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ASSISTED DYING, PALLIATIVE CARE AND CHOICE

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Abstract

This paper examines assisted dying, palliative care, and individual choice considering New Zealand's recently enacted euthanasia legislation the End of Life Choice Act 2019 (EOLCA). The key ethical argument against the legislation is that euthanasia is incompatible with preserving the sanctity of human life. However, New Zealand has overcome the ethical debate over euthanasia and legalised medically assisted dying for terminally ill patients, which will come into force on 7 November 2021.

The main argument advanced in the paper is that assisted dying and palliative care need to co-exist to achieve good outcomes for terminally ill patients, but conflicting ideologies and strong opposition from health professionals will make it a difficult co-existence.

Nevertheless, while implementing the Act, the appropriateness of conscientious objections raised by health professionals and the participation of family needs to be examined. Assisted dying is opposed in principle by healthcare professionals and Māori. Nonetheless, it is about choice. The EOLCA gives the terminally ill with unbearable suffering the option of a dignified death on their terms.

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I Introduction

Euthanasia in New Zealand is controversial. There is strong opposition from health professionals claiming euthanasia is antithetical to medical practice, while proponents of euthanasia quote patient autonomy and the right to a dignified death as the moral basis for legalising euthanasia. Euthanasia means “a gentle and easy death”,¹ and legalised euthanasia refers to voluntary active euthanasia.² The key ethical argument is that euthanasia is incompatible with preserving the sanctity of human life.³ New Zealand has previously attempted to legalise euthanasia through the Death with Dignity Bill 2003. However, *Seales*⁴ was the catalyst for enacting the End of Life Choice Act 2019 (EOLCA). In *Seales*, a dying lawyer sought declarations from the Court that her doctor would not be held criminally liable if she administered a fatal drug. This case rejuvenated the euthanasia debate in New Zealand.

New Zealand has now legalised medically assisted dying for terminally ill patients by enacting the EOLCA and voting “yes” in the 2020 referendum. The EOLCA will come into force on 7 November 2021. This means New Zealand’s existing end-of-life care needs to accommodate the operation of the EOLCA to provide patients who request assisted dying with good and culturally appropriate health outcomes. New Zealand’s take on assisted dying is constrained. Eligibility is limited to citizens and residents aged 18 years and over who suffer a terminal illness that will end their lives within six months.⁵ To be eligible, the person must also have an irreversible decline in physical capability, experience unbearable suffering, and be competent enough to make an informed decision.⁶

The requirement for an irreversible physical decline, unbearable suffering, and terminal illness means people eligible for assisted dying will have some interaction with the healthcare system. In addition, palliative care will likely address the management of pain and physical limitations of terminally ill persons. This means palliative care is likely to be a person’s alternative treatment or complementary to assisted dying. Therefore, the interaction between palliative care and assisted dying must be considered, including how assisted dying will fit New Zealand’s existing end-of-life care model. This paper argues that assisted dying and palliative care need to co-exist to achieve good outcomes for terminally ill patients, but conflicting ideologies and strong opposition from health professionals will make it difficult to co-exist.

¹ *Oxford English Dictionary* (Oxford University Press, 2019).

² Emily Jackson and John Keown *Debating Euthanasia* (Hart Publishing, Oxford, 2012) at 2.

³ At 37.

⁴ *Seales v Attorney-General* [2015] NZHC 1239, [2015] 3 NZLR 556.

⁵ End of Life Choice Act 2019, s 5(1).

⁶ Section 5(1).

Part II discusses the tension and common values of assisted dying and palliative care. Part III canvasses the views of Hospice New Zealand (Hospice NZ) and the New Zealand Medical Association (NZMA). Part IV analyses the conscientious objection provision in the EOLCA and conscientious objections in healthcare generally. Part V examines *Hospice NZ*, focusing on the availability of organisational conscientious objection in the EOLCA and Crown funding of palliative services. Part VI considers guidance from the Ministry of Health (MOH) including practical considerations for health practitioners and health service providers intending to provide assisted dying services. Part VII explores Māori understandings of assisted dying. Part VIII considers protections available to health professionals and statutory oversight in the EOLCA. Part IX is the conclusion.

II Assisted Dying and Palliative Care

The tension between assisted dying and palliative care is due to the different and unreconcilable objectives. Palliative care “...provides people with humane and dignified support and services as they face a life-limiting condition”.⁷ Palliative care in New Zealand is based on the World Health Organisation’s definition. It does not seek “...to hasten nor postpone death”.⁸ Instead, palliative care aims to optimise a person’s quality of life until natural death, including addressing their physical, psychosocial, spiritual, and cultural needs.⁹ Providing good quality palliative care is part of New Zealand’s international human rights obligations, notably, the “right of everyone to the enjoyment of the highest attainable standard of physical and mental health”.¹⁰ In contrast, the EOLCA allows eligible people “...to end their lives in peace and dignity, surrounded by loved ones”.¹¹ However, there is no clear evidence that legalising euthanasia impedes the development of palliative care.

Instead, the operation of the EOLCA is expected to increase the quality and uptake of palliative care resulting in a positively enhanced doctor-patient relationship.¹² This is supported by the experiences of countries that have legalised assisted dying. A study of seven European countries that included three that permitted euthanasia and four that were non-permissive concluded that regulating assisted dying promotes the expansion of palliative care.¹³ For example, Belgium is pro-euthanasia. Yet Belgium increased its expenditure on palliative care,

⁷ Ministry of Health “Palliative care” (9 September 2011) <www.health.govt.nz>.

⁸ Elizabeth Davies and Irene Higginson (ed) *EN: Better Palliative Care for Older People* (2004) World Health Organization Europe <www.euro.who.int> at 14.

⁹ Ministry of Health, above n 7.

¹⁰ United Nations international Covenant on Economic, Social and Cultural Rights 993 UNTS 3 (opened for signature 16 December 1966, entered into force 3 January 1976), art 12.

¹¹ End of Life Choice Bill 2017 (269-1) Explanatory Note.

¹² End of Life Choice Bill, above n 11, Explanatory Note.

¹³ Kenneth Chambaere and Jan Bernheim “Does legal physician-assisted dying impede development of palliative care? The Belgian and Benelux experience” (2015) 41 *J Med Ethics* 657.

averaging an increase of around 12 per cent annually since legalising euthanasia in 2002.¹⁴ However, this increase in palliative care funding can also be attributed to how Belgium categorises palliative care funding. For instance, Belgium re-categorised spending on conventional home care as palliative care while the increase to specialist palliative care funding was modest.¹⁵

Additionally, palliative care specialists in Belgium have the additional workload of dealing with work-intensive euthanasia requests.¹⁶ This suggests that legalising euthanasia did not necessarily lead to Belgium increasing its specialist palliative care funding and capabilities. Therefore, to increase funding and capabilities of specialist palliative care, governments need to make deliberate policy choices. There is no correlation between palliative care funding and the legalisation of assisted dying. However, the long-term effects of legalising assisted dying are still unknown.¹⁷ So, the output and quality of palliative care will need to be monitored.¹⁸ It is necessary to ensure that people eligible for assisted dying do not choose assisted dying due to inadequate palliative care.¹⁹

The EOLCA has limited participation of whānau, and it does not have any provisions aimed at addressing the needs of whānau. In contrast, palliative care also supports a person's whānau and caregivers, including bereavement if needed.²⁰ This highlights the need for palliative care and assisted dying to co-exist rather than being mutually exclusive. Additionally, palliative care and assisted dying do share common values. Both focus on reducing human suffering, share an aversion to neglecting the humanity in the dying person, give patients control at the end of life, and do not view death as the "worst evil".²¹ Traditionally, palliative care and assisted dying were viewed as adversaries due to the misconception that the expansion of one would harm the other.²² The better view is that the likely overlap in patient care means there is a need for palliative care and assisted dying to co-exist to achieve good patient outcomes.

However, the co-existence of palliative care and assisted dying can result in undesirable outcomes. For example, a faith-based palliative care organisation in Victoria refused to verify the deaths of patients who died at home through assisted dying, and this caused their families

¹⁴ At 657.

¹⁵ At 658.

¹⁶ At 658.

¹⁷ At 660.

¹⁸ At 660.

¹⁹ At 660.

²⁰ Ministry of Health, above n 7.

²¹ Samia Hurst and Alex Mauron "The ethics of palliative care and euthanasia: exploring common values" (2006) 20 *Palliative Medicine* 107.

²² At 111.

distress.²³ This shows there is a need for a clear delegation of roles, regulations, and professional standards to avoid such situations. Moreover, the EOLCA is silent about Treaty obligations. This suggests the EOLCA might be incompatible with the Māori worldview and maybe the more holistic approach of palliative care is better suited to accommodating Māori views than the EOLCA. This suggests the co-existence of palliative care and assisted dying in New Zealand might be uneasy. Māori perspectives are further explored in part VII of this paper.

III Oppositions to EOLCA

A Hospice NZ

From the onset, health professionals opposed the EOLCA. The Justice Select Committee received numerous submissions. Hospice NZ and all medical professional bodies were against legalising euthanasia, viewing it as incompatible with medical ethics and practice. Hospice NZ, which represented all of New Zealand's hospice services, disagreed with the intent of the End of Life Choice Bill.²⁴ It viewed assisted dying to be against the core values of palliative care, particularly not hastening death.²⁵ There was concern that putting the option of assisted dying alongside palliative care would undermine the intent of palliative care and may pressure people with terminal illnesses to choose immediate death over dying naturally.²⁶ Hospice NZ also disliked the use of “unbearable suffering” in s 5, which is a criterion for being eligible for assisted dying. It noted that suffering and tolerance of treatment is subjective and could vary from day to day.²⁷

Additionally, Hospice NZ said that society perceives a person with a terminal diagnosis to have no prospect of improvement, but with proper support, a person can enjoy some things that bring them joy.²⁸ This suggests that legalising euthanasia will change societal values and perceptions resulting in more people with terminal illnesses choosing immediate death. However, there is no clear evidence of this in Oregon. Oregon legalised euthanasia in 1997 for people with terminal illnesses and has a similar population to New Zealand. Since 1997, 1905 people have died from euthanasia in Oregon.²⁹ The number of deaths per year due to euthanasia has remained steady, with 245 people in 2020 dying from physician-assisted deaths.³⁰ The majority

²³ Melissa Cunningham “‘Discriminatory and unethical’: palliative care service criticised over failure to verify euthanasia deaths” *The Sydney Morning Herald* (online ed, Australia, 17 April 2021).

²⁴ Hospice New Zealand “Submission to the Justice Select Committee on the End of Life Choice Bill 2017” at 1.

²⁵ At 2.

²⁶ At 2.

²⁷ At 2.

²⁸ At 2.

²⁹ Public Health Division *Oregon Death with Dignity Act 2020 Data Summary* (Center for Health Statistics, 26 February 2021) at 5.

³⁰ At 5.

of physician-assisted deaths in Oregon happen at home (92 per cent), and 95 per cent of these people were in hospice care.³¹

New Zealand can likely expect similar patient characteristics and number of deaths from assisted dying as Oregon. The Oregon experience indicates that people eligible for assisted dying do not need to choose between assisted dying and palliative care. These options do not need to be mutually exclusive as per Hospice NZ's submission. Palliative care can complement assisted dying, including assisted dying being an option at the end of a palliative care pathway. Given Hospice NZ's conscientious objection to assisted dying, it is unclear if palliative care in New Zealand will evolve to allow assisted dying to be available at the end of a palliative care pathway. Practically, that might involve referrals to external providers of assisted dying. This might happen in the future with changing societal views and assisted dying becoming more acceptable.

B New Zealand Medical Association (NZMA)

The NZMA is New Zealand's largest medical organisation and has members from all areas of medicine.³² An essential role of the NZMA is its Code of Ethics. It sets out principles of ethical behaviour for New Zealand's medical profession and provides recommendations for ethical practice.³³ This means the NZMA's position on assisted dying influences the medical profession, including what constitutes ethical practice. The NZMA did not support the End of Life Choice Bill as it viewed assisted dying "...practices to be unethical, and harmful to individuals, especially vulnerable people, and society".³⁴ The NZMA also believed the Bill had severe shortcomings, and this reflected the impossibility of making doctor-assisted dying legislation effective in "...defining those eligible, ensuring a free choice, protecting the vulnerable, and ensuring competency".³⁵ The means euthanasia conflicts with the ethical principles of medical practice and would fundamentally change the doctor-patient relationship.³⁶

The NZMA supported the discussion about end-of-life options and respected patient autonomy.³⁷ However, the NZMA believes that individual patient autonomy has limits. To protect the wider community, the medical profession must balance other ethical considerations

³¹ At 6.

³² New Zealand Medical Association (NZMA) "Submission to the Justice Select Committee on the End of Life Choice Bill 2017" at 1.

³³ At 1.

³⁴ At 1.

³⁵ At 1.

³⁶ At 1.

³⁷ At 2.

that include non-maleficence, beneficence, and justice.³⁸ Arguably, giving people the autonomy to end their lives ignores the vulnerabilities that influence people, such as fear of future pain, incapacity, and not being a burden to others.³⁹ The NZMA believes that legalising assisted dying would negatively impact the implicit trust that people have in doctors.⁴⁰ Doctors become life takers if the option to end life is present in medical care.⁴¹ Patients will no longer believe that doctors hold a presumption that favours life.⁴² The counterargument is that doctors make decisions that shorten a patient's life even outside of assisted dying. Legalising assisted dying provides terminally-ill people with more end-of-life choices and enhances patient autonomy.

Terminal sedation is common practice in palliative care. It relieves distress in terminally ill patients towards the end of their life through continuous intravenous or subcutaneous infusion of a sedative.⁴³ The use of life-shortening analgesics is justified in palliative care by the principles of proportionality and double effect. Proportionality requires the benefits of any intervention to outweigh the harms of that intervention.⁴⁴ Further, the principle of double effect allows for life-shortening clinical interventions if the physician's intent is different such as relieving pain.⁴⁵ The widespread use of terminal sedation shows that clinicians knowingly take actions that hasten death. Doctors do not always make life-saving decisions, and clinical intervention can include those that hasten death while the intent is easing suffering. Assisted dying comes within the ambit of relieving suffering, but the intention is taking life, unlike terminal sedation. Therefore, assisted dying cannot be justified under the principles of proportionality or double effect.

However, assisted dying enhances patient autonomy by giving terminally-ill people the option of choosing death on their own terms. The NZMA believes that patient autonomy is adequately protected by s 11 of the New Zealand Bill of Rights (NZBORA) that gives people the right to refuse medical treatment, and the Code of Patient Rights allows consumers to refuse services and may use advance directives to do so.⁴⁶ Therefore, without the option of assisted dying, a terminally ill person's only available option is to refuse treatment with the possibility of death by terminal sedation. This is a sharp contrast to assisted dying, which allows a person to choose

³⁸ At 3; Alastair Campbell, Grant Gillet and Gareth Jones *Medical Ethics* (4th ed, Oxford University Press, Melbourne, 2005) at 12.

³⁹ At 2-3.

⁴⁰ At 8.

⁴¹ At 8.

⁴² At 8.

⁴³ At 11.

⁴⁴ At 11.

⁴⁵ Roger Magnusson "The Devil's Choice Re-Thinking Law, Ethics, and Symptom Relief in Palliative Care" (2006) 34 *Journal of Law, Medicine and Ethics* 550 at 561.

⁴⁶ New Zealand Medical Association, above n 32, at 2.

their time of death while being surrounded by family and friends. It is important to note that the NZMA's position that euthanasia is unethical with medical practice is consistent with the views of the World Medical Association (WMA).⁴⁷ Additionally, most of the world's medical associations oppose euthanasia, with only Belgium, Luxemburg, Switzerland, and Canada taking neutral positions, while the Royal Dutch Medical Association is the outlier and actively advocates for euthanasia.⁴⁸

It is arguable that after a country has legalised euthanasia, it would be better for the medical association to adopt a neutral position. This would reflect societal values and assure the public that the medical profession would not undermine the operation of the euthanasia legislation. It will be interesting to see if the NZMA changes its ethical position on assisted dying in the future. The ethical dilemma that assisted dying poses is reflected in the EOLCA through the conscientious objection provision and not requiring health practitioners with conscientious objections to make referrals.⁴⁹ This is consistent with the WMA's guidance, which states that no doctor should be forced to participate in euthanasia or be obliged to make referral decisions to this end.⁵⁰ If the NZMA and the medical community continue to oppose assisted dying, rather than taking a neutral position, it would negatively impact the availability and acceptability of assisted dying services in New Zealand.

C Outlook After Legalisation of Assisted Dying

In February 2021, the MOH surveyed health practitioners to gauge the number of practitioners willing to play a role in assisted dying and see if any concerns could be addressed in planning and implementing the EOLCA.⁵¹ Of the 1980 responses, 53 per cent opposed assisted dying, 47 per cent supported assisted, and around 30 per cent indicated they would possibly or definitely provide assisted dying services.⁵² The survey was of individual practitioners. Therefore, 30 per cent is not a reflection of the health service providers willing to provide assisted dying services. There will need to be a coming together of health service providers and health practitioners willing to provide assisted dying services. Additionally, health practitioners wanted more information about the end-to-end process, training, guidance and support available to clinicians, and funding arrangements.⁵³ The MOH has recently provided guidance

⁴⁷ World Medical Association "WMA declaration on Euthanasia and Physician-Assisted Suicide" (October 2019) <www.wma.net>.

⁴⁸ New Zealand Medical Association, above n 32, footnote 22.

⁴⁹ End of Life Choice Act, ss 8 and 9.

⁵⁰ World Medical Association, above n 47.

⁵¹ New Zealand Doctor Rata Aotearoa "End of Life Choice Act – workforce survey" (29 March 2021) <www.nzdoctor.co.nz>.

⁵² New Zealand Doctor Rata Aotearoa, above n 51.

⁵³ New Zealand Doctor Rata Aotearoa, above n 51.

about assisted dying, including how it will fit into New Zealand’s existing end-of-life care. This is considered in part VI of this paper.

IV Conscientious objection

A The Law

The conscientious objection under the EOLCA “means an objection on the grounds of conscience”.⁵⁴ It is a cornerstone of the EOLCA and embodies the principle that no person must do anything under the EOLCA they do not wish to do.⁵⁵ Section 8 is the conscientious objection provision. It states that a “health practitioner” is under no obligation to assist a person seeking assisted dying if they have a conscientious objection. A “health practitioner” refers to any person who has obligations to assist the EOLCA.⁵⁶ However, suppose the “attending medical practitioner” has a conscientious objection. In that case, they must tell the person requesting assisted dying about their conscientious objection, and about their right to ask the Support and Consultation for End of Life in New Zealand (SCENZ) Group for the details of a replacement medical practitioner.⁵⁷ Parliament has clarified that the obligation to tell the person seeking assisted dying about the SCENZ Group is not intended to be a referral.⁵⁸ Instead, it gives publicly available information about how to get a replacement medical practitioner.⁵⁹

B Non-Referral Requirement and Access

The non-referral requirement is consistent with the Victorian position where health practitioners with conscientious objections have no obligation to refer people requesting assisted dying to another provider.⁶⁰ However, the non-referral requirement in Victoria has raised concerns about a patient’s right to access, particularly in rural areas with fewer healthcare providers.⁶¹ Arguably, making it compulsory for a health practitioner with a conscientious objection to refer the patient to the SCENZ Group strikes the right balance between the rights of the health practitioner and the person requesting assisted dying. It prevents a health practitioner from making a clinical judgment against their conscience and referring a patient to another health practitioner for assisted dying services. On the other hand,

⁵⁴ End of Life Choice Act, s 4.

⁵⁵ (21 August 2019) NZPD (End of Life Choice Bill — In Committee — Part 2, David Seymour).

⁵⁶ *Hospice New Zealand v Attorney-General* [2020] NZHC 1356, BC202063612 at [75].

⁵⁷ End of Life Choice Act, s 9(2).

⁵⁸ Hansard, above n 55.,

⁵⁹ Hansard, above n 55.

⁶⁰ Voluntary Assisted Dying Act 2017 (Vic), s 7.

⁶¹ Carolyn Johnston and others “Navigating Assisted Dying in Victoria” (13 November 2018) Pursuit by The University of Melbourne <www.pursuit.unimelb.edu.au>.

the person requesting assisted dying will have access to a list of health practitioners willing to provide assisted dying services. New Zealand will probably have the same issues as Victoria regarding access. The number of healthcare providers willing to provide assisted dying services is likely to be low, especially in rural areas.

C Assisted Dying and Conscience

Section 10 expressly states that a health practitioner cannot initiate any discussion about assisted dying. There was some discussion in Parliament about whether the operation of s 10 would prohibit advertising of assisted dying.⁶² It appears New Zealand would follow Victoria's approach, where the requirement not to initiate a conversation about assisted dying was interpreted so as to prohibit advertising, and breaches could result in disciplinary proceedings by the Health and Disability Commissioner.⁶³ Prohibiting health practitioners from initiating the discussion about assisted dying is likely to avoid any undue influence. However, the Victorian experience suggests that waiting for patients to request assisted dying may affect access, notably for people with low health literacy and disadvantaged groups.⁶⁴ Furthermore, being unaware of assisted dying could impact a person's ability to provide informed consent to other medical procedures.⁶⁵ Informed consent includes receiving information that you need to make decisions about procedures and treatments.⁶⁶ This would include information about alternative treatments or options.

The Victorian Legislative Council's inquiry into end-of-life choices highlighted the public's lack of awareness and understanding of advance care planning attributing it to death being a taboo subject.⁶⁷ Arguably, health practitioners should more frequently discuss advance care planning, and this should consider all options, including assisted dying. However, health practitioners in New Zealand cannot initiate any discussion about assisted dying.⁶⁸ In addition, the use of advance directives to request assisted dying is prohibited.⁶⁹ This means in New Zealand, assisted dying cannot be considered in advance care planning. A health practitioner is forbidden from discussing assisted dying to prevent undue influence on the person requesting assisted dying. This is further bolstered by s 24. Section 24 prohibits assisted dying when a medical practitioner reasonably suspects pressure from another person. Preventing undue influence by medical practitioners and prohibiting assisted dying when pressure is suspected

⁶² Hansard, above n 55.

⁶³ Hansard, above n 55.

⁶⁴ Johnston, above n 61.

⁶⁵ Johnston, above n 61.

⁶⁶ Ministry of Health "Your rights" (26 October 2016) <www.health.govt.nz>.

⁶⁷ Legal and Social Issues Committee *Inquiry into end of life choices Final Report* (Parliament of Victoria, Legislative Council, June 2016) at xix.

⁶⁸ End of Life Choice Act, s 10.

⁶⁹ Section 33.

are legitimate safeguards. However, limiting discussions and information about assisted dying due to conscientious objections is problematic.

The conscientious objection provision in healthcare legislation allows health professionals to opt out of performing certain procedures or caring for particular patients on the grounds of personal religious or moral beliefs.⁷⁰ Conscience clauses in health care came from conscientious objections to military service, but unlike conscripted soldiers, health professionals voluntarily choose their roles.⁷¹ Therefore, Stahl and Emanuel argue that professional associations should not sanction conscientious objection as acceptable practice.⁷² Moreover, Parliament's reluctance to repeal statutory conscientious objection provisions when procedures become medically acceptable can impact public perception and accessibility to these procedures. After a conscientious objection is enacted, it is rarely repealed even when the medical procedure becomes medically acceptable. This is highlighted by the conscientious objection provision that still exists for abortion.

D Comparison with Abortion Conscientious Objection

Healthcare should be patient-centric, which means providing medically accepted procedures based on a patient's reasoned decisions.⁷³ A conscientious objection to medically accepted procedures is effectively substituting cultural and political views for professional medical knowledge.⁷⁴ Stahl and Emanuel acknowledge that conscientious objection is appropriate in situations such as euthanasia, where the healthcare profession is still debating whether participation is appropriate.⁷⁵ However, the issue is that once a conscientious objection is available for a certain procedure, it is unlikely to be repealed. An example is abortion that recently got decriminalised in New Zealand with amendments to the Contraception, Sterilisation, and Abortion Act 1977 and the Crimes Act 1961. Abortion has been available in New Zealand since the 1970s. However, the recent decriminalisation aims to increase accessibility to abortion.⁷⁶

The conscientious objection provision in the abortion legislation is similar to the EOLCA. It requires health practitioners with conscientious objections to tell the person requesting abortion

⁷⁰ Ronit Stahl and Ezekiel Emanuel "Physicians, Not Conscripts — Conscientious Objection in Health Care" (6 April 2017) 376 N Engl J Med 1380.

⁷¹ At 1380.

⁷² At 1380.

⁷³ At 1383.

⁷⁴ At 1383.

⁷⁵ At 1383.

⁷⁶ Ministry of Health "Abortion legislation: information for health practitioners" (30 April 2021) <www.health.govt.nz.

about their conscientious objection and provide contact details of another provider.⁷⁷ However, the recent amendments go further and require the health practitioner with the conscientious objection to provide details of the closest provider of abortion services.⁷⁸ The closest provider is determined based on physical distance, date and time of the request, and the operating hours of the provider of the abortion service.⁷⁹ In contrast, the conscientious objection provision in the EOLCA requires the health practitioner with the conscientious objection only to provide contact details of the SCENZ group to the person requesting assisted dying. The difference in the referral requirements is likely due to there being more providers of abortion services, and abortions can be more time-sensitive than assisted dying.

The recent decriminalisation would suggest abortion is now considered more medically acceptable, at least up to 20 weeks.⁸⁰ However, the only amendment to the conscientious objection provision was to provide more details about an alternative service provider. This as per Stahl and Emanuel's view would be substituting cultural and political views for professional medical knowledge. Additionally, health professionals have the freedom to choose their scope of practice. Therefore, instead of providing a conscientious objection provision for medically acceptable procedures, health practitioners should choose their scope of practice based on their personal beliefs. In reality, this might not be possible due to overlap, such as health professionals involved in obstetrics might mainly deal with delivering babies but might receive abortion requests on occasion.

Conscientious objections exist to protect health practitioners from participating in procedures that are against their personal beliefs. However, the continued existence of conscientious objections even when the procedure becomes medically acceptable likely undermines the legitimacy of such procedures and could limit access to these procedures. In the United Kingdom, there was some suggestion that nowadays employers might refuse to hire anyone with a conscientious objection to abortion given that a lack of such an objection is a genuine qualification requirement.⁸¹ To avoid such consequences, the United Kingdom's Supreme Court interpreted the conscientious objection provision in the abortion legislation narrowly.⁸² This might be why the conscientious objection provision in the EOLCA expressly states that an employer cannot deny an employee employment or privileges due to the employee having

⁷⁷ Contraception, Sterilisation, and Abortion Act 1977, s 19(2).

⁷⁸ Abortion Legislation Bill 2019 (164-3), cl 19(2)(b).

⁷⁹ Clause 19(2A).

⁸⁰ Ministry of Health "Questions and answers on abortion in New Zealand" (18 December 2020) <www.health.govt.nz>.

⁸¹ *Greater Glasgow Health Board v Doogan* [2014] UKSC 68, [2015] 1 AC 640 at [25].

⁸² At [38].

a conscientious objection to assisted dying.⁸³ The High Court considered the EOLCA's conscientious objection in *Hospice NZ*.

V *Hospice New Zealand v Attorney-General*

A *Background*

Hospice NZ was one of the most vocal oppositions to the EOLCA. Its most significant concern was if it could maintain a conscientious objection and keep its facilities “euthanasia-free” without impacting Crown funding. Hospice NZ wanted to clarify these positions before the EOLCA came into effect and sought declarations from the High Court. Palliative Care Nurses New Zealand Incorporated and Australian and New Zealand Society of Palliative Medicine Limited were granted intervener status and supported Hospice NZ's position.⁸⁴ Mallon J made it clear the Court's jurisdiction was limited to the statutory interpretation of the EOLCA.⁸⁵ Her judgment did not consider whether the Act should be enacted or complied with the rights in the NZBORA.⁸⁶

To ensure their facilities remain “euthanasia-free”, Hospice NZ wanted the Court to determine whether an organisational conscientious objection provision was available or if the conscientious objection was limited to individual practitioners. Hospice NZ argued that s 13 of the NZBORA affirms everyone's right to conscience while s 29 provides that, as far as practicable, affirmed rights apply to legal persons as well as natural persons.⁸⁷ Therefore, Hospice NZ submitted that organisations could have a right to conscience.⁸⁸ This also makes a case for allowing organisations to utilise the conscientious objection provision in the EOLCA. Mallon J accepted Hospice NZ's proposition that organisations should benefit from the right to freedom of conscience.⁸⁹ However, she held the provision's textual interpretation suggests Parliament intended the conscientious objection provision to be available to individual health practitioners.⁹⁰

In particular, the reference to “health practitioners” in s 8 suggests individuals rather than an organisation. This is consistent with the definition of ‘health practitioner’ in s 4 of the EOLCA. The definition of “health practitioner” in the EOLCA is the same as s 5(1) of the Health

⁸³ End of Life Choice Act, s 8(3).

⁸⁴ *Hospice NZ*, above n 56, at [8].

⁸⁵ At [47].

⁸⁶ At [47].

⁸⁷ At [91].

⁸⁸ At [91].

⁸⁹ At [103].

⁹⁰ At [116].

Practitioners Competence Assurance Act 2003 (HPCA). The definition in the HPCA applies to individual health practitioners and not organisations as it refers to practitioners registered with a health profession. Mallon J noted that the conscientious objection provision being available to individual health practitioners did not preclude organisations from making arrangements to exclude assisted dying.⁹¹ However, health practitioners employed by organisations that exclude assisted dying can still provide assisted dying services if they do not hold a conscientious objection to assisted dying.⁹² Mallon J further stated that it was not the Court's role to propose arrangements that would exclude assisted dying.⁹³

B Organisational Conscientious Objection

Mallon J's decision to disallow an organisational conscientious objection was also supported by Parliament's rejection of the Supplementary Order Paper (SOP) introduced by Hon Michael Woodhouse. The SOP would have inserted cl 5B to the EOLCA. This would have extended the conscientious objection protection to organisations that did not wish to offer assisted dying services on the grounds of conscience.⁹⁴ The SOP acknowledged the need for an organisational conscientious objection provision as many organisations involved in medical, aged, and palliative care believe in promoting healthy living and not hastening death through assisted dying.⁹⁵ This is consistent with reconciling the two opposing principles of the EOLCA. That is, giving eligible people the option of assisted dying while also providing health professionals the option to not participate in assisted dying.⁹⁶

An organisational conscientious objection provision would have allowed an organisation to promote itself as having a conscientious objection to assisted dying.⁹⁷ This would have permitted organisations to include in their employment contracts and other agreements that their employees, health practitioners, and volunteers were bound by the organisation's prohibition on assisted dying.⁹⁸ In addition, the clause clarified that an organisation could maintain a conscientious objection even if it received Crown funding for services unrelated to assisted dying.⁹⁹ Clause 5B(4) of the SOP explicitly stated that government entities, including District Health Boards (DHBs) could not make funding decisions against an organisation because the organisation has a conscientious objection to providing assisted dying services.

⁹¹ At [116].

⁹² At [116].

⁹³ At [116].

⁹⁴ Supplementary Order Paper 2019 (295) End of Life Choice Bill (269-2), Explanatory Note.

⁹⁵ SOP, above n 94, Explanatory Note.

⁹⁶ SOP, above n 94, Explanatory Note.

⁹⁷ *Hospice NZ*, above n 56, at [59].

⁹⁸ At [59].

⁹⁹ SOP, above n 94, cl 5B(1)(b).

Nor could government entities offer agreements for service or other funding arrangements based on the condition that the organisation offered assisted dying services.¹⁰⁰

An organisational conscientious objection provision would have clarified how an organisation could, in practice, apply the conscientious objection provision. However, ultimately the SOP was rejected because it was considered unnecessary. The argument was that the EOLCA does not require any institution to provide assisted dying services, so an organisational conscientious objection provision would be redundant.¹⁰¹ Mallon J confirmed this position declaring that the EOLCA does not require organisations to provide assisted dying services, which is not contingent on an organisation having a conscientious objection.¹⁰² David Seymour noted that Canada and both states of Australia rejected organisational conscientious objection provisions.¹⁰³ He also had concerns about the funding provisions in the SOP, arguing that the proposed amendments would make it impossible for DHBs to contract with any organisation to provide assisted dying services.¹⁰⁴ David Seymour's concerns about the funding provisions in the SOP were unfounded.

C Crown Funding

The funding provisions in the SOP would have prevented government entities from making funding decisions against an organisation because they have a conscientious objection or make funding arrangements conditional on an organisation offering assisted dying services.¹⁰⁵ For example, if the organisational conscientious objection provision were enacted, the Crown would still provide Hospice NZ's palliative care funding. However, the Crown cannot deny Hospice NZ palliative care funding because it has a conscientious objection to assisted dying. Nor make the funding conditional on Hospice NZ providing assisted dying services. Parliament rejected the SOP and an organisational conscientious objection provision. The SOP would have provided clarity for organisations such as Hospice NZ, which oppose assisted dying, and would have alleviated concerns about access to Crown funding. However, as confirmed by Mallon J in *Hospice NZ*, the EOLCA does not require organisations to provide assisted dying services.¹⁰⁶ This is why an organisational conscientious objection in the EOLCA was considered unnecessary by Parliament.¹⁰⁷

¹⁰⁰ SOP, above n 94, cl 5B(4)(b).

¹⁰¹ Hansard, above n 55.

¹⁰² *Hospice NZ*, above n 56, at [214].

¹⁰³ Hansard, above n 55.

¹⁰⁴ Hansard, above n 55.

¹⁰⁵ SOP, above n 94, cl 5B (4).

¹⁰⁶ *Hospice NZ*, above n 56, at [214].

¹⁰⁷ Hansard, above n 55.

The central government mainly funds New Zealand's health sector.¹⁰⁸ DHBs operate in geographically defined areas, and each DHB has the discretion to contract for health services according to their objectives and functions.¹⁰⁹ Palliative care can be part of a person's standard clinical practice.¹¹⁰ It can also be provided by general practice teams, Māori health teams, aged care facilities, and district nurses while ward staff provide palliative care in hospitals.¹¹¹ Hospice NZ's concerns about losing Crown funding if they do not provide assisted dying services might not be completely unfounded. It is not a stretch for DHBs and, in the future, Health NZ to fund organisations that also provide assisted dying services. It might be a matter of operational efficacy. Therefore, the funding protections in the proposed organisational conscientious objection provision might have been valuable. However, given the size and proliferation of hospice services across New Zealand, it is unlikely the Crown will stop funding Hospice NZ.

Hospice services in New Zealand are free and Crown funding is critical to its operation. This is because the yearly cost of providing these services is \$155 million, of which only 77 million comes from fundraising and Hospice NZ's retail network.¹¹² More than half of Hospice NZ's operational funding come from contracts with DHBs.¹¹³ The current health reforms signal the demise of the 20 DHBs, with Health NZ taking over the DHBs operational functions in partnership with the Māori Health Authority.¹¹⁴ Hospital and specialist care will be nationally planned, with operational matters managed through wider regional networks.¹¹⁵ These structural reforms to New Zealand's health sector might impact the funding of palliative care. However, it is unlikely to be influenced by the legalisation of assisted dying, given the projected number of assisted deaths being low. Also, experiences of other jurisdictions show that legalising euthanasia usually results in an expansion in palliative care.

VI *Incorporating Assisted Dying in New Zealand's End-of-Life Care*

The MOH has clarified that not all health service providers will provide assisted dying services.¹¹⁶ This could be due to the views of the organisation or practicality considerations.¹¹⁷

¹⁰⁸ *Hospice NZ*, above n 56, at [119].

¹⁰⁹ At [120].

¹¹⁰ At [121].

¹¹¹ At [121].

¹¹² *Hospice NZ*, above n 56, at [11]; Hospice New Zealand "Hospice Care" <www.hospice.org.nz>.

¹¹³ At [11].

¹¹⁴ Department of the Prime Minister and Cabinet *Our health and disability system: Building a stronger health and disability system that delivers for New Zealand* (April 2021) <www.dpmmc.govt.nz> at 6.

¹¹⁵ At 9.

¹¹⁶ Ministry of Health *End of Life Choice Act 2019: Information for health service providers* (May 2021).

¹¹⁷ Ministry of Health, above n 116.

Factors that will influence whether a health service provider will provide assisted dying services are if a provider:¹¹⁸

- a) currently provides end-of-life care;
- b) have health practitioners willing to provide assisted dying per the EOLCA;
- c) have health practitioners willing to provide support such as talking to patients about assisted dying and making practical arrangements;
- d) have guidance and support for health practitioners involved in assisted dying and those who choose not to be involved.

The above factors suggest that in New Zealand, providers of assisted dying will likely be providers who already work in end-of-life care and have sufficient support and systems in place to facilitate assisted dying. This will not include providers such as Hospice NZ due to their conscientious objections to euthanasia or providers with insufficient staff willing to be involved in assisted dying. The opposition from all of New Zealand's health professional bodies and the majority of health professionals indicates the number of health service providers providing assisted dying will be low.

Even if assisted dying is not contrary to the health service provider's views, it might not have sufficient staff willing to provide assisted dying services. The low number of health service providers likely to provide assisted dying can lead to inequity regarding access to assisted dying services. However, the low number of providers of assisted dying might not be an issue as the number of valid assisted dying requests is expected to be low due to limited eligibility under the EOLCA. Nevertheless, there will still be some inequity as low demand will likely result in providers of assisted dying being limited to the major cities.

Additionally, the MOH has provided guidance for health service providers intending to provide assisted dying services. This includes training staff to respond appropriately to assisted dying requests, ensuring continuity of care, and considering available care pathways, which may involve moving between services.¹¹⁹ Some suggestions regarding appropriate internal systems for health services providers intending to provide assisted dying services were:¹²⁰

- a) forming a multidisciplinary team that includes Māori representation to oversee assisted dying services;
- b) establishing a contact for staff's ethical and legal queries;
- c) developing processes to support staff such as debriefing about responding to assisted dying requests or providing assisted dying services.

¹¹⁸ Ministry of Health, above n 116.

¹¹⁹ Ministry of Health, above n 116.

¹²⁰ Ministry of Health, above n 116.

In addition, the MOH has provided guidance about the discussion between a health practitioner and a person who has requested assisted dying. A health practitioner's discussion with a person who has requested assisted dying must include other end-of-life options such as palliative care.¹²¹ The health practitioner must also encourage the person to discuss their choice with family, talk to the person's family if the person consents, and speak to other health practitioners the person is in regular contact with.¹²² Suppose a person's family asks about assisted dying. In that case, the health practitioner can only direct them to general information, and if appropriate, tell them they cannot make an assisted dying request on behalf of another person.¹²³

The participation of whānau in assisted dying requests is limited. The rationale behind this limited participation of whānau is to avoid any possibility of coercion. However, the minor involvement of whānau in decision-making in assisted dying might not always be culturally appropriate, including for Māori. This might make assisted dying an undesirable option for specific groups. On the other hand, discussing assisted dying as an option might be offensive to certain people based on their personal beliefs. Therefore, it might be appropriate to leave the decision and discussions about assisted dying to the person requesting assisted dying with limited participation from whānau. This is consistent with the EOLCA embodying the principle of choice.

VII Assisted Dying and Māori Perspectives

Māori perspectives on death and dying are diverse. Tikanga and the Māori legal system place a high value on life.¹²⁴ For Māori, life comes from ngā atua tūtutu o te whenua (traditional gods).¹²⁵ Human beings should be enhancing their mauri and the EOLCA permitting the end of life violates this mauri principle. Tino Rangatiratanga allows people to make their own decisions and is akin to personal autonomy.¹²⁶ However, unlike the Western conceptualisation of individual autonomy, Tino Rangatiratanga has two limitations.¹²⁷ The two limitations are hurting yourself or hurting others.¹²⁸ This means Tino Rangatiratanga does not permit assisted dying. Also, under the EOLCA, a person is not required to discuss their choice of assisted

¹²¹ Ministry of Health *End of Life Choice Act 2019: Information for the public* (May 2021).

¹²² Ministry of Health, above n 116.

¹²³ Ministry of Health *End of Life Choice Act 2019: Information for health professionals* (May 2021).

¹²⁴ Edward Carrucan "Tikanga Māori issues with the proposed End of Life Choice Act 2019" (15 September 2020) New Zealand Law Society <www.lawsociety.org.nz>.

¹²⁵ Carrucan, above n 124.

¹²⁶ Carrucan, above n 124.

¹²⁷ Carrucan, above n 124.

¹²⁸ Carrucan, above n 124.

dying with others. This completely opposes tikanga, where these people and elements are interconnected.¹²⁹

Assisted dying is of significance to Maori, and the lack of Māori perspectives in assisted dying is concerning.¹³⁰ Kaumātua narratives differed in understandings of assisted dying, but the majority opposed assisted dying. The media heavily influenced the attitudes and perceptions of assisted dying.¹³¹ Some viewed assisted dying as “destructive” and a “cousin” to suicide.¹³² One participant commented that assisted dying strips tikanga, and losing the mana of an individual impacts the wellbeing of the whole whānau.¹³³ Some kaumātua saw a place for assisted dying as it gives people the right to get rid of pain.¹³⁴ Another participant explained that hastening death was not unfamiliar to Māori and elders in his community have a method of ending life.¹³⁵ Moreover, most participants viewed whānau to be central to the dying process and have a collective responsibility for the decision-making of their members.¹³⁶ This is at odds with the EOLCA.

The EOLCA places the burden of decision-making on the person requesting assisted dying, including the ability to exclude whānau from the discussion. Participants were also concerned about the power held by health professionals. Some Kaumātua felt that if medical professionals demonstrated cultural safety, they could exercise their authority appropriately, while others firmly believed that end-of-life decisions should lie with whānau.¹³⁷ The guidance from the MOH recommends that health service providers establish an internal multidisciplinary team to oversee assisted dying that includes Māori representation. This might ensure that the internal practices of health service providers providing assisted dying are culturally safe for Māori. However, given it is only a recommendation, it is uncertain if every health service provider providing assisted dying services will have such a team and develop culturally safe practices.

Palliative care for Māori is centred around whānau, and home is the preferred place of care in the final stages of life.¹³⁸ Home is often symbolic — its meaning more than the physical

¹²⁹ Carrucan, above n 124.

¹³⁰ Phillipa Malpas and others “‘It’s not all just about the dying’ kaumātua Māori attitudes towards physician aid-in dying: A narrative enquiry” (2017) 31 *Palliative Medicine* 544 at 545.

¹³¹ At 547.

¹³² At 547.

¹³³ At 547.

¹³⁴ At 547-548.

¹³⁵ At 547-548.

¹³⁶ At 548.

¹³⁷ At 548-549.

¹³⁸ Gary Bellamy and Merryn Gott “What are the priorities for developing appropriate palliative and end-of-life care for older people? The views of healthcare staff working in New Zealand” (2013) 21 *Health and Social Care in the Community* 26 at 29.

location.¹³⁹ The important role of elders and extended family networks is why homes are the preferred place of care.¹⁴⁰ Furthermore, institutional care settings allowing the family to provide ‘hands-on’ care was important rather than staff performing personal care.¹⁴¹ The key to Māori satisfaction with end-of-life care was providing appropriate support and education from the sidelines.¹⁴² This highlights the central role family plays in end-of-life care for Māori. Additionally, hospices have facilities to accommodate Māori and Pasifika families by having adjoining rooms that allow the family to be close.¹⁴³ Treaty obligations require culturally safe palliative care and this means working in partnership with the family.¹⁴⁴

Working in partnership with the family will need to be extended to assisted dying to ensure culturally safe practices. The majority of Māori value life and do not view assisted dying to be consistent with tikanga. The EOLCA is the embodiment of personal autonomy, allowing an eligible person to request dying without any involvement from others. In contrast, Māori conceptualisation of individual autonomy has limits, and it does not extend to ending a person’s life. Further, whānau is considered to be integral in making end-of-life decisions. There is some suggestion that Māori have a way of ending life, but it is not the majority view. It is unlikely that assisted dying can conceptually be reconciled with tikanga. Therefore, the principle of partnership requires the assisted dying process to accommodate Māori end-of-life decision-making, which is centred around family.

The statutory framework allows the exclusion of families from the decision-making process. However, to ensure culturally safe end-of-life care for Māori, the family will need to play a central role in decision-making. This means, in practice, a Māori person’s family might be influential in their assisted dying decision. This could undermine the statutory safeguards intended to prevent coercion. If this happens, it suggests the EOLCA was not drafted in a way that accommodates Māori interests and is inconsistent with the Crown’s Treaty obligations. In reality, each health service provider will likely develop guidelines for culturally safe practices with guidance from the MOH. Assisted dying seems unreconcilable with tikanga. Therefore, the EOLCA should accommodate Māori views by allowing family decision-making in assisted dying in line with the partnership principle.

¹³⁹ At 29.

¹⁴⁰ At 29.

¹⁴¹ At 29.

¹⁴² At 29.

¹⁴³ At 30.

¹⁴⁴ At 31.

VIII *Other Considerations*

The EOLCA provides health practitioners immunity from criminal and civil liability if they have acted in good faith and without negligence.¹⁴⁵ The purpose of the civil immunity provision was to clarify that the immunity did not extend to disciplinary proceedings under the HPCA or to breaches of the Code of Health and Disability Services Consumers' Rights under the Health and Disability Commissioner Act 1994.¹⁴⁶ Additionally, the EOLCA will have some statutory oversight. A Review Committee consisting of a medical ethicist and two medical practitioners with at least one medical practitioner practising in end-of-life care will consider all assisted death reports and report to the Registrar (assisted dying) if there is satisfactory statutory compliance.¹⁴⁷

The SCENZ Group will deal with operational matters, including maintaining a list of health practitioners willing to participate in assisted dying, preparing standards of care, advising on medical and legal procedures, and providing practical assistance.¹⁴⁸ The MOH must review the EOLCA three years after commencement, consider if amendments are necessary, and report findings to the Minister of Health.¹⁴⁹ After the initial three-year review, such reviews must happen at least every five years.¹⁵⁰ Therefore, the EOLCA has safeguards to protect health practitioners, is proactive in ensuring compliance, and has a statutorily mandated periodical review to ensure the ongoing appropriateness of the EOLCA's provisions.

IX *Conclusion*

Palliative care and assisted dying need to co-exist to achieve good outcomes for terminally ill patients, but conflicting ideologies and strong opposition from health professionals will make it difficult to co-exist. The main tension between assisted dying and palliative care is that the core ethos of palliative care does not allow hastening death unless justified by the principles of proportionality and double effect. Further, there is concern that legalising assisted dying will impede the development of palliative care. The experience of other jurisdictions points to the contrary with evidence of an expansion in palliative care in countries that have legalised euthanasia. The Belgian experience highlights that an increase in palliative care does not necessarily mean better quality palliative care. It depends on what constitutes palliative care and the funding allocated to specialist palliative care.

¹⁴⁵ End of Life Choice Act, ss 37 and 38; *Hospice NZ*, above n 56, at [54].

¹⁴⁶ *Hospice NZ*, above n 56, at [54].

¹⁴⁷ End of Life Choice Act, ss 26 and 27.

¹⁴⁸ Section 25.

¹⁴⁹ Section 30.

¹⁵⁰ Section 30.

Hospice NZ opposed assisted dying in principle and had concerns that legalising euthanasia would change societal views and pressure terminally ill people to choose immediate death over dying naturally. This is likely an unfounded concern as Oregon, since legalising assisted dying in 1997, has not experienced significant increases in the annual number of deaths. The NZMA's position was that assisted dying is inconsistent with ethical medical practice, and changing the role of medical practitioners to be life takers will fundamentally change the doctor-patient relationship. The conscientious objection provision in the EOLCA is only available to individual health practitioners as confirmed in *Hospice NZ*. The conscientious objection means a health practitioner can refuse to participate in assisted dying. However, the medical practitioner must tell the person requesting assisted dying about their conscientious objection and contact SCENZ Group for a replacement medical practitioner.

Stahl and Emanuel argue that allowing conscientious objection provisions is inappropriate for medically acceptable procedures. A comparison with abortion legislation shows that once a conscientious objection provision is available for a procedure, it is unlikely to be repealed even if the medical procedure becomes more widely accepted. The EOLCA does not require an organisation to provide assisted dying services as confirmed in *Hospice NZ*. Therefore, organisations opposed to assisted dying have ways of making arrangements to exclude assisted dying services. Parliament considered an organisational conscientious objection to be unnecessary. However, it would have provided clarity to organisations seeking to exclude participating in assisted dying, including the protection of Crown funding. MOH has indicated that providers of assisted dying will be those that currently provide end-of-life care. In addition, there was guidance regarding internal controls for health services providers intending to provide assisted dying services and guidance for health practitioners, including how to have discussions about assisted dying.

Palliative care in New Zealand seems to provide end-of-life care to Māori in a culturally safe manner. This is done by making family central while health professionals guide from the sidelines. In contrast, assisted dying in principle cannot be reconciled with tikanga. Moreover, the EOLCA allows the family to be excluded from assisted-dying decisions. The Treaty requires the participation of Māori, and the Māori family-central end-of-life decision-making will need to be accommodated in practice to ensure assisted dying is provided in a culturally safe manner. Assisted dying is opposed in principle by most healthcare professionals and Māori – but it is about choice. The EOLCA gives the terminally ill with unbearable suffering the option of a dignified death on their terms.

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