under the End of Life Choice Act **2017**, the fact that the person died as a result of the provision of assisted dying under the End of Life Choice Act **2017**:~~ 15

~~(xiiic) the interval between onset of the cause of death and death, in respect of each cause of death, subject to **subparagraph (xiiid)**:~~ 20

~~(xiiid) in respect of a person who died as a result of the provision of assisted dying under the End of Life Choice Act **2017**, the interval between onset of the cause of death and death by assisted dying, in respect of each cause of death:~~

28 Amendments to other enactments 25

Amend the enactments specified in the **Schedule** as set out in that schedule.

Schedule
Amendments to other enactments

s 28

Part 1
Amendments to Acts

5

Burial and Cremation Act 1964 (1964 No 75)

In section 2(1), definition of **certificate of cause of death**, replace “or 46C” with “, 46C, or **46CA**”.

After section 46C, insert:

46CA Certificate of cause of death in relation to assisted dying

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(1) This section applies if a person dies as a result of the provision of assisted dying under the **End of Life Choice Act 2017**.

(2) The medical practitioner who was available to the person until the person died must, immediately after the person’s death, give a certificate of cause of death.

(3) However, a certificate of cause of death must not be given under this section if the coroner has decided to open an inquiry into the death.

15

Coroners Act 2006 (2006 No 38)

After section 13(2), insert:

(2A) However, subsections (1) and (2) do not apply in any case in which the death was a result of the provision of assisted dying under the **End of Life Choice Act 2017**.

20

In section 60(1)(a), after “self-inflicted”, insert “(other than as a result of the provision of assisted dying under the **End of Life Choice Act 2017**)”.

After section 71(1)(b), insert:

(c) the death was a result of the provision of assisted dying under the **End of Life Choice Act 2017**.

25

Crimes Act 1961 (1961 No 43)

In section 41, insert as subsection (2):

(2) However, a person who knows or has reasonable grounds for believing that a person has requested the option of assisted dying under the **End of Life Choice Act 2017** is not justified under **subsection (1)** in using any force to prevent the person from exercising that option.

30

In section 48, insert as subsection (2):

Crimes Act 1961 (1961 No 43)—continued

(2) However, a person is not justified under **subsection (1)** in using any force to defend any other person who is taking any action that they are required or authorised to take under the **End of Life Choice Act 2017**.

Health Act 1956 (1956 No 65)

In section 22B, replace the definition of **services** with:

services has the same meaning as in section 6(1) of the New Zealand Public Health and Disability Act 2000, and includes assisted dying services provided under the **End of Life Choice Act 2017**.

In section 112B, replace the definition of **health information** with:

health information has the meaning set out in paragraphs (a) and (c) of the definition of that term in section 22B, but does not include information about assisted dying services provided under the **End of Life Choice Act 2017**.

Health and Disability Commissioner Act 1994 (1994 No 88)

In section 2(1), replace the definition of **health consumer** with:

health consumer includes—

- (a) any person on or in respect of whom any health care procedure is carried out; and
- (b) any person who, under the **End of Life Choice Act 2017**, requests to receive assisted dying.

After section 30(b)(i), insert:

- (ia) health consumers who, under the **End of Life Choice Act 2017**, request to receive assisted dying; and

Part 2**Amendments to legislative instruments****Births, Deaths, Marriages, and Relationships Registration (Prescribed Information) Regulations 1995 (SR 1995/183)**

Replace regulation 7(1)(a)(xiii) with:

(xiii) the cause or causes of the person's death, subject to **subparagraph (xiiiia)**:

(xiiiia) in respect of a person who died as a result of the provision of assisted dying under the **End of Life Choice Act 2017**, the terminal illness or medical condition that gave rise to the person's eligibility for assisted dying:

(xiiiib) in respect of a person who died as a result of the provision of assisted dying under the **End of Life Choice Act 2017**, the fact

Births, Deaths, Marriages, and Relationships Registration (Prescribed Information) Regulations 1995 (SR 1995/183)—continued

that the person died as a result of the provision of assisted dying under that Act:

(xiic) the interval between onset of the cause of death and death, in respect of each cause of death, subject to **subparagraph (xiid)**:

(xiid) in respect of a person who died as a result of the provision of assisted dying under the **End of Life Choice Act 2017**, the interval between onset of the terminal illness or medical condition that gave rise to the person’s eligibility for assisted dying and death by assisted dying:

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Cremation Regulations 1973 (SR 1973/154)

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In regulation 7(1)(a), replace “or 46C(1)” with “, 46C, or **46CA**”.

In Schedule 1, form B, replace “or 46C(1)” with “, 46C, or **46CA**”.

In Schedule 1, form B, replace items 6 and 7 with:

6 Did you attend the deceased before the deceased’s death?

If so, for how long?

7 If you attended the deceased before the deceased’s death, when did you last see the deceased alive?

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In Schedule 1, form B, item 8, delete “Period elapsing between onset of each condition and death (*years, months, or days*).”

In Schedule 1, form B, replace item 9(a) with:

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(a) immediate cause—the disease, injury, or complication that caused the death, or assisted dying? [*specify*]

In Schedule 1, form B, replace item 10 with:

10 What was the mode of death if other than by assisted dying?

In Schedule 1, form B, replace item 14 with:

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14 In view of your knowledge of the deceased’s habits and constitution, do you feel any doubt whatever as to the cause of the deceased’s death?

In Schedule 1, form B, replace the paragraph immediately following item 17 with:

I certify that the answers given above are true and accurate to the best of my knowledge and belief, and that there is no circumstance known to me that can give rise to any suspicion that the death was due wholly or in part to any other cause than that stated that makes it desirable that the body should not be cremated.

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Health and Disability Commissioner (Code of Health and Disability Services Consumers’ Rights) Regulations 1996 (SR 1996/78)

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In the Schedule, clause 4, replace the definition of **services** with:

Health and Disability Commissioner (Code of Health and Disability Services Consumers' Rights) Regulations 1996 (SR 1996/78)—continued

services—

(a) means—

(i) health services; and

(ii) disability services; and

(iii) the provision of assisted dying under the **End of Life Choice Act 2017**; and

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(b) includes health care procedures.

Health (Retention of Health Information) Regulations 1996 (SR 1996/343)

In regulation 2, replace the definition of **services** with:

services has the same meaning as in section 6(1) of the New Zealand Public Health and Disability Act 2000, and includes assisted dying services provided under the **End of Life Choice Act 2017**.

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Legislative history

8 June 2017
13 December 2017

Introduction (Bill 269–1)
First reading and referral to Justice Committee