

Departmental Report

End of Life Choice Bill

December 2018

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Terminology

For consistency, this report uses the language in the Bill rather than the language of submitters, for example, “medication” or “medical practitioners”.

The Bill uses “assisted dying” to refer to both euthanasia and assisted suicide. Euthanasia refers to a patient being administered a lethal drug by a medical practitioner. Assisted suicide refers to a patient receiving lethal drugs at their request, which they take by themselves. This report uses “assisted dying”, except where it makes sense to distinguish between these two concepts.

This report often refers to “the Code”. This is the *Code of Health and Disability Services Consumers’ Rights*, a regulation under the Health and Disability Commissioner Act 1994. It establishes the rights of health and disability services consumers, and the duties and obligations of health care and disability services providers.

Introduction

1. This report has been prepared by the Ministry of Justice and the Ministry of Health.
2. The End of Life Choice Bill (the Bill) is a Member's Bill in the name of David Seymour, MP for Epsom. The Bill was introduced on 8 June 2017 and had its first reading on 13 December 2017.
3. The Explanatory Note sets out that the Bill intends to give people with a terminal illness or a grievous and irremediable medical condition the option of requesting assisted dying. The Bill sets up new processes within the health system to provide this option and to implement the choice of a person who is eligible for assisted dying.
4. Officials have been made available by Ministers as advisers to the Committee on the Bill. The role of officials on members bills is to help the Committee understand how the bill intersects with, and will change, relevant regulatory frameworks. It is for the Committee to determine whether any change is beneficial.
5. Assisted dying raises ethical and value-based judgments over which philosophical, moral, religious, and clinical views are divided. The overarching issues are expected to be matters of conscience for MPs. It is for the Committee to determine its advice to the House, and this report makes no recommendation on any matter of conscience.
6. The Justice Committee received about 37,200 unique written submissions from organisations and individuals. In addition, it held over 40 hearings of oral evidence, during which it heard about 1,600 submitters. Around 36,700 submissions have a discernible view. We have interpreted some 33,500 as opposing the Bill (about 90%) and over 3,100 supporting (about 8.5%). Despite their disagreement, many submitters who oppose the Bill note the compassionate intent of submitters who support the Bill.
7. This report contains a thematic summary of the views of submitters on the issue of assisted dying and on the Bill itself, and a full summary of submissions. We have not put numbers on how many submitters had a particular view, or how many times an issue was raised, as the volume and varied nature of the submissions make this impractical.
8. This report is divided into sections based on clauses. As we cannot be certain of the intent of some clauses, the Committee may want to complement this report with input from the sponsoring member.
9. We have made some suggestions as to how the Committee may wish to think about implementation issues. In some instances, we have made recommendations. The intent of these is to provide that, should the Bill progress, it has a clear statutory framework that is consistent with those already operating in the health and justice systems.

10. This report is not a statement of Government policy, and nothing in it should be construed as a Government view in favour of or against a regime for assisted dying.

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Outline of the Bill

11. The Bill is built on three core elements:
 - defining those who are eligible for assisted dying
 - ensuring that the person requesting assisted dying is mentally capable of understanding the nature and consequences of their decisions
 - ensuring there is free choice, without coercion, to engage in the process.
12. The key role in the process is that of the “attending medical practitioner”, defined in the Bill as the medical practitioner of the person who wishes to exercise the option of requesting assisted dying.

Eligibility criteria

13. The criteria a person must meet before they could be considered for assisted dying are found in clause 4 of the Bill. The criteria were the part of the Bill most commented on. A full discussion of clause 4 and the submissions is found from page 29.

Mental capability

14. The ability to understand the nature of assisted dying and the consequences for the person of assisted dying are included as an eligibility criterion in clause 4 and are also used as the definition of “competent” in clause 3. A full discussion of the submissions and the concept of competence is found from page 36.

Free choice, made without coercion

15. The Bill sets out several measures that are intended to address the risk of coercion. When the person makes a request the attending medical practitioner must to do their best to ensure that the person expresses their choice free from pressure from any other person by:
 - talking with other health practitioners who are in regular contact with the person
 - talking with members of the person’s family approved by the person.
16. The attending medical practitioner must also:
 - discuss the choice with the person, at intervals determined by the progress of his or her terminal illness or medical condition
 - ensure that the person understands their other options for end of life care
 - ensure that the person knows they can change their mind at any time.

17. The person confirms their request by signing and dating a form or having another person sign and date the form on their behalf. This person must not benefit from the death of the person to whom the form relates, and the attending medical practitioner must be present when the form is signed.
18. The attending medical practitioner is also required to check with the person at the following points in the assisted dying process:
 - when the method of administration of the medication is chosen, the attending medical practitioner must ensure the person knows they can change their mind at any time
 - prior to the medication being administered, the attending medical practitioner must ask the person if they choose to receive the medication.

The process of assisted dying

19. The process begins with an initial request to the person's attending medical practitioner.
20. Any person, who is authorised or required to do anything set out in the Bill, can conscientiously object and is not required to do that thing. At the beginning of the process, if an attending medical practitioner has an objection, they must inform the person of the objection and that a replacement medical practitioner can be organised. Clauses 6 and 7 set out the conscientious objection mechanism and are discussed in more detail from page 41.
21. The Bill sets out the process of assisted dying in clauses 8 – 18. These clauses are discussed in more detail from page 46.
22. The opinions of two medical practitioners are required as to whether the person is eligible for assisted dying, or would be eligible if their competence were established. A third opinion may be required to determine competence if either medical practitioner is unsure of the person's competence.
23. If a person is determined to be ineligible or not competent, the process ends. If the person is found to be eligible and competent, provisional arrangements for the administration of the medication are made.
24. The person selects a method for receiving the lethal dose of medication, either by ingestion triggered by the person, intravenous delivery triggered by the person, ingestion through a tube, or injection.
25. At the chosen time of administration, the attending medical practitioner must ask the person if they choose to receive the medication. If the person chooses to receive it, the attending medical practitioner administers the medication by providing it to the person. A medical practitioner must be available to the person until the person dies. The death must be reported within 14 days.

26. If the person does not want to receive the medication, the medication is removed and returned to the dispensing pharmacist.

Other matters

27. The Bill sets up three new administrative bodies within the health system, provides for reviews of processes and of the operation of the Act, and sets out other matters to assist in the functioning of the Act.
28. The three bodies are the Support and Consultation for End of Life in New Zealand Group (the SCENZ Group), the Review Committee, and the Registrar (assisted dying) (the Registrar). Details of the accountability regime are discussed from page 61.
29. Existing rights to refuse nutrition, hydration and life-sustaining medical treatment are not affected. The Bill also does not affect a medical practitioner's duty to alleviate suffering in accordance with standard medical practice.
30. A person who dies because of assisted dying is taken for all purposes to have died as if assisted dying had not been provided. Persons are immune from liability in civil or criminal proceedings for acts and omissions in good faith, and without negligence, in providing or intending to provide assisted dying.
31. However, it is an offence to wilfully fail to comply with a requirement in the Bill or to complete or partially complete, or alter or destroy, a prescribed form without consent of the person to whom the form relates. A person is liable on conviction to imprisonment of a term not exceeding three months and/or a fine not exceeding \$10,000.
32. Details of the liability, offences and penalties regime are discussion from page 70.
33. The Bill amends the Births, Deaths, Marriages, and Relationships Registration (Prescribed Information) Regulations 1995 to reflect that the death of the person was because of the provision of assisted dying under the Bill. Details on reporting of death are found from page 81.

The current law

Procedures that are not assisted dying

34. The withdrawal of treatment by a medical practitioner at the patient's request, or because the treatment is futile, is lawful and generally considered ethical. It does not constitute assisted dying. Section 11 of the New Zealand Bill of Rights Act 1990 (Bill of Rights Act) provides that everyone has the right to refuse to undergo any medical treatment.
35. Medication given for pain relief with the primary aim of relieving patient distress is lawful and ethically acceptable, even when it may have the secondary effect of shortening life.

Crimes Act 1961

36. Assisted dying is currently prohibited in New Zealand by the operation of four sections of the Crimes Act:
 - section 63 (consent to death) provides that a person cannot consent to have death inflicted upon themselves. If a person is killed their consent shall not affect the criminal responsibility of any person who was party to the killing.
 - section 179 (aiding or abetting suicide) creates an offence to incite, counsel, or procure any person to commit suicide, if that person commits or attempts to commit suicide as a result, or to aid or abet any person in the commission of suicide.
 - section 160(2)(a) (culpable homicide) states that homicide is culpable when it consists of the killing of any person by an unlawful act. Culpable homicide is either murder or manslaughter.
 - section 164 (acceleration of death) creates an offence of acceleration of death. Everyone who by an act or omission causes the death of another person, kills that person. This is even though the injury caused by that person merely hastened death, and the person had some underlying disorder or disease.
37. Sections 63, 160(2)(a) and 164 prohibit euthanasia, while section 179 applies only to assisted suicide.

Past cases

38. High-profile cases in New Zealand of family members or friends assisting a person to die include:
 - Lesley Martin, who was sentenced to 15 months in prison in 2004 on a charge of attempted murder

- Professor Sean Davison, who was sentenced to five months home detention in 2011 on a charge of counselling and procuring suicide
- Evan Mott, who was discharged without conviction in 2012
- Susan Austen, who was convicted of importing a class C drug in 2018 and fined \$7,500.

Seales v Attorney General

39. Sections 160 and 179 of the Crimes Act, were considered in *Seales v Attorney General*.¹ Ms Seales sought a declaration that these sections were inconsistent with sections 8 (Right not to be deprived of life) and 9 (Right not to be subject to torture or cruel treatment) of the Bill of Rights Act. Justice Collins did not issue the requested declarations, as the changes to the law sought by Ms Seales could only be made by Parliament.
40. Additionally, *Seales* discussed the operation of sections 196 (assault) and 200 (poisoning with intent) of the Crimes Act. It was concluded that the administration of a lethal drug to Ms Seales by her medical practitioner would constitute assault. This situation would also likely be a breach of section 200 of the Crimes Act, which makes it an offence to administer a poison or other noxious substance to another person intending to cause them grievous bodily harm.

¹ *Seales v Attorney General* [2015] NZHC 1239.

Thematic summary of submissions

41. The Justice Committee received about 37,200 unique written submissions from organisations and individuals. In addition, Members of the Committee held over 40 hearings of oral evidence in centres and regions around New Zealand. In total, about 1,600 submitters were heard.
42. This summary categorises the views that were read and heard by their main themes. A more comprehensive summary is in Annex A. That summary also contains less frequently mentioned views and some of the nuance behind the views expressed. All submissions can be found at: www.parliament.govt.nz.
43. Officials have not put numbers on how many submitters or how many times an issue was raised, as the volume and varied nature of submissions make this impractical. Officials have indicated by other descriptors how frequently that view may have been held amongst submitters as a whole, or amongst the submitters commenting on that issue, depending on the context.
44. Submissions on particular clauses are found in the clause by clause analyses from page 20.

Description of written response

45. Written submissions were received through a range of channels including the www.parliament.govt.nz website, post, and email. Submissions were received from individuals and about 200 organisations. Around 26,700 submissions are brief and contain only a single sentence or a short paragraph. Other submissions are substantial in length and discuss the Bill in detail.
46. Around 36,700 submissions have a discernible view. Officials have interpreted approximately 33,500 as opposing the Bill (about 90%) and over 3,100 supporting (about 8.5%). The majority of submissions comment on whether assisted dying should be allowed in principle and do not refer to the Bill. Most submissions evidence strongly held beliefs. Discussion is both religious and secular. Submitters often share personal stories including discussing the way they might wish to experience their own end of life in the circumstances raised by the Bill.
47. Many of the smaller submissions addressing the concept of assisted dying, but not the Bill, contain similar material, including identical phrases. Submitters ticked arguments they agree with from a list or matrix of concerns.

Themes raised by submitters

Principles of assisted dying

48. Many of the submissions discuss whether assisted dying should be allowed in principle. Nearly all submitters who support the Bill believe that individuals are autonomous and will necessarily have their own view about what amounts to a quality life and dignified death. They consider that enabling choice over the end of life process, through access to assisted dying, will respect people's inherent autonomy and dignity. Some submitters supporting the Bill further believe that regardless of the effectiveness of medical care, suffering individuals should have the choice as to whether they engage in medical and palliative services, or choose assisted dying.
49. Submitters who oppose the Bill believe that personal autonomy is not absolute but rather constrained by obligations to others and the wider community. They believe the Bill will have a negative impact on the family and friends of people who access assisted dying and on wider society. Many submitters opposing the Bill consider all life to be sacred, irrespective of its quality. Many also believe that people do not have the prerogative to end their own or another's life, even with permission.
50. Some submitters think that allowing assisted dying in the manner outlined in the Bill would be tantamount to actively supporting suicide or legalising murder.
51. Submissions show conflicting views as to whether assisted dying is compassionate. Submissions in support consider that where people are suffering, it is compassionate to assist in their death. Many point to animal euthanasia as demonstrating society's acceptance of this understanding.
52. Many submitters who oppose the Bill believe it is not compassionate to enable suffering people to access assisted dying. Many consider that treatment with care, love, and support is the only compassionate response. Some submitters further believe that suffering is part of the human experience and has benefits, namely, it teaches resilience and gratitude and brings people closer to their family, community, and spiritual beliefs. Submitters who oppose the Bill often distinguish assisted dying from animal euthanasia as they think that humans are inherently distinct from animals.
53. Despite their disagreement, many submitters who oppose the Bill note the compassionate intent of submitters who support the Bill.
54. Some submitters who oppose the Bill consider assisted dying to be a breach of the state's core role of protecting its citizens. Some submitters believe the Bill was created with the intent of reducing state health costs. Some submissions consider assisted dying to be against cultural values, especially for the Māori and Pasifika communities.

People or groups who are eligible

55. To be eligible for assisted dying, individuals must meet the criteria outlined in clause 4 of the Bill. Many submitters comment on eligibility, often in reference to one or more

criterion in the Bill, but not always. Some submitters who oppose the Bill consider the criteria to be vague and open to various interpretations. Many submitters who oppose the Bill are greatly concerned for the individuals or groups they perceive would be eligible.

People with disabilities, or degenerative or chronic conditions

56. Some submitters who oppose the Bill are concerned that all or many people with disabilities, or degenerative or chronic conditions would meet the criteria of the Bill. Submitters are concerned that these people will consequently be coerced or forced to access assisted dying. Most of these submitters believe that as a result of meeting the Bill's criteria, people's lives will be devalued. Some submitters believe that society's acceptance and treatment of people with disabilities, or degenerative or chronic conditions, will be negatively impacted and that fewer health resources will be allocated to them as a result.
57. By contrast, submitters who support the Bill often do not have these concerns as they perceive the process outlined in the Bill to be consensual and self-selecting. Some believe that people with disabilities and degenerative or chronic conditions who meet the criteria should be able to access assisted dying, as it is for them to assess their unique circumstances and make their own choices about end of life.

People with mental illness

58. Many submitters who oppose the Bill interpret it as allowing assisted dying for mental illnesses, such as depression. Other submitters who oppose the Bill believe that only physical conditions and illnesses would be eligible. Many of these submitters, however, are concerned that eligible people may be mentally ill at the time they decide to access assisted dying, or consider that only mentally ill people want to die.
59. Many submitters are averse to mentally ill people accessing assisted dying on the basis that such illnesses impair a person's decision-making capabilities. Submitters often share stories about how they or someone they know had once wished to end their life but are now glad they had not. Others comment that depression and other mental illnesses are often experienced following terminal or life-changing diagnoses and prognoses. Many of these submitters are concerned that the Bill would allow mentally ill people to access assisted dying or would not adequately prevent mentally ill people from doing so.
60. By contrast, some submitters who support the Bill regard the process outlined in the Bill as capable of preventing mentally ill people from accessing assisted dying. Fewer supporting submissions believe that mental illnesses should not prevent people from accessing assisted dying where the criteria are met, if that is what the person wishes.
61. Many submitters, regardless of their stance on the Bill, think there should be more funding to address mental health.

Widening of criteria and application over time

62. Many submitters who oppose the Bill are concerned not with how the Bill looks now, but rather how it may look and be applied in the future. Many of these submitters believe that the Bill's eligibility criteria will expand over time. Submitters often refer to this expansion as the 'slippery slope'. Most are concerned that in the future, assisted dying will become permissible for children, and people with psychiatric and mental health conditions.
63. Submitters who oppose the Bill are also concerned that over time assisted dying will be normalised, and the application of the criteria liberalised. These submitters commonly give the Contraception, Sterilisation, and Abortion Act 1977 as an example of legislation that they consider having expanded in scope. Many submitters who oppose the Bill consider that in the future it will be interpreted to allow assisted dying without consent, while some submitters interpret the Bill as presently doing so. In discussing their predictions for the future scope or interpretation of the Bill, submitters who oppose the Bill often refer to overseas jurisdictions that permit some form of assisted dying.
64. Submitters who support the Bill refer positively to overseas experiences with assisted dying. Some perceive these experiences to provide evidence that the Bill and its application will not change in the future. Other submitters support the Bill being widened to include other groups, such as children and those with psychiatric and mental conditions, as they consider that these people can equally face unbearable and non-remediable suffering.

Coercion

65. Submitters who oppose the Bill often reject the idea that assisted dying gives greater autonomy and choice. Some of these submitters believe the Bill already allows assisted dying without an individual's consent at the approval of medical practitioners and/or family members.
66. Many other submitters who oppose the Bill believe assisted dying as outlined in the Bill does require the individual's approval, but express concern that people will be coerced into consenting to it. They consider that people who meet the criteria outlined in the Bill may begin to regard themselves as a burden to friends and family, caregivers, and/or wider society. Such people may therefore believe they have a duty to die. Submitters are concerned that comments and actions by those surrounding eligible people may encourage the perception that they are a burden, even when this is not intended.
67. Submitters also believe that family, friends, and caregivers may intentionally coerce eligible people. Such submitters are especially concerned that this may occur where someone stands to benefit from a person's death. Submitters thought that this could be a financial gain but also through not having to care for the person any longer. Many submitters are also concerned that elderly people in particular will be coerced into accessing assisted dying and that the Bill will consequently encourage greater elder abuse. Other submitters are concerned that people facing economic disadvantages will be coerced into, or face strong incentives to choose, assisted dying.

68. Some submitters who oppose the Bill are also concerned that the medical practitioner referred to in the Bill has great power to coerce their patients. They perceive that the medical practitioners who will volunteer to be involved in assisted dying will be biased towards allowing it. Some submitters who oppose the Bill are further concerned that, on occasion, medical practitioners may coerce their patients for their own malicious purposes, or to free up health resources.
69. Submitters also believe that patients may be encouraged to access assisted dying by the prognosis or diagnosis they receive from the medical practitioner. Many submitters are consequently concerned about the accuracy of such prognoses and diagnoses. Submitters often tell stories of how they, or people they knew, had lived much longer than a prognosis predicted.
70. Some submitters who support the Bill believe that any potential coercion will be mitigated by the process outlined in the Bill. By contrast, many submitters who oppose the Bill consider its safeguards insufficient to identify people at risk of coercion and protect them against it. Many believe that coercion can be too subtle to be identified, or they regard medical practitioners as not well-placed to identify it.
71. Some submitters who oppose the Bill believe that no safeguards could ever provide sufficient protection. Submitters often comment on the irreversible nature of death and consider the Bill to provide insufficient protection if it allowed even one death against a person's true will.

Role of health practitioners

72. Submitters express varying views regarding which health professionals would be involved in the process, though most submitters believe it would be medical practitioners. Some submitters think that other health practitioners could also be involved. Some submitters interpret the Bill as not involving medical practitioners and often express their disapproval of this.
73. Many submitters who oppose the Bill are concerned with the involvement of health practitioners in assisted dying. Some of these submitters believe that assisted dying is contrary to the role of health professionals, the Hippocratic Oath, and/or is medically unethical. A portion of these submitters reference statements from the World Medical Association and the New Zealand Medical Association to support this stance.
74. Some submitters who oppose the Bill consider assisted dying to not be a form of healthcare. Many of these submitters consequently perceive the involvement of health practitioners as an attempt to medically legitimise the process outlined in the Bill. By contrast, some submitters in support of the Bill believe that allowing assisted dying gives greater respect to patient autonomy and greater ability to the health sector to reduce suffering.
75. To remove the involvement of health practitioners, some submitters suggest alternative processes to that outlined in the Bill. Most commonly, submitters advocate for the involvement of the family court, lawyers, or the creation of a special role.

76. Many submitters who oppose the Bill are concerned that the availability of assisted dying will undermine medical practice. They consider that it will negatively impact the relationship of trust that people have with medical practitioners, and undermine and discourage medical and palliative efforts to treat patients. Some submitters believe that funding and research for terminal illnesses, pain relief, and end-of-life-care may consequently be reduced. By contrast, some submitters who support the Bill believe assisted dying would enhance medical and palliative care. They believe assisted dying permits patients to more openly discuss their views on end of life with medical practitioners and alleviates fears of future pain.
77. Many submitters who oppose the Bill believe that most health practitioners will not want to assist in people's deaths. Some submitters identify themselves as health practitioners and express that they would not take part in the process. Some submitters who oppose the Bill question the effectiveness of the conscientious objection mechanism. Some submitters are concerned that medical practitioners will be pressured to engage in assisted dying against their will by their patients, their family and friends, or workplaces.
78. Some submitters believe that if the Bill were to pass, many health practitioners would leave the health sector as a result. Many submitters who support the Bill, by contrast, consider that conscientious objection sufficiently enables medical practitioners who oppose assisted dying to disengage. Some submitters who support the Bill identify themselves as health practitioners who will offer assisted dying if the Bill is to pass.

Messaging on suicide

79. Many submitters discuss the relationship between assisted dying and suicide. Reference is often made to current government policy, recent statistics, and overseas studies. Many submitters who support the Bill believe assisted dying and suicide to be distinct. They consider that where a person chooses to access assisted dying, the person does not truly want to die, but rather seeks to escape unbearable or inevitable suffering.
80. Some submitters who oppose the Bill perceive there to be no distinction between death by assisted dying and suicide. They regard the Bill as actively supporting suicide. Other submitters who oppose the Bill are concerned that allowing assisted dying will legitimise death as an acceptable response to suffering. They are concerned that this will encourage those contemplating suicide, particularly young people, to follow through. Many submitters who oppose the Bill believe the Bill will increase current suicide statistics. Some submitters who oppose the Bill further believe that it will undermine current mental health and suicide prevention programmes.
81. Many submitters, regardless of their stance on the Bill, desire further funding for suicide prevention programmes.

The status quo

82. Most submitters who oppose the Bill believe that the current medical and legal framework works well. Many believe that the health sector can prevent unbearable

suffering and that medical advances are continuously improving available pain relief. Some submitters identify rights which allow people to exercise their autonomy to die, such as refusing medical treatment. Others note that it is already lawful to refuse to provide futile treatment.

83. Some submitters comment that in situations of unbearable suffering, health practitioners can administer pain relief that has the ancillary effect of hastening death. By contrast, some submitters who oppose the Bill believe there are still cases of unbearable suffering, however they perceive these cases as too few to warrant legislative change.
84. Some submitters further believe that the option already exists for people to suicide and/or that the law has been compassionately lenient for those who have assisted. Others think, however, that relying on lenient sentencing is not an appropriate way of dealing with the issues.
85. Nearly all submitters who support the Bill believe that people are still suffering under our current legal and medical framework. Many submitters who support the Bill acknowledge that there are currently ways for people to die, but perceive such ways to be lengthy, painful, and as not giving proper regard to people's dignity and autonomy. Some supporters also believe that without assisted dying, some terminally ill people end their lives earlier while they still have the physical capacity to commit suicide. These submitters express their dismay and grief towards their perceived loss of time with the person concerned, and for such people having to die alone.

Palliative and hospice care

86. Palliative and hospice care is addressed and described in a variety of ways by submitters. Submitters often describe negative and positive experiences that they and their loved ones have had with such care. Many submitters who oppose the Bill believe that assisted dying is not necessary, as suffering can be adequately managed by palliative and hospice care. Some of these submitters regard New Zealand's current palliative and hospice care services as sufficient, while other submitters who oppose the Bill believe that these services are not sufficient, especially in rural areas. They believe that greater governmental funding for these services should be given, instead of progressing the Bill.
87. By contrast, many submitters who support the Bill believe some people still face unbearable suffering even with these services, and that no amount of palliative or hospice care will ever be sufficient to alleviate some pain. In particular, these submitters point to neurological and spinal conditions that remain unmanageable by current care.
88. Many submitters support further funding for palliative care services.

Cultural considerations

89. Many submitters are concerned that the Bill is based on a Western philosophy of valuing individual autonomy, which is inconsistent with the value systems of non-Pākehā cultural groups within New Zealand. Most of these submitters mention Māori tikanga (values).

Others mention values they attribute to Pasifika or other ethnic communities. Submitters describe the core values of these groups as less individualistic and more family and community oriented, with a high value on life.

90. In particular, many submitters describe a Māori worldview in which people are a part of their whānau, hapū, and iwi, where care, respect and reverence are shown for the elderly and the terminally ill, and life and wairua (spirituality) are valued. Other submitters feel that assisted dying will breach the tapu (sacredness) of the person and have spiritual ramifications for all of those involved.
91. Not all submitters identifying as Māori oppose the Bill, however, or consider it inconsistent with tikanga.
92. Some submitters think that the Bill breaches the Treaty of Waitangi. In particular, tiaki (protection) of Māori values as an underlying principle of the Treaty and the concept of the taonga (treasure) of life under Article 2.
93. Other submitters think the Bill contravenes holistic models of Māori Health such as Te Whare Tapa Whā, which sets out four equally balanced cornerstones - physical, spiritual, family and mental - of Māori health. Some feel that there should be more use of rongoā Māori (traditional healing) in the health system.
94. Some submitters are concerned that the operation of assisted dying will reflect existing discrimination and prejudice in the health system. These submitters consider that Māori and Pasifika are less likely to be able to pay for healthcare, receive lower standards of care and have less access to palliative care. They feel that these groups will therefore be more likely to request assisted dying on a per capita basis than other groups.
95. Submitters also think that these groups are less likely to be treated by health practitioners of their own culture or those that understand their worldview. Submitters think it is important that medical practitioners are competent in the correct procedures regarding tāngata māuiui (sick people) and their transition to death, as well as the procedures surrounding the treatment of tūpāpaku (the deceased).
96. Many submitters mentioned the fear that may be felt by a very sick Māori or Pasifika person, knowing their medical practitioner may not help heal them or help them live.
97. Many submitters think it is important that leaders of non-Western cultures should be consulted separately about the Bill and the impact on the members of those groups. Submitters raise that a written submission process will not necessarily be fully representative of the views of these groups. Some submitters recognise that for Māori, tikanga (procedures) around life and death will not be the same across the country so it was important to have wide ranging consultation.
98. Some submitters commenting on cultural issues are concerned about the impact of the Bill on the suicide rates of Māori and Pasifika. They note that Māori and Pasifika people are currently disproportionately represented in suicide statistics and express concern that the Bill will make the problem worse.

Further information

Suicide prevention

99. The relationship between assisted dying and suicide is a common theme in submissions. Many submitters are concerned about the impact of the Bill on suicide statistics.
100. Suicide is a serious concern for New Zealand. Over 500 people die by suicide every year, with many more attempting it. Suicide also affects the lives of many others including families, whānau, friends, colleagues, and communities.
101. In New Zealand, suicide is defined as a death where there is evidence that the person deliberately brought about their own death. Classification of a death as suicide is based on a coronial verdict.
102. Recent suicide prevention activity has been guided by the New Zealand Suicide Prevention Strategy 2006–2016. The strategy recognises that assisted dying and suicide are not comparable acts, specifically stating that the strategy does not address "the issue of physician-assisted suicide or euthanasia, which raises separate ethical, legal, and practical issues".
103. A range of suicide prevention efforts are underway in New Zealand. This includes a national suicide prevention programme for Māori and Pasifika, suicide prevention training, and support for individuals and communities bereaved by suicide. Government agencies also fund a range of other services that contribute to preventing suicide, such as work to prevent bullying, reduce child poverty, and improve mental health. Additionally, some other initiatives that are funded and provided by community and private organisations which contribute to preventing suicide.
104. Future suicide prevention activity, including any new strategy, will be informed by the Government Inquiry into Mental Health and Addiction.² The Inquiry included a specific focus on preventing suicide as well as support for those close to someone who has taken their own life. The Inquiry report was released on 4 December 2018.
105. Many submitters cite a 2015 study published in the Southern Medical Journal: "*How Does Legalization of Physician-Assisted Suicide Affect Rates of Suicide?*"³ as evidence that allowing assisted dying would increase suicide. That study found an increase in rate of total suicides in states when assisted dying was allowed. However, the increase included assisted dying cases. There is no evidence that assisted dying impacts suicide rates.

² <https://mentalhealth.inquiry.govt.nz/>

³ David Albert Jones, DPhil; David Paton, PhD. Southern Medical Journal 2015; 108(10):599-604, retrieved from Medscape.

Palliative care

106. The practice of palliative care in New Zealand is raised often by submitters.
107. Palliative care is care for people of any age with a progressive, life-limiting medical condition. It affirms life, regards dying as a normal process, and intends neither to hasten nor postpone death. It may be suitable whether death is days, weeks, months, or occasionally even years away.
108. Palliative care aims to:
- optimise a person's quality of life until death by addressing their physical, psychosocial, spiritual, and cultural needs
 - support the individual's family and whānau and other caregivers where needed, through the illness and after death.
109. Important features of good palliative care are that it is:
- available wherever the person lives
 - provided by all health care professionals, supported where necessary by specialist palliative care services
 - provided in a way that meets the unique needs of people from particular communities or groups, including Māori, Pasifika and other ethnic minorities, older people, disabled people, children and young people, refugees, and those in isolated communities.
110. In New Zealand, primary and specialist palliative care is delivered in hospital, aged residential care, private home, and in-patient hospice settings by a combination of District Health Boards and hospice services. It is funded by a combination of public funding and charitable donation. In 2018 District Health Boards funded around half of hospice costs, with the balance generated from public donations and hospice retail shops.

Palliative Care Action Plan 2017

111. The Ministry of Health Palliative Care Action Plan 2017 provides a plan for managing future demand and achieving the overarching goals in adult palliative care. The actions are grouped under five priority areas. One of the shorter-term actions is focused on gaining a greater understanding of national needs for palliative care.
112. Recent work has shown that there are shortfalls and that projected need will continue to outstrip current service levels. Access to palliative care is inequitable and the quality of palliative care is variable across different settings and regions. While some services are delivering excellent care, some communities or groups of people continue to struggle to access appropriate palliative care. The Ministry of Health is developing indicative options and costings for addressing these challenges.

Clause by Clause: Submissions and comment by Departments

113. This part of the report sets out the clauses in the Bill, what the clause or clauses do, what submitters said about them and any comment from the Ministry of Justice or the Ministry of Health.
114. There was no substantive comment on clause 5 (Act binds the Crown) or clause 24 (Other rights and duties not affected), nor do departments have any comment on them. They are not included in this report.
115. Nothing in this section constitutes an endorsement of the Bill by these agencies.

Summary of recommendations

116. Should the Bill progress, the following recommendations for amendment are those that officials consider will provide a clearer and more consistent statutory framework that will enable the Bill to function within the health and justice systems:
- that the Bill comes into force 12 months after either it receives Royal assent or, if a referendum is held on bringing the Bill into effect, 12 months after any positive referendum result is declared by the Electoral Commission
 - review existing definitions in health legislation and regulation to incorporate assisted dying
 - review the conscientious objection clause (clause 6 and 7).
 - review the accountability regime (clause 19-21 and 28)
 - review the liability, offences, and penalties regime (clause 25-27 and 28).
 - align processes for the reporting of death (clause 28).
117. The table below is the full list of recommendations and considerations for the Committee discussed in the clause by clause sections.

Table 1: Summarising recommendations and considerations for the Committee

Clause	Departmental Comment
Clause 2	We recommend the Bill comes into force 12 months after either it receives Royal assent or, if a referendum is held on bringing the Bill into effect, 12 months after any positive referendum result is declared by the Electoral Commission.
Clause 3	<p>The Committee may wish to consider amending the definitions of “medical practitioner”, “pharmacist”, and “psychologist” to align with the approach in the Health Practitioners Competence Assurance Act 2003.</p> <p>The Committee may wish to consider amending the definition of “conscientious objection” in clause 3 to “an objection on the grounds of conscience”.</p> <p>We recommend the Committee align assisted dying under the Bill into the language and processes of existing health legislation and regulation.</p>
Clause 6	<p>The Committee may wish to consider:</p> <ul style="list-style-type: none"> targeting the objection to assisting in the death of any person if the person has a conscientious objection (rather than providing that the Act does not require a person to do anything to which they have a conscientious objection). amending section 6(2)(a) to ensure that those that choose to participate and then fail to meet the requirements of the Bill are still liable.
Clause 8	<p>The Committee may wish to consider clarifying whether medical practitioners are permitted to raise assisted dying with the individual prospectively or are prohibited from doing so.</p> <p>The Committee may wish to consider amending “talk” in clause 8(2)(b) to “communicate in person” to cover all forms of communication, not only speaking.</p> <p>The Committee may wish to consider setting out that if coercion is found, the person is not eligible for assisted dying.</p>
Clause 9	<p>The Committee may wish to consider clarifying the procedure around the ‘signing on behalf’ mechanism. This could involve:</p> <ul style="list-style-type: none"> clarifying what “benefit” and/or “mental disability” mean providing for a more overt independent process providing for consequences where the criteria are not met.

Clause	Departmental Comment
Clause 15	The Committee may wish to consider clarifying that the clause 15(3)(iii) and (iv) are “triggered” or “activated” by the medical practitioner.
	The Committee may wish to consider amending the requirement for the Registrar to co-sign the prescription under clause 15(6) and instead provide for the Registrar to notify the attending medical practitioner that they are satisfied that the process has been complied with. Clause 18(3) (actions if the Registrar is holding the prescription when the person dies) would also need to be amended accordingly.
Clause 18	The Committee may wish to consider aligning the clause 18 requirements with existing management of medicine processes.
Clause 19 and 20	<p>The Committee may wish to consider clarifying the following matters for the SCENZ Group and the Review Committee:</p> <ul style="list-style-type: none"> • powers, duties, and responsibilities • membership including composition, length of tenure, reappointment, remuneration, and resignation or removal of members • procedures including quorums and absences, chairpersons and deputy chairpersons, decision-making and voting, sub-Groups or Committees, conflicts of interest, appointment of experts, and timeframes.
Clause 19	The Committee may wish to consider the purpose of the SCENZ Group.
	The Committee may wish to consider identifying the status of the SCENZ Group lists as either being public lists or being excluded from release under the Official Information Act.
Clause 20	We recommend the Committee clarifies the status of the Review Committee and prescribe a clear purpose to guide its work.
	The Committee may wish to consider providing details on the type of consideration and reporting the Review Committee carries out and the information and powers it requires to carry out its work.
	The Committee may wish to consider whether the Review Committee requires administrative assistance such a Secretariat within the Ministry of Health, or, if it is a separate entity, the ability to source staffing resources.
	The Committee may wish to consider also including a reporting requirement from the Review Committee to the Minister who appoints the members and whether this report should then put before the House.

Clause	Departmental Comment
Clause 21	We recommend the Committee clarify how the complaints procedure fits into existing accountability processes.
	<p>We recommend the Committee clarify:</p> <ul style="list-style-type: none"> • how the complaints procedure is to operate including how complaints are accepted, actioned and investigated, how decisions are made, and provide for appeal processes and other procedural matters • the relationship between the complaints procedure and the immunity provision in clause 26 and the offence provision in clause 27.
	The Committee may wish to consider clarifying whether the Registrar requires powers for the proper functioning of the complaints procedure, such as for investigation and evidence-gathering.
	The Committee may wish to clarify how the discretion of the Registrar to follow up reports of the Review Committee is exercised.
	The Committee may wish to consider whether the report of the Registrar to the Minister should be made public or put before the House.
	The Committee may wish to consider the purpose of the register and its intended use and availability.
Clause 22	The Committee may wish to consider only providing for a completion date for the reviews.
Clause 23	<p>The Committee may wish to consider further regulations making powers such as:</p> <ul style="list-style-type: none"> • a general regulation making power to provide for matters that enable the functioning of the Bill • setting out the contents of the report required under clause 17 and the Annual Reports of the Registrar.
Clause 25	We recommend the Committee clarify the intention of clause 25.
Clause 26	We recommend the Committee clarify the application of the Code and the Health Practitioners Competence Assurance Act in the context of clause 26.
	The Committee may wish to consider also providing immunity for other persons assisting and supporting the medical practitioner in providing or intending to provide assisted dying.
	We recommend the Committee clarifies how the immunity clause is to operate.
	We recommend the Committee clarifies that section 41 and section 48 of the Crimes Act do not apply in the context of assisted dying.
	We recommend the Committee clarify the immunity clause so that it does not apply to clause 27.

Clause	Departmental Comment
Clause 27	We recommend the Committee narrow clause 27 to include only the attending medical practitioner, the independent medical practitioner, and the specialist.
	We recommend the Committee amend the wording of key obligations within the Bill so that they are clear in the context of clause 27.
	We recommend that the Committee considers adding a defence to clause 27(2)(b) and (c).
	We recommend the Committee stratify the penalties between the distinctions of seriousness of breaches.
	The Committee may wish to consider a new offence to capture those who intentionally cause another person to request assisted dying against the person's will, with an appropriate penalty.
Clause 28	The Committee may wish to consider whether the death certificate should only require medical practitioners to record the grievous and irremediable medical condition for which assisted dying was provided and not state it as the cause of death.
	We recommend the Committee clarify the relationship between the Bill, the Burials and Cremation Act, and the Coroners Act.
	The Committee may wish to consider how the obligations to report to the Registrar and the Registrar's investigatory functions align with the existing processes.
	The Committee may wish to consider clarifying the legislative purposes for the collection of information under the Bill In light of the existing death reporting and investigatory processes.

Title and Commencement

Clause 1: Title

119. Only a few submitters commented on this clause. All of these submitters are opposed and are concerned that the title of the Bill is either not sufficiently accurate or a euphemism. Some submitters think that the title implies the only choice at end of life is assisted dying. Some think that the title of the Bill should use technical terminology such as ‘assisted’, ‘administered’, or suicide. Others thought the effect of shortening life should be included.

Clause 2: Commencement

120. The Bill provides that the Bill comes into force six months after the date on which it received the Royal Assent.

What submitters said

121. Some submitters think that any time period prior to commencement needs to be sufficient to develop guidelines and tools to assist the medical profession in implementing the legislation. They question whether six months would be long enough and note the Victoria legislation provides for an 18-month lead in time.

Comment

122. The Ministry of Health advises that six months may be insufficient time for it to establish the new processes required by the Bill, establish and make appointments to new roles and complete required regulatory processes. Developing and delivering guidance and training would also need to be considered.
123. Officials have consulted the Department of Internal Affairs, which advises a longer timeframe will assist it in amending the regime for death certificates, including potentially significant operational and systems changes.
124. Officials note that there is a prospect of a referendum being held on this legislation. In this case, the Bill’s implementation would be contingent on a public vote in favour.

We recommend the Bill comes into force 12 months after either it receives Royal assent or, if a referendum is held on bringing the Bill into effect, 12 months after any positive referendum result is declared by the Electoral Commission.

Clause 3: Interpretation

125. Clause 3 sets out definitions of several terms used in the Bill.

What submitters said

126. Only a few submitters comment specifically on the definitions contained in clause 3. These are discussed below. Other submitters think that additional terms used in the Bill should be defined. These suggestions are set out in the relevant clause by clause analysis.

Meaning of assisted dying

127. Submitters often express strong views that the term “assisted dying” is a euphemism. Submitters variously think that the terms ‘suicide’, ‘assisted suicide’, ‘euthanasia’ and/or ‘killing’ or similar should replace or be included in the definition. Some submitters feel the use of the term ‘assisted dying’ is inappropriate, offensive, or an insult to hospice and palliative care workers whose role includes caring for someone who is dying and is often termed ‘assisted dying’.
128. Submitters also often think that the use of ‘medication’ in the definition is misleading. Submitters suggest using ‘lethal drug’, ‘lethal dose’ or ‘lethal quantity’, ‘toxin’, ‘poison’, ‘overdose’ and/or ‘death dealing drug’ or similar.
129. Other submitters think that the definition does not include the self-administration option set out in the Bill and that clarity about what is being referred to and when is important. Some submitters recommend adopting the terminology of ‘assisted dying’ and ‘euthanasia’ used by the Health Select Committee in its 2017 report.

Comment

130. Officials note that the definition of “administration” and “administer” is particular to this Bill and is different to other health legislation (e.g. the Medicines Act 1981). However, it is internally consistent and appears to mean “provide for the use of the methods set out in clause 15(3)(a)”.

Meaning of medical practitioner

131. Submitters think that the definition of medical practitioner, while technically correct, is too broad. Submitters think that it should be specified that a medical practitioner practicing in this area of medicine should have a minimum length of experience and/or the medical practitioner should be limited to those practicing in specified areas of medicine and/or should have experience in the medical condition of the person seeking assisted dying.

Comment

132. Officials note that the definition of “medical practitioner”, “pharmacist” and “psychologist” in clause 3 of the Bill do not align with the approach to the referencing these professions set out in health legislation and therefore have meanings specific to the Bill.

The Committee may wish to consider amending the definitions of “medical practitioner”, “pharmacist” and “psychologist” to align with the approach in the Health Practitioners Competence Assurance Act.

Alignment with health legislation

133. This report assumes that the intention is for assisted dying to be considered a health service. In which case, officials consider that some amendment to health legislation and regulation will be required to ensure the Bill is consistent. Any mis-alignment may impact on the effectiveness of the Bill, if it is enacted.
134. As an example, the Health and Disability Commissioner Act 1994 requires that health service providers apply the Code when delivering “health services”. This term is defined as including services to promote health, services to prevent disease or ill-health, treatment services, rehabilitative services, and psychotherapy and counselling services. Assisted dying does not readily align with this definition and it is not clear that the consumer rights focus of the Code will be sufficient to ensure that consumers receiving assisted dying will be covered by the Code protections.
135. Similarly, the Medicines Act provides for the approval of medicines for “therapeutic purposes”, defined in section 4 of the Medicines Act. As a substance may be approved as a medicine only where it is used for a therapeutic purpose, it may be helpful to clarify whether the use of a substance for assisted dying is a use for a therapeutic purpose and can be approved as a medicine.
136. It may also be helpful to clarify how medicines would be approved for use in assisted dying under the Medicines Act. For example, before consenting to the distribution of a medicine, s 22(c) of the Medicines Act provides that the Minister of Health “shall weigh the likely therapeutic value of the medicine against the risk (if any) of the use of the medicine injuriously affecting the health of any person”. This requirement may be difficult to apply in the case of a substance indicated for use in assisted dying. Medicines approval processes are relevant to both new medicines and approvals for new uses of medicines that are already available in New Zealand.
137. If the substances constitute a medicine, medical practitioners may be able to prescribe the medicine for an unapproved use under s 29 of the Medicines Act, provided that this use can be described as being for the “treatment” of an individual person. This relies on an individual practitioner’s judgment regarding the appropriateness of the use of the substance. Medical practitioners may be reluctant to prescribe in these circumstances. This would also remove the additional quality protections provided by the medicines approval processes.

138. Similarly, the Health Information Privacy Code (HIPC) applies and protects information obtained in the course of a receiving a health service, which includes a personal health service. The definition of a “personal health service” does not clearly fit with the provision of assisted dying, as this is a service that is provided for the purposes of “improving or protecting” the health of an individual. As the Privacy Act 1993 does not generally apply to deceased natural persons, protection of personal information about the services provided would require the HIPC to apply in the context of end of life services.
139. The Bill also interacts with the Burial and Cremation Act and the Coroners Act. This is further discussed in the section on reporting of death from page 81.
140. If assisted dying is not intended to be a health service, this would significantly impact on the operation of the Bill, especially aspects of process, accountability, and liability.

<p>We recommend the Committee align assisted dying as set out in the Bill with the language and processes of existing health legislation and regulation.</p>
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Clause 4: Eligibility

141. To be eligible for assisted dying a person must meet the criteria under clause 4 of the Bill:
- 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
 - c. suffers from—
 - i. a terminal illness that is likely to end his or her life within 6 months; or
 - ii. a grievous and irremediable medical condition; and
 - 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 considers tolerable; and
 - f. has the ability to understand—
 - i. the nature of assisted dying; and
 - ii. the consequences for him or her of assisted dying.
142. The eligibility criteria are not standalone, and all are required for a person to be eligible for assisted dying. A table comparing the eligibility criteria in the Bill with other jurisdictions that permit some form of assisted dying is attached as Annex C.
143. Officials have highlighted comments from submitters in this section that directly comment on the Bill. Many submitters comment on eligibility as a concept. These comments are found in the thematic and full summaries of submissions.
144. Whether these criteria are appropriate or should be changed in response to submissions is a decision for the Committee.

Clause 4(a): aged 18 years or over

145. Clause 4(a) begins the list of criteria to establish whether a person is eligible for assisted dying. To be eligible a person must be aged 18 years or over.

What submitters said

146. Some submitters think that the inclusion of an age limit is sensible. Other submitters commenting on this clause have varying thoughts as to whether the age restriction of 18 is appropriate.

147. Some medical organisations and many other submitters argue that a person who is 18 is not at the age of full cognitive maturity. Submitters think this age may not be until 25 years of age, particularly for males. These submissions appear to support an age limit being raised to this level. Other submitters believe that the limit should be much higher – anywhere from 30 to 50 years.
148. Some submitters argue that the suffering of a person under age 18 is no less worthy of assisted dying and should not be excluded. Some submitters think the age should be set lower than 18 years, for example 16 years (with or without parental consent), or a person aged less than 18 should have the ability to access assisted dying with support and/or independent representation.
149. By contrast, other submitters state that they oppose lowering the age restriction. Some submitters believe that teenagers have not yet developed an accurate view of time and effect, often ride an ‘emotional roller coaster’, are subject to peer pressure, put little or no value on their lives, have limited capacity to make informed judgements, and often make decisions they later regret. Other submitters are concerned that if the age restriction was lowered, the decision to access assisted dying would be made by the parents or guardians, rather than the child.
150. Some submitters share stories of themselves or of people they know who had once been at a low point in their life when young but had gone on to be thankful that they had not died by suicide.
151. Some submitters think that other criteria in the Bill ensure the person is capable to make the decision to access assisted dying and that including a stated age limit is therefore unnecessary.

Report under section 7 Bill of Rights Act

152. The report of the Attorney-General found the age restriction of 18 years to be inconsistent with the right to freedom from discrimination on the basis of age. This right commences at 16 years of age and is provided by section 19(1) of the Bill of Rights Act.
153. Many submitters refer to this report when discussing whether they oppose or support the age restrictions. Some submitters believe the report supports their argument for lowering or abolishing the age restriction, while others suggest that the Bill should limit the right to be free from age related discrimination and consider that this would be justified. Others are concerned that because the report states the age restriction in the Bill could not be justified, that this would result in a lower age restriction.

Comment

154. Under section 5 of the Bill of Rights Act, limitations on rights may be justified where the limits are prescribed by law, reasonable, and demonstratively justified in a free and democratic society. The Attorney General in his report, found the age limitation in the Bill was not justified because the age restriction is not rationally connected to the objective of ensuring that only competent people are able to access assisted dying.

155. New Zealand legislation sets out several age restrictions. This is because in different circumstances, a different age restriction is agreed to be appropriate, and which may or may not *prima facie* engage Bill of Rights Act issues.
156. In health and disability services, section 36 of the Care of Children Act 2004 provides that a child of or over the age of 16 can consent, or refuse to consent, to medical treatment as if they were of full age. Minors above the age of 16 are presumed to be capable of giving consent.
157. Where the child is not in a position to decide, parents have a role in the decision, as provided for under the Care of Children Act. Under this, the “duties powers, rights and responsibilities of a guardian” are expressed as including that of determining for and with the child, or helping the child to determine, questions about “important matters” affecting the child. This category of “important matters” includes “medical treatment for the child (if that medical treatment is not routine in nature)”.
158. Domestic legislation is informed by the House of Lords case *Gillick v West Norfolk and Wisbech Area Health Authority*⁴ which considered whether a medical practitioner can give contraceptive advice and treatment to a girl under 16 without parental consent. The Court found a minor’s consent could be given without parental permission where the minor had reached an age where they had sufficient understanding and intelligence to fully understand what was being proposed. In practice, this will be a case by case assessment.

Overseas jurisdictions

159. Most overseas jurisdictions that provide for assisted dying allow it for those aged 18 and above. Only two jurisdictions currently allow for people under 18 to access assisted dying:
- the Netherlands allows people between the ages of 12 and 17 years to access assisted dying, providing the person has a reasonable understanding of their interests and, depending on the age of the person, the parent(s) and/or guardian agree or are involved in the decision process.
 - in Belgium, all references to age limits were removed in a 2014 amendment to the legislation. The person must have the capacity of discernment, assessed by a child psychiatrist or psychologist, and the legal representatives of the minor must agree. The person must be in a terminal condition of physical suffering only.
160. While Canada currently only allows assisted dying for people over the age of 18, an independent review of assisted dying for mature minors has been published. This sets

⁴ *Gillick v West Norfolk and Wisbech Area Health Authority* [1985] 3 All ER 402.

out the impacts and unique considerations of allowing assisted dying for minors, for further consideration by the federal government.

Clause 4(b): citizenship or permanent residence

161. Clause 4(b) continues the list of criteria for a person to be eligible for assisted dying.

What submitters said

162. Very few submitters address this clause. Of those who do, submitters consider that the intent of the clause is to limit 'euthanasia tourism'. Some submitters think this is sensible, while others consider it to be discriminatory and an arbitrary limitation. Other submitters think that there should be more restrictions to avoid tourism, such as continuously living in New Zealand.

Comment

163. The Bill permits a narrower range of people to be eligible for assisted dying than are eligible for publicly funded health services.

164. The Health and Disability Services Eligibility Direction 2011 sets out the eligibility criteria for publicly funded health and disability services in New Zealand. Being eligible gives a person a right to be considered for publicly funded health or disability services (i.e. free or subsidised). It is not an entitlement to receive any particular service. Examples are:

- Australian citizen or permanent resident who has lived, or intends to live, in New Zealand for two years or more
- work visa holder eligible to be in New Zealand for two years or more
- interim visa holders
- refugees and protected persons, applicants and appellants for refugee and protection status, and victims of people trafficking offences.

Clauses 4(c) – (e): the person's condition

165. Officials have combined the analyses of these sub-clauses as they all relate to the required state of the person who wishes to be assisted to die. Comments from submitters have similar themes across all of these sub-clauses.

What submitters said

Terminology

166. Many submitters consider that the terms used in the eligibility clause are vague, subjective and could be open to interpretation. Terms that submitters comment on include:

- grievous and irremediable medical condition

- advanced state of irreversible decline in capability
 - unbearable suffering
 - relief that is not considered tolerable.
167. Submitters think that it is unclear who would assess the person's condition. For example, some submitters query whether a medical practitioner will make the determination or whether it is the subjective view of the person who wishes to access assisted dying.
168. Some submitters express concern that medical practitioners may have various interpretations of these terms. They recommend that definitions be included to ensure that the criteria are consistently measured.

Comment

169. It is desirable for law to be clear and certain. This allows the law to function as intended. Some of the terms highlighted by submitters, including medical practitioners, are not currently in use in the health sector.
170. The Canadian legislation does define a person with a "grievous and irremediable" condition. The Bill uses most of these concepts as eligibility criteria. In Canada, a person has a grievous and irremediable medical condition only if they meet all of the following criteria:
- the person has a serious and incurable illness, disease, or disability
 - the person is in an advanced state of irreversible decline in capability
 - their illness, disease or disability, or state of decline causes the person enduring physical or psychological suffering that is intolerable to them and that cannot be relieved under conditions that they consider acceptable
 - the natural death of the person has become reasonably foreseeable, considering all of their medical circumstances, without a prognosis necessarily having been made as to the specific length of time that they have remaining.
171. If the Committee were of a view that "grievous and irremediable" should be defined similarly to the Canadian legislation, a restructure of sub-clauses 4(c) to (e) would be required to avoid overlap and internal inconsistencies.

Terminal illness vs grievous and irremediable medical condition

172. Many submitters think that eligibility should be limited to terminal illness only.
173. Some submitters think 'grievous and irremediable' is a low threshold to meet and the criterion is inclusive and not exclusive. Some submitters think the inclusion of a criterion such as this could be reconsidered when the law is reviewed. Other submitters suggest that a timeframe for death should also be added to this criterion.
174. Some submitters think that limiting assisted dying to terminal illness would be inadequate and cruel. Submitters give the example of conditions such as motor neuron

disease which causes suffering that may become intolerable to the person, but is not necessarily terminal.

175. Submitters think that the terminal illness criterion could be combined with the grievous and irremediable criterion and a timeframe for both considered. Suggestions include a 'reasonably foreseeable death' or a more specific threshold, such as six or 12 months. Examples of timeframes from other jurisdictions are provided.

Prognosis

176. Many submitters who comment on clause 4(c) consider that it is difficult for medical practitioners and specialists to make an accurate prognosis including estimates of life expectancy. Submitters think that medical practitioners could make errors, or sometimes are unable to make accurate prognoses due to the nature of the medical condition.
177. Some submitters share stories about themselves or of people known to them who survived for longer, and sometimes far longer, than the initial medical prognosis. Some submitters suggest that medical practitioners are more likely to be more accurate within a three-month timeframe than the six months currently specified.
178. Some submitters think the alleviation of suffering should be the priority, and an arbitrary timeline of six months could prolong avoidable suffering. Fixing a life expectancy limit does not take account of the unpredictable nature of many different diseases and illnesses, or of people's wishes.
179. Some submitters are also concerned that medical practitioners can misdiagnose conditions, which could lead to incorrect decisions about treatment. Some submitters share stories of struggling for long periods of time, only to eventually find a treatment for their condition that meant they could enjoy life again.
180. Submitters are concerned that people may be assisted to die because of an inaccurate prognosis or misdiagnosis. Submitters feel this would mean that people would die when they may have had more time to live, or might have even recovered and gone on to live fulfilling lives. Submitters think these would be wrongful deaths. Some submitters query whether medical practitioners would or should be liable in these instances.

Collection of conditions

181. Some submitters think it is unclear whether a person with a collection of conditions should be permitted to access assisted dying if they so wish. This is where none of the conditions on their own would be 'grievous and irremediable', but the collection of conditions could meet the criterion.

Common conditions

182. Many submitters are of the belief that assisted dying would automatically be offered to people with grievous and irremediable medical conditions.

183. Submitters think the criterion would allow people to be eligible if they had a permanent and painful condition that is not necessarily terminal but also has no cure. Submitters mention conditions including rheumatoid arthritis, chronic pain syndromes, cerebral palsy, and heart disease.
184. Other conditions that submitters think would be covered by 'grievous and irremediable' include blindness, deafness, arthritis, diabetes, dementia, incontinence, gluten intolerance, genetic defects, grief, those with intellectual disability, muscular dystrophy, asthma, autism, loneliness, spina bifida, and Down syndrome. Many submitters mention the Netherlands and Belgium as examples of jurisdictions they believe have expanded eligibility to include such conditions.

Disability

185. Many submitters think that the criterion enables a pathway for people with disabilities to access assisted dying. The submitters include people who have a disability or who represent groups of people with disabilities. Further, some of these submitters consider the criterion as giving the message that the lives of people with disabilities are not worth living and are therefore of less value. Some submitters who represent disability groups report that their lives are already seen by some as being undignified.
186. Some submitters suggest that the Bill follow provisions in the Australian state of Victoria's legislation where a disability, on its own, is not sufficient to access an assisted dying process. Other submitters think that a person with a disability should never be able to access assisted dying.
187. Conversely, other submitters agree that people with disabilities should have the same autonomy of decision-making as an able-bodied person and should be able to choose assisted dying if eligible to do so.

Mental illness

188. Many submitters recognise that "suffering" could include not just physical pain but also psychological, social, spiritual, and existential pain. Commonly, submitters consider that only physical pain should be included as 'suffering'.
189. Many submitters are concerned that people with mental illness will be able to access assisted dying. Submitters are often concerned that these conditions might be temporary. The condition most often mentioned is depression.
190. Most of the submitters think that mental illness is not a legitimate reason to be assisted to die. Many submitters recommend that, if the Bill were to progress, it be made explicitly clear that mental illness is not a criterion, on its own, for assisted dying. Other submitters think that eligible people suffering from mental illnesses should be disqualified from accessing assisted dying, including those with a history of mental illness.
191. Other submitters most commonly consider that those with mental illnesses will not meet the full criteria and should get the alternative assistance they require. Others suggest that a patient with depression or other mental illness should not automatically be

prevented from accessing assisted dying, or advocate for assisted dying to be provided on the grounds of mental illness.

Refusal of treatment

192. Some submitters are concerned that sick people would refuse treatment in order to gain entry to assisted dying. These submitters do not consider that this should enable a person to access the assisted dying process. However, many other submitters also recognise that people are entitled to refuse treatment.

Clause 4(f): Competence

193. Clause 4(f) provides that to be eligible for assisted dying, a person must have the ability to understand the nature of assisted dying, and the consequences that assisted dying would have for them.

What submitters said

194. Submitters who comment on this clause (whether for or against) think it is important that a person's competence is assessed before they are eligible for assisted dying. Submitters also use terms such as 'capability' or 'decision-making' as well as 'competence'. The terms 'competence' and 'capacity' are also often used interchangeably.
195. Submitters consider the requirement of competency in the Bill to be very specific. Submitters think that the clause would only exclude a very narrow group of people who are unable to understand the 'basic' proposition that assisted dying would cause their own death.
196. Many submitters consider that the definition of competence in the Bill is different to other definitions of competence used for the purposes of making decisions about medical treatment. As such, they think that the Bill replaces a medical practitioner's usual obligations in respect of assessing a patient's competence with a lower standard.
197. In particular, many submitters are concerned that the assessment of competence as part of eligibility does not require an assessment of informed consent. Several submitters think that therefore the clause is inconsistent with rights in the Code, such as Right 6, the "right to be fully informed" or Right 7 "the right to make an informed choice and give informed consent".
198. Submitters point to legislation in other jurisdictions that permit some form of assisted dying (e.g. Canada), which includes consent as a part of the eligibility assessment.
199. Conversely, other submitters consider that medical practitioners are not capable of providing the information required for true consent by a patient even if it is required in the Bill. For example, submitters think that it is hard to explain complex medical procedures to people with limited medical knowledge.

200. Submitters think that a person suffering or feeling distress or panic about their illness would not be able to make the rational decisions that should be permitted to bind them to a course of action. Some submitters think that a diagnosis of a terminal or serious condition will always result in depression and suicidal thoughts and that these conditions limit a person's decision-making capacity.
201. Other submitters believe that a person who is being treated for their disease may already be under the influence of pain medication, which they consider could be mind-altering and could lead to suicidal ideation. Many of these submitters think that people who have suicidal thoughts may present as, or in fact be, competent to make decisions, and the Bill does not prevent this.
202. There are submitters who disagree with these arguments. Some submitters with terminal illnesses are not comfortable with the suggestion that they should not be able to make decisions for themselves simply because they are ill.
203. Some submitters consider the Bill is not clear about what happens when a person is competent to make decisions in some areas of their lives, but not others, as this can add to the complexity of conducting competency assessments.
204. Submitters also think that the Bill is not clear about what happens when a person who has requested the option of assisted dying loses competency part-way through the process. Some submitters note that a further test of 'consent' appears to be required just prior to the person being provided the lethal dose of medication but it does not seem to them that a further test of competence is required by the Bill at that point.
205. Other submitters, including medical practitioners, note that determining a person's competence, or capacity, is complex and challenging. These submitters note that there is no absolute test for capacity, and patients that appear completely mentally competent may not in fact be so, that someone's level of competence can vary day by day, particularly if they are suffering from a terminal illness. They also note that any assessment is subject to error.
206. Some submitters are concerned that the Bill appears to solely require competence to be assessed by whichever medical practitioner the person first approaches, regardless of the practitioner's expertise or experience in assessing competence. Some submitters, including medical practitioners, mention that an assessment of capacity often involves input from, and assessment by, other medical practitioners, including specialists such as geriatricians or psychiatrists. Other submitters consider that medical practitioners are not well placed to assess competence.

Comment

207. Whether someone is competent to make decisions involves the application of a legal test. The test is to determine that a person understands the nature, and can foresee the consequences of decisions in respect of matters relating to his or her personal care and welfare or property; and is able to communicate his or her decision.

208. Although capacity is a legal construct, the information needed to make that legal decision comes from health practitioners. This also means that those decisions may be the subject of review by the Courts.
209. Concepts of competence are found in other legislation. For example, the Protection of Personal and Property Rights Act 1988 presumes that every person, unless the contrary is proved, has the capacity:
- to understand the nature, and to foresee the consequences, of decisions in respect of matters relating to his or her personal care and welfare
 - to communicate decisions in respect of those matters.
210. Similarly, the Substance Addiction (Compulsory Assessment and Treatment) Act 2017 sets out that a person does not have the capacity to make informed decisions if they are unable to:
- understand the information relevant to the decisions
 - retain that information
 - use or weigh that information as part of the process of making the decisions
 - communicate the decisions.
211. The Code also presumes that a consumer of health and disability services is competent to make an informed choice and give informed consent unless there are reasonable grounds for believing that the consumer is not competent.
212. Right 7 of the Code provides consumers with a right to make an informed choice and give informed consent. The Code also provides that where a consumer has diminished competence, that consumer retains the right to make informed choices and give informed consent, to the extent appropriate to his or her level of competence.
213. The definition in the Bill is different in that it does not state a presumption of competence and does not include concepts of retention and use of information, or communication of decisions
214. There is no national standard for completing clinical capacity assessments, but tools and guidelines are available to clinicians, and assessments are most commonly done by structured or semi-structured interview. A common misperception is that capacity is “all or nothing” when in fact it is specific to a decision. An assessment will typically identify one specific decision that needs to be made. The clinical assessment also aims to determine the extent, cause, and possible reversibility of the person’s incapacity.
215. Current clinical practice is that the ability to give informed consent would be assessed as a matter of course, in any assessment of competence. In general, prior to performing any healthcare procedure on a person, a medical practitioner is required to obtain the patient’s informed consent.

Advance directives and powers of attorney

216. Some submitters raise the issue of whether advance directives could or should be relied on to give consent under clause 4(d). Some submitters advocate for the inclusion of advance directives. They believe that advance directives would allow people to end their life with autonomy and choice, even where they lack competence or become incompetent during the process. Other submitters express concern that advance directives may undermine consent and authority as people who may have changed their minds would be forced to continue with their original intention.
217. Some submitters think that an enduring power of attorney under the Protection of Personal and Property Rights Act gives people the ability to make decisions on behalf of people who are not competent to make decisions themselves. Submitters are concerned that legalisation of assisted dying would lead to abuses in this decision-making process, with some decision-makers deciding that it is in a person's "best interests" to have an assisted death.

Comment

218. Advance directives are defined in the Code as written or oral directives in which a patient makes a choice about a future health care procedure. This choice is intended to be effective only when the patient is no longer competent. Advance directives are sometimes referred to as 'living wills'.
219. Right 7(5) of the Code gives every individual the legal right to use an advance directive in accordance with common law, and health care providers are obliged to take account of advance directives when deciding which services to provide to an incompetent patient. Advance directives can be modified or revoked by the individual at any time, while they are still competent.
220. The Bill requires assessments of competence and consent at various times in the process, including a requirement to choose to receive the medication at the chosen time of administration.
221. An advance directive established in common law that requests assisted dying in the event the person is no longer competent would not be able to override any statutory provisions for competence and consent.
222. If the Committee wishes to consider providing for advance directives that bind a medical practitioner to assist the person to die, regardless of level of competence at that time, this would need to be established in law.

Powers of attorney

223. The Protection of Personal and Property Rights Act allows for court orders to be made so that people can make decisions on behalf of people who fully or partially lack capacity.

224. Some decisions cannot be made by others. For example, a welfare guardian or enduring power of attorney cannot refuse consent to the administering to that person of any standard medical treatment or procedure intended to save that person's life or to prevent serious damage to that person's health (section 18).
225. In terms of advance directives, an enduring power of attorney may follow any advice given in an advance directive, unless it is something that the Protection of Personal and Property Rights Act specifies a person may not do on behalf of another person (section 99A).
226. Officials consider it is unlikely that people with decision-making powers for others would be permitted to make decisions for others about assisted dying under the provisions of the Bill. If such a decision was sought, it would need to go to a court.
227. The Bill envisages the individual having capacity at the time that they make a specific request to a specific practitioner. On this basis, people that have lost capacity would appear to be ineligible for assisted dying and this could not be overcome through appointment of a statutory decision maker.

Summary of issues raised by submitters

Questions raised by submitters on eligibility that the Committee may wish to consider include:

- Should assisted dying be limited to those with a terminal illness, and not include those with a grievous and irremediable medical condition?
- Should the timeframe for likely life expectancy for those with a terminal illness be shorter than six months, or should there be no timeframe?
- Should a timeframe for likely life expectancy also apply to a grievous and irremediable medical condition?
- Should disability and/or mental illness as a basis for eligibility be explicitly excluded?
- Should a collection of more minor conditions be able to be assessed as a whole in terms of whether the criteria are met?
- Are the settings correct for the assessment of competence?

Clauses 6 and 7: Conscientious objection

228. The Explanatory Note to the Bill sets out that “no person is obligated to take a role under the Bill, although medical practitioners who conscientiously object must refer people to the SCENZ Group”.

What the clauses do

229. Clauses 6 and 7 outline the mechanism to allow a conscientious objection to be made. A conscientious objection is defined in clause 3 as “an objection to doing anything authorised or requested by this Act”.

Process

230. The clauses operate in the following way:

- clause 6 sets up the terms of the conscientious objection. It says that the Act does not require a person to do anything to which they have a conscientious objection. This applies despite any legal obligations the person is subject to, except for the circumstances described in clause 7.
- clause 7 sets out that when a person first tells the attending medical practitioner that they wish to have the option of receiving assisted dying, the attending medical practitioner must tell the person if he or she has a conscientious objection and tell them that they may ask the SCENZ Group for details of a replacement medical practitioner.

231. These clauses allow any person the freedom to not do anything that they have an objection to and, consistent with existing standards of care, do not delay the process for the person who wishes to have the option of receiving assisted dying.

Penalties

232. Under clause 27, a wilful failure to comply with a requirement of the Act is an offence punishable by a maximum of three months’ imprisonment and/or a maximum fine of \$10,000. It will be an offence for an attending medical practitioner with a conscientious objection to wilfully fail to tell the person who wishes to have the option of receiving assisted dying that they may ask the SCENZ Group for details of a replacement medical practitioner.

Comparison

233. Conscientious objection provisions exist in several comparable pieces of New Zealand legislation. A comparison of the conscientious objection mechanism in the Bill with other domestic legislation and with relevant overseas jurisdictions that permit some form of assisted dying is set out in Annex D.

234. The objection mechanism of the Bill is different to other domestic legislation in the following ways.

- the objection is not restricted to prescribed grounds such as conscience or religious belief or philosophical or humanitarian convictions.
- it requires the medical practitioner with an objection to explicitly state that objection to the person requesting the option of assisted dying. Belgium and the Australian State of Victoria have a similar provision in their legislation.
- criminal liability may result from a failure to state the objection or to not tell the person who wishes to have the option of assisted dying they may ask the SCENZ Group for details of a replacement medical practitioner.
- the objection is drafted to state that the Act does not require a person to do “anything” to which a person has a conscientious objection, rather than as an exemption to providing a particular service on conscientious grounds.

What submitters said

235. Many submitters commenting on clauses 6 and 7 support the intent of the clauses to provide a mechanism for practitioners to conscientiously object to providing assisted dying. However, many submitters also think the mechanism is deficient.

Requirement to tell the person about the SCENZ Group

236. The most discussed part of the conscientious objection clauses is the requirement in clause 7(2)(b) for a medical practitioner with a conscientious objection to tell the person at the time of the initial request that they may ask the SCENZ Group for details of a replacement medical practitioner.

237. Most submitters who comment on this clause feel this is a ‘referral’. Submitters who oppose the Bill object to any referral requirement. These submitters feel that because the medical practitioner is advising the person about the SCENZ Group, the medical practitioner is still participating in a system they object to.

238. These submitters feel that clause 6 and 7 is not a true conscientious objection. This is because a medical practitioner is still required to play a part in the person’s assisted dying. The submitters feel this would put some practitioners in the position of choosing between compliance with the law and their own values.

239. Submitters who oppose the Bill strongly feel that there should be no obligation on a medical practitioner to refer the person to the SCENZ Group and that 7(2)(b) should be removed from the Bill. Others suggest that the onus should be on the person who wishes to have the option of assisted dying and that details of the SCENZ Group could be on the medical practice website or that pamphlets and other material could be available in medical waiting rooms.

240. Some submitters are concerned that if a medical practitioner who objects does not tell the person they have a conscientious objection or does not tell the person they may ask

the SCENZ Group for details of a replacement medical practitioner, they would be criminally liable and might go to jail. Submitters feel this is coercive.

241. Some submitters think that the referral also puts the medical practitioner in a difficult situation as it is necessarily to someone who is less familiar with the patient.
242. Some submitters suggest that medical practitioners who conscientiously object could register their objection with an accessible government body (such as the SCENZ Group). Having a list of practitioners unwilling to participate in assisted dying could be useful to the person who wishes to have the option of assisted dying. Conversely, another suggestion is that medical practitioners who are willing to provide assisted dying services should 'opt-in', rather than there being the mechanism to 'opt-out' based on objection.
243. However, other submitters support the requirement to refer a person on to the SCENZ Group and do not believe it should be left to the person to find a suitable medical practitioner. They say that it would add to the person's stress to have to seek out a SCENZ practitioner themselves. Other submitters say that people who are extremely unwell may feel they are failing at the first hurdle in their request for the option of assisted dying if their medical practitioner turns them down without referring them on, and that they may not have the strength to continue to seek assistance.

Comment

244. Section 13 of the Bill of Rights Act affirms the right to freedom of conscience, including the right to adopt and hold opinions without interference. Section 14 of the Bill of Rights Act affirms the right to freedom of expression. This includes the freedom to seek, receive, and impart information and opinions of any kind and in any form. The right has been interpreted as including the right not to be compelled to say certain things or to provide certain information.
245. In both cases, the Attorney-General considered the requirement *prima facie* engaged the right to freedom of conscience because it requires the medical practitioner to assist the person to do something the practitioner conscientiously objects to. The Attorney-General concluded, however, that the limits are justified for the effective functioning of the regime for assisted dying and that the Bill appears to be consistent with the right to freedom of conscience and freedom of expression affirmed in the Bill of Rights Act.
246. Officials do not consider that the requirement to tell the person is a 'referral' from a clinical perspective. Within the health system 'referral' is generally used to mean a request for advice or support for the management of a patient that may or may not include a short or long term transfer of care.
247. There is a similar requirement for health practitioners who have a conscientious objection to providing services related to contraception, sterilisation or abortion to inform that services can be obtained from another health care provider. Such a requirement is not found in the legislation of other jurisdictions who permit some form of assisted dying.

248. In addition, for general health and disability services, the Code gives consumers the right to be fully informed, including how to obtain an opinion from another provider.

The scope of the objection

249. Some submitters feel the objection mechanism should go further and explicitly include anyone who might be involved in the process, even if they are not authorised or required to do anything under the Bill. A common example given is nurses or health care assistants who could potentially be unwillingly “caught up” in the assisted dying process, with no right of conscientious objection, and with unintended consequences for their mental health and wellbeing.
250. Other submitters note that the mechanism allows “a person” to object and consider this to be too broad as it allows others mentioned in the Bill, such as the Minister or the Director-General of Health, to object to their role.
251. Some submitters think that the right to object should be extended to organisations such as hospices, allowing them to object to their staff and facilities being involved in the process.
252. Conversely, submitters in support think that conscientious objection should only be exercised by a person, not by an organisation and that this should be made clearer in the Bill to avoid situations overseas where faith-based institutions have prevented their staff from participating in assisted dying.
253. Some submitters raise that a practitioner's conscience in relation to assisting dying may not be fixed, and “a crisis of conscience” could happen part-way through the assisted dying process. They submit that practitioners must be assured that their right to conscientious objection under the Bill may be asserted at any time and that they may remove themselves from the assisted dying process at any point. An example given is a practitioner who has no conscientious objection to assisted dying generally, but finds themselves unwilling to assist because of concerns about their own competency, specialist skills, or experience.
254. Some submitters are concerned that the Bill lacks a provision that prohibits discrimination of any form against those who hold a conscientious objection. Submitters are concerned that people with a conscientious objection to providing assisted dying could be ‘screened out’ of medical school or from hiring decisions or that there would be pressure on medical practitioners and other staff to provide information, or the option of assisted dying, despite having a conscientious objection.
255. Conversely, some submitters raise that medical practitioners who support assisted dying could also be discriminated against within their organisation.
256. Submitters suggest that the Bill explicitly provides that a person who raises a conscientious objection should not be discriminated against as a result of that objection.

Comment

257. For those involved in the process, even if they are not authorised or required to do anything under the Bill, the Bill of Rights Act gives everyone the right to freedom of thought, conscience, religion and belief, including the right to adopt and to hold opinions without interference (section 13), and the right to freedom of expression including the freedom to seek, receive, and impart information and opinions of any kind and in any form.
258. It is a prohibited ground under the Human Rights Act 1993 to discriminate against a person on the basis of religious or ethical belief. This includes in employment matters. Disputes about compliance with the Human Rights Act 1993 are facilitated by the Human Rights Commission in the first instance.
259. Officials do however, consider that the drafting of the objection mechanism is not targeted, and this raises two issues.
260. Firstly, apart from the circumstance described in clause 7(1), the medical practitioner or other person is not required to tell anyone of their objection, including the person who wishes to have the option of assisted dying. For example, the medical practitioner could decide at any point that they now had an objection to doing anything required in the Bill.
261. This means that, except at the beginning of the process in clause 8, the person who wishes to have the option of assisted dying may not be informed of the objection and may not be told to contact the SCENZ Group for a replacement practitioner. Officials do not know if this is the intended outcome.
262. Secondly, the right of conscientious objection is not restricted to:
- allowing an objection to providing assisted dying
 - prescribed grounds or sections of the Bill.
263. This means that an individual could cite the conscientious objection provision as a basis for refusing to perform a procedural requirement that would otherwise constitute an offence under clause 27. This objection could, for example, be an objection to completing aspects of the assisted dying process or an objection to report writing.
264. The breadth of the current objection provision creates a risk that a medical practitioner could impede or hasten an assisted dying process or undermine the review functions in the Bill and could use the conscientious objection provision as a justification.

The Committee may wish to consider:

- targeting the objection to assisting in the death of any person if the person has a conscientious objection (rather than providing that the Act does not require a person to do anything to which they have a conscientious objection).
- amending section 6(2)(a) to ensure that those that choose to participate and then fail to meet the requirements of the Bill are still liable.

Clauses 8 to 18: Process

265. Clauses 8 to 18 of the Bill set out the process to be undertaken by medical practitioners to give effect to a request for assisted dying. After meeting the eligibility criteria, people must follow the process outlined in the Bill to access assisted dying.

Timeframes

266. Many submitters raise issues about timeframes for the process in the Bill. Submitters often suggest that the processes should be pursued with appropriate urgency and efficiency, given that people in these severe circumstances and in the terminal phase of life are suffering and experiencing tremendous personal distress and uncertainty.
267. Some of these submitters also suggest that it should be specified that a decision to stop at any time in the process constitutes a pause in the process rather than requiring the person to go back to the beginning of the process each time. They consider that this would maintain control and autonomy for the person and reduce the risk of pressure to proceed.
268. Conversely, other submitters do not want the person feeling rushed or pressurised into proceeding and want to minimise any risk of coercion. Some suggest a cooling off period or periods at various points in the process.
269. Submitters raise both having maximum or minimum timeframes depending on their views.

Comment

270. Most steps in the process are not time bound and the process could take many months. The time to complete the process is largely set by the person requesting assisted dying, subject to factors such as the availability of parties involved and the time they take to progress the steps.
271. The minimum possible timeframe to complete the process provided for in the Bill from request made, to death reported, in a secondary care (hospital) setting is estimated to be four working days. This assumes all parties involved are immediately available, there are no conscientious objections and there are no concerns about competency. This scenario may be unlikely in practice.
272. The likely minimum timeframe to complete the process provided for in the Bill from request made, to death reported, in a primary care (residential) setting, with all parties involved readily available, is estimated to be 15 working days. Again, this is likely to take longer in practice.

Clause 8: Request made

273. The process begins in clause 8. This clause provides the structure for the first interaction(s) following a request for assisted dying between a medical practitioner and the person wishing to access assisted dying.
274. Clause 8 provides that the person wishing to have the option of receiving assisted dying must tell their attending medical practitioner of their wish. It is at this point that a medical practitioner with a conscientious objection must tell that to the person and must also tell the person that they may ask the SCENZ Group for the name and contact details of a replacement medical practitioner.
275. The replacement medical practitioner (who now becomes the attending medical practitioner) must then have a conversation (or conversations) with the person which must cover certain prescribed information, including:
- a. giving the person the following information:
 - i. the prognosis for the terminal illness or grievous and irremediable medical condition; and
 - ii. the irreversible nature of assisted dying; and
 - iii. the anticipated impacts of assisted dying; and
 - b. talk with the person about his or her wish at intervals determined by the progress of his or her terminal illness or medical condition; and
 - c. ensure that the person understands his or her other options for end of life care; and
 - d. ensure that the person knows that he or she can change his or her mind at any time; and
 - e. encourage the person to talk about his or her wish with others such as family, friends, and counsellors; and
 - f. ensure that the person knows that he or she is not obliged to talk to anyone; and
 - g. ensure that the person has had the opportunity to talk about his or her wish with those whom he or she chooses; and
 - h. do his or her best to ensure that the person expresses his or her wish free from pressure from any other person by—
 - i. talking with other health practitioners who are in regular contact with the person; and
 - ii. talking with members of the person's family approved by the person; and
 - i. complete the first part of the prescribed form requesting the option of assisted dying by recording the actions he or she took to comply with paragraphs (a) to (h).

What submitters said

276. Some submitters think it is important to clarify whether a medical practitioner can raise the prospect of assisted dying with a person or must wait until the person raises it with them. Some think that it should be a requirement that the request is only brought up by the person of their own accord, to safeguard against coercion by the medical practitioner.
277. Some submitters consider that the request process triggers a complex and time-consuming process for the medical practitioner and query how the time and costs involved would be funded.

Comment

278. The Bill is silent as to whether a medical practitioner can raise the option of assisted dying with a person prior to the individual's request to commence the process.
279. Submitters raise the tension between section 179 of the Crimes Act, which criminalises inciting and counselling suicide, and the duty of medical practitioners to ensure informed consent under the Code and under common law. Under the Code, a consumer has the right to be fully informed, including an explanation of his or her condition, and an explanation of the options available.
280. Submitters are concerned that if a medical practitioner raises the option of assisted dying with the patient, they could be seen to be breaching section 179 of the Crimes Act. Alternatively, if the practitioner doesn't raise the option of assisted dying (e.g. because of a conscientious objection), they could be breaching their duty under the Code.
281. It is likely that the immunity clause and the conscientious objection clause would prevent liability, as the rights in the Code are subject to other legislative requirements.

The Committee may wish to consider clarifying whether medical practitioners are permitted to raise assisted dying with the individual prospectively or are prohibited from doing so.

Encouragement to talk to others and knowing they are not obliged to

282. Many submitters strongly disagree with the person not being obliged to talk to anyone. Reasons include:
- family members and loved ones frequently play an integral role in the care of someone with a terminal illness and may be able to seek additional or alternative support to address what has motivated their loved one to make a request
 - it could be devastating for those who will be affected by the death if it wasn't discussed with them
 - often concerns about coercion, influence or psychological control are raised by neighbours, social workers, district nurses, care providers, or extended family

- no one else may ever know that the person died by assisted dying apart from two medical practitioners and the Registrar.
283. Some submitters recommend that meetings with family members, carers and involved medical practitioners should be compulsory.
284. Conversely, others think that family members should not be able to be involved so that the person can have free and frank discussions with the medical practitioner, as they consider it is only the opinion of the person seeking assisted dying that matters.
285. Many submitters question what “ensuring the opportunity to talk about their wish to those they choose” would involve and how a medical practitioner would ensure that this has been done effectively.
286. Some submitters raise that using the language of “talk” does not appear to include those who cannot physically talk and use other forms of communication, for example sign language.

Comment

287. The use of the word “talk” restricts the communication able to take place between the person and the medical practitioner. This does not seem necessary.

The Committee may wish to “talk” in clause 8(2)(b) to “communicate in person” to cover all forms of communication, not only speaking.

“Do his or her best”

288. Many submitters are concerned that to “do his or her best” to ensure the person is free from pressure from any other person is a subjective and low threshold, and that the absence of coercion would not be assured under this safeguard, particularly for vulnerable people. Others say that this measure also presents a risk to the attending medical practitioner as it is difficult to define, demonstrate, or prove.
289. Some submitters say it should be made clear whether it is compulsory or optional for the person requesting assisted dying to authorise the medical practitioner to talk to at least one other person, as this would raise privacy issues for the person.
290. Many submitters say that coercion is often difficult to detect, that pressure may be subtle, and that medical practitioners may not have the time or skills to determine that the person is free from pressure or coercion. Further, if coercion or abuse is taking place by family members, it is unlikely that the person would approve the medical practitioner talking to those family members under clause 8(h)(ii).
291. Some suggest that other professionals, such as social workers and psychologists, would be better placed to assess and prevent abuse and coercion.

292. Other submitters think that the Bill is not clear about what would happen if coercion is found and whether that would mean the person was not eligible.

Comment

293. If a medical practitioner was to discover coercion, this is not an explicit ground for making a negative decision (although it may be implicit).

The Committee may wish to consider setting out that if coercion is found, the person is not eligible for assisted dying.

Safeguards at time of initial request

294. Some submitters think aspects of the process set out in clause 8 are not clear, for example what is meant by “anticipated impacts” of assisted dying.
295. Many submitters say that the process set out in clause 8 is impractical and that the safeguards are inadequate, particularly for people who may be vulnerable to coercion. Submitters raise the risk that the request requirements will become a rubber-stamping exercise, with no accountability other than self-reporting by the medical practitioner. To mitigate this risk, submitters’ suggestions include:
- a second independent medical practitioner should be involved at the time of request
 - an independent body, for example the SCENZ Group, should manage the request process
 - the initial request should have to be made in writing or videoed, to protect both the person and the attending medical practitioner.
296. Many strongly recommend that, when a person requests assisted dying, there should be a requirement for an immediate referral to a counsellor, social worker, psychologist or psychiatrist so conditions such as mental illness and depression are not missed.
297. Some submitters think that detailed guidance on the information to be provided to the person by the attending medical practitioner should be developed. Some submitters think that the resources should be disease specific, evidence based, and publicly available.
298. Submitters strongly support the requirements for the attending medical practitioner to ensure the person understands other options for end of life care and that they can change their minds at any time. Some submitters note this requirement is about competence, but is not explicitly linked. Submitters say that it is not clear whether the person would be eligible if they did not understand.

Clause 9: Request confirmed

299. Clause 9 applies after clause 8 is complied with. This clause confirms the request and ensures the person consents to assisted dying. If the person wants to proceed, they must sign and date the second part of the prescribed form mentioned in clause 8 or, if the person cannot write, have another person sign and date it on their behalf and in their presence. The person signing on behalf of the person must not be:

- the health practitioner caring for the person
- an individual who know that he or she stands to benefit from the death of the person requesting for assisted dying
- a person under the age of 18
- a person with a mental disability.

300. The attending medical practitioner must be present when the form is signed. The form is sent to the Registrar.

What submitters said

301. Some submitters specifically support having the request confirmed in writing.

302. Other submitters think that the process is open to abuse, such as someone signing on behalf of the person without the person's consent, presence, or knowledge, and that proving that the person or attending medical practitioner was present, or not present, would be difficult.

303. Some submitters think there should be no ability for someone to sign on behalf of the person making the request for assisted dying, to mitigate the risk of abuse or deception.

304. Many submitters recommend that an independent witness, for example a Justice of the Peace, should be required when the request confirmation is signed.

305. Others think that the criteria for those who are not eligible to sign on behalf of the person are not clear, including the difficulty in proving that someone knows they would benefit, and what the meaning of "benefit" and "mental disability" are in this context.

Comment

306. The criteria around the person signing of behalf of the person appear to be intended to establish the independence and competency of the person signing on behalf.

307. It is not specified what happens if the form is completed and signed by someone who does not meet the criteria. For example, the effect on the eligibility of the person seeking assisted dying or the consequences for the person signing on behalf are not specified. This latter case may constitute an offence under clause 27(1) in some circumstances, but not always, as the failure to meet the requirements may not be wilful and the individual may consent to the completion of the form by the person.

308. How other jurisdictions that permit some form of assisted dying provide for signing requirements is found in the comparison table in Annex C.

The Committee may wish to consider clarifying the procedure around the 'signing on behalf' mechanism. This could involve:

- clarifying what "benefit" and/or "mental disability" mean
- providing for a more overt independent process
- providing for consequences where the criteria are not met.

Clauses 10 – 12 First, second and third opinions

309. Clause 10 sets out that the attending medical practitioner must reach the opinion that the person is eligible or ineligible for assisted dying or would be eligible if their competence were established. A form is then completed and sent to the Registrar.
310. Following this, clause 11 sets out that a second opinion is needed from an independent medical practitioner. The attending medical practitioner contacts the SCENZ Group and obtains the details of an independent medical practitioner.
311. The independent medical practitioner must examine the person and give an opinion as to whether the person is eligible or ineligible for assisted dying, or whether the person's competence needs to be established. A form is then completed and sent to the attending medical practitioner and the Registrar.
312. If either or both the attending medical practitioner and independent medical practitioner are unsure of the person's competence, clause 12 sets out that they must contact the SCENZ Group and obtain the details of a specialist (a psychiatrist or psychologist). The psychiatrist or psychologist must reach a decision as to whether the person is competent. A form is then completed and sent to the attending and independent medical practitioners and to the Registrar.

What submitters said

Assessment of competence

313. Some submitters think that a mental health assessment by a psychiatrist, psychologist or mental health professional to determine a person's competence to make an end of life choice decision should be a compulsory step rather than an option.
314. Alternatively, other submitters consider that there should only be a third opinion when there are clear signs that a person is not competent.
315. Some submitters suggest that a copy of any first, second and third opinions should be given to the person who has requested assisted dying

Safeguards

- 316. A few submitters comment that the process of having two medical practitioners involved provides adequate safeguards. A few submitters go further and think that a second opinion is not needed.
- 317. Many others view the safeguards as inadequate. To strengthen the safeguards, many submitters suggest that the independent medical practitioner should also have to go through the process outlined in clause 8, including being satisfied that the person is free from coercion.
- 318. Others suggest that the second opinion be undertaken by a panel of medical practitioners with a range of specialties, or with the support, expertise, and wisdom of a wider multi-disciplinary team including palliative care specialists, chaplains, psychologists, and nurses.
- 319. Others suggest an appeal process for opinions, for example through the SCENZ Group or by an independent appeal authority.
- 320. Some submitters suggest that a court should be overseeing or making decisions about a person's eligibility for assisted dying. Submitters give examples of other processes that use courts.

Independence of the medical practitioners

- 321. Many submitters think there are difficulties in establishing independence and impartiality of the medical practitioners.
- 322. Submitters think that there would be a selection bias of those participating who support assisted dying and that there may also be a cognitive bias towards a positive decision.
- 323. Submitters also consider there to be a risk of unethical practice and unethical collaboration. Submitters' suggestions to mitigate this perceived risk include the SCENZ Group not allowing consecutive or repetitive pairing of attending and independent medical practitioners and not allowing the sharing of opinions.

Area of expertise of medical practitioners and specialists

- 324. Many submitters have strongly held views that either the attending or independent medical practitioner should have a certain level of expertise or be a specialist in the presenting condition of the person, or in palliative care medicine. In addition, others recommend that attending and independent medical practitioners be from different medical specialties, and preferably be involved in the person's care.
- 325. Several submitters think that the assisted dying process would divert a limited supply of psychiatrists and psychologists away from front line mental health issues. In addition, submitters do not think these specialists are often involved with dying patients and should be trained.

326. Some submitters consider that there are differences in the specialities of psychiatry and psychology. They recommend that the specialist opinion on competency should only be given by a psychiatrist with relevant experience, a psychogeriatrician or a palliative medicine physician.

Comment

327. Under the Health Practitioners Competence Assurance Act, health practitioners must not perform a health service that does not form part of their scope of practice. In addition, good medical practice is that a medical practitioner has the care of the patient as their first concern.
328. Sound clinical practice suggests that clinical decisions regarding end of life choices would likely be taken by those with expertise in the areas concerned, including specialists in the presenting condition or palliative care medicine. Others typically involved would include those who have a clinical relationship with the person, nurses, chaplaincy and social support. Legal advisors may also be involved in end of life decisions.

Clauses 13 - 14 Negative and positive decisions

329. If either the attending medical practitioner or the independent medical practitioner determines that the person is ineligible for assisted dying, or if the specialist determines that the person is not competent under clause 13, they must explain their reasons to the person. This is called a 'negative decision' and ends the process. A form is completed and sent to the Registrar.
330. If the person is found to be eligible and competent, this is called a 'positive decision'. Under clause 14, the attending medical practitioner must talk to the person about the likely timing for the assisted dying and make provisional arrangements to administer the medication.

What submitters said

331. Some clinicians recommend that appropriately detailed and nuanced guidance around negative and positive conversations be established.

Negative decision

332. Most submitters agree that the reason for a negative decision should be explained to a person and, in addition, some think that it should be provided in writing for the person's reference and for monitoring and review purposes.
333. Others submit that the reason for a negative decision should not be provided to the person as it could give them information with which to manipulate another request to minimise rejection. Some submitters also think that the fear of delivering "bad news" might bias the medical practitioner toward approving the request.

334. Many submitters are concerned about the risks of people “shopping around for a positive decision” and that there should be criteria, including a minimum timeframe, for reapplying following a negative decision. Others think there should be an appeal process following a negative decision.
335. Many submitters recommend that following a negative decision, the attending physician should be obliged to arrange for palliative care, suicide prevention intervention, psychological support, counselling, and other services and support for the person as appropriate. Others raise concerns that a person may be more inclined to take their own life after a negative decision.

Positive decision

336. Submitters raise the concern that the Bill does not clearly address who is responsible for the patient’s continuing care once a positive decision has been made.
337. Submitters suggest that following a positive decision, the person should also receive psychological support, as the decision is momentous for the person and loved ones. As another safeguard, some submitters think that family or close friends should be notified of a positive decision and a written response should be required from them stating they have no concerns with the process. Some submitters suggest that family and friends should also have access to psychological support.

Comment

338. Good clinical practice would involve the medical practitioner offering ongoing support services to the person and/or their family and friends as is relevant in the circumstances, regardless of a negative or positive decision.

Clauses 15 - 16 Assisted dying

339. Clause 15 sets out that when the person wishes to exercise the options of receiving assisted dying, they must tell the medical practitioner.
340. The medical practitioner must tell the person about the methods for the administration of the lethal dose of medication and the person must select a method:
- ingestion or intravenous delivery triggered by the person, or
 - ingestion through a tube, or
 - injection.
341. When the method of administration of the medication is chosen, the medical practitioner must ask the person to choose the time they wish the medication to be administered and ensure the person knows they can change their mind at any time.
342. At least 48 hours prior to the administration of medication, the medical practitioner must write the prescription, advise the Registrar of the method and time chosen and provide

the Registrar with the prescription. The Registrar must then check that the Bill's process has been complied with (clauses 8 to 14) and, if satisfied, co-sign the prescription.

- 343. Clause 16 provides that at the chosen time of administration, the attending medical practitioner must ask the person if they choose to receive the medication.
- 344. If they do not, the medication must be removed and returned to the pharmacist who dispensed it, and a prescribed form is filled out.
- 345. If the person does wish to receive the medication, the medical practitioner must administer the medication in the chosen method and remain available to the person, either in the same or in close proximity, until the person's death.

What submitters said

Assisted suicide and euthanasia

- 346. Many submitters raise a distinction between assisted suicide and euthanasia.
- 347. Some submitters support both options, noting that some people who are eligible for assisted dying would not be capable of self-administering medication. Other submitters favour self-administration or consider that self-administration is more acceptable or not as 'unethical' as administration by a medical practitioner.

Definition of terms used

- 348. Some submitters think terms are unclear, such as "administration", "triggered by the person", "providing it" and "providing it to the person".
- 349. Submitters suggest that if it was intended that some of these options were to be "triggered by a medical practitioner", this should be made clear.

Comment

- 350. Submitters appear to be concerned that clause 15 is not clear about who the administrator is, the person or the medical practitioner.

The Committee may wish to consider clarifying that the clauses 15(3)(iii) and (iv) are "triggered" or "activated" by the medical practitioner.
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Registrar's process

- 351. Some submitters think that the 48 hours mentioned is a maximum timeframe and that it would often not be practical for the Registrar to ensure that all the process steps had taken place, return the counter-signed prescription to the medical practitioner and allow enough time for them to obtain the medication and keep to the person's chosen time of administration.

352. Submitters also suggest that the Registrar's approval to proceed is required to be provided expediently, or within a required timeframe.
353. Submitters raise further logistical issues, including securely transmitting prescriptions for lethal substances, establishing a process for dispensing pharmacists to check the veracity of a signature by a Registrar, and ensuring that legal requirements for medicines and controlled drugs are complied with throughout all steps of the process.

Comment

354. Under clause 15(6) the Registrar is required to co-sign the prescription after being satisfied that the process in clause 8 to 14 of the Bill have been complied with.
355. The Bill does not set out how the Registrar is to check compliance with clause 14 as, unlike with the other clauses, no form is required to be filled in and sent to the Registrar.
356. Co-signing is not required in any other legislative context. If co-signing is a proxy for the Registrar to indicate satisfaction that processes have been complied with, the Registrar could do this by notifying the attending medical practitioner. Prescriptions are otherwise written by authorised or delegated prescribers under the Medicines Act by those who have knowledge of the person being prescribed for.

The Committee may wish to consider amending the requirement for the Registrar to co-sign the prescription under clause 15(6) and instead provide for the Registrar to notify the attending medical practitioner that they are satisfied that the process has been complied with. Clause 18(3) (actions if the Registrar is holding the prescription when the person dies) would also need to be amended accordingly.

Competency at time of administration

357. Submitters are concerned that, when asking if the person wishes to receive the medication, there is no further requirement for the medical practitioner to inquire, or be satisfied, that the person is fully competent and/or acting free from coercion. It is contended that any lack of competency at this stage undermines the other protections required in the Bill.
358. Submitters' suggestions to manage these risks and to protect both the person and the medical practitioner include:
- requiring an impartial witness (or trusted or independent third party), or a second medical practitioner, to be present to ensure the medication has been administered at the request of the patient.
 - the person completes a form confirming their consent at the time.

Risk of something going wrong

359. Some submitters recognise that there is a risk that something could go wrong when administering the medicine, for example choking, seizures, unexpected pain, drawn out

death, or failed death. Submitters recommend that the procedure requires specialist training and expertise, or that it is undertaken by an anaesthetist or palliative care medicine specialist to minimise these risks.

- 360. Submitters are also concerned about what happens if something does go wrong and clarifying the proper role of the medical practitioner at that point. Some suggest that clinical guidance would be needed.
- 361. Some suggest narrowing the definition of being “available” in the Bill to mean the medical practitioner must be in the same room and close to the person to help if something goes wrong. Other submitters think the presence of the medical practitioner would put pressure on the person to go through with the process.

Support for health professionals involved

- 362. Some employers say that there would be significant difficulties protecting the mental health of health practitioners who may feel vulnerable and unsafe legally and ethically. These submitters think that there should be appropriate support systems in place for health practitioners who are engaged in this work.
- 363. Submitters suggest that to lessen the emotional burden, a different medical practitioner or person should administer the lethal medication rather than those practitioners who assessed the person.

Changes that could be made

- 364. Submitters think the Bill should allow for the person to fill a prescription and store the medication until they decide to use it, if at all. Examples of other jurisdictions are provided.
- 365. Submitters believe the Bill should provide for the medical practitioner to sedate the person prior to administering the medication if the person desires.

Clause 17 Death Reported

366. Clause 17 requires the medical practitioner to send a report to the Registrar within 14 days of the death, containing the following information:
- a. the attending medical practitioner's name; and
 - b. the person's name; and
 - c. the person's last known address; and
 - d. the fact that the person 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
 - 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
 - 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.
367. The Registrar must send the report to the Review Committee.

What submitters said

368. Submitters say it is important to know what the information collected under this clause will be used for, who will have access to it and for what purposes, if it will be made public, and if it will be subject to the Official Information Act 1982.
369. Submitters say additional demographic information should also be collected at this time, for example ethnicity, religion, usual residence, living situation, personal care services being delivered to the person, and primary health care provider.

Comment

370. This report adds to a number of death reporting and investigatory processes already provided for in law. It would be desirable to clarify the relationship between the Bill, the Burials and Cremation Act and the Coroners Act. This is discussed further in clause 28 from page 81.
371. Once it is determined what the relationship is and what the purpose of the report is, it will be clear what information this form needs to collect.

Clause 18 Return of unused medication

372. If the person does not want to receive the medication, or dies before the medication is used, clause 18 requires the prescription to be destroyed or the medication to be returned to the dispensing pharmacist for destruction. Forms are completed by the medical practitioner and sent to the Registrar, or the Registrar also records the destruction of the prescription if they are holding it at that time.

What submitters said

373. A few submitters specifically support the return of unused medicine. Some recommend that prescribed lethal doses of medication are dispensed, held and administered under careful control to enable tracking at all times. Others state the need for inclusion of the actual process of return and method of disposal of the medicine by the pharmacist, especially if the dispensed medicine is a controlled drug.

Comment

374. The Bill assumes the medication is dispensed by a pharmacist (and not a medical practitioner, as can currently occur) and is returned to the particular pharmacist.
375. There are established legislative requirements, guidelines and protocols for prescribing, dispensing, storing and disposing of medicines, including under the Medicines Act and the Misuse of Drugs Act.

<p>The Committee may wish to consider aligning the clause 18 requirements with existing management of medicine processes.</p>

Clauses 19 to 23: Accountability

- 376. The Bill establishes three administrative bodies, a process to review the Bill if it were to be enacted, and a system of prescribed forms.
- 377. Officials think that the Bill's accountability regime needs review and further development so that it closer aligns to best practice.

Clauses 19, 20 and 21: The administrative bodies

- 378. Clauses 19, 20 and 21 set up three new administrative bodies within the health system.

The SCENZ Group

- 379. The first administrative body is the Support and Consultation for End of Life in New Zealand Group (the SCENZ Group) set up under clause 19. The Director-General of Health appoints the number of medical practitioners they consider appropriate.
- 380. The SCENZ Group makes and maintains a list of pharmacists and medical practitioners who are willing to perform the functions set out in the Bill. The SCENZ Group provides contact details for replacement medical practitioners, the independent medical practitioner for the second opinion, and the psychiatrist or psychologist where a third opinion is required.
- 381. The SCENZ Group also prepares standards of care, advises on medical and legal procedures and provides practical assistance in relation to the administration of the medication, if required.

Review Committee

- 382. The second administrative body is the Review Committee set up under clause 20. The Minister of Health appoints a medical ethicist, a medical practitioner specialising in end of life care, and another medical practitioner.
- 383. The Review Committee considers the report of the attending medical practitioner about the death of a person who was assisted to die, states its satisfaction or otherwise to the Registrar, and recommends follow up action where it is not satisfied.

Registrar (assisted dying)

- 384. The third administrative body is a person within the Ministry of Health who is appointed by the Director-General of Health as the Registrar under clause 21. The Registrar receives the prescribed forms sent by the attending medical practitioner, independent medical practitioner, and by the specialist (if required), and establishes and maintains a registry of forms. The report of the death, written by the attending medical practitioner, is received by the Registrar and then sent to the Review Committee who reports back to them. The Registrar must establish and maintain a complaints procedure and must report annually to the Minister.

What submitters said

385. Submitters who comment generally support the establishment of oversight groups with the roles set out. Submitters think it is important that they are funded and resourced appropriately. However, other submitters are concerned that these administrative bodies are only checks and audits of the process after a person has been assisted to die and that the accountability mechanisms lack detail and appear weak.

Membership

386. Most comments from submitters on the administrative bodies are around membership.
387. Some submitters think that the number or minimum number and composition of the SCENZ Group should be stipulated in the Bill, while others agree that it should be up to the Director-General of Health.
388. Many submitters recommend that membership of the SCENZ Group and the Review Committee should include a range of health practitioners. Other suggestions include those with cultural expertise, Māori, minority groups, representatives of people with disabilities and others with specific skills or expertise. Many submitters who comment question why a medical ethicist is a member of the Review Committee but not the SCENZ Group.
389. Some submitters strongly recommend establishing a pool of medical practitioners who may be called upon to join the Review Committee to provide expert specialised advice.
390. Several submitters comment that there is no requirement in the Bill for the Registrar to have any medical background or have any relevant experience or skills in order to perform their role. Some suggest that the Registrar should be a judicial officer, at least at District Court Judge level.
391. Other submitters believe that there should be a time limit of membership and regular turnover.

Independence

392. Many submitters think that those who agree to be on the SCENZ Group or on the Review Committee would have a pre-existing bias in favour of assisted dying. Submitters are concerned that they may not be objective and may have the inclination to broaden access to assisted dying. A suggestion made to balance a perceived bias is that there should be members who are opposed to assisted dying. Alternatively, some submitters suggest that members should be required to be non-religious.

Powers and functions

393. Some submitters are concerned about the lack of detail about how these administrative bodies will operate and exactly what they would do. These submitters think it is unacceptable to have such a degree of uncertainty about core functions and

composition. For example, submitters are not clear if the SCENZ Group is to act collectively or as individuals, what the review of the report of death by the Review Committee would look like, or how complaints would be dealt with by the Registrar, including screening for inappropriate or vindictive complaints.

- 394. Submitters in general also think that the administrative bodies need more powers. For example, for the SCENZ Group to test, assess and audit, for the Review Committee and/or the Registrar to have powers of inquiry or investigation, and a power to act if non-compliance is found.
- 395. There is strong support from some submitters for the SCENZ Group or others to develop clinical guidelines relating to assisted dying. Submitters think this should include assessing an individual's competence, key legal requirements, and interpretation and expected standards of care for individuals wishing to die. Submitters feel this would ensure consistency and reduce subjectivity around the process.
- 396. Submitters think that the guidelines should be publicly available, and only be prepared following full consultation e.g. with the Medical Council of New Zealand and relevant vocational Colleges, the Health and Disability Commissioner, and patient advocacy groups.
- 397. Many of the submitters who comment support establishing and maintaining a list of practitioners and pharmacists willing to act for the purposes of the Bill. Some suggest lists of other health practitioners, or those willing to address spiritual matters.
- 398. Some submitters think that it would be more appropriate if the administrative functions of the SCENZ Group were carried out by the Registrar.

Information and privacy issues

- 399. Some submitters from the medical profession strongly contend that the lists of those willing to act for the purposes of the Bill be kept confidential to protect them from undue pressure to participate or not to participate.
- 400. Other submitters think that the lists should be made public, so people can make informed choices of who they consult.

Reports

- 401. Some submitters think the Review Committee should be required to report annually in relation to its overall activities and findings, to the responsible minister and the New Zealand public, not to the Registrar.
- 402. Many submitters think that the annual report of the Registrar to the Minister should be made public and include essential statistics and aggregated qualitative and quantitative information about how assisted dying is being put into practice.

Registers

403. Some submitters think that the Bill should identify the purpose of the Register, provide for access and define how information will be used and shared.

Comment

404. Officials provide the following comment based on existing accountability models within the health sector.
405. Officials consider the accountability regime requires review and further development to align more closely to best practice so that the roles and functions of the accountability bodies are clear.
406. For example, it is not usual for legislation setting up accountability bodies to be silent on matters of membership and procedure. If this was the intent of the Bill, there is also no indication of who is to decide these matters at a practical level.

The Committee may wish to consider clarifying the following matters for the SCENZ Group and the Review Committee:

- powers, duties and responsibilities
- membership including composition, length of tenure, reappointment, remuneration and resignation or removal of members
- procedures including quorums and absences, chairpersons and deputy chairpersons, decision-making and voting, sub-Groups or Committees, conflicts of interest, appointment of experts, and timeframes.

407. In addition, officials have identified specific matters the Committee may wish to consider addressing for each group.

The SCENZ Group

408. The Review Committee and the Registrar have the substantive functions within the accountability regime in the Bill. The SCENZ Group appears largely administrative.
409. The Committee may wish to consider whether this group is required. For example, the list functions of the SCENZ Group could be transferred to the Registrar and the guidance functions removed from the Bill and, as is currently the situation, left to the relevant professional bodies to develop if they consider it is necessary. Alternatively, these functions could be transferred to the Review Panel or to the Ministry of Health.
410. In any case, given its limited functions, it is not clear that there is any need for the SCENZ Group to be separately serviced by the Ministry of Health.

The Committee may wish to consider the purpose of the SCENZ Group.

The Review Committee

411. The Review Committee is appointed by the Minister. This provides an independent perspective to its role. Otherwise, its status is unclear and does not align with existing models such as a Ministerial Advisory Board, or a Crown Entity.

We recommend the Committee clarifies the status of the Review Committee and prescribe a clear purpose to guide its work.

The Committee may wish to consider providing details on the type of consideration and reporting the Review Committee carries out and the information and powers it requires to carry out its work.

The Committee may wish to consider whether the Review Committee requires administrative assistance such a Secretariat within the Ministry of Health, or, if it is a separate entity, the ability to source staffing resources.

412. The reports the Review Committee considers under clause 17 are provided to it by the Registrar, and it reports to the Registrar.

The Committee may wish to consider also including a reporting requirement from the Review Committee to the Minister who appoints the members and whether this report should then put before the House.

413. Consideration of the Review Committee and any action by the Registrar in response to the report and recommendations of the Review Committee is impacted by the timing issues around the reporting of death. This is discussed in the clause 28 section from page 81.

Registrar

414. There are a number of aspects the Committee may wish to consider about the roles and functions of the Registrar.

Complaints procedure

415. The Registrar is to establish and maintain a procedure to deal with complaints about breaches of the Bill, if it were to be enacted.
416. If assisted dying is to be a health service, there are existing mechanisms within the health system to respond to complaints about health or disability services and matters of competence of health practitioners. There are also existing coronial and police processes.

We recommend the Committee clarify how the complaints procedure fits into existing accountability processes.

417. If a separate complaints procedure is desirable, it is not usual for legislation setting up complaints procedures to be silent on matters of procedure.

We recommend the Committee clarify:

- how the complaints procedure is to operate including how complaints are accepted, actioned and investigated, how decisions are made, and provide for appeal processes and other procedural matters.
- the relationship between the complaints procedure and the immunity provision in clause 26 and the offence provision in clause 27.
- The Committee may wish to consider clarifying whether the Registrar requires powers for the proper functioning of the complaints procedure, such as for investigation and evidence-gathering.

Reports and recommendations of the Review Committee

418. The Review Committee reports to the Registrar under clause 20 about its satisfaction or otherwise with the medical practitioner report under clause 17 and the recommended actions the Registrar may take to follow up. It is not clear why the Registrar has a discretion as to whether it should act where the Review Committee is not satisfied with a case that has been reported.

The Committee may wish to consider clarifying how the discretion of the Registrar to follow up reports of the Review Committee is exercised.

The Committee may wish to consider whether the report of the Registrar to the Minister should be made public or put before the House.

Privacy issues

419. One of the roles of the SCENZ Group would be to give people who want to request assisted dying the names of participating attending medical practitioners. This means that participating medical practitioners will be known over time and further, these lists are also likely to be available under the Official Information Act 1982.

The Committee may wish to consider identifying the status of the SCENZ Group lists as either being public lists or being excluded from release under the Official Information Act.

Registers

420. A large amount of information about a person requesting assisted dying is collected by the Registrar and kept on a register. The purpose of the register would usually be set out, along with its intended use and availability. For example, whether it is a public

register, or whether it will be shared with other agencies including enforcement agencies.

421. It should be clear in legislation as to why an individual's information is being collected, how it will be used and by whom. Determining these matters will also assist in deciding if forms or reports should be amended to collect other information or whether all information proposed to be collected is required.

The Committee may wish to consider the purpose of the register and its intended use and availability.

Clause 22: Review of operation of Act

422. Clause 22 provides for regular reviews of the operation of the Act by the Ministry of Health.
423. The first review must start three years after commencement of the Act, followed by review every five years. Every review must be completed within six months and must consider whether any amendments are necessary or desirable.
424. The Ministry of Health must report to the Minister responsible for the administration of the Act on every review and that Minister must present the report to the House of Representatives as soon as practicable.

What submitters said

Effectiveness

425. A few submitters specifically support the review provisions, in particular that the first review would be done in three years and that the reviews would be made public.
426. Some suggest that more detail is needed on what the reviews should include, for example review of any regulations, processes and practices of the Registrar, the SCENZ Group and the review committee, and implementation by relevant health boards and organisations.
427. Other submitters strongly contend that public consultation be a statutory requirement of the review process, as the Bill's operation would be a matter of public conscience. Others advocate that the medical community be involved in the review process.
428. Submitters also recommend that the reviews be required to include statistics and information about the underlying reasons for requesting assisted dying so that targeted care can be implemented where possible.
429. A few suggest that the reviews should be undertaken by an independent governance committee.

Limitations of review

430. Some submitters think that the review processes are limited to legal administration matters. They contend that the review could not ensure that inappropriate decisions were not made due to misdiagnosis or uncertainties around prognoses.
431. Others comment that the purpose of the review should be made clear.

Timing of reviews

432. Some submitters say that the Act should be first reviewed much earlier than three years after commencement and more regularly than every five years due to the significant and irreversible impact of the Bill.
433. There is an opposing view that a specific timeframe for review should not be prescribed, as Ministers of the day make decisions about priorities for officials and the allocation of resources to competing priorities.
434. Some consider that six months may not be enough time for a full review and that only the completion date should be prescribed.

Comment

435. No part of the Bill can be changed, once it is enacted, without an amendment Bill being agreed through the parliamentary process. This would include public consultation at the select committee stage.
436. The Bill provides that a legislative instrument (regulations) can be made in one instance - prescribing forms for the purposes of this Act. Regulations made under an Act may be developed, brought into force, and subsequently amended by Cabinet without going through the parliamentary process.
437. If a change was put forward by the Government on either the Act or the regulations, there would be earlier public consultation as a matter of standard practice.
438. Some submitters consider that there should be a requirement for the Act to be reviewed sooner or more regularly. The Bill does not prevent more frequent reviews being undertaken.
439. Six months to fully review an Act is extremely rigid timing that will severely limit the scope of the review.

<p>The Committee may wish to consider only providing for a completion date for the reviews.</p>

Clause 23 Regulations prescribing forms

440. The Bill sets up a form based system to record compliance with the assisted dying process. These forms are kept on a register, administered by the Registrar. There are ten forms across the Bill, the content of which would be set out in regulations:

- clause 9 – how the medical practitioner complied with clause 8 and for the person who wishes to have the option of assisted dying to confirm their request
- clause 10 – the medical practitioner records the first opinion
- clause 11 – the independent medical practitioner records the second opinion
- clause 12 – the specialist records the third opinion, if required
- clause 13 – notifying of a negative decision
- clause 16 – tracking of unused medication
- clause 17 – reporting of death
- clause 18 – medical practitioner destroying prescription, Registrar destroying prescription, and return of unused medication.

What submitters said

441. There were very few submissions on clause 23. Some submitters think the details of the prescribed forms should be included in legislation and not in regulations.

442. Other submitters are concerned about the amount of information that is to be collected about a person and think that privacy issues are raised that should be considered by the Privacy Commissioner.

443. Other submitters think that the regulation making power should be widened to include the contents of any annual reports. A suggestion is also made to include a general regulation-making power so that other appropriate matters could be prescribed in order for the process to function properly.

Comment

444. Regulations are often made on matters that are not policy but that enable an Act to function, as they allow more flexibility to respond to technical or other changes. This could include the contents of the report required under clause 17 and the Annual Reports of the Registrar. In addition, a more general power to make regulations is often included in case matters arise that are suitable for regulations that were not contemplated when an Act is passed.

The Committee may wish to consider further regulation making powers, such as a general regulation making power to provide for matters that enable the functioning of the Bill, and a power to set out the contents of the report required under clause 17 and the Annual Reports of the Registrar.

Clauses 25 to 27: Liability, offences, and penalties

445. Officials consider that the Bill's liability regime needs review and further development so that it closer aligns to best practice, ensures that blameworthy and harmful behaviour that was intended to be punished and deterred will be, and that there are no unintended consequences.

Clause 25: Effect of death under this Act

446. Clause 25 sets out that "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."
447. The intention of this clause within the Bill is not clear.
448. Officials have included clause 25 in this section as, on its face, it interacts with the liability regime set out in the Bill. However, officials note the clause is similar to provisions in reference to contractual and insurance purposes found in other jurisdictions that permit some form of assisted dying. The intent in these instances is to ensure that the assisted dying of a person does not void a contract and prevent a payment or other benefit being made to the estate of the person.

What submitters said

449. Most submitters who comment on clause 25 are strongly opposed to its inclusion.

Relationship with other clauses

450. Many submitters consider that the wording of the clause is against principles of honesty, openness, and transparency, and that its purpose is to hide the fact that a person was assisted to die. Submitters strongly disagree with this approach. Some think it would allow or encourage deaths from assisted dying to not be reported.
451. Submitters think that the clause overrides other sections of the Bill. Many submitters see a direct link to clause 28 and consider this clause to mean that the death certificate should state the cause of death as though assisted dying had not been provided. These submitters feel strongly that this is 'fraud' and a 'falsification' of the death certificate that would lead to incorrect reporting of deaths and inadequate review processes.
452. Some submitters suggest that the inconsistency between the two provisions could be removed by making clause 25 subject to clause 28.
453. Other submitters also question how this clause interacts with the immunity provision set out in clause 26. Submitters think that wrongful deaths would go unpunished.

Insurance implications

454. Of those submissions that view the clause as being about insurance, some submitters consider that a requirement to pay out a policy would incentivise behaviour of insurers to change behaviour to resist payment or otherwise try to ‘get around’ the law. Other submitters think a more certain payment of a life insurance policy would incentivise assisted dying and lead to higher premiums.

Comment

455. Clause 25 and clause 28 use the same term “as if assisted dying had not been provided”. Many submitters therefore believe the two clauses to be related. Clause 28 sets out that the cause of death will be the underlying medical condition while it will also be noted that the person died as a result of the provision of assisted dying.
456. Clause 28 is discussed in more detail from page 80.

Relationship with other clauses

457. Submitters most often interpret clause 25 to mean that assisted dying ‘never happened’. officials note that if this is the intention, it would be possible that there could not be a wrongful death under the Bill.
458. This means that there are no breaches of the Bill that would require the establishment and maintenance of a complaints procedure by the Registrar, that health practitioner complaints and disciplinary processes would not be required and that there is no offending that requires immunity under clause 26 (even if there was a lack of good faith or negligence). It may also mean that there would be no offences committed under clause 27.

We recommend the Committee clarify the intention of clause 25.
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Effect on insurance policies

459. Clause 25 may be intended to address any issues that arise for the person’s estate or for beneficiaries from the manner of death of a person. For example, for insurance purposes, ensuring payment to beneficiaries even if the policy holder dies by ‘suicide’ where this would otherwise mean the person was not covered.
460. If the Committee takes the view that clause 25 is intended to remove any effect of assisted dying for the purposes of contracts the person entered into (including insurance contracts) officials recommend that the clause be amended to reflect that intention. This would remove the complications of any alternative meaning to clause 25 outlined above.

Clause 26: Immunity in civil or criminal proceedings

- 461. Clause 26 states that “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.”
- 462. The Explanatory Note sets out that the Bill provides a legal pathway that prevents medical practitioners from being charged with an offence when the request for assisted dying comes from the expressed will of a person who is suffering unbearably. The Explanatory Note further explains that it remains a criminal offence to assist a person to die except by an action undertaken by a medical practitioner in the very limited circumstances prescribed.
- 463. The Legislative Design and Advisory Committee and the New Zealand Law Society both submitted on this clause, supported by similar submissions from other legal professionals. Officials agree with many of the comments of submitters. Officials consider there are several issues that should be reviewed about the immunity provision.

What submitters said

- 464. While most submitters who comment on this clause recognise and/or support that some sort of immunity is appropriate in the circumstances, most of these submitters have concerns about the clause.
- 465. Some submitters think the clause as a whole should be clearer. Other submitters address legal and drafting matters or make suggestions to amend the clause.

The effect of the clause

- 466. Most submitters consider that the clause means that medical practitioners would not be found guilty under the Crimes Act for murder or aiding and abetting suicide, if the criteria in the clause were met.
- 467. As regards immunity from liability in civil proceedings, some submitters are concerned that clause 26 would override existing complaints and discipline regimes. These are complaints to the Health and Disability Commissioner about compliance with the Code, and complaints to professional bodies to ensure competent practice under the Health Practitioners Competence Assurance Act.
- 468. Conversely, other submitters think that the clause does not override existing complaints and discipline regimes and think that these processes should be specifically limited. Submitters think this would avoid family members who oppose assisted dying using these processes to ‘attack’ the medical practitioner involved.
- 469. Other concerns are that medical practitioners may experience backlash from their professional associations regarding their decision to either participate, or not participate, in the provision of assisted dying.

470. Other submitters feel the clause allows those providing assisted dying to exercise a lower level of professional skill and competence than any other medical procedure.

Comment

471. If assisted dying is to be treated as a health service, the Health and Disability Commissioner Act and the Health Practitioners Competence Assurance Act provide for a number of disciplinary processes that can investigate the actions of medical practitioners to assess whether they have met appropriate standards of care.
472. It appears that the immunity provision would exempt practitioners who perform assisted dying services from investigation, provided they have acted in good faith and without negligence. It is not clear whether the intent is to exempt practitioners from investigation under the existing processes as part of the civil immunity, or from a proceeding taken by private individuals, or both.
473. The application of the Code and the Health Practitioners Competence Assurance Act in the context of clause 26 should be clarified, especially as these provide mechanisms for investigation into the overall performance of services to an individual, and therefore may provide wider obligations than the duties under the Bill.
474. This would also assist to clarifying the scope of the Registrar's investigatory role (discussed in the section on accountability from page 61), as well as that of the Coroner (discussed in the section on reporting of death from page 81).

<p>We recommend the Committee clarify the application of the Code and the Health Practitioners Competence Assurance Act in the context of clause 26.</p>
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Scope of the clause

475. Some submitters have concerns about who the clause would apply to and for what offences. Submitters feel this makes it hard to determine who would be covered by immunity under this clause.
476. Submitters are concerned that if the clause only applies to persons who “provide or intend to provide assisted dying”, it is not clear whether the immunity provisions would apply to those who assist or more generally encourage or support a person through the assisted dying process. Examples given are health practitioners such as nurses and pharmacists, but also families or carers who would be discussing the process with the person. Submitters are concerned this might be viewed as aiding and abetting suicide.
477. Other submitters raise whether or not those who provide advertising or promotion of assisted suicide services or drug choices would be covered by the immunity clause.
478. Other submitters suggest that consideration be given to limiting the circumstances in which medical practitioners can be named as parties to litigation about assisted dying and therefore forced to participate in proceedings to review or injunct an assisted dying process.

Comment

479. The Explanatory Note appears to limit the application of the immunity provision to medical practitioners. Officials note that overseas jurisdictions that permit some form of assisted dying have a variable approach where protection may be given to only the medical practitioner, or specified additional persons, or ‘persons’ in general.
480. Submitters are most concerned about nurses and family members who assist or support the process of assisted dying being charged with a crime. Officials consider this is possible because the way the immunity clause appears to operate means that a crime is still committed. While a medical practitioner is immune from liability, prosecutions for those assisting or supporting the process could still be undertaken.

The Committee may wish to consider providing immunity for other persons assisting and supporting the medical practitioner in providing or intending to provide assisted dying.

How the clause works

481. Several submitters think that rather than providing immunity, it would be clearer if assisted dying was decriminalised through repealing or amending relevant provisions in the Crimes Act.
482. Many submitters comment on the thresholds in the clause. Most submitters who comment think that “good faith” sets a ‘low bar’ and provides ‘blanket immunity’. Submitters think that this would allow abuse and unnecessary deaths.
483. Many submitters think that it is not clear what “good faith” means, that it is subjective, and that it would be difficult if not impossible to prove that good faith was lacking.
484. Some submitters think that imposing criminal liability on the basis of “negligence” is unusual and would mean serious potential criminal consequences for conduct that falls short of being conscious or intentional.

Comment

485. Submitters are concerned that “good faith” is a low threshold to meet to be immune to liability. Officials note that “good faith” is used in other jurisdictions who permit some form of assisted dying such as the Australian State of Victoria.
486. There are structural issues with how the clause works. Officials consider the operation of the clause needs to be clearer, for example whether it operates as a justificatory defence provision or an immunity to prosecution, and who has the burden of proof.
487. Further difficulties arise with the immunity clause because it includes both civil and criminal immunity. As the civil and criminal burdens of proof are different, further clarity is required as to which standard applies.
488. One option to do this would be to separate the liabilities for civil and criminal matters. Some submitters mention directly amending the Crimes Act so that assisted dying,

undertaken under the Bill, is not a criminal offence. Alternatively, in the Canadian legislation, exemptions are provided in the Criminal Code for medical assistance in dying for medical practitioners or nurse practitioners and others across a range of offences including culpable homicide and counselling and aiding suicide.

489. In either case, a general provision would be retained in the Bill for immunity for civil proceedings.
490. Another option is also separating out criminal and civil immunity, but retaining both provisions in the Bill. If this approach is taken, or if the current provision remains, imposing criminal liability on the basis of “negligence” may require further consideration.

We recommend the Committee clarifies how the immunity clause is to operate.

Relationship with other offences

491. Some submitters raise that the clause does not seem to address several provisions in the Crimes Act that either place a duty on others to prevent harm, or that provide a defence to reasonable force used in preventing suicide or assault.
492. Submitters think that some people, including medical practitioners who conscientiously object, could still be prosecuted for failing to prevent the assisted dying.
493. Another provision mentioned by submitters is where a person’s consent to their own death does not affect the criminal responsibility of the person who was a party to the killing.
494. Other submitters think that the immunity clause would be redundant, because clause 25 negates the existence of a death by assisted dying.
495. Other submitters do not think the relationship between this clause and clause 27 (offences) is clear. Some submitters feel the relationship removes any obligation to comply with the steps set out in the Bill.

Comment

496. Officials agree that the approach of the immunity clause means that other provisions of the Crimes Act will still operate for proceedings that are not about providing or intending to provide assisted dying. In particular, section 41 (prevention of suicide or certain offences) and section 48 (self-defence and defence of another (against assault)) could allow persons to use force on, or assault, those providing assisted dying.
497. In addition, clause 26 does not distinguish what civil or criminal proceedings a person is immune from. People to whom immunity applies in clause 26 are also immune against liability for committing an offence under clause 27, unless they did not act in good faith and without negligence. Officials do not know if this is the intended outcome.

We recommend the Committee clarifies that section 41 and section 48 of the Crimes Act do not apply in the context of assisted dying.

We recommend the Committee clarify the immunity clause so that it does not apply to clause 27.

Clause 27: Offences

498. Clause 27 states that:

- a. A person commits an offence who—
 - i. wilfully fails to comply with a requirement in this Act; or
 - ii. (b) completes or partially completes a prescribed form for a person without the person's consent; or
 - iii. (c) alters or destroys a completed or partially completed prescribed form without the consent of the person who completed or partially completed it.
- b. The person is liable on conviction to either or both of—
 - i. (a) a term of imprisonment not exceeding 3 months;
 - ii. (b) a fine not exceeding \$10,000.

499. The clause intends to ensure compliance with the requirements of the Act, and to maintain the integrity of the paper documentation of the assisted dying process.

What submitters said

Penalty is too lenient

500. Many submitters consider that the only penalties for wrongful death under the Bill are those contained in clause 27. Many draw a comparison between assisting death in the manner outlined by the Bill and criminal provisions such as murder, manslaughter, and aiding and abetting suicide. They note that the penalties in the Bill are far lower than the criminal provisions.

501. Most commonly, submitters believe that the penalties are not sufficient given that non-compliance with the Act or falsifying the material on a form can result in the death of a person without their consent.

502. Additional comparisons are made between the clauses 27(1)(b) and 27(1)(c) and other similar offences. One submitter notes that the penalty for altering documents with the intent to deceive carries a penalty of up to 10 years imprisonment.

503. Submitters suggest a range of higher penalties they consider to be more appropriate.

Penalty is too severe or inappropriate

504. Some submitters believe that the offence applies to all requirements and prescribed forms within the Bill and express concern that people could be fined or imprisoned for administrative errors. They think the Bill's penalties are too severe in such situations.

505. Other submitters believe that the clause contains strict liability offences without defences. They suggest that strict liability may not be appropriate for all circumstances, particularly where family members and friends carry out a prohibited action out of a sense of obligation to a loved one.

New offences

506. Some submitters believe that clause 27 does not capture all concerning behaviour and consequently advocate for additional offences. Several of these submitters advocate for an offence for coercing, threatening, or incentivising another person to access assisted dying. Others suggest an offence for helping a non-eligible person access assisted dying. One submitter seeks an offence for using information obtained for research under clause 20(2) for accountability purposes.

Investigative shortcomings

507. Several submitters express concern for how offences would be investigated. In particular, submitters believe there will be practical difficulties in prosecuting a person for destroying or altering a document without consent as the main witness, the person accessing assisted dying, would be dead. Others believe similar difficulties would exist for prosecuting a person who had correctly complied with the process and paperwork but ultimately administered the medication without the person's consent.

Comment

508. Without knowing the policy intention behind the offence provision, for the purposes of discussion on this section, officials have assumed:

- that as is usually the case in legislation, the offence provision applies only to the requirements in the Bill. Existing offences, such as those in the Crimes Act, still apply to other behaviours that appear to require sanction but are not covered by the offence provision (subject to clarification of the intended effect of clause 25)
- the immunity provision in clause 26 does not apply to the offences set out in clause 27.

509. Officials think several issues should be reviewed about the offence provision.

Clause 27 is very wide

510. Clause 27 applies to every requirement and every actor described in the Bill. This may have been intended but is not usual when designing offence and penalty provisions.

511. Clause 27 states that the offence applies to a "person". It therefore appears this provision applies variously to the attending medical practitioner and the independent medical practitioner (sometimes jointly), the person seeking assisted dying, the specialist, the Registrar, the Director-General of Health, the Ministry of Health and the Minister.

512. Officials do not consider it is necessary, or usual, to capture the administrative bodies and other ancillary actors in a penalty provision.

We recommend the Committee narrow clause 27 to include only the attending medical practitioner, the independent medical practitioner, and the specialist.

The prohibited behaviour is not clear

513. The specific behaviour the Bill intends to penalise is extremely broad. Clause 27 firstly provides it is an offence to fail to comply with “a requirement in this Act”. There are approximately 70 requirements in the Bill. While it is more usual for offences to target specific behaviour, it may be that every requirement in the Bill plays an important role in ensuring compliance with the process and therefore a blanket offence may be appropriate.
514. However, many of the requirements within the Bill are not clearly defined and the exact obligations they create are unclear. For example, it is unclear in clause 8 what “ensure” or “do his or her best” are intended to mean or, in clause 9(4)(d), what amounts to a “benefit”.
515. It is important that those potentially liable know the legal boundaries of their behaviour and actions to be able to comply with the law. Otherwise there may be inconsistent application and enforcement, unintended changes in behaviour, and the Bill may fail to preclude conduct that was intended to be prohibited. It will be left to the courts to clarify the exact boundaries of Bill’s obligations.

We recommend the Committee amend the wording of key obligations within the Bill so that they are clear in the context of clause 27.

Strict liability

516. The second and third offences under clause 27 do not contain any mental element. It is not necessary that a defendant intended to commit the offence. Under these offences a medical practitioner could be liable where they reasonably believed the person consented to them completing a form for them.
517. Strict liability offences generally do not carry penalties of imprisonment and it is best practice that strict liability offences have defences, for example to allow for reasonable conduct.

We recommend that the Committee considers adding a defence to clause 27(2)(b) and (c).

Penalties

518. Breaches of some requirements in the Bill are more serious than others and that the approach in the Bill of one penalty for all breaches should be refined.

We recommend the Committee stratify the penalties between the distinctions of seriousness of breaches.

New offence needed

519. The current offence only captures coercion by the medical practitioner where it materialises as a breach of a Bill's requirement or falsifying a form without consent. Wider instances of coercion or coercion by people other than the medical practitioner will not be captured by the Bill or by other relevant offences.

The Committee may wish to consider a new offence to capture those who intentionally cause another person to request assisted dying against the person's will, with an appropriate penalty.

Clause 28: Reporting of death

520. Regulation 7 of the Births, Deaths, Marriages, and Relationships Registration (Prescribed Information) Regulations 1995 (the regulations) sets out information that must be recorded on a death certificate. Clause 28 amends regulation 7(1)(a)(xiii), which covers the cause or causes of death, in two ways:

- firstly, the cause of death would be recorded as the underlying medical condition, as if assisted dying had not been provided
- secondly, the fact that the person died of assisted dying would be recorded.

521. The amended regulation would also set out the interval between the onset of the cause of death and the death by assisted dying for each cause of death listed on the death certificate.

522. The amendments to regulation 7(1)(a)(xiii) are:

Existing regulation 7 (1)(a)(xiii)	Amended regulation 7 (1)(a)(xiii)
<p>Cause of death</p> <p>(xiii) the cause or causes of the person's death, and</p> <p>Interval between onset and death</p> <p>(if more than 1, in respect of each) the interval between onset and death:</p>	<p>Cause of death</p> <p>(xiii) the cause or causes of the person's death, subject to subparagraph (xiiia):</p> <p>(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:</p> <p>(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:</p> <p>Interval between onset and death</p> <p>(xiiic) the interval between onset of the cause of death and death, in respect of each cause of death, subject to subparagraph (xiiid):</p> <p>(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:</p>

What submitters said

- 523. Most submitters who comment on clause 28 believe it amounts to the falsification of death certificates and that medical practitioners are being asked to be 'dishonest'. They often advocate for "assisted dying" or the method of assisted dying to be recorded as the cause of death, instead of the underlying medical condition.
- 524. Some submitters comment that in many cases when a person is suffering from a terminal condition, they will die of an unanticipated event, for example pneumonia, an infection or a stroke. Medical practitioners may therefore be unable to determine what would have caused or contributed to a death had assisted dying not been provided.
- 525. Submitters identify that it would be particularly difficult or problematic to anticipate what the cause of death would be, had assisted dying not been provided, in instances of a grievous and irremediable medical condition, compared to those with a terminal illness.
- 526. Some submitters think that this could potentially mean a bias of outcomes where the records would show shorter survival rates over time. Progressively, people with those same conditions will be given poorer and poorer prognoses and hence would be more likely to seek early death.
- 527. Conversely, other submitters support the intent of the clause that the recorded cause of death should be the underlying disease process or primary diagnosis that made the patient eligible for an assisted death. These submitters often comment about how the fact that a person died of assisted dying is still recorded.

Comment

Perceived falsification of cause of death

- 528. Many submitters comment on the perceived falsification of death certificates, because the cause of death would be recorded as the underlying medical condition. Officials do not consider this is the case as the clause also requires that the fact that the person died of assisted dying to be recorded on the death certificate.

Other jurisdictions

- 529. Both Hawaii and Victoria⁵ contain similar provisions for death certificates in their legislation. In these jurisdictions the underlying illness, or the grounds for the person to access assisted dying, are also recorded as the cause of death. In Canada, guidelines specify that the medical certificate of death is to include both the immediate cause of death (lethal medication) and the underlying cause (the disease or condition).

⁵ The Victoria legislation only applies to people with terminal illnesses.

Purpose of death certificates

530. A death certificate is a record of death containing personal information about the deceased, including the cause of death. Death certificates are issued by the Registrar under the Births, Deaths, and Marriages and Relationships Registration Act 1995 (BDMRRA) as a record of the fact that a person is dead. The death certificate is used for various purposes such as the administration of the person's estate or applying for a funeral grant from ACC. The cause of death as recorded on the death certificate does not affect these purposes. This certificate is the culmination of a number of underlying processes.
531. Death certificates offer a genealogical record to families and descendants. Therefore, underlying cause of death may be important to descendants, as well as the information that the person died under provisions of the Bill.
532. Officials note that it may be problematic to anticipate what the cause of death would be, had assisted dying not been provided, in instances of a grievous and irremediable medical condition, compared to those with a terminal illness.

The Committee may wish to consider whether the death certificate should only require medical practitioners to record the grievous and irremediable medical condition for which assisted dying was provided and not state it as the cause of death.

Reporting cause of death – current requirements

533. The issuing of a death certificate under the Births, Deaths, and Marriages and Relationships Registration Act is the final step in the death certification process. Legislative requirements under the Burial and Cremation Act 1964 and the Coroners Act 2006 arise prior to a death certificate being issued under that Act.
534. Before a body can be buried or cremated in New Zealand, a medical certificate outlining the cause of death or a coroner's authorisation must be obtained. This provides a safeguard against the disposal of bodies in circumstances where the death may have been preventable or may have arisen as a result of a wrongful or negligent act or omission. Where the death is natural, and a medical certificate is given, this ensures that health information is obtained and recorded, serving the interests of public health.
535. Provisions under the Births, Deaths, and Marriages and Relationships Registration Act and the Burials and Cremation Act ensure that the cause of death is accurately recorded. The Coroners Act ensures that any suspicious circumstances around a death are investigated.
536. As the Bill is currently drafted, it is unclear if a death under the assisted dying provisions would be a natural consequence of illness that justifies the provision of a medical certificate of cause of death under the Burial and Cremation Act. This appears to be the intent of clause 25. However, it is unclear whether this pathway would be intended in circumstances where there are grounds to suspect that an offence under clause 27 has

arisen, or there is an allegation that conduct has occurred that justifies the removal of the immunity provision. These circumstances would generally be grounds for investigation by Police and the Coroner.

Deaths that are a natural cause of illness

537. Where death occurs as a natural consequence of illness, health practitioners complete a medical certificate of cause of death under the Burials and Cremation Act.
538. Section 46B of the Burials and Cremation Act provides for deaths that are a “natural consequence of illness”. In such cases a (Medical) Certificate of Cause of Death is issued by the health practitioner who attended the person during their illness, or any other if they are not available. If the individual is to be cremated, a cremation certificate is also completed under the Cremation Regulations 1973. Following this, the cause of death is reported to, and recorded by, the Registrar under the Births, Deaths, and Marriages and Relationships Registration Act. A death certificate then becomes available, which incorporates the recorded cause of death information.
539. Certificates are required to be completed under the Burials and Cremation Act in a prompt manner (effectively within 24 hours). This allows for timely cremation or burial. If a death is unexplained or suspicious, this enables coronial investigations to be conducted expeditiously. This facilitates the conduct of post mortems if necessary to ascertain cause of death.
540. The format of the certificate under the Burials and Cremation Act is set by the World Health Organization to ensure international consistency in the collection of cause-of-death statistics by requiring that the underlying cause of death is collected. Statistics about the underlying cause of death are important and are used to:
- measure the health status of populations
 - form health policy
 - monitor the effectiveness of cancer screening, immunisations and other health programmes
 - compare the cause of death statistics across countries.

Deaths that are not a natural cause of illness, stillbirth or injury to someone over 70

541. If a certificate of death is not given under the Burials and Cremation Act because the death is suspicious or unexplained (this includes where there is a poisoning), it must be reported to the police. Police report the death to the coroner under the Coroners Act. This commences an investigation into the circumstances surrounding the event (unless a stillbirth or the result of an injury to someone over 70 years). The coroner has a range of investigative powers to ascertain cause of death, including the power to arrange for a post mortem. The individual's body must not be cremated until the coroner gives authorisation. These legislative processes constitute a key interface between health and justice systems.

We recommend the Committee clarify the relationship between the Bill, the Burials and Cremation Act and the Coroners Act.

The Committee may wish to consider how the obligations to report to the Registrar and the Registrar's investigatory functions align with the existing processes.

542. The Burials and Cremation Act relies on honest and accurate reporting of the cause of death by practitioners, who would be assisting under the Bill and would therefore be the subject of any investigation if bad faith or negligence was later alleged.
543. Officials consider it is important that to review how conduct that constitutes a breach of the offence provision in clause 27, or which justifies the protection of the immunity provision in clause 26 being lifted, is identified and should be investigated.
544. Where negligence or bad faith is suspected or where issues arise in the provision of assisted dying (such as problems with dosage), consideration may need to be given as to the role of Police and the Coroner and how reporting would work. This could consider the timeframe within which practitioners are required to report to the Registrar, as unless referred to a Coroner, a body would typically be buried or cremated within the fourteen-day timeframe within which practitioners are required to report to the Registrar. This may hinder the Registrar or the Coroner's investigatory functions.

The Committee may wish to consider clarifying the legislative purposes for the collection of information under the Bill in light of the existing death reporting and investigatory processes.

Consequential amendments

545. If it is the intention of the Bill that a death under assisted dying provisions would not need to be reported to the Coroner under the Coroners Act, then amendments would be required to the Burials and Cremation Act. Any such amendments to the Burials and Cremation Act would need to:
- provide for deaths under assisted dying provisions to be given a medical certificate of cause of death by a practitioner, and for how cause of death is recorded
 - identify which practitioner may give the certification of cause of death
 - provide for amendments to the Cremation Regulations 1973 in relation to the cause of death on the Cremation certificate for a death by assisted dying
 - provide that deaths under assisted dying provisions would not need to be reported to a Coroner under the Coroners Act, or would need to be reported in certain defined circumstances.

If an assisted dying death is not to be reported to the Coroner, we recommend the Committee considers appropriate consequential amendments to the Burials and Cremation Act.

Annex A: Summary of submissions

1. The Justice Committee received about 37,200 unique written submissions from organisations and individuals. Over 36,700 of these submissions have a discernible view. Of these:
 - over 33,500 submissions (approximately 90%) appear to oppose the Bill
 - over 3,100 submissions (approximately 8.5%) appear to support the Bill
 - a very small number of submissions have been interpreted as having a neutral stance towards the Bill or the submitter's view is unclear.
2. In addition, the Justice Committee held over 40 hearings of oral evidence in Wellington and in other centres and regions. In total, about 1,600 submitters were heard.
3. The following is a full summary of submissions that contains the views put to the Committee, and some of the nuance behind those views. A shorter summary that concentrates on main themes arising from submissions is found from page 10.
4. This document is a representation of the views of members of the public who made a submission to the Select Committee. All care has been taken to accurately represent the views of submitters, but this may not have occurred in all cases and some errors, omissions or inadvertent misrepresentations may have been made.
5. This report contains a thematic summary of the views of submitters on the issue of assisted dying and on the Bill itself, and a full summary of submissions. We have not put numbers on how many submitters had a particular view, or how many times an issue was raised, as the volume and varied nature of the submissions make this impractical.

Sources and format of written submissions

6. Written submissions were received through the parliament.govt.nz website, email and post. As well as the use of computer word processing programmes, many submissions are handwritten. All submissions can be found online at the parliament.govt.nz website.
7. Most submissions are brief, containing only a single sentence or a short paragraph. Some of these submissions simply state whether or not they want the Bill to proceed. In contrast, other submissions extend to or over a page. Fewer are substantial in length. These submissions tend to discuss the Bill in greater detail.
8. Many submissions opposing the Bill consist of proforma sheets where submitters tick, circle or write arguments they agree with from a list. No information is given as to the source of these sheets. Many submissions also include identical phrases. This is particularly so for short submissions where the phrase is stated in isolation.

Profile of submitters

9. Most submitters identify themselves as an individual. A small number of submitters provide demographic information, including age, religion, ethnicity and whether they have any disabilities or degenerative or chronic conditions. Some submitters provide information about their occupation. Of those submissions, many identify themselves as working in the health sector.
10. Other submitters identify themselves as a group of individuals. Most commonly, submissions are signed by family members. Other submissions appear to be similar to a petition and are signed by many individuals.
11. Other submitters identify themselves as an organisation. These organisations include representative organisations, not-for-profit organisations, charities, and churches among others. A list of these organisations can be found in Annex B.
12. A few submissions were received from overseas individuals or organisations.

Content

13. Most submissions do not address the Bill specifically. Rather, they discuss whether assisted dying should or should not be allowed in principle. Other submissions address specific clauses of the Bill in isolation. Fewer submissions provide detailed views as to how the Bill may work in its entirety.
14. Many submissions contain strong views on the Bill and assisted dying more generally. Submissions often tend to be strongly worded and contain emotive language.
15. Despite the strong differences in opinion, many supporting and opposing submitters comment that they understand that the views of the other side are compassionately motivated.
16. Many submissions contain personal and/or professional stories submitters believe are relevant to the Bill. Some submitters detail their own preferences for their own end of life.
17. Some submissions contain religious arguments. In general, these are submitters that oppose the Bill, but not in all cases. Some submitters who support the Bill believe that religious arguments should not be taken into account as not all New Zealanders are religious or share the same spiritual beliefs. In contrast, some submitters who oppose the Bill believe that their arguments should not be dismissed merely because they are based on religious values.
18. Individual submissions sometimes refer to organisations' submissions. Other submissions simply state that they endorse the views of particular organisations.
19. Submitters' views on the Bill and assisted dying more generally are described below. Views have been organised thematically. Comments and views on particular clauses and their operation are addressed in clause by clause summaries from page 20.

Principles of assisted dying

Sanctity of life

20. Most commonly, submitters who oppose the Bill and/or assisted dying more generally express the view that all life is inherently sacred and therefore should be protected and maintained irrespective of its perceived quality. In contrast, many submitters supporting the Bill believe that the quality of someone's life may be more important than its length, and that this question is for the individual concerned to judge.

Prerogative over life

21. Many submitters discuss whether people ever have a prerogative to end another's life. Submitters who support the Bill believe that informed and free consent and altruistic motives are a sufficient basis for assisting in the death of another. Submitters who oppose the Bill often believe that it is wrong to facilitate death in all circumstances, including those set out in the Bill. Many submitters who oppose the Bill consequently perceive it to be actively supporting suicide or legalising murder.
22. Submitters who identify as having faith-based beliefs often state that the timing of life and death is for God to decide. They often quote the Old Testament commandment, 'thou shall not kill' among other theological and biblical quotes as evidence that assisting another to die is not compatible with their religion. Of these submitters, many explicitly state that they believe assisted dying is a sin and discuss what they believe the spiritual repercussions would be for those accessing or providing assisted dying.

Natural death

23. Some submitters that oppose the Bill perceive assisted dying to be 'unnatural'. They instead endorse people living out their lives until their death occurs by its own accord. Some submitters supporting the Bill believe there is little difference between assisted dying and other methods of dying, such as palliative sedation. Other submitters who support the Bill think that because modern medical treatment extends people's lives, most deaths these days could be considered unnatural regardless of whether assisted dying is used or not.

Autonomy and choice

24. Nearly all submitters who support the Bill believe assisted dying provides personal choice and autonomy over the end of life process. Many of these submitters perceive individual autonomy and self-determination to be the cornerstones of modern New Zealand society. These submitters believe that people should have the freedom to determine their own fate. Some submitters refer to the circumstances of Lecretia Seales as an example of when people should have autonomy over their life and death.
25. Submitters in support of the Bill often consider there to be a 'human right' to decide the timing and circumstances of their own death. Some of these submitters consider people to have different thresholds and conceptions of what amounts to a 'quality' life and death. Many submitters who support the Bill believe having the autonomy and choice over one's death helps to alleviate the fear of dying that many people have. These submitters

believe that having access to assisted dying does not necessarily mean people will choose it. Rather, people will feel at ease knowing they can legally and painlessly end their life if their pain and suffering overtakes the limits of their tolerance.

26. Some submitters consider that people should have the autonomy to decide how they treat their unbearable suffering. They believe that even if modern medical care such as palliative and hospice care could relieve all suffering, people should still retain the autonomy to decide whether or not they engage in these services or something else.
27. Some submitters detail their own preference for their end of life and how they would like to spend their final days. Others describe the impact of having to care for or witness a friend or family member experience an end of life they knew was against their family member or friend's wishes.
28. A smaller number of submitters state that having the autonomy to determine how their assets are used, whether that be for their end of life care, or to support family members, is also important.
29. Many submitters who oppose the Bill believe that personal autonomy is not absolute, but rather must be balanced with the needs of other people and the wider community. Submitters often give examples of what they see as well-accepted and regarded limitations on personal autonomy. They state that humans do not live in isolation and that individuals' autonomy must therefore be restricted to ensure the safety and wellbeing of the entire community. Submitters often state that they do not believe the Bill should be passed to benefit a few people at what they perceive is the detriment of many.
30. Some submitters who support the Bill advocate for the inclusion of advanced directives. They believe that advance directives would allow people to end their life with autonomy and choice, even where they have reduced capacity. In contrast, submitters who oppose the Bill disagree with it being extended to include advance directives. They express concern that advance directives may undermine consent as people who may have changed their minds would be forced to continue with their original intention.

Dignity

31. Submitters speak about dignity in a variety of ways. Many submitters who support the Bill regard assisted dying as allowing a dignified death. These submitters believe that people have different conceptions as to what a dignified death means, and that people should not be forced to die in a manner they perceive to be undignified. Submitters who support the Bill often regard dignity as retaining independence, choice and/or control.
32. Some submitters opposing the Bill believe that all deaths are dignified, regardless of circumstances and/or perceived quality of life. Of these submitters, many comment that they find the concept of an undignified death, especially where expressed as a loss of independence, control or choice, as offensive.
33. Other submitters opposing the Bill believe that deaths are, by their nature, always undignified. They therefore think that the Bill's purpose is unachievable.

Compassion

34. Some submitters who support the Bill believe that when people are suffering it is compassionate to assist in their deaths. They consider that some people live with unbearable suffering or indignity and believe that without assisted dying people would have to continue in this state. Submitters sometimes regard this as inhumane and tantamount to torture. Submitters often tell stories of family and friends who had or are experiencing unbearable suffering or indignity.
35. Some submitters who support the Bill believe that animal euthanasia shows that society accepts that in some cases it is compassionate to assist in another's death. These submitters often describe their own experiences with animal euthanasia and question why the same response could not be given to their friends and family suffering in unbearable pain or indignity. In this regard, some submitters comment that they believe animals are treated better than people.
36. In contrast, some submitters who oppose the Bill believe animal euthanasia is completely distinct. Many of these submitters regard animals as people's property and believe that decisions to euthanise animals are made on different considerations. Submitters who identify as holding faith-based beliefs often perceive that humans are inherently more valuable than animals as they were created in the image of God. They therefore believe people should be treated differently.
37. Submitters who oppose the Bill believe that assisting in another's death is not a compassionate response to suffering. They are concerned that people may suffer degrading or painful side-effects as a result. Of these submitters, some refer to examples from assisted deaths or capital punishment in other jurisdictions. Other submitters question whether, given the unknown nature of death, assisted dying does in fact relieve a person's suffering.
38. Submitters who oppose the Bill also believe that compassion is not allowing assisted dying, but rather treating, caring and supporting people with love. These submitters often share stories of caring for another person. Some desire a cultural change in how New Zealand treats those who are suffering and greater funding for support and care programmes.
39. A small number of submitters who oppose the Bill believe the restrictions of the eligibility criteria, such as age, undermine the compassionate intention of the Bill. They question why, if people need assisted dying to treat unbearable suffering, the Bill then excludes particular groups from this who are also facing unbearable suffering. These submitters therefore consider the Bill to be contradictory.

Hope

40. Submitters opposing the Bill often express a belief that the Bill removes 'hope' from people's lives. These submitters consider that the final and irreversible nature of death removes opportunities for miracles and/or an unexpected change of circumstances. Some submitters note that medical science is always evolving and there is therefore a risk that a person might be assisted to die when a cure is about to be found.

41. Some of these submitters believe that allowing assisted dying would discourage a hopeful and optimistic social attitude, especially amongst young people.
42. Submitters in support feel that knowing assisted dying is available would give the person peace of mind that this is an option, and that it did not mean they would request it or go through with it.

The role of the state

43. Some submitters who oppose the Bill consider assisted dying to be against the proper role of the State. Of these, many comment that they believe the purpose and role of the State is to protect its citizens and enhance peoples' life. They consider that allowing people to be assisted to die is against this.
44. In contrast, some submitters who support the Bill believe the state and law is designed to respond to the needs and desires of its citizens. They believe the current legislative framework causes people to suffer and consider the state to therefore have a duty to alleviate this harm.
45. Some submitters who are opposed to the Bill explicitly state that they are against their tax payer money being used to fund assisted dying.
46. Many submitters believe that legislation should reflect the majority's opinions. Both opposing and supporting submitters perceive the New Zealand public majority to favour their own stance. Submitters who oppose the Bill often interpret the Petition of Hon Maryan Street and 8,974 others as showing that the majority of the New Zealand public is against assisted dying. Submitters who support the Bill often refer to public opinion polls that they believe show that the majority of the New Zealand public support the Bill and/or assisted dying more generally.
47. Some submitters believe Parliament does not have the right to decide whether the Bill should pass and should therefore hold a binding referendum on the matter. Some submitters explicitly state that they support NZ First's stance on a referendum. Other submitters who oppose the Bill believe the New Zealand public do not have a good understanding of what the Bill entails, and that a referendum will be insufficient to capture their true views.
48. Some submitters who support the Bill regard assisted dying to be the natural next step in New Zealand becoming a more modern and liberal state. Some of these submitters believe that providing assisted dying would keep New Zealand in line with other modern liberal states, such as the Netherlands and Belgium. In contrast, some submitters that oppose the Bill believe that New Zealand is different from overseas jurisdictions that permit some form of assisted dying, and that it is not necessary to follow their precedent.
49. Some submitters who oppose the Bill believe it has been put forward to reduce state costs. These submitters consider that financial concerns should never be a reason for ending life.

Cultural considerations

50. Some submitters who oppose the Bill consider it to be ignorant of or dismissive of other cultures and their values. In particular, some submitters are concerned that the Bill is incompatible with what they perceive are Māori and Pasifika values and culture. Some of these submitters consider that Māori culture is collective rather than individually based and places great value on the elderly and ill.
51. Some submitters question whether sufficient efforts had been made to ensure the Bill complies with the Treaty of Waitangi and its principles. Others believe the Bill is a breach of the Crown's obligations under the Treaty.

Effects on family and friends

52. Some submitters who support the Bill believe that assisted dying is beneficial for family and friends. Most of these submitters believe that family and friends are often distressed when witnessing someone close to them suffer unbearably or live in an undignified manner. These submitters often tell personal stories of witnessing someone close to them suffer at the end of their life. These submitters experienced a desire to ease the other's suffering. Some comment that they knew it was the person's wish to be assisted to die and being unable to fulfil that wish caused distress.
53. Submitters who support the Bill also believe that assisted dying allows family and friends to grieve and feel closure. Some submitters suggest that assisted dying means that families and friends will be involved at the time of death and some quote overseas experiences of this.
54. A small number of submissions comment on how a relative who was terminally ill or who was suffering had suicided alone. These submitters often express how they felt guilt and remorse for not being able to support their loved ones in their final moments.
55. In contrast, some submitters who oppose the Bill also perceive the end of life as an incredibly valuable time for them to be with the sick or dying person. They express concern that the availability of assisted dying would cut this time short, and so limit family and friends' grieving process and their ability to have closure. Submitters believe that strained or distanced relationships often tend to be healed during this time.
56. Other submitters who oppose the Bill believe that suffering is an important part of the human experience. Some of these submitters consider that suffering enriches people's lives by teaching hope, resilience and gratitude. Submitters often tell stories about spending time with a person at the end of life and how this changed them as a person. Other submitters believe that suffering helps bring people closer to their religion or spiritual beliefs.
57. Some of these submitters believe the Bill does not require an individual to communicate their wish to die to their friends and family, and consequently express concern that people could access assisted dying without their family or friends knowing. Some submitters express concern that the availability of assisted dying may cause disagreements within families.

58. Several submitters include personal stories about how their or an acquaintance's life was impacted by a loved one who had accessed assisted suicide overseas.

People or groups who are eligible

59. To be eligible for assisted dying a person must meet the criteria under clause 4 of the Bill. Many submitters who oppose the Bill believe the criteria to be too wide and vague. Submitters who oppose the Bill are often concerned with the types of people or groups who could be eligible.
60. In contrast, submitters who support the Bill believe the criteria are adequate to protect particular people or groups in society. Some of these submitters suggest improvements on how the Bill could be strengthened.

People with disabilities, or degenerative or chronic conditions

61. Some submitters who oppose the Bill are concerned that those with disabilities, or degenerative or chronic conditions, would be eligible for assisted dying under this Bill. Submitters often share their own or another's personal experiences with disabilities or chronic or degenerative conditions.
62. Submitters who oppose the Bill are concerned that in meeting its criteria, the lives of these people would be devalued. They believe that society's attitudes towards these people would change for the worse. They are concerned that society may begin to consider such people a burden and these people would be coerced or forced into accessing assisted dying.
63. Some of these submitters believe that less resources would be put towards people with disabilities or degenerative or chronic conditions. In particular, submitters are concerned that the state would use assisted dying as a cost-effective treatment for these people. They suggest that research to improve their quality of life or find cures will consequently lose funding.
64. In contrast, submitters who support the Bill think that those who are suffering should not have to continue their life in pain if they do not want to and that it should not matter if they also have a disability, or a degenerative or chronic condition. These submitters consider the Bill would create a huge relief knowing there was an alternative to this suffering. Submitters consider that those suffering would not have to access assisted dying. Rather, assisted dying would just allow for another available option and would not impact on other care and assistance options.

People with mental illness

65. Many submitters who oppose the Bill are concerned that people would be eligible for assisted dying if they suffer from mental illness. Most of these submitters think that people with mental illness should not be able to access assisted dying, as they believe mentally ill people do not have the competence to make this decision. Submitters are also concerned that mental illnesses, such as depression, are often easy to hide and difficult to diagnose.

66. Many submitters who oppose the Bill also believe that people suffering from mental illnesses should be cared for and supported during this time. Many of these submitters share personal stories of how they, or someone they love, had a depressive episode in their life and wished to end their suffering by suicide. They state they have since been thankful that they or the person did not end their life.
67. Some submitters who oppose the Bill consider anyone who wants to proceed with assisted dying as mentally ill. They believe therefore that anyone meeting the criteria should be excluded. Other submitters who oppose the Bill believe that depression often follows terminal or detrimental diagnoses.
68. Some submitters who support the Bill believe that people should be able to access assisted dying for mental illness. They believe that excluding mental illnesses from eligibility is discriminatory and delegitimises the pain that mentally ill people suffer. These submitters often comment negatively on how society perceives the mentally ill.
69. Other submitters believe that people should not be prevented from accessing assisted dying if they suffer from a mental illness and are otherwise eligible. Many of these submitters believe that facing unbearable suffering often makes people depressed and mentally ill. They therefore consider preventing mentally ill people from accessing assisted dying will make the process unduly restrictive and exclude people who need it most. Several submitters who support the Bill state that their own mental illness has not stopped them from being able to make important decisions about their life.
70. Submitters who both support and oppose the Bill desire further funding for mental health programmes.

Widening of criteria and application over time

71. Many submitters who oppose the Bill are concerned that if the Bill is passed, its criteria and application will extend over time – this is often referred to as the ‘slippery slope’.
72. Submitters who oppose the Bill often refer to overseas jurisdictions that permit some form of assisted dying that they consider had expanded the criteria or application over time. Most commonly, they refer to the Netherlands and Belgium.
73. In contrast, many submissions that support the Bill perceive the experiences of overseas jurisdictions positively, and believe that they show the criteria and application will not expand over time, or only by democratic processes.

Eligibility criteria will be extended

74. Many submitters who oppose the Bill are concerned that over time the Bill will be extended through amendments to include people who are not currently eligible under the Bill. In particular, submitters are concerned that the eligibility criteria will be extended to children under the age of 18. Submitters often refer to the Section 7 report of the Attorney General which found the age restriction discriminatory and unjustified under the Bill of Rights Act. They believe this finding will provide the pathway for allowing children to access assisted dying.

75. Some submitters who oppose the Bill believe it will be expanded over time to allow assisted dying solely for mental illnesses or psychiatric conditions.
76. Some submitters support the widening of the criteria over time. These submitters believe that people who are suffering should have access to assisted dying, regardless of their age or whether the suffering is physical or mental.

More deaths

77. Some submitters who oppose the Bill are concerned that the Bill would create a different New Zealand where society would become more tolerant of assisted dying, and therefore expect people who are eligible to make that choice. Submitters think this would lead to a higher number of deaths.

Will extend to people who have not consented

78. Some submitters who oppose the Bill believe that in the future, people will be assisted to die without their explicit consent. In particular, they express concern for people in incapacitated states or those whose disability or medical condition prevents communication.
79. Some submitters interpret the Bill as currently providing for assisted dying without consent. Of these submitters, many believe that people could be assisted to die with the consent of their family, medical practitioners or the state. Other submitters interpret it as requiring consent only at the start of the process. They believe that people who change their minds part way through the assisted dying process will not be allowed to disengage.
80. Submitters who support the Bill believe the Bill does not provide for, nor will it be extended to, provide for assisted dying without a person's consent. Most of these submitters think the processes in the Bill are sufficient to prevent assisted dying without consent.

Eugenics

81. Some opposing submitters are greatly concerned that the Bill is the beginning of a eugenics programme. Many of these submitters are concerned that the Bill will lead to a situation akin to that of Nazi Germany, which saw the genocide of Jews and other groups in Europe in the 1930s and 1940s.

Coercion

82. Most submitters who support the Bill believe that assisted dying provides for individual autonomy and choice. Many submissions from both sides discuss the potential for autonomy and choice to be undermined through coercion and whether they believe the Bill is sufficient to protect against this. Some of these submitters suggest changes.

'A duty to die'

83. Submitters are also concerned that people may choose to access assisted dying for fear that they are a care and/or financial burden on their family members, friends, the health

system and/or wider society. Some of these submitters suggest that when people realise they meet the criteria to access assisted dying, their self-worth may decrease, and they may feel implicitly required to access assisted dying. Submitters often phrase this concern as people feeling a 'duty to die'.

84. Other submitters believe that people may feel pressured to choose assisted dying to end the emotional suffering of family and friends watching them at the end of their life. A small number of submitters suggest that people may access assisted dying to donate their organs to a family member or loved one in need.
85. Submitters consider that these fears could easily be enhanced by the actions and words of those around them, whether intentional or not. Submitters give examples such as an adult child telling their elderly parent about their financial concerns or a caregiver sighing after a long day. Submitters are concerned that the subtle and potentially non-intentional nature of this coercion would make it impossible for others to identify.

Intentional coercion and abuse

86. Submitters who oppose the Bill are concerned that people may be intentionally coerced by those around them. They believe that family, friends and caregivers may encourage a person to access assisting dying to relieve themselves from the time, financial or emotional burdens of caring for them.
87. In particular, submitters are concerned that elderly people will be coerced to access assisted dying. Some submitters share personal stories of alleged elder mistreatment, abuse and coercion. Some submitters comment on current elder abuse statistics and suggest that levels of elder abuse will rise if the Bill passes. Other submitters express concern that abuse rates more generally may rise.

Economic coercion

88. Some submitters who oppose the Bill are concerned that people will be coerced into accessing assisted dying as a cost-effective solution to remedy their suffering. Some submitters are concerned that people may not have the financial resources to receive the pain medication and/or medical treatment they require to prevent or ease their suffering. Such people would therefore be forced to access assisted dying. A small number of submitters raise this concern in relation to Māori and Pasifika people and the systemic economic disadvantage they consider these people to face.
89. Some submitters express concern that people may be inclined to choose assisted dying to save their financial resources for their family and friends. A small number of submitters suggest that people may access assisted dying to sell their organs for money.
90. Submitters often believe that decisions surrounding life and death should never be economically motivated. Some submitters suggest providing more financial support to disadvantaged members of society, so they can afford better health care alternatives.
91. Submitters suggest that 'unscrupulous' family members may encourage an earlier death to receive inheritances and limit the finances being put towards their care. Some

submitters believe that people who meet the eligibility criteria are more likely to be highly dependent on others and therefore more vulnerable to such coercion.

Medical coercion

92. Some submitters who oppose the Bill are concerned about the potential for the medical practitioners to coerce people to access assisted dying. Some submitters believe that only medical practitioners who are predisposed (subconsciously or otherwise) towards allowing, and/or participating in, assisted dying will agree to take part in the process.
93. Other submitters suggest that over time medical practitioners may become laissez faire or mentally impacted by the process. They are concerned that medical practitioners will consequently take less care in administering the process.
94. Some submitters suggest that people put a high level of trust in their medical practitioners. They are therefore concerned that people would follow suggestions by medical practitioners to access assisted dying without further consideration.
95. Some submitters are also concerned that medical practitioners may not recommend or make clear that other options that are available to the patient. Some submitters suggest that medical practitioners are fallible and that there are disparities in the level of treatment they give.
96. Submitters express concern that medical practitioners may encourage assisted dying to treat a patient's condition where they feel unable to treat the patient further, regardless of whether another medical practitioner may be able to. These submitters regard the person's choice therefore as heavily dependent upon the advice and expertise they receive from their medical practitioners.
97. Some submitters who oppose the Bill are concerned that the state may encourage people to choose assisted dying to lower healthcare costs. Some submitters think this might become more of a concern in the future when they believe the healthcare system will face higher demand. A small number of submitters share experiences with healthcare professionals who they believe were motivated by a need to save healthcare resources. Several submitters comment that the state may coerce people to access assisted dying to gain their organs.
98. Some submitters suggest that medical practitioners may coerce people to access or be biased towards allowing assisted dying in order to gain the person's business. There are concerns that the availability of assisted dying will become profit-driven and that medical practitioners may start their own businesses to provide assisted dying.
99. Other submitters suggest that some medical practitioners may coerce people into accessing assisted dying for their own malicious desires. Submitters often share stories, either personal or ones they have heard, about medical practitioners who they believe enjoyed watching and making their patients suffer. Submitters believe that such abuse would be more profound and widespread under the Bill.
100. Many submitters who oppose the Bill believe that receiving a particular diagnosis or prognosis might encourage people to access assisted dying. Some submitters believe

that diagnoses and prognoses are by their nature inaccurate, while others believe that they are occasionally inaccurate due to human error. Some of these submitters tell stories about receiving, or someone they know receiving, an inaccurate prognosis or diagnosis.

101. Some submitters express concern that whether by malicious desire or mistake, the availability of assisted dying will undermine any potential enforcement or liability a medical practitioner may face for wrongly assisting in the death of a patient. Submitters often phrase this as allowing medical practitioners to 'get away with murder'.

Safeguards will not be adhered to

102. Some submitters who oppose the Bill believe that New Zealand's tolerance for assisted dying will increase over time and that non-compliance with the safeguards will increase. Of these submitters, many compare the Bill to the Contraception, Sterilisation, and Abortion Act 1977. Submitters believe the restrictions on accessing abortions contemplated by this Act are nowadays not complied with, and women can easily obtain an abortion through falsely claiming mental health issues.
103. Some submitters believe there would be an increase in deaths not reported correctly to cover malicious practices in the medical sector.

Health practitioners and the health sector

104. Submitters have a variety of views as to which health practitioners would be involved in administering assisted dying. Most submitters believe that the role of the medical practitioner outlined in the Bill will be filled by medical practitioners. Some submissions interpret the Bill as allowing nurses to be the medical practitioner or believe nurses will assist in peoples' deaths regardless of what the Bill states.
105. Some submitters are concerned that nurses, pharmacists and allied medical staff may play an indirect role in administering assisted dying and believe that this is not provided for in the Bill.

Compatibility with health sector and practice

106. Submitters who oppose the Bill are especially concerned that medical practitioners would be the medical practitioners under the Bill. Many of these submitters consider that it is a medical practitioner's role to heal and care for patients, and that a role for medical practitioners in assisted dying would undermine that role.
107. Some submitters who oppose the Bill believe assisted dying is not a form of healthcare. They perceive the purpose of medicine is to care and heal and believe that offering assisted dying is outside of this purpose. Of these submitters, some express the belief that medical practitioners are involved in the Bill solely to provide 'medical legitimacy'.
108. Many submitters who oppose the bill believe the Bill is medically unethical. Of these, most reference statements from the World Medical Association, the New Zealand Medical Association and other medical organisations to support their stance. Some

therefore consider that passing the Bill would undermine medical organisations' authority and demean their expertise.

109. Submitters express concern that assisted dying undermines medical practice and care. They suggest that allowing assisted dying will decrease the medical profession's motivation to care for and heal patients. Some submitters also believe it will discourage research in finding or improving cures, and pain or symptom relief. Of these submitters, many are particularly concerned that funding for medical practice and research will decrease as assisted dying becomes a cheaper financial option to alleviate suffering.
110. Some submitters are concerned that, as a result, people will in future access assisted dying to relieve their suffering where previously medical treatment would have sufficed.
111. Submitters who oppose the Bill often express concern that allowing medical practitioners to administer assisted dying will adversely affect their relationship with their patients. These submitters state that patients need to trust their medical practitioners and express concern that, by allowing assisted dying, this trust may be reduced as their role changes. Many of these submitters believe that if medical practitioners provide assisted suicide, this would change the nature of their role. Some of these submitters believe that medical practitioners would become 'murders' or 'executioners' as a result. Other submissions suggest that assisted dying is incompatible with the Hippocratic Oath and the commitment to do no harm.
112. Submitters suggest that if the Bill is passed, people will no longer trust their medical practitioner, for fear that their medical practitioner may attempt to pressure them into assisted dying or would administer assisted dying without the submitter's consent. Some also suggest that with assisted dying, medical practitioners may no longer act in the patient's best interests. A small number of submitters tell stories of relatives and/or friends who live in overseas jurisdictions that permit some form of assisted dying and who consequently fear seeing medical practitioners or visiting hospitals.
113. Conversely, submitters who support the Bill believe that assisted dying enhances medical treatment. They think that the relationship between medical practitioner and patient would be strengthened under the Bill through allowing greater openness and honesty when discussing end of life care and death.
114. Some submitters are concerned that people who wish to access assisted dying may use medical practitioners they do not know. They believe that people may use new medical practitioners for many reasons, including their own practitioner conscientiously objecting or believing that they are more likely to be found eligible with a new practitioner. These submitters believe that the lack of previous relationship between the medical practitioner and person would limit the practitioner's ability to properly assess the person.
115. Because of the concerns regarding the involvement of the medical sector, some submitters suggest that people other than medical practitioners would be more appropriate to uptake the roles outlined in the Bill. Most commonly, submitters advocate for lawyers, judges or members of parliament.

116. Several submitters suggest that assisted dying should be carried out by a group of specially trained people only, such as was the case with capital punishment.

Commercialisation

117. Some submitters think the Bill would enable the creation of a death related industry driven by profit. Submitters consider it would provide an opportunity for pharmaceutical companies or medical professionals to make money and therefore erode any incentive to avoid unnecessary deaths. Submitters do not think that any person involved in assisted dying should be paid extra or receive any benefit for their services.
118. Other submitters think that those who are very sick should not be subject to a system where companies profit from people dying slowly and suffering unbearably for longer.
119. Other submitters are concerned about potential advertising of assisted dying and if there should be any rules around this.

Impact on medical professionals

120. Some submitters who oppose the Bill are concerned that medical professionals would be psychologically impacted through administering assisted dying. Submitters are concerned that the medical practitioners and other professionals involved in the assisted dying process may feel guilt or remorse and that their mental health may consequently be impacted in the short or longer term. These submitters often speak about the impact of animal euthanasia on veterinarians and their suicide rate.
121. Some submitters perceive the Bill to be an unwanted burden on medical staff. They suggest it would bring additional stress to what they regard as an already over-burdened sector.
122. In contrast, supporting submitters believe the Bill to be adequately designed to allow medical practitioners to disengage when they desire. They also consider that some medical professionals will want to have the option of providing assisted dying.
123. Some submitters who oppose the Bill are concerned that it would have a negative impact on the medical sector more generally. Some of these submitters believe that the Bill may have a divisive effect on medical professions and facilities as people take strong stances on either side. Many submitters are concerned that assisted dying would cause recruitment and retention issues for the medical sector, in medical, nursing and allied health roles.
124. Some submitters who identify themselves as health practitioners state that they would leave their profession because of the Bill or refuse to comply with its procedures, including that of conscientious objection. Other submitters state that they know medical professionals who would leave their profession because of the Bill. Some submitters who identify themselves as medical students' state that they would reconsider entering the profession.

Messaging on suicide

125. Many submitters who oppose the Bill see no difference between assisted dying and suicide. Some submitters share stories of people they know who had suicided and express concern towards the emotional impact these deaths had.
126. Conversely, many submitters who support the Bill perceive there to be a distinction between suicide and assisted dying. They believe that people facing unbearable suffering do not want to die, rather they want to ease their suffering.
127. Other submitters who oppose the Bill are concerned that suicide will become more prevalent in society if the Bill should pass. They believe the availability of assisted dying normalises and validates suicide and endorses a message that people should 'give up' when faced with hardship. These submitters often share how they, or someone they know, had previously wanted to end their life. They describe, however, how they or the person were since glad they had decided not to.
128. In contrast, submitters who support the Bill believe assisted dying reduces the likelihood of suicide occurring, especially for those who are terminally ill or who have a degenerative condition. They believe there would be a reduction in suicide rates if people are able to choose the timing of their death, rather than be forced to prematurely act for fear of potential future pain and later losing the capability to end their life.
129. Both opposing and supporting submitters refer to New Zealand's current suicide statistics and regard these statistics as too high.
130. Many submitters, regardless of their stance on the Bill, believe there should be greater funding and public education put into suicide prevention.

Youth suicide

131. Submitters who oppose the Bill are particularly concerned about the impact the Bill will have on the suicide rates of young people. They believe that young people will see people they know accessing assisted dying and will therefore believe that ending their life is an option. Submitters are concerned that passing the Bill will endorse a damaging message. In discussing suicide statistics, many submitters focus on youth suicide rates. A small number of submitters identify themselves as working with youth and tell personal stories of the impact they have seen from youth suicides.

Māori and Pasifika suicide

132. Some submitters who oppose the Bill are particularly concerned about the impact the Bill will have on the suicide rates of Māori and Pasifika people. They believe that Māori and Pasifika people are currently disproportionately represented in suicide statistics and express concern that the Bill would make this worse.

The status quo

133. Some submitters who oppose the Bill believe that assisted dying is not necessary, as there is no need for people to experience unbearable suffering. They believe that

modern medicine already provides adequate pain relief and is improving every day. Conversely, some submitters who support the Bill believe there is no adequate pain relief, and that people should not have to continue to suffer due to the inadequacies of current pain relief.

134. Others suggest that there needs to be greater funding and provision of pain relief. Some submitters request greater research into pain relief and end of life care. Other submitters refer to drugs and medication they believe should be funded, legalised or made available in New Zealand to reduce people's suffering. Most commonly, these submissions advocate for the legalisation of medicinal marijuana.
135. Many submitters who oppose the Bill believe assisted dying is unnecessary, as unbearable suffering can be alleviated in different ways. They refer to medical practitioners' ability to withdraw futile treatments and turn off life support. Some also consider that medical practitioners can administer palliative sedation or pain medication, such as morphine, even where it has the dual effect of hastening death.
136. Several submitters who support the Bill perceive actions such as palliative sedation treatment and pain relief to be the same as assisted dying. They therefore believe that assisted dying already happens in New Zealand. Some of these submitters are concerned that these actions lack legal guidance. They believe that passing the Bill will regulate assisted dying and make medical practitioners' actions more accountable and transparent.
137. Some submitters who oppose the Bill regard assisted dying as unnecessary, as they consider people to already have the autonomy to end their life. They refer to people's right to refuse medical treatment, nutrition and hydration and the option of 'do not resuscitate' directives.
138. Some submitters who support the Bill believe these options are not sufficient. They consider dying through starvation or without medical intervention to be a lengthy and painful death. Several submitters share person stories of people they knew dying through these methods.
139. Other submitters who oppose the Bill believe that assisted dying is unnecessary since suicide is legal. They consider that people are already able to end their life when they wish to do so. As discussed, many of these submitters believe it is inappropriate for people to ask or have other people assist in their death. In contrast, submitters who support the Bill believe that the current laws force people to suicide alone and usually through painful methods. Some of these submitters share stories of people they knew who had suicided to escape their suffering. They express their remorse and distress that the person had to die alone and the stigma they believe is now associated with their death.
140. Some submitters who oppose the Bill believe the current law provides sufficient leniency for people who compassionately assist in the death of another. Conversely, submitters who support the Bill perceive it as inappropriate for people who compassionately assist another's death to have to go through the court system.

Palliative and hospice care

141. Many submitters who oppose the Bill suggest that assisted dying is unnecessary, given that palliative and hospice care already provide comfort for people at the end of life. Submitters often comment that they believe New Zealand to have one of best palliative care systems in the world.
142. Conversely, many submitters who support the Bill believe that sometimes no type of care is sufficient in relieving a person's pain due to the severity of a person's illness/condition.
143. Some submitters who oppose the Bill consider many palliative and hospices services to be underfunded and as reliant upon community generosity. Several submitters suggest that there is an uneven level of available end of life care services across the country and that rural areas in particular need greater access to palliative care.
144. Many submitters, regardless of their stance on the Bill, believe there should be greater funding and improving of palliative care services. Some submitters believe that greater education on the benefits of palliative and hospice care is needed to encourage the public to engage in these services.

Annex B: Organisational submitters

	Name of organisation
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 Center
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
31	Conservative Party of New Zealand
32	Cromwell & Upper Clutha Catholic Parish

	Name of organisation
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
66	Just Life, Palmerston North
67	Justice and Peace Commission, Catholic Diocese of Auckland
68	Kaitaia Union Parish Church

	Name of organisation
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)
101	Not Dead Yet Aotearoa
102	New Zealand Christian Network
103	Oasis Family Church, Blenheim
104	Office of the Privacy Commissioner

	Name of organisation
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
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

	Name of organisation
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 Andrews 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
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

	Name of organisation
177	Third Age Health
178	Tino Rangatiratanga Commission Hamilton Catholic Diocese
179	Turangi Catholic Womens' 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	Waiholo 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

Annex C: Eligibility comparison of the Bill with overseas jurisdictions

Jurisdiction	Age	Citizenship	Person eligible	Other eligibility criteria	Free choice / made without coercion	Competence / capability	Assisted suicide or euthanasia
New Zealand End of Life Choice Bill	The person must be aged 18 years or over	The person must be a New Zealand citizen or permanent resident	A person is eligible for assisted dying if they suffer from either: <ul style="list-style-type: none"> a terminal illness that is likely to end their life within six months, or a grievous and irremediable medical condition 	A person is eligible if: <ul style="list-style-type: none"> they are in an advanced state of irreversible decline in capability, and they experience unbearable suffering that cannot be relieved in a manner that they consider tolerable 	The attending medical practitioner must do their best to ensure that the person expresses their choice free from pressure from any other person by: <ul style="list-style-type: none"> talking with other health practitioners who are in regular contact with the person talking with members of the person's family approved by the person the attending medical practitioner must also: <ul style="list-style-type: none"> discuss the choice with the person, at intervals determined by the progress of his or her terminal illness or medical condition ensure that the person understands their other options for end of life care ensure that the person knows they can change their mind at any time the person must confirm their request by signing and dating a form the attending medical practitioner is also required to check with the person at other points in the assisted dying process 	The person must have the ability to understand: <ul style="list-style-type: none"> the nature of assisted dying, and the consequences for them of assisted dying 	Both
Australia: Victoria Voluntary Assisted Dying Act 2017	The person must be aged 18 years or over	The person must be an Australian citizen or permanent resident who normally resides in Victoria	The person must: <ul style="list-style-type: none"> 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 if the person is diagnosed with a disease that is neurodegenerative, that disease must be expected to cause death within 12 months a person is not eligible for access to voluntary dying if they have a mental illness only, or if they have a disability only 	The person must be experiencing suffering that cannot be relieved in a manner that the person considers tolerable Those with mental illness or disabilities are not precluded from taking part in the process if they fulfil the rest of the eligibility criteria	The person must: <ul style="list-style-type: none"> make a clear and unambiguous request to a medical practitioner a health practitioner must not initiate a discussion about assisted dying nor suggest it to a person Coordinating and consulting medical practitioners must ensure the person is acting voluntarily and without coercion a person must make a written declaration once they have been found eligible. This declaration states that the person is acting voluntarily, without coercion and understands the nature of the declaration that they are making. This must be signed in the presence of two witnesses and the co-ordinating medical practitioner 	<ul style="list-style-type: none"> the person must exhibit decision making capacity: understand the information relevant to the decision relating to access to voluntary assisted dying and the effect of the decision retain that information to the extent necessary to make the decision use or weigh that information as part of the process of making the decision communicate the decision and the person's views and needs as to the decision in some way, including by speech, gestures or other means 	Both

Jurisdiction	Age	Citizenship	Person eligible	Other eligibility criteria	Free choice / made without coercion	Competence / capability	Assisted suicide or euthanasia
Belgium Act on Euthanasia 2002	From 2014, there is no reference to age. The medical practitioner must ensure that: <ul style="list-style-type: none"> the minor is a minor with the capacity of discernment; the minor is consulted by the physician and a child psychiatrist or psychologist; and the parent or legal guardians of the minor consent in writing 	None stated	The person is in a medically futile condition resulting from a serious or incurable disorder caused by illness or accident	The person is in a condition of constant unbearable physical or mental suffering that cannot be alleviated	<ul style="list-style-type: none"> the request is voluntary, well considered and repeated, and is not the result of any external pressure the medical practitioner and person must together come to the belief that “there is no reasonable alternative to the person’s situation and that the person’s request is completely voluntary” the person’s request must be in writing and signed by the person themselves or someone the person has designated to do so if they can’t themselves 	To request euthanasia a person must be legally competent and conscious at the moment of making the request	Both
Canada Criminal Code An independent review of assisted dying for mature minors, advance requests and requests where mental illness is the sole underlying medical condition has been published for review by the federal government.	The person must be at least 18 years of age	The person must be eligible for health services funded by the Canadian government	The person must have a grievous and irremediable medical condition	The person must be informed of the means that are available to relieve their suffering, including palliative care	<ul style="list-style-type: none"> the person must have made a voluntary request for assisted dying that was not made because of external pressure the request is signed and dated by the person (or other person) in front of two independent witnesses who then also sign and date the request ensure that the person has been informed that they may at any time and in any manner withdraw their request ensure that there are ‘10 clear days’ between the day the request was signed and the day on which the medically assisted dying is provided 	The person seeking assisted dying must: <ul style="list-style-type: none"> be capable of making decisions with respect to their health give informed consent to receive medical assistance in dying 	Both

Jurisdiction	Age	Citizenship	Person eligible	Other eligibility criteria	Free choice / made without coercion	Competence / capability	Assisted suicide or euthanasia
Netherlands Termination of Life on Request and Assisted Suicide (Review Procedures) Act 2002	Minors from the age of 12 can access assisted dying provided: <ul style="list-style-type: none"> for minors aged between twelve and sixteen their parent(s) or legal guardian give consent for minors aged between sixteen and eighteen their parent(s) or legal guardian are consulted 	Not stated	The physician: <ul style="list-style-type: none"> holds the conviction that the patient's suffering was lasting and unbearable has informed the patient about the situation they are in and about their prospects and the patient hold the conviction that there is no other reasonable solution for the situation has consulted at least one other, independent physician who has seen the patient and has given a written opinion on the requirements of due care 		The physician must hold the conviction that the request by the patient was voluntary	The physician must hold the conviction that the request by the patient was well considered The patient must have a reasonable understanding of their interests	Both
United States of America: Oregon The Oregon Death with Dignity Act 1994	The person must be at least 18 years of age	The person must be an Oregon resident	A person is eligible where two medical practitioners agree that a person is terminally ill (6 months or less to live)	The person must be able to swallow the medication or self-administer through their feeding tube	<ul style="list-style-type: none"> request must be in writing and confirmed by two witnesses the person must be determined to be free of a mental condition impairing judgment if the request is authorised, the person must wait at least fifteen days and make a second oral request before the prescription may be written. The person has a right to rescind the request at any time. Should either physician have concerns about the person's ability to make an informed decision, or feel the person's request may be motivated by depression or coercion, the person must be referred for a psychological evaluation 	The person must be mentally capable to make their own medical decisions	Assisted suicide only
Switzerland	Not legislated			A person who assists with suicide for 'selfish motives' commits an offence	Not legislated. Associations that provide assisted suicide services may set their own process to access a request for assisted suicide		Assisted suicide only

Annex D: Conscientious objection comparison of the Bill with domestic legislation and with overseas jurisdictions

New Zealand Legislation	Who it applies to	What it applies to	Description	Requirement to state objection to person	Further requirement	Explicit protection from discrimination when objection expressed	Liability
Proposed End of Life Choice Bill, section 6 and 7	A person	Who has an objection	To do anything authorised or required by the Bill, despite any legal obligation to which the person is subject, however the obligation arises	Yes, at time of initial request, medical practitioner	Yes, at time of initial request, the attending medical practitioner only must tell the person that they may ask the SCENZ Group for the details of a replacement medical practitioner	No	If medical practitioner wilfully fails to comply with clause 7(2), liable on conviction to a term of imprisonment not exceeding 3 months and/or a fine not exceeding \$10,000
Contraception, Sterilisation and Abortion Act 1977, section 46(2)	Medical practitioner, nurse or other person	Grounds of conscience	To perform or assist in the performance of an abortion or any operation for the purpose of rendering the patient sterile or to fit or assist in the fitting, or supply or administer or assist in the supply or administering, of any contraceptive, or to offer or give any advice relating to contraception	No	Abortion, sterilisation: Yes, health practitioner to inform that service can be obtained from another (section 174 Health Practitioners Competence Assurance Act)	Yes	Abortion, sterilisation: None stated
					Contraception for complainants of sexual violation: Yes, to advise of rights to obtain services from another (section 5)		Contraception: professional misconduct (section 5)
Health Practitioners Competence Assurance Act 2003, section 174	Health practitioners	Ground of conscience	Duty of health practitioners in respect of reproductive health services	No	Yes, to inform that service can be obtained from another	No	None stated
Marriage Act 1955, section 29	Marriage celebrants who are recognised ministers of scheduled religions or a person of an approved organisation	Contravening the religious beliefs of the religious body or the religious beliefs or philosophical or humanitarian convictions of the approved organisation	Licence authorises but not obliges marriage celebrant to solemnise marriage	No	No	No	No

Jurisdiction	Who it applies to	What it applies to	Description	Requirement to state objection to person	Further requirement	Explicit protection from discrimination when objection expressed	Liability
Australia: Victoria Voluntary Assisted Dying Act 2017, section 7	A registered health practitioner	Who has a conscientious objection to voluntary assisted dying has the right to refuse...	Objection permitted: <ul style="list-style-type: none"> to provide information about voluntary assisted dying to participate in the request and assessment process to apply for a voluntary assisted dying permit to supply, prescribe or administer a voluntary assisted dying substance to be present at the time of administration of a voluntary assisted dying substance to dispense a prescription for a voluntary assisted dying substance 	Yes, after receiving: <ul style="list-style-type: none"> a first request a referral for a consulting assessment 	No	No	No
Belgium Act on Euthanasia 2002, section 14	Physician	No physician may be compelled...	To perform euthanasia	Yes, and reasons	No. But upon request must communicate the patient's medical record to the physician designated	No	No
	Other person	No other person may be compelled...	To assist in performing euthanasia	No	No		
Canada Criminal Code, section 241.2 (9)	An individual	Nothing in this section compels	To provide or assist in providing medical assistance in dying	No	No	No	No
Oregon The Oregon Death with Dignity Act 1994, section 4	Health care provider	No health care provider shall be under any duty...	To participate in the provision to a qualified patient of medication to end his or her life in a humane and dignified manner	No	No. But upon request shall transfer a copy of the patients' relevant medical records to a new health care provider	Yes, from professional organisations or associations and other health care providers. Also for a participating health care provider A health care provider can 'notify', then sanction a participating provider for actions defined as 'participation'	No

Legislation in the Netherlands does not contain provision for objection or refusal but does have a constitution protecting freedom from discrimination. Switzerland has no legislation, provision or participation assisted suicide is entirely voluntary.

Annex E: Information previously provided to the Committee

1. The Committee raised a number of issues over the course of the hearings on the Bill that officials responded to with further information. This information is reproduced here so that all information is in one document. The documents have been reformatted. The table summarising the Bill against main features of overseas jurisdictions that have legalised some form of assisted dying is not replicated again, as it is now Annex C.
2. Officials also provide one update for the Committee.

Update on the Dutch investigations

3. The Committee asked for information on the current investigations by the Netherlands Public Prosecution Service, as reported in The Guardian on 12 March 2018.⁶
4. On 8 March 2018, the Netherlands Public Prosecution Service announced it was instituting four criminal investigations into possible criminal euthanasia. The cases under review are described in English in the press release: <https://www.om.nl/vaste-onderdelen/zoeken/@102371/four-criminal/>
5. These four cases are in addition to the investigation launched last year by the Netherlands Public Prosecution Service into a possible punishable case of euthanasia carried out by a physician in a nursing home: <https://www.om.nl/vaste-onderdelen/zoeken/@100430/investigation-into/>
6. A more complete summary of that case is set out in English in the 2016 annual report of the Euthanasia Review Committee (Case number 2016-85, pages 54-58): <https://english.euthanasiecommissie.nl/the-committees/documents/publications/annual-reports/2002/annual-reports/annual-reports>
7. The Netherlands Public Prosecution Service announced on 9 November 2018 that a nursing home medical practitioner will be prosecuted. This is the first prosecution since the Netherlands legislation came into force. A hearing date has not been set. The same press release advised that a definitive answer will be provided within a few weeks about two of the other criminal investigations. The other two cases have been dismissed.

⁶ <https://www.theguardian.com/world/2018/mar/12/dutch-prosecutors-investigate-euthanasia-cases-sharp-rise-doctor-assisted-deaths-netherlands>

12 June 2018

Raymond Huo
Chairperson
Justice Committee
Parliament Buildings
Wellington

Dear Mr Huo

END OF LIFE CHOICE BILL – FURTHER INFORMATION

1. This briefing responds to the request on 21 May 2018 of the Justice Committee to provide further information on the following issues on the End of Life Choice Bill (the Bill):
 - A. Does “examine the person” mean a physical examination (i.e. not remotely)?
 - B. What is the expected participation of practitioners based on Oregon experience?
 - C. What is the legal significance of clause 25 and why has it been included in the Bill?
 - D. Re clause 28 and recording of death. Are there similar provisions in other legislation?
 - E. The implications of referring to a “lethal dose of medication” i.e. poison, as “medication”.
 - F. How the Hippocratic Oath interacts with this legislation.
 - G. Information on the relationship between regulation of medical practitioners and the Bill.
 - H. Is there any discrepancy between the position taken in Attorney-General’s section 7 Bill of Rights Act 1990 Report and the initial briefing on the Bill?
 - I. Regarding people with disabilities (minor or substantive), to what extent could disabled people be subject to the provisions of this Bill. How does the Bill protect those with disabilities?
 - J. What is the current status of Advanced Care Plans and Advanced Care Directives?
 - K. The term “grievous and irremediable medical condition” is not clear. Are there relevant international comparisons, (and if so, how has it been interpreted by the courts). Was it used in the Maryan Street End of Life Choice Member’s Bill of 2012?
2. The Committee also asked for a comparison, along several parameters, of the Bill with the legislation and the experiences of overseas jurisdictions that have legislated for assisted dying. This information is more complex and is still being compiled.

A. Does “examine the person” mean a physical examination (i.e. not remotely?)

3. The Bill does not define the term ‘examine’, which could include remote examination. Generally, and traditionally, in health practice “examine” means a face-to-face physical examination. However, new technologies have made other types of consultation and examination possible, for example tele-conferencing and video-conferencing.

B. What is the expected participation of practitioners based on Oregon experience?

4. We have answered this question in two parts.

How many physicians have been willing to participate in the Death with Dignity Act in Oregon?

5. A precise figure for the number of physicians willing to participate under the Act is not available. The Oregon Health Authority does not recommend doctors, nor does it provide the names of participating physicians or patients due to the need to protect confidentiality. The number of doctors who have participated is very small, reflecting the small number of requests. Survey responses indicate about half of the doctors approached have been willing to participate.⁷

What is the expected participation rate of medical practitioners in New Zealand?

6. We refer the Committee to a June 2017 New Zealand Medical Journal article summarising a study on New Zealand doctors’ and nurses’ views on legalising assisted dying in New Zealand.⁸ This article is submitted with this briefing for reference.
7. The study “explored the views of New Zealand doctors and nurses on legalising assisted dying (AD), including level of support or opposition for legalisation, willingness to engage in legal AD services, what factors might deter generally willing doctors and nurses from providing AD services and what professional supports were perceived as essential or desirable to enable willing engagement in AD service provision”.
8. The results showed that “while only 37% of doctors supported legalising AD in New Zealand, 67% of nurses were supportive”. The study concluded that “there is a substantial cohort of doctors and nurses in New Zealand who support legalising AD, potentially sufficient for reasonable seeker access to AD services once legalised. However, many doctors in particular still oppose AD.”

C. What is the legal significance of clause 25 and why has it been included in the Bill?

9. Clause 25 sets out that “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.” The clause would apply in situations where dying as a result of assisted dying caused impacts for the person that would not have eventuated if the person had died of, for example, an underlying medical condition.
10. The Bill does not explain why this clause is included. The Committee may wish to raise this with the Member responsible for the Bill. On its face, the clause is similar to provisions

⁷ Linda Ganzini et al, *Physicians’ Experiences with the Oregon Death with Dignity Act*, New England Journal of Medicine, May 18 2000, Vol 342 (20) No 1538.

⁸ Oliver P, Wilson M, Malpas P *New Zealand doctors’ and nurses’ views on legalising assisting dying in New Zealand*, NZMJ 2 June 2017, Vol 130 No 1456.

found in other jurisdictions that have legislated for assisted dying in reference to, for example, contracts of insurance (in Hawaii and in Oregon).

D. Re clause 28 and recording of death. Are there similar provisions in other legislation?

11. Clause 28 amends the Births, Deaths, Marriages, and Relationships Registration (Prescribed Information) Regulations 1995 so that a death certificate of a person who died as a result of the provision of assisted dying under the Bill will record:
 - the cause or causes of death as if assisted dying had not been provided
 - the fact that the person died as a result of the provision of assisted dying under the Bill
 - the interval between the onset of the cause of death and death by assisted dying in respect of each cause of death.
12. We have not found any New Zealand legislation that requires amending or adding to the contents of death certificates. We have found provisions amending or adding to the contents of death certificates in other jurisdictions that have legislated for assisted dying (in Hawaii and in Victoria).

E. The implications of referring to a “lethal dose of medication” ie poison, as “medication”.

13. The Bill uses the term “medication” when referring to the substance that is used to effect assisted dying. The term is not defined in the Bill.
14. The definition of a medicine is contained in the Medicines Act 1981 and includes substances intended to take effect by influencing, inhibiting, or modifying a physiological process (section 4(b)).
15. Many medicines are capable of causing ill health, injury or death at high doses. We understand substances that are used to effect assisted dying in other jurisdictions include pentobarbital and secobarbital. These products are prescription medicines in New Zealand.

F. How the Hippocratic Oath interacts with this legislation.

16. The Declaration of Geneva was first adopted in 1948 by the World Medical Association General Assembly, and most recently revised in October 2017. It is used by physicians across the world and is regarded as a modern version of the Hippocratic Oath. A copy is attached at Appendix A.
17. The Bill makes no reference to the Declaration, or the Hippocratic Oath.

G. Information on the relationship between regulation of medical practitioners and the Bill.

18. The Health Practitioners Competence Assurance Act 2003 (the Act) sets up the framework to regulate health practitioners, including medical practitioners. The purpose

of the Act is to protect the health and safety of members of the public by providing mechanisms to ensure the lifelong competence of health practitioners.

19. The Medical Council of New Zealand (the Council) is responsible under the Act for the regulation of medical practitioners. The Council registers doctors in New Zealand and sets standards of clinical competence, cultural competence and ethical conduct for doctors.
20. The standards aim to assist doctors to provide good medical practice, and may be used by the Council, the Health Practitioners Disciplinary Tribunal, and the Health and Disability Commissioner as a standard by which doctors can be measured.⁹
21. In particular, the Good Medical Practice publication sets standards in which the public and the profession expect a competent doctor to meet. Good Medical Practice is not intended to be exhaustive. Specific advice on ethical issues, ethical frameworks and ethical decision-making is provided by the New Zealand Medical Association. The New Zealand Medical Association undertakes advocacy and leadership activities on behalf of its members.
22. The Bill sets out in clause 19 that the Support and Consultation for End of Life in New Zealand Group is responsible for preparing standards of care in relation to the administration of the lethal dose of medication.

H. Is there any discrepancy between the position taken in Attorney-General's section 7 Bill of Rights Act 1990 Report and the initial briefing on the Bill?

23. The initial briefing contains two paragraphs on page 5 under the heading New Zealand Bill of Rights Act 1990. These were drawn from the introductory paragraphs of the Report of the Attorney-General. The Committee may also find it helpful to refer to the conclusion of the Report of the Attorney-General at paragraph 70. This is set out in full below:

1. *I therefore conclude:*

- (a) *the Bill engages the right not to be deprived of life (s 8 of the Bill of Rights Act), but does not prima facie limit that right; and*
- (b) *to the extent the Bill limits the right to freedom of conscience and expression (ss 13 and 14 of the Bill of Rights Act respectively), the limits are justified; but*
- (c) *the Bill appears to be inconsistent with s 19(1) (freedom from discrimination) of the Bill of Rights Act in respect of age and the limit cannot be justified under s 5 of the Act.*

I. Regarding people with disabilities (minor or substantive), to what extent could disabled people be subject to the provisions of this Bill. How does the Bill protect those with disabilities?

24. The Bill's provisions, rights, safeguards and protections apply equally to those with disabilities.
25. Submitters have commented extensively on this issue, and we will summarise their views in the departmental report.

⁹ <https://www.mcnz.org.nz/news-and-publications/statements-standards-for-doctors/>

J. What is the current status of Advanced Care Plans and Advanced Care Directives?

26. Advance directives are defined in The Code of Health and Disability Consumers' Rights (the Code) as written or oral directives in which a patient makes a choice about a future health care procedure, and this choice is intended to be effective only when the patient is no longer competent. Advance directives are sometimes referred to as 'living wills'.
27. Right 7(5) of the Code gives every individual the legal right to use an advance directive in accordance with common law and health care providers are obliged to take account of advance directives when deciding which services to provide to an incompetent patient. Attorneys and welfare guardians are also required to have regard to any advance directive.
28. Advance directives and advance care plans can be modified or revoked by the individual at any time, while they are still competent.

K. The term "grievous and irremediable medical condition" is not clear. Are there relevant international comparisons, (and if so, how has it been interpreted by the courts). Was it used in the Maryan Street End of Life Choice Member's Bill of 2012?

29. The term "grievous and irremediable medical condition" is only used in the 2016 Canadian assisted dying legislation.¹⁰ The term was not used in Maryan Street's End of Life Choice Member's Bill. For someone to qualify as having a "grievous and irremediable medical condition" in Canada, they must meet 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; and
 - 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.
30. We have found no cases in Canada that interpret the term "grievous and irremediable medical condition" as it is set out in the legislation.

Caroline Greaney

**General Manager, Civil and Constitutional
Policy**

Ministry of Justice

John Doyle

**Acting General Manager, Regulatory
Policy**

Ministry of Health

¹⁰ BILL C-14 (first session, 42nd Parliament).

<http://www.parl.ca/DocumentViewer/en/42-1/bill/C-14/royal-assent>

Appendix A: World Medical Association Declaration of Geneva

***Adopted by the 2nd General Assembly of the World Medical Association, Geneva, Switzerland, September 1948
and amended by the 22nd World Medical Assembly, Sydney, Australia, August 1968
and the 35th World Medical Assembly, Venice, Italy, October 1983
and the 46th WMA General Assembly, Stockholm, Sweden, September 1994
and editorially revised by the 170th WMA Council Session, Divonne-les-Bains, France, May 2005
and the 173rd WMA Council Session, Divonne-les-Bains, France, May 2006
and amended by the 68th WMA General Assembly, Chicago, United States, October 2017***

The Physician's Pledge

AS A MEMBER OF THE MEDICAL PROFESSION:

I SOLEMNLY PLEDGE to dedicate my life to the service of humanity;

THE HEALTH AND WELL-BEING OF MY PATIENT will be my first consideration;

I WILL RESPECT the autonomy and dignity of my patient;

I WILL MAINTAIN the utmost respect for human life;

I WILL NOT PERMIT considerations of age, disease or disability, creed, ethnic origin, gender, nationality, political affiliation, race, sexual orientation, social standing or any other factor to intervene between my duty and my patient;

I WILL RESPECT the secrets that are confided in me, even after the patient has died;

I WILL PRACTISE my profession with conscience and dignity and in accordance with good medical practice;

I WILL FOSTER the honour and noble traditions of the medical profession;

I WILL GIVE to my teachers, colleagues, and students the respect and gratitude that is their due;

I WILL SHARE my medical knowledge for the benefit of the patient and the advancement of healthcare;

I WILL ATTEND TO my own health, well-being, and abilities in order to provide care of the highest standard;

I WILL NOT USE my medical knowledge to violate human rights and civil liberties, even under threat;

I MAKE THESE PROMISES solemnly, freely, and upon my honour.

26 June 2018

Raymond Huo
Chairperson
Justice Committee
Parliament Buildings
Wellington

Dear Mr Huo

END OF LIFE CHOICE BILL – FURTHER INFORMATION

1. This briefing responds to requests from the Committee for international jurisdiction information and further information requests from the 11 June session.

Information on other jurisdictions that have legalised some form of assisted dying.

2. We provide a high-level summary of the eligibility criteria, process and oversight of six overseas jurisdictions and provided links to documents. These jurisdictions are those most often mentioned by submitters and represent different approaches due to different social contexts, baseline practices and different mechanisms of legal change.
3. Summaries of the regimes in those jurisdictions are included at Appendix A:
 - Australia: Victoria
 - Belgium
 - Canada
 - Netherlands
 - United States of America: Oregon
 - Switzerland.
4. A combined table summarising main features of these overseas jurisdictions against the Bill is included at Appendix B.

Information requests from 11 June oral hearings

5. At the meeting on 11 June, the Committee requested:
 - a. Oregon data on reasons for choosing assisted dying and the study of impact of physician-assisted suicide and suicide rates
 - b. Māori health models related to the Bill
 - c. a summary of what is enshrined in the Bill and what could be changed by subordinate legislation (regulation, order in council) without it being amended by the House
 - d. existing definitions of terms used in the Bill in other New Zealand legislation: “irremediable”, “grievous”.

Oregon data on assisted dying

Reasons for choosing assisted dying

6. This information is found in the annual reports issued by the Oregon Health Authority. The most recent data is from 2017 and is reproduced below. The full report is available at:

<https://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Pages/ar-index.aspx>

Characteristics	2017 (N=143)	1998–2016 (N=1,132)	Total (N=1,275)
End of life concerns⁴	(N=143)	(N=1,132)	(N=1,275)
Losing autonomy (%)	125 (87.4)	1,029 (91.4)	1,154 (90.9)
Less able to engage in activities making life enjoyable (%)	126 (88.1)	1,011 (89.7)	1,137 (89.5)
Loss of dignity (%) ⁵	96 (67.1)	769 (76.9)	865 (75.7)
Losing control of bodily functions (%)	53 (37.1)	526 (46.8)	579 (45.7)
Burden on family, friends/caregivers (%)	79 (55.2)	475 (42.2)	554 (43.7)
Inadequate pain control or concern about it (%)	30 (21.0)	297 (26.4)	327 (25.8)
Financial implications of treatment (%)	8 (5.6)	39 (3.5)	47 (3.7)

⁴ Affirmative answers only ("Don't know" included in negative answers). Categories are not mutually exclusive. Data unavailable for four patients in 2001.

Impact of physician-assisted suicide on suicide rates

7. A copy of a 2015 study from the United States is submitted with this document.¹¹ This study examined the association between the legalisation of assisted suicide and state-level suicide rates in the United States between 1990 and 2013.
8. The study found no significant effect on suicide rates. The total number of suicides only rose if assisted deaths were included.

Māori health models related to the Bill.

9. Māori philosophy towards health is based on a wellness or holistic health model. A health practitioner is able to utilise any model of health care with a patient, including Māori health models, in accordance with good medical practice.
10. Health practitioners are expected to have an understanding of Māori culture sufficient to respond appropriately to patients' needs. The Code of Health and Disability Consumers Rights provides that: "Every consumer has the right to be provided with services that take

¹¹ Jones DA, Paton D. *How Does Legalization of Physician-Assisted Suicide Affect Rates of Suicide?* South Med J. 2015 Oct;108(10):599-604.

into account the needs, values, and beliefs of different cultural, religious, social, and ethnic groups, including the needs, values, and beliefs of Māori".

11. Examples of Māori health models can be found at <https://www.health.govt.nz/our-work/populations/maori-health/maori-health-models>
12. The Committee may wish to consider seeking specialist advice on Māori health models and their applicability to this Bill.

A summary of what is enshrined in the Bill and what could be changed by subordinate legislation (regulation, order in council) without it being amended by the House.

13. No part of the Bill can be changed, once it is enacted, without an amendment Bill being agreed through the parliamentary process.
14. The Bill provides that a legislative instrument (regulations) can be made in one instance, set out in clause 23:

23 Regulations prescribing forms

The Governor-General may, by Order in Council, make regulations prescribing forms for the purposes of this Act.

15. Regulations made under an Act, may be developed, brought into force and subsequently amended by Cabinet without going through the parliamentary process.

Existing definitions of terms used in the Bill in other New Zealand legislation:

Irremediable

16. No New Zealand legislation uses the word "irremediable".

Grievous

17. No New Zealand legislation uses the word "grievous" except in the context of "grievous bodily harm", for example in the Crimes Act 1961.
18. The New Zealand courts have determined that "grievous bodily harm" means "really serious hurt" or "really serious harm".
19. We are currently working through the information requests of 18 June and will provide that information in due course.

Caroline Greaney
**General Manager, Civil and Constitutional
Policy
Ministry of Justice**

John Doyle
**Acting General Manager, Regulatory
Policy
Ministry of Health**

Appendix A: Summaries of the regimes in overseas jurisdictions that have legalised some form of assisted dying

- Australia: Victoria
- Belgium
- Canada
- Netherlands
- United States of America: Oregon
- Switzerland.

Australia: Victoria

Relevant legislation

- **Voluntary Assisted Dying Act 2017**

[http://www.legislation.vic.gov.au/Domino/Web_Notes/LDMS/PubStatbook.nsf/f932b66241ecf1b7ca256e92000e23be/B320E209775D253CCA2581ED00114C60/\\$FILE/17-061aa%20authorised.pdf](http://www.legislation.vic.gov.au/Domino/Web_Notes/LDMS/PubStatbook.nsf/f932b66241ecf1b7ca256e92000e23be/B320E209775D253CCA2581ED00114C60/$FILE/17-061aa%20authorised.pdf)

- The Act comes into force on 19 June 2019, unless brought into force earlier.

Brief description of regime

The process is based around the co-ordinating medical practitioner being granted a voluntary assisted dying permit, either a *self-administration permit* to prescribe the substance for the person to self-administer or a *practitioner administration permit* whereby the medical practitioner administers the substance.

Eligibility

The patient must:

- be 18 years or older
- be an Australian citizen or permanent resident who normally resides in Victoria
- have decision making capacity in relation to 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, that disease must be 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 access to voluntary dying if they have a mental illness only, or if they have a disability only. Those with mental illness or disabilities are not precluded from taking part in the process if they fulfil the eligibility criteria.

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

If either the coordinating or consulting practitioners are unable to determine whether the person has decision-making capacity, or a disease that meets the eligibility requirements,

they must refer the person to a specialist in the relevant area who can make the determination.

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

The process

- the person makes a first request
- the person is assessed as eligible for access to voluntary assisted dying by—
 - the co-ordinating medical practitioner for the person
 - a consulting medical practitioner for the person
- The person makes and signs a written declaration that they understand the nature and the effect of the declaration. 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
- The co-ordinating medical practitioner certifies that the request and assessment process has been completed as required by this Act
- The person is the subject of a voluntary assisted dying permit.

Oversight

- The Act provides that the person seeking assisted dying, their agent or any other person who has a special interest in the medical treatment of the person seeking assisted dying can apply to the Victorian Civil and Administrative Tribunal for review of certain decisions of the coordinating or consulting practitioner.
- The Act sets up the Voluntary Assisted Dying Review Board reviewing the function of the Act and providing advice to relevant Ministers. Reports may make recommendations on any systemic voluntary assisted dying matter identified by the 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, voluntary assisted dying.

Belgium

Relevant legislation

- **The Belgian Act on Euthanasia (2002)**

http://www.ejustice.just.fgov.be/cgi_loi/change_lg.pl?language=fr&la=F&cn=2002052837&table_name=loi

- Unofficial English translation: <http://www.ethical-perspectives.be/viewpic.php?TABLE=EP&ID=59>
- In 2014, the legislation was amended to include terminally ill children (unemancipated minors). Unofficial English translation of the amendments: <http://eol.law.dal.ca/wp-content/uploads/2014/02/Law-of-28-May-2002-on-Euthanasia-as-amended-by-the-Law-of-13-February-2014.pdf>

Brief description of regime

Eligibility

A physician 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 terminally ill children (those under 18 years):

- the minor has the capacity of discernment
- is 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 also be consulted to assess the capacity of discernment
- the legal representatives of the minor must agree.

Process

- The physician 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 physician 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 Act 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 is required to draft reports every two years that include statistics on certain information from the registration form, an evaluation of the implementation for euthanasia law, and any recommendations. The most recently available report in English (for 2014/15) can be found here: <https://www.ieb-eib.org/en/pdf/20161008-en-synthese-rapport-euthanasie.pdf>

Definitions in legislation

- Euthanasia is defined as “intentionally terminating life by someone other than the person concerned, at the latter’s request”. There are no other definitions.

Canada

Relevant legislation

- **Federal law: BILL C-14 2016** – amending the Criminal Code:
<http://www.parl.ca/DocumentViewer/en/42-1/bill/C-14/royal-assent>
- **Quebec provincial law: Act Respecting End-Of-Life Care 2014**
<http://www.legisquebec.gouv.qc.ca/en/ShowDoc/cs/S-32.0001>
- There have been no changes to the legislation since it came into force in 2017.

Brief description of regime

Eligibility

Federal Bill C-14

To be eligible for assisted dying, 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.

Quebec Act Respecting End-Of-Life Care

- Very similar eligibility criteria to federal law with minor wording changes. Additionally, the person must be an insured person within the meaning of the Health Insurance Act.

Process

Federal Bill C-14

Before a medical practitioner or nurse practitioner can providing someone with assisted dying they must:

- ensure that the person's request for medical assistance in dying was made in writing, and signed in front of two independent witnesses
- ensure that the person has been informed that they may at any time and in any manner withdraw their request
- ensure that another independent medical practitioner or nurse has provided a written opinion confirming that the person meets the eligibility criteria
- ensure 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, give 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 provision of medical assistance in dying. A summary can be found here:

<http://www.cbc.ca/news/canada/nova-scotia/assisted-death-guidelines-canadian-provinces-1.3600738>

Quebec Act Respecting End-Of-Life Care

- Very similar process to federal law with minor wording changes.

Oversight

Federal Bill C-14

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

- no later than 180 days after Royal Assent: An independent review must happen, looking at the following things: medical assistance in dying requests by minors, advance requests, and requests where mental illness is the sole underlying medical condition. This report-back is due by December 2018.
- 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 receives 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.

Quebec Act Respecting End-Of-Life Care

- The Act establishes a commission on end of life care 'Commission sur les soins de fin de vie'. 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 latest annual report is only available in French at: <https://collectifmedecins.org/en/commission-sur-les-soins-de-fin-de-vie-annual-report-2016-2017/>
- 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 sur les soins de fin de vie.

Definitions

Federal Bill C-14

- Definitions in the legislation include medical assistance in dying, medical practitioner, nurse practitioner and pharmacist.
- "grievous and irremediable medical condition", is defined as where a person meets the 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; and
 - 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.

Quebec Act Respecting End-Of-Life Care

- Definitions in the legislation include end-of-life care, palliative care, continuous palliative sedation, medical aid in dying.

Netherlands

Relevant legislation

- **Termination of Life on Request and Assisted Suicide (Review Procedures) Act 2002**

<http://wetten.overheid.nl/BWBR0012410/2012-10-10>

Unofficial English translation: <https://www.ieb-eib.org/fr/pdf/loi-euthanasie-pays-bas-en-eng.pdf>

- There have been no changes to the legislation since enactment in 2002.

Brief description of regime

The legislation 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

The *requirements of due care* mean that the physician:

- holds the conviction that the request by the patient was voluntary and well-considered,
- holds the conviction that the patient's suffering was lasting and unbearable,
- has informed the patient about the situation he was in and about his prospects,
- and the patient holds the conviction that there was no other reasonable solution for the situation he was in,
- has consulted at least one other, independent physician who has seen the patient and has given his written opinion on the requirements of due care, referred to in parts a - d, and
- has terminated a life or assisted in a suicide with due care.

Age criteria:

- the patient is between 12 years and 16 years and deemed to have a reasonable understanding of their interests and the parent(s) and/or guardian agree
- the patient is between 16 years and 18 years and deemed to have a reasonable understanding of their interests and the parent(s) and/or guardian have been involved in the decision process
- the patient is over 16 and is not capable of expressing their will but prior to reaching this condition was deemed to have a reasonable understanding of their interests and made a written request (ie advance directives are permitted)
- the patient is over 18 years and capable of expressing their will.

The process

- The process to access termination of life or assisted suicide is not set out in the legislation.
- The Regional Review Euthanasia Committees have published a joint Code of Practice that outlines the issues and considerations that the Regional Review Committees regard as relevant in connection with their assessment of the statutory due care criteria for euthanasia. The Code (in English):
<https://english.euthanasiecommissie.nl/the-committees/code-of-practice>

Oversight

- There are five Regional Review Committees who review reported cases of the 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 due care 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. The latest report in English is for the 2016 calendar year:
<https://english.euthanasiecommissie.nl/the-committees/documents/publications/annual-reports/2002/annual-reports/annual-reports>

Definitions

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

The Groningen Protocol

- This 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:
<https://www.nejm.org/doi/full/10.1056/NEJMp058026>

United States of America: Oregon

Relevant legislation

- **Oregon Death with Dignity Act 1997**
<https://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Documents/statute.pdf>

Brief description of regime

In October 1997 Oregon enacted the Death with Dignity Act (the Act) which allows terminally ill Oregon residents to end their lives through self-administration of lethal medications.

Eligibility

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

- two doctors must agree that (to the best of their medical judgement) a patient is terminally ill (6 months or less to live)
- the patient must be an Oregon resident, at least 18 years of age and be mentally capable to make their own medical decisions
- the patient must be able to swallow the medication or self-administer through their feeding tube
- the patient must be capable (defined as able to make and communicate health care decisions).

The person must be able to self-administer the medication either by swallowing or by self-administering a feeding tube.

The process

- residents of Oregon must make three requests in writing to their prescribing physician, two verbal requests and one written request that is a minimum of 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 Act requires that the Oregon Health Division monitor compliance with the law, collect information about the patients and physicians who participate in physician-assisted suicide and publish an annual statistical report. The most recent report can be found here
<https://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Documents/year20.pdf>
- 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 review all physician reports and contact reporting physicians regarding 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

- The Act requires the Oregon Public Health Division to collect information about the patients and physicians who participate in the Act and publish an annual statistical report.

Definitions

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

Other United States jurisdictions

Six other states also allow patient assisted suicide in legislation modelled on the Oregon Death with Dignity Act 1997:

- Washington Death with Dignity Act 1999
- Vermont Patient Choice and Control at End of Life Act 2013
- California End of Life Option Act 2015
- Colorado Proposition 106 End of Life Options 2016
- District of Columbia Death with Dignity Act 2016
- Hawaii Patient Choice at End of Life Act 2017

In the state of Montana, a 2009 decision, confirmed by the Montana Supreme Court, found that state law allows for terminally ill Montanans to request lethal medication from a physician under existing law.

Switzerland

Relevant legislation

- Swiss Criminal Code (of 21 December 1937, in force 1 January 1942, as of 1 March 2018) <https://www.admin.ch/opc/de/classified-compilation/19370083/index.html>
- Unofficial English translation: <https://www.admin.ch/opc/en/classified-compilation/19370083/201803010000/311.0.pdf>

Brief description of regime

Switzerland is a federal state, with a confederation of 26 cantons and half-cantons.

The Swiss Criminal Code allows for assisted or accompanied suicide (not euthanasia), by making assistance with suicide an offence where it is conducted due to self-interest.¹²

Eligibility

There are no explicit provisions at the federal level on organised assisted suicide.¹³ In 2012 some of the Swiss cantons were considering introducing legislation regulating assisted suicide. We have not been able to verify whether this has in fact occurred.

There are private associations operating in Switzerland that offer assistance to its 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 (<http://www.dignitas.ch/>).

Dignitas requires that to access their assisted suicide service, a person must:

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

Age criteria:

¹² Swiss Criminal Code, Article 115 - Any person who for selfish motives incites or assists another to commit or attempt to commit suicide is, if that other person thereafter commits or attempts to commit suicide, liable to a custodial sentence not exceeding five years or to a monetary penalty.

¹³ After several in-depth reviews during the 2000s, in 2011 the Federal Council (the Swiss Federal Government) concluded that criminal law in Switzerland does not require any explicit provisions on organised assisted suicide, as any abuses that may occur can be combated effectively by existing legal means <https://www.bj.admin.ch/bj/en/home/gesellschaft/gesetzgebung/archiv/sterbehilfe.html> Federal Office of Justice, Switzerland (site visited 5 June 2018).

- Any person capable of judgement can resort to assisted suicide regardless of age.¹⁴

The process

- The process to access assisted suicide is not set out in the legislation.
- Information on the processes followed by the associations that operate in Switzerland are available on their websites. For example, Dignitas - http://www.dignitas.ch/index.php?option=com_content&view=article&id=20&Itemid=60&lang=en

Oversight

- Prosecution by the authorities for breach of the Swiss Criminal Code.

Definitions in legislation

- Not applicable.

¹⁴ <https://www.bfs.admin.ch/bfs/en/home/news/whats-new.gnpdetail.2016-0138.html> Federal Statistics Office, *Cause of Death Statistics 2014 – Assisted suicide and suicide in Switzerland*, published 11 October 2016 (site visited 20 June 2018).

Appendix B: table summarising the Bill against main features of overseas jurisdictions that have legalised some form of assisted dying

This table is not replicated. It is now Annex C.

17 July 2018

Raymond Huo
Chairperson
Justice Committee
Parliament Buildings
Wellington

Dear Mr Huo

END OF LIFE CHOICE BILL – FURTHER INFORMATION

1. This briefing responds to requests from the Committee for the following information from the 18 June session:
 - a) any recent surveying of the medical profession on attitudes to euthanasia or medically assisted suicide
 - b) information about the Liverpool Care Pathway for the Dying Patient
 - c) information on the Dutch investigations
 - d) information on recording the cause of death
 - e) a definition of a palliative sedation.

Recent surveying of the medical profession on attitudes to euthanasia or medically assisted suicide

2. The Committee asked for information about more recent polling the New Zealand Medical Association had carried out with its members. Officials do not have access to this study but we understand the Clerk is following up with the New Zealand Medical Association.
3. We have accessed an April 2018 feature in the New Zealand Doctor bulletin. This reports on a Horizon Research poll commissioned by New Zealand Doctor of 545 GPs and registrars.
4. Averaging across a number of questions, the survey found that male respondents were more likely than their female peers to be in favour of a law change and that more than half the respondents oppose the change (52%). A sizeable minority of doctors were in favour (37%). However, even those in support of a change do not necessarily want to write the prescription for the lethal medication or administer the fatal injection.
5. A copy of the article is submitted with this briefing.

Information about the Liverpool Care Pathway for the Dying Patient

6. The Committee asked for more information about the Liverpool Care Pathway mentioned by some submitters at the hearing.
7. The Liverpool Care Pathway for the Dying Patient was developed in the 1990s by the Royal Liverpool University Hospital and the Marie Curie Hospice, and was widely used in UK until 2014. It was an attempt to make the high-quality palliative care provided by hospices more widely available, for example for people in their homes at end-of-life. The pathway sets out possible treatment options and likely outcomes. It is not a pathway in the sense of being a definite way to a pre-determined outcome, rather the pathway was one approach to end of life integrated care for the last days and hours of life. However, it was commonly misunderstood to be a single defined course of action.
8. An independent panel reviewed the pathway in 2013 after public concern about its use. The panel found that the pathway was ethically sound, and had enabled good clinical decision-making for dying patients. However, the panel also found that it had been used inappropriately in many cases. In particular, the guidance on nutrition and hydration was often not followed, which was the source of most criticism of the pathway.
9. The Review Report can be found at:
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/212450/Liverpool_Care_Pathway.pdf
10. The panel recommended the pathway be phased out and guidance developed to support individual end-of-life care plans for patients. That guidance was developed the following year and can be found at <https://www.gov.uk/government/publications/liverpool-care-pathway-review-response-to-recommendations>

Information on the Dutch investigations

11. The Committee asked for information on the current investigations by the Netherlands Public Prosecution Service, as reported in *The Guardian* on 12 March 2018.¹⁵
12. On 8 March 2018, the Netherlands Public Prosecution Service announced it was instituting four criminal investigations into possible criminal euthanasia. The cases under review are described in English in the press release: <https://www.om.nl/vaste-onderdelen/zoeken/@102371/four-criminal/>
13. These four cases are in addition to the investigation launched last year by the Netherlands Public Prosecution Service into a possible punishable case of euthanasia carried out by a physician in a nursing home. <https://www.om.nl/vaste-onderdelen/zoeken/@100430/investigation-into/>
14. A more complete summary of that case is set out in English in the 2016 annual report of the Euthanasia Review Committee (Case number 2016-85, pages 54-58):

¹⁵ <https://www.theguardian.com/world/2018/mar/12/dutch-prosecutors-investigate-euthanasia-cases-sharp-rise-doctor-assisted-deaths-netherlands>

15. We have not found any further updates from the Netherlands Public Prosecution Service since the March announcement.

Recording the cause of death

16. The Committee asked about the implications of recording the cause of death on a death certificate as the underlying condition rather than assisted dying. Submitters at the hearing had raised issues of lawfulness and falsification.
17. Clause 28 of the Bill, sets out an amendment to regulation 7(1)(a)(xiii) of the Births, Deaths, Marriages, and Relationships Registration (Prescribed Information) Regulations 1995. Regulation 7(1)(a)(xiii) sets out the information that must be recorded on a death certificate.
18. The Bill amends the regulation in two ways for a person accessing the assisted dying process. Firstly, the fact the person died of assisted dying would be recorded. Secondly the cause of death would also be recorded on a death certificate as the underlying condition. Appendix A sets out a tracked changes version of regulation 7(1)(a)(xiii) of the Regulations as proposed to be amended by the Bill.¹⁶
19. The information about cause of death on a death certificate is obtained from the “Certificate of cause of death” completed by health practitioners under the Burial and Cremation Act 1964. The format of the certificate is set by the World Health Organization to ensure international consistency in the collection of cause-of-death statistics by requiring that the underlying cause of death is collected.¹⁷
20. Statistics about the underlying cause of death are important and are used to:
- measure the health status of populations
 - form health policy
 - monitor the effectiveness of cancer screening, immunisations and other health programmes
 - compare the cause of death statistics across countries.
21. A death certificate is a more detailed record of death containing personal information about the deceased including the cause of death. Death certificates are issued by the Registrar under the Births, Deaths, and Marriages and Relationships Registration Act

¹⁶ Note that any drafting of proposed changes to regulation 7(1)(a) of the Regulations will be subject to advice from the Parliamentary Counsel Office about the best approach to give them the necessary legislative effect and to ensure compliance with current drafting styles.

¹⁷ The ‘underlying cause of death’ is defined by the World Health Organization as: “the disease or injury which initiated the train of morbid events leading directly to death, or, the circumstances of the accident or violence which produced the fatal injury.”

1995 as a record of the fact that a person is dead. The death certificate is used for various purposes such as the administration of the person's estate or applying for a funeral grant from ACC. The cause of death as recorded on the death certificate does not affect these purposes.

22. As outlined in the further information provided in response to requests of 21 May, both Hawaii and Victoria contain similar provisions for death certificates in their legislation ie that the underlying illness, or the grounds for the person to access assisted dying, are also recorded as the cause of death. In Canada, guidelines specify that the medical certificate of death is to include both the immediate cause of death (lethal medication) and the underlying cause (the disease or condition).

Palliative sedation

23. The Committee asked for a definition of 'palliative coma' as it was raised by some submitters at the hearing. Health practitioners use the term 'palliative sedation therapy'.
24. Palliative Sedation Therapy is defined 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. 18
25. Palliative Sedation Therapy is distinguished from other types of sedation used in palliative care as follows:
- ordinary sedation: sedation used to relieve anxiety, restlessness and insomnia
 - proportionate palliative sedation: the use of medication actively titrated to relieve symptoms but not produce unconsciousness.

Other matters

26. We understand that the Clerk has already provided to the Committee:
- the 2017 report commissioned by the New Zealand Medical Association from Professor Grant Gillett: *A report on euthanasia*
 - information compiled from the Parliamentary Library from other jurisdictions about costs/savings to the health budget identified from the use/legalisation of euthanasia or medically assisted suicide.

20. Caroline Greaney

21. **General Manager, Civil and Constitutional Policy**

22. **Ministry of Justice**

23. John Doyle

24. **Acting General Manager, Regulatory Policy**

25. **Ministry of Health**

¹⁸ Australian and New Zealand Society of Palliative Medicine (2017). ANZSPM Guidance Document on Palliative Sedation Therapy. Available publicly at: <http://www.anzspm.org.au/c/anzspm?a=da&did=1005077>

Appendix A: Regulation 7(1)(a)(xiii) of the Births, Deaths, Marriages, and Relationships Registration (Prescribed Information) Regulations 1995 as amended by the Bill

7 Death certificates

(1) There is hereby prescribed to be contained in a death certificate relating to any person—
(a) in all cases,—

(i) the person's full name:

(ii) the person's full name at birth (if not the person's full name at death):

(iii) the date of the death:

(iv) the place of the death:

(v) the person's usual residential address:

(vi) the person's usual occupation, profession, or job:

(vii) the person's sex:

(viii) the person's date of birth and age at death:

(ix) where the person was born:

(x) in the case of a person born outside New Zealand who died in New Zealand, how long the person had been in New Zealand before death:

(xi) in relation to the person's parents, full name; and full name at birth (if not full name at death):

(xii) relationship status immediately before death:

(xiia) in respect of each time (if any) that the person entered a civil union, the person's age at the time of the civil union, the place of solemnisation of the civil union, the civil union partner's full name at that time, and the sex and age of the partner when the person died (if still living at that time):

(xiib) in respect of each time (if any) that the person married, the person's age at the time of the marriage, the place of solemnisation of the marriage, the spouse's full name at that time, and the sex and age of the spouse when the person died (if still living at that time):

(xiic) in respect of each time (if any) that the person entered a de facto relationship, the partner's full name, and the sex and age of the partner when the person died (if still living at that time):

(xiid) the sex and age of the person's children when the person died (if still living at that time):

~~(xiii) the cause or causes of the person's death, and (if more than 1, in respect of each) the interval between onset and death:~~

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

(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:

(xiib) 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:

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

(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:

(xiv) the name of the health practitioner who gave the certificate of cause of death and, if applicable, the date on which the person was last attended by that health practitioner:

(xv) the date on which and place where the person's body was buried, cremated, or otherwise disposed of; and

(b) in the case of death in respect of which the information was expressly recorded,—

(i) the person's kainga (residence), iwi (tribe) or subtribe, and ahuatanga (description):

(ii) the degree of Maori ancestry of the person:

(iii) the kainga, iwi or subtribe, ahuatanga, and degree of Maori ancestry (if any) of the person's father:

(iv) the kainga, iwi or subtribe, ahuatanga, and degree of Maori ancestry (if any) of the person's mother; and

(c) in the case of a death in respect of which information has been recorded under section 50 of the Act, or a corresponding provision of any former Act,—

(i) the name of the force or unit in which the person concerned was serving at the time of death:

(ii) the person's official number (if any) and rank at the time of death:

(iii) the person's last occupation, profession, or job, and usual residential address, before departure from New Zealand:

(iv) the source or sources of information from which particulars of the place, time, date, and cause, of the death, and the place in which the person's body was buried, cremated, or otherwise disposed of, were obtained.

(2) The number of a person's legal relationships for which details must be contained in a death certificate is limited to the 4 most recent relationships before death.

(3) In subclause (2), **legal relationship** means a marriage, civil union, or de facto relationship.