IN THE HIGH COURT OF NEW ZEALAND
WELLINGTON REGISTRY

I TE KŌTI MATUA O AOTEAROA
TE WHANGANUI-A-TARA ROHE

CIV 2020-485-176
[2020] NZHC 1356

BETWEEN	HOSPICE NEW ZEALAND Applicant
AND	ATTORNEY-GENERAL Respondent

Hearing: 25-26 May 2020

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D R La Hood, A R T Garrick and O R Payne for Respondent
I C Bassett for Palliative Care Nurses New Zealand Incorporated (Intervener)
M S Smith for Australian and New Zealand Society of Palliative Medicine Limited (Intervener)

Judgment: 16 June 2020

JUDGMENT OF MALLON J

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Introduction

> Whether the criminal law should permit voluntary euthanasia and/or physician-assisted suicide is one of the most important ethical debates in developed nations, from the United States and Canada to Australia and New Zealand.[1]

[1] New Zealand voters will be asked to decide on what side of this debate they stand in this year's general election. Specifically, they will be asked to consider whether voluntary euthanasia and assisted suicide will be lawful in the circumstances that are set out in the End of Life Choice Act 2019.

[2] This Act has been passed by Parliament and has received its Royal Assent but is not yet in force. If it comes into force, it will give persons who have a terminal illness and meet certain other criteria the option of lawfully requesting medical

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1 John Keown "Debating euthanasia: a reply to Emily Jackson" in Mark Heneghan and Jesse Wall (eds) *Law, Ethics, and Medicine: Essays in Honour of Peter Skegg* (Thomson Reuters, Wellington, 2016) at 65.

assistance to end their lives and will establish a lawful process for assisting eligible persons to exercise that option. The assistance will be provided by health practitioners and it will be an offence for a health practitioner to wilfully fail to comply with any requirement on them under the Act. However, health practitioners will not be under any obligation to assist if they have a conscientious objection.

[3] Whether the Act is to come into force is to be determined by a majority of electors voting in a referendum.[2] The question that will be put to electors in the referendum will be: "Do you support the End of Life Choice Act 2019 coming into force?".[3] Electors will be given two options to choose between:[4]

(a) "Yes, I support the End of Life Choice Act 2019 coming into force"; or

(b) "No, I do not support the End of Life Choice Act 2019 coming into force".

[4] If a majority of voters chooses the first option, it comes into force 12 months after the date on which the official result of the referendum is declared.[5]

[5] Hospice New Zealand (Hospice NZ) has applied for declarations intended to clarify the scope of the conscientious objection rights provided by the Act. Hospice NZ considers the Act is unclear as to:

(a) whether organisations such as hospices can exercise a right of "institutional" conscientious objection consistent with their core values without exposing its health practitioners to criminal prosecution;

(b) whether Crown funding could be declined for the services an organisation does provide if the organisation exercised a conscientious objection consistent with its core values a conscientious objection consistent with its core values;

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2 End of Life Choice Act 2019, s 2(1).
3 Section 2(2).
4 Section 2(3).
5 Section 2(1).

(c) whether the obligations on a health practitioner under the Act override the health practitioner's ethical, clinical or professional judgement and the practitioner's obligations under the Code of Health and Disability Services Consumers' Rights (the Code); and

(d) whether a health practitioner could conscientiously object to assisting if he or she holds as a core value that they must not act contrary to their ethical, clinical or professional judgement or their obligations under the Code.

[6] Hospice NZ seeks declarations answering five questions on these four topics.[6] The declarations are sought in the context of what is believed to be a unique constitutional situation in this country, if not the Commonwealth, in Parliament having assigned the final step in the law-making function to the electorate via a binding, binary, referendum. Hospice NZ submits it is important that electors be clear as to what they are voting for when they are asked to carry out this function. Hospice NZ says that declarations will allow it and its member organisations, and all those who are or may be involved in their services, to understand the implications of the Act and in turn permit them, and the public at large, to fully engage in the public debate on the referendum question.

[7] The Attorney-General represents the public interest, with no particular stance one way or the other on the propriety of assisted dying. He submits the Court should not issue declaratory orders. He submits the Court should be cautious about its proper role in the constitutionally unique circumstances of the case, especially as the questions posed by Hospice NZ are hypothetical and without the full factual context, and when the declarations would not provide the certainty Hospice NZ seeks.

[8] Palliative Care Nurses New Zealand Incorporated (PCNNZ) and Australian and New Zealand Society of Palliative Medicine Limited (ANZSPM), who were

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6 The specific declarations that are sought are set out in full when they are discussed later in this judgment. There are five questions because the third topic is asked both at a general level and with reference to particular issues.

granted intervener status, support Hospice NZ's position that declaratory relief should be given to provide clarity to voters before the referendum takes place.

[9] With the general election taking place on 19 September 2020,[7] a determination from this Court is sought before 19 June 2020. This is because the regulated period of campaign activity commences on this date.[8] Hospice NZ's application was filed on 9 April 2020. It sought a priority hearing. This was granted by the Court with the consent of the Attorney-General.[9] The hearing took place over two days on 25 and 26 May 2020. It has been necessary to consider the application on an urgent basis.

The parties

Hospice NZ

[10] Hospice NZ is a national organisation representing 33 independently operating hospice services in New Zealand. Each hospice is a charitable organisation providing care and support free of charge to people who are dying. In 2019 New Zealand hospices supported over 19,677 people and their families and whānau.

[11] Each hospice receives a portion of its operating funding from the government under a range of contracts with its District Health Board (DHB). This funding is not sufficient to meet the full cost of providing hospice services. Nationally, it costs around $155 million each year to provide these services. Around $77 million is needed each year to meet the funding gap. These funds are obtained through community fundraising and income from the hospice retail network.

[12] Dame Cicely Saunders is credited with being the modern founder of the hospice movement.[10] The world's first modern hospice facility was opened under her care in London in 1967. New Zealand's hospice movement began in the late 1970s when three founding hospices were established.[11] A network of hospices has been

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[7] Overseas advance voting commences on 2 September 2020. New Zealand advance voting commences on 5 September 2020. Advancing voting closes on 18 September 2020.

[8] Pursuant to the Electoral Act 1993.

[9] *Hospice New Zealand v The Attorney-General* HC Wellington CIV-2020-485-176 5 May 2020.

[10] See *Seales v Attorney-General* [2015] 3 NZLR 556 at [35] for its earlier Irish roots.

[11] Mary Potter Hospice in Wellington established by the religious nursing order, the Little Company of Mary; Te Omanga House in Lower Hutt established by private donors; and St Joseph's Mercy Hospice in Auckland established by, and still closely linked to, the Sisters of Mercy.

established across New Zealand. A number were established by religious orders and retain strong links to them.

[13] Hospice services are based on a philosophy of care. Anyone with a life-limiting condition can access palliative care from hospice services. Mary Schumacher, the Chief Executive of Hospice NZ, explains:

> The ethos of hospice and palliative care as defined by the World Health Organisation is that it "intends neither to hasten nor postpone death". This philosophy is the cornerstone of hospice care in New Zealand, and a defining value of Hospice NZ and its members.

[14] Ms Schumacher says it is often perceived that people with a terminal diagnosis have no hope. The hospice philosophy is that people with a terminal diagnosis can, and do, continue to enjoy the many things in life that have always brought them joy. Hospice NZ and its members believe that with good support, people who are at the end of their lives can develop a greater depth of meaning to life, enjoying time with people and doing things that are important to them.

[15] She says:

> From experience we know that people who are coming to the end of their lives are vulnerable … . We know that the underlying factor that can drive a desire to end life is often fear. … People can feel they are a burden on their family, carers and society and can feel pressured to end their lives. … We believe that as people face the end of their lives they need to feel loved and valued and are entitled to receive the care that helps them to live their lives well and to the full until they die.

[16] Hospice care has a "whole person" approach. This means physical, spiritual, cultural, emotional and social needs are seen as equally important. A multi-disciplinary team of professionals is involved in each person's care. This can involve a doctor, nurse, social worker, spiritual care advisor, counsellor, kaimahi/cultural liaison and occupational therapist or physiotherapist.

[17] Each member hospice expresses its values and core beliefs in slightly different ways. Ms Schumacher describes these values and beliefs are fundamental to the work they do. For example, Mary Potter Hospice states: "The values of the Venerable Mary

Potter and the vision of Dame Cicely Saunders are deeply held by Mary Potter Hospice staff and volunteers and underpin all the work we do”.[12]

[18] Ms Schumacher describes Hospice NZ’s view of euthanasia or assisted suicide as follows:[13]

> Hospice NZ is opposed to euthanasia or assisted suicide in any form, and believes it is incompatible with the palliative care services member hospices provide to people with life limiting conditions, and their family and whānau. Euthanasia and assisted suicide are contrary to our foundational belief that our services neither hasten nor postpone death, and contradicts our core function of caring for – and providing the assurance to our patients that they will be truly cared for and not abandoned – through to their natural death.

[19] Hospice NZ and many of its members and clinicians have spoken out strongly against a law change. Hospice NZ made submissions to the Health Select Committee investigating a law change. It also made a submission to the Justice Select Committee on the End of Life Choice Bill. Ms Schumacher provided an affidavit, along with a number of expert palliative care clinicians, in *Seales v Attorney-General* (discussed below),[14] outlining concerns with the declaratory orders sought in that case. Ms Schumacher says the introduction of euthanasia and assisted suicide “goes to the very heart of the values of the hospice movement”.

[20] Hospice NZ is concerned there is confusion about whether it will be lawful for a hospice or other organisation to provide a “euthanasia-free” service or a “safe space”. It is also concerned that there is confusion about the mandatory obligations on health practitioners and whether they override the health practitioner’s own ethical, clinical or professional judgement and their obligations to a patient under the Code. Ms Schumacher says this confusion is affecting how Hospice NZ’s members and communities are preparing to respond to the Act and the public debate leading to the referendum. Hospice NZ is concerned this confusion will affect how people vote in the referendum.

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12 <marypotter.org.nz/about-us/our-values>

13 “Hospice New Zealand position statement on euthanasia and assisted dying” (2017) Hospice New Zealand <www.hospice.org.nz>. Similar statements are published by many of Hospice NZ’s member organisations.

14 *Seales*, above n 10.

PCNNZ

[21] PCNNZ is an incorporated society. Its objectives include representing the professional interests of nurses providing palliative care. It is a voluntary organisation. Of the 1,372 registered nurses and 125 enrolled nurses involved in palliative care,[15] it has a current membership of 95 registered, enrolled and student nurses. Its members are employed as nurses across all practice settings providing palliative care, in hospitals, hospices, aged residential care and the community (including district nurses and practice nurses).

[22] In September 2012 PCNNZ issued a public position statement regarding euthanasia. It is opposed to euthanasia and assisted dying as being fundamentally contrary to the concept of palliative care and nursing. It supports the position of the ANZSPM, which advocates that the focus should be on excellence in hospice and palliative care and not euthanasia or assisted dying. It made written and oral submissions to the Justice Select Committee on the End of Life Choice Bill.

[23] PCNNZ has filed an affidavit from Aileen Collier. She is a senior lecturer of nursing at the University of Auckland and the Chair of PCNNZ's governing committee. She advises that PCNNZ's members have a range of views regarding euthanasia and assisted dying. Some members opposed the Bill prior to its enactment by Parliament and remain opposed to any participation in any step under the Act. Some are willing to participate to varying degrees but would refuse to participate if any of the steps or tasks involved a breach of the Code.

[24] Ms Collier says those members of PCNNZ with conscientious objections have strong interests in being able to plan prospective employment and to plan alternative career options if need-be. She says they have strong interests in: having the choice not to be employed with any organisation that provides assisted dying processes and procedures; or to be employed by an organisation that lawfully elects to be a euthanasia-free service, if that is available, or to know if no such alternative is lawfully available.

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15 *The New Zealand Nursing Workforce* (Wellington, The Nursing Council of New Zealand, 2019) at 38-39 and 52.

[25] Ms Collier says it will be nurses, and palliative care nurses in particular, who will often develop the closest professional relationships with a patient and their wider family and whānau. They are therefore very likely to be the first health practitioner to become aware of a patient's suicidal thoughts and intention and the person to whom a patient is most likely to express his or her wish to exercise the option of receiving assisted dying. Nurses are also often more likely to become aware of any breach of a patient's rights under the Code. For these reasons, Ms Collier says that palliative care nurses have a very strong interest in knowing whether their statutory mandatory obligations to administer lethal medication override their ethical, clinical or professional judgement and their obligations under the Code and the Nursing Council Code of Conduct for Nurses (2012).

ANZSPM

[26] ANZSPM is a not for profit speciality medical society. It is incorporated in Australia. Its members are medical practitioners who either practise or have an interest in palliative medicine. They include palliative medicine specialists, doctors training in the palliative medicine discipline, general practitioners (GPs), and doctors who are specialists in other disciplines such as oncologists, haematologists, intensivists, psychiatrists and geriatricians. ANZSPM currently has 443 members, with 122 of them in New Zealand. Eighty five of those 122 work in a hospice setting.

[27] ANZSPM's objects include advancing the discipline of palliative medicine; providing a voice on policies relating to palliative medicine; promoting, researching and evaluating medical and related issues in palliative medicine; and liaising with other bodies with similar objects. It has been actively involved in debating issues concerning the End of Life Choice Act. It made a submission opposing the End of Life Choice Bill in 2018 opposing it. It also expressed concern that the Bill's drafting presented risks to the community and to medical practitioners. ANZSPM's published position statement opposes euthanasia and physician-assisted suicide as conflicting with the basic ethical principles of medical practice.[16]

[16] Published position statement last updated on 31 March 2017.

[28] ANZSPM has filed an affidavit from Dr Rachel Wiseman. She is a Senior Medical Officer in Respiratory Medicine and Palliative Care at Christchurch Hospital and teaches medical student from time to time. She is Chair of the ANZSPM. She says a majority of patients enrolled in a hospice service would be eligible for assisted dying. She says it is likely that a majority of patients who may seek assisted dying will be receiving specialist palliative care services concurrently in some form. Specialist palliative care services also provide assistance and support to providers of generalist palliative care (which may be anyone providing care to a dying person).

[29] Dr Wiseman says ANZSPM embraces the definition of palliative medicine adopted in Great Britain in 1987:

> Palliative Medicine is the study and management of patients with active, progressive, far-advanced disease for whom the prognosis is limited and the focus of care is the quality of life.

[30] Dr Wiseman says that suicidal ideation, which can be mistaken for a request for euthanasia, is encountered by those practising specialist palliative care. Exploring and understanding the motivations for such a request is a frequent part of this practice.

[31] ANZSPM supports Hospice NZ's application. Dr Wiseman says it is unfair if health practitioners do not have certainty as to the meaning of the Act and could end up facing criminal prosecution for non-compliance. This risk could lead to health practitioners working in palliative care looking for other employment. Dr Wiseman is concerned that funding cuts to hospices that do not provide the option of euthanasia could lead to their collapse.

Others

[32] A number of other organisations were served with the proceedings but did not seek intervener status.[17] Together they comprised all the organisations that represent specialist palliative care providers. This included the New Zealand Medical

[17] The New Zealand Medical Association; the New Zealand Nurses Organisation; the Royal Australian and New Zealand College of Psychiatrists; the Royal Australasian College of Physicians; and the Australia and New Zealand Society for Geriatric Medicine. These organisations, like PCNNZ and ANZSPM, made submissions on the End of Life Choice Bill. The Attorney-General had proposed that these organisations be served. In addition, the proceedings were served on the Māori Medical Practitioners Association, Te Ohu Rata ō Aoteoroa.

Association (NZMA), which requested that its support for the application be conveyed to the Court in the following terms:[18]

> The NZMA agrees that it is critical that the questions outlined by Hospice NZ in the statement of claim are resolved now before the End of Life Choice Act comes into force. It is important that members of the medical profession and other health practitioners and service providers have clarity on these issues and we also agree that the New Zealand public should be fully informed before the referendum.

[33] The parties did not propose that the proceeding be served on any pro-euthanasia organisation.[19]

Jurisdiction

[34] It is not in dispute that the Court has jurisdiction to make the orders sought under the Declaratory Judgments Act 1908.

[35] The Court "may make binding declarations of right, whether consequential relief is or could be claimed or not".[20] Section 3 provides:

> Where any person has done or desires to do any act the validity, legality or effect of which depends on the construction … of any statute …
>
> Where any person claims … to be in any other manner interested in the construction or validity thereof …
>
> such person may apply to the High Court by originating summons for a declaratory order determining any question as to the construction … of such statute … or of any part thereof.

[36] This confers a "very broad right to seek the Court's assistance on construction".[21] A declaration can be sought in anticipation of any act or event.[22]

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18 The Attorney-General had no objection to this being placed before the Court.
19 For example, Voluntary Euthanasia Society of New Zealand (Inc), an organisation represented in *Seales v Attorney-General*, above n 10.
20 Declaratory Judgments Act 1908, s 2.
21 *Royal Forest and Bird Protection Society of New Zealand Inc v Minister of Conservation* [2006] NZAR 265 at [4].
22 Section 9.

Discretion

[37] The Court's jurisdiction to give or make a declaratory order is discretionary.[23] Whether I should exercise my discretion to give declaratory orders is in issue here. The Attorney-General submits the Court should decline to make the declarations sought for five reasons.

[38] First, the Attorney-General submits the Court should be cautious about its role in the constitutionally unique circumstances of the case. He accepts the Court has the function to interpret the law (including to authoritatively construe legislation).[24] In doing so, it gives effect to the will of Parliament. Here, Parliament has not decided whether the End of Life Choice Act should be law. It has divested its final step in law-making to the electorate. The Attorney says that, if the Court issues declaratory relief, it would intrude into the legislative process. Restraint is appropriate.[25]

[39] The Attorney-General submits that, had these proceedings been brought while the End of Life Choice Bill was still before Parliament, the Court would have declined to intervene.[26] He refers to McGechan J in *Turners and Growers Exports Ltd v Moyle*, who said "under no circumstances will a Judge wish to appear to be attempting to influence the course which controversial legislation currently before the House should take".[27] The Attorney submits that, if the Court issues declaratory relief here, it will have the effect of influencing voters. He says this would be improper, in the same way as it would have been if the relief was sought while the Bill was before the House. Put another way, the Attorney submits it is inevitable that the Court's judgment will be used in the political debate on the question of whether the Act should become law.

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23 Section 10.

24 Referring to *Electoral Commission v Tate* [1999] 3 NZLR 174 (CA) at [31]-[31]; *Van Leeuwen Group Ltd v Attorney-General* [2020] NZHC 215 at [23].

25 In support of this submission, the Attorney-General refers to *Attorney-General v Taylor* [2017] NZCA 215, [2017] 3 NZLR 24 at [72]-[74]; *Westco Lagan Ltd v Attorney-General* [2001] 1 NZLR 40 (HC) at [98]; and *Ngāti Whātua Ōrākei Trust v Attorney-General* [2018] NZSC 84, [2019] 1 NZLR 116 at [46].

26 In support of this submission, the Attorney-General refers to *Te Runanga o Wharekauri Rekohu Inc v Attorney-General* [1993] 2 NZLR 301 (CA); *Westco Lagan Ltd v Attorney-General*, above n 25; *Te Ohu Kai Moana Trustee Ltd v Attorney-General* [2016] NZHC 1798, [2016] NZAR 1169; *Ngāti Mutunga O Wharekauri Asset Holding Company Ltd v Attorney-General* [2020] NZCA 2; *Rothmans of Pall Mall (NZ) Ltd v Attorney-General* [1991] 2 NZLR 323 (HC).

27 *Turners and Growers Exports Limited v Moyle* HC Wellington, CP 720/88, 15 December 1988.

[40] Secondly, the Attorney-General submits the Court's role is to interpret law with respect to a particular set of facts and to determine the rights, duties and powers of the particular parties of the case before it. Here, the questions posed are hypothetical and devoid of factual context. They are hypothetical because the End of Life Choice Act is not in force and may never come into force. The relief sought therefore deals only with possible rights or impacts on rights. There are no patients or health practitioners currently engaged in the Act's processes, and their rights or obligations cannot be considered in their factual context.[28]

[41] Thirdly, and related to the second submission, the Attorney-General submits the questions seek an advisory opinion in effect. This is because the declarations are about the effect of the Act "in principle" and the primary dispute is whether declaratory relief is appropriate. The Attorney accepts there does not need to be a dispute or a lis for the Court to issue declaratory relief.[29] However, the absence of an actual dispute is relevant to the Court's discretion. Moreover, Hospice NZ's legal rights and interests are not directly affected by the Court's interpretation of the Act – it is ultimately the rights and obligations of health practitioners and the rights of patients that will be affected. The Attorney submits that, because there is no actual dispute, there is also no proper contradictor – that is, organisations that have the opposite stance on assisted dying to Hospice NZ and the interveners.

[42] Fourthly, the Attorney-General submits that any declarations would not be binding on the persons whose rights, liabilities or obligations are sought to be determined and therefore cannot provide the certainty sought by Hospice NZ.[30] That is because the Court is being asked to consider the liability of individuals not before the Court. The orders would not bind a future court and could be subject to appeal. This means that Hospice NZ's objective of providing certainty to the public before the

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[28] The Attorney-General refers to *Gazley v Attorney-General* (1994) 8 PRNZ 313 (CA) at 315 as illustrative of the Court's reluctance to investigate broad questions that require a full review of all hypothetical scenarios.

[29] As was held in *Mandic v Cornwall Park Trust Board* [2011] NZSC 135, [2012] 2 NZLR 194 at [9].

[30] The Attorney-General refers to s 4 of the Declaratory Judgments Act 1908 which provides: Any declaration so made on any such originating summons shall have the same effect as the like declaration in a judgment in an action, and shall be binding on the person making the application and on all persons on whom the summons has been served, and on all other persons who have been bound by the said declaration if the proceedings wherein the declaration is made had been in action.

referendum cannot be achieved. The Court's judgment would be no more than an informational tool to guide voters because it cannot be authoritative.

[43] Fifthly, the Attorney-General submits any declarations risk prejudicing future criminal proceedings. He refers to the well-established principle that the Court should be cautious when declarations relate to matters that may be the subject of criminal proceedings.[31] Although declaratory relief was provided in *Auckland Area Health Board v Attorney-General*, that was in relation to a specific case and the Court said the jurisdiction was "to be sparingly exercised and with the greatest of care".[32]

[44] On the first point, I accept the submissions of Hospice NZ and ANZSPM that the declaratory relief that is sought does not intrude upon the legislative process. The principle of restraint and comity applies to the processes of Parliament but, in relation to the End of Life Choice Act, its processes are at an end.[33] The Court is being asked to state the meaning of the Act in relation to issues that the parties say are causing public confusion. These parties are in a position to know whether that is the case. They are concerned that published referendum material be accurate. The Court's determination is intended to inform the public of what the Act means as a matter of law on the matters where confusion has arisen. It does not involve the Court expressing a political opinion. As it was put in *Electoral Commission v Tate* "[m]uch legislation has a 'political' content and, indeed, may be 'politically' controversial".[34] The Court's constitutional role is to interpret legislation in cases that come before it.

[45] On the second and third points, Hospice NZ submits that they are purely questions of statutory interpretation on factual situations that are straightforward and clear. On the fourth and fifth points, Hospice NZ submits declaratory relief will provide binding authority on the Act, unless and until it is overturned by higher authority. This is an ordinary feature of *stare decisis* and the common law. Hospice NZ says the declarations will be binding on the parties to whom the proceedings were served as well as the members and practitioners represented by Hospice NZ. It submits

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31 For example, *Ambrose v Attorney-General* [2012] NZAR 23 (HC) at [36]; *Shark Experience Ltd v PauaMAC5 Inc* [2019] NZSC 111 at [111], [2019] 1 NZLR 791.

32 *Auckland Area Health Board v Attorney-General* [1993] 1 NZLR 235 (HC) at 243. See also at 244 to the effect that declarations in civil proceedings are not binding in criminal proceedings.

33 The Parliamentary Privilege Act 2014 does not apply. The Attorney-General accepts this.

34 *Electoral Commission v Tate*, above n 24, at [34].

the courts' caution towards providing declarations in the context of potential criminal prosecution arises where there is a genuine risk of interfering with an actual prosecution. This occurs where the declaration will pre-empt, on mixed law and fact questions, whether particular conduct falls within an offence provision. Hospice NZ submits this is not the case here.

[46] I am satisfied that I should at least consider whether the questions that are raised for declaratory relief give rise to statutory interpretation questions that the Court can properly answer on clear and straightforward facts that are not context dependent. If the Court can do so, it should. The proceeding has been brought by a party with a genuine and substantial interest in the interpretation issues. It is supported by others with genuine and substantial interests in them. The importance of the subject, and the constitutionally unique process for deciding whether the End of Life Choice Act will come into force, supports this.

[47] I acknowledge that organisations with views on euthanasia that are different from Hospice NZ and the interveners are not represented before me. However, the Court is being asked to interpret legislation, not to give a view on whether the Act should come into force or whether it complies with the rights affirmed by the New Zealand Bill of Rights Act 1990 (NZBORA).[35] I will keep in mind whether I have all the relevant information and arguments before me when considering the questions Hospice NZ has raised.

The legislative framework

Background

[48] There have been previous, unsuccessful, attempts to legalise voluntary euthanasia.[36] The issue was given new focus in 2015 when Lecretia Seales, a 42 year

[35] The Attorney-General gave a s 7 report to the House finding that the Act complied with NZBORA, with the exception that those aged 16 and 17 years old were excluded from eligibility: Hon Christopher Finlayson *Report of the Attorney-General under the New Zealand Bill of Rights Act 1990 on the End of Life Choice Bill* (August 2017).

[36] 1995: leave sought to introduce the Death with Dignity Bill was not granted (61 votes to 29); 2003: a Death with Dignity Bill was drawn from the ballot but was rejected at its first reading (60 votes to 58); 2012: and End of Life Choice Bill was included in the ballot but was later withdrawn by Hon Maryan Street, the Bill's promoter, because of the then upcoming general election.

old lawyer who was dying from an inoperable brain tumour, brought a proceeding in the High Court. Ms Seales wanted to have the option of determining when she died. To do that, she wanted her doctor to be able to either administer to her, or provide her with, medication to enable her to end her life by herself. Her doctor was willing to take either of these steps providing she could be assured that she would be acting lawfully if she did so.

[49] Ms Seales sought declarations concerning the meaning of provisions in the Crimes Act 1961 to determine whether these steps would be lawful. The High Court determined that Ms Seales' doctor would be exposed to prosecution under the Crimes Act if she supplied Ms Seales with medication with the intention that Ms Seales would use it to take her own life and Ms Seales did so.[37] The Court further determined that, if Ms Seales' doctor were to administer medication to Ms Seales with the intention of terminating her life, she would probably commit offences under the Crimes Act.[38]

[50] In the alternative, Ms Seales sought declarations that the offence provisions of the Crimes Act were not consistent with two rights guaranteed by NZBORA: the "right not to be deprived of life" (s 8); and the "right not to be subjected … to cruel, degrading, or disproportionately severe treatment" (s 9). The Court concluded that the Crimes Act provisions were consistent with the NZBORA with the Judge commenting:[39]

> The complex legal, philosophical, moral and clinical issues raised by Ms Seales' proceeding can only be addressed by Parliament passing legislation to amend the effect of the Crimes Act. …

[51] On 23 June 2015, just a few weeks after the Court's decision in *Seales*, the petition of the Hon Maryan Street was presented by Ian Lees-Galloway, Member of Parliament, and referred to the Health Committee.[40] The petition requested that the House of Representatives investigate public attitudes towards the introduction of legislation that would permit medically-assisted dying in the event of a terminal illness

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37 *Seales v Attorney-General*, above n 10; Crimes Act 1961, s 179 (aiding and abetting suicide).

38 Crimes Act, s 196 (assault), and s 200 (administering a substance intending to cause grievous bodily harm), which would be unlawful acts in the context of culpable homicide under s 160(2)(a).

39 *Seales v Attorney-General*, above n 10, at [211].

40 Two earlier petitions in 2002 were taken in opposition to voluntary euthanasia: Petition 2002/53 and Petition 2002/50.

or an irreversible condition that made life unbearable. The Health Committee began oral hearings on the petition in August 2016. A total of 21,891 written submissions were received. The Health Committee's report was presented on 2 August 2017. It made no recommendations about introducing assisted dying legislation.

[52] David Seymour, Member of Parliament for Epsom, introduced the End of Life Choice Bill as a private member's bill on 8 June 2017.[41] The Explanatory Note referred to the *Seales* case as having promoted nationwide debate around assisted dying. The Bill, as introduced, had the same basic scheme as it does now, involving a request to the attending medical practitioner, an independent medical practitioner, and a third opinion on the competence of the person making the request if necessary. The Explanatory Note stated: "No person is obligated to take a role under the Bill, although medical practitioners who conscientiously object must refer people to the SCENZ Group".[42] The Bill had its first reading on 13 December 2017.

[53] The Justice Select Committee reported its findings on the Bill to the House on 9 April 2019. It had received and considered 39,159 submissions from interested groups and individuals and heard oral evidence from 1,350 submitters. Roughly 90 per cent of submitters opposed the Bill. The Committee said it was "unable to agree that the bill be passed". It said:

> This bill is expected to result in conscience votes by members in the House. In previous situations where a bill was expected to result in conscience votes, committees have recommended amendments that left the policy content of the bill largely intact, while trying to ensure that the bill was a coherent and workable piece of legislation – particularly regarding consequential amendments and amendments to related legislation.
>
> The eight members of this committee hold diverse views. We decided to report the bill back with minor, technical, and consequential amendments only. We leave it the full membership of the House to resolve the broader policy matters.

[54] One of the recommended changes was made to the provision for civil and criminal immunity provisions. At its first reading, there was a combined provision which provided: "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

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41 It being drawn from the ballot on this day.
42 The SCENZ is discussed later.

to provide assisted dying". This was replaced with two sections, one for criminal liability immunity and the other for civil liability immunity. The recommended new civil liability provision is essentially that which is now in the End of Life Choice Act.[43] It was intended to make it clear that the immunity did not extend to disciplinary proceedings or proceedings for breach of the Code.[44] The Committee also recommended that "services" under the Code would include the provision of assisted dying under the End of Life Choice Act.

[55] The Bill had its second reading on 26 June 2019. Between the second reading and the consideration of the Bill by the Committee of the whole House on 23 October 2019, a considerable number of Supplementary Order Papers (SOPs) were tabled.

[56] This included amendments proposed by Mr Seymour. These amendments were prepared by the Parliamentary Counsel Office with assistance from the Ministry of Justice, the Ministry of Health and in consultation with external experts, including legal counsel who had acted for Ms Seales.[45] They included more detailed criteria for assessing the competence of a person wishing to exercise the option of assisted dying; "a broader conscientious objection provision … that applies to all health practitioners";[46] an amendment to the Health and Disability Commissioner Act 1994 to include assisted dying services as a health service to ensure "that persons providing assisted dying services who are not health practitioners are also subject to the duties in the Code …"; and what became the proposed new clause 5A of the Code (discussed below) "to set out how the Code operates with the Bill".[47]

[57] Melissa Lee tabled an SOP proposing to replace the definition of "attending medical practitioner" so that it would mean a medical practitioner who had personally

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43 Sections 36 and 37.

44 The change to the civil immunity provision to clarify that proceedings for breach of the Code could still be brought followed a recommendation that the scope of this provision be clarified: Departmental Report on the End of Life Choice Bill (Ministry of Health and Ministry of Justice, December 2018) at 72-73.

45 (21 August 2019) NZPD (End of Life Choice Bill – In Committee – Part 2).

46 The Bill as introduced had provided: "This Act does not require a person to do anything to which the person has a conscientious objection" and this applied despite any other legal obligation but did not apply to the requirement to tell the person requesting assisted dying of their conscientious objection and that the person can ask the SCENZ Group for the name of a replacement medical practitioner.

47 Supplementary Order Paper 2019 (259) End of Life Choice Bill (269-2).

attended the person in a professional capacity for a period of not less than six months, or on at least three occasions, provided these attendances had taken place at intervals not less than one month apart.[48] This SOP was rejected.[49] However, on the topic of the experience and qualifications of medical practitioners, Mr Seymour said:[50]

> … the fact is that medical practitioners are required to be qualified and they are required not to practice outside their scope of practice. So you will not find doctors in New Zealand doing things that they are not able and qualified to do. If they were, there would be a much bigger problem in New Zealand than simply with this bill.

[58] Hon Michael Woodhouse tabled an SOP that would have allowed an organisation to exercise a conscientious objection right.[51] It would have applied to an organisation providing health and disability services, aged residential care services, long term hospital care, dementia care, services for persons with physical or intellectual disabilities, palliative care, hospice care, or any other service that might bring the organisation into contact with a person who wishes to exercise the option of assisted dying.

[59] The SOP would have provided that an organisation could promote itself as having a conscientious objection to providing assisted dying; an organisation would be permitted to include in its employment and other agreements that employees, and health practitioners and volunteers with admission or access rights, were bound by the organisation's prohibition on assisted dying; and public funders would be prohibited from denying funding to an organisation because it had a conscientious objection to providing assisted dying services, or offering funding on the condition it provide such services.

[60] Several Members of Parliament spoke in favour of this SOP. This included the Minister of Health. They made the point that the amendment was consistent with Mr Seymour's intention that no-one should be required to do anything they did not want to do, while still providing the option of assisted dying services from

48 Supplementary Order Paper 2019 (269) End of Life Choice Bill (269-2).
49 It was regarded as inconsistent with the decision already reached on Mr Seymour's SOP.
50 Hansard, above n 45.
51 Supplementary Order Paper 2019 (295) End of Life Choice Bill (269-2).

organisations prepared to offer them. However, the proposed amendments in this SOP were rejected.

[61] Mr Seymour said that conscientious objection "has always been a cornerstone of this bill". In speaking against the Hon Michael Woodhouse's SOP, he said:[52]

> Let me just say that again: nowhere in this bill is any institution required to do anything. I don't see where the logic is in being able to object conscientiously to do something that an institution isn't required to do in the first place. That may be why it is that, in every jurisdiction that's legalised assisted dying, opponents have brought up the possibility of such a provision but, in Canada and in both States of Australia so far, it has been rejected.

[62] The Bill passed at its third reading on 13 November 2019. It received Royal Assent on 16 November 2019.

The Act

[63] The Act establishes a lawful process by which persons may request and receive medical assistance to end their life. The purpose of the Act is expressed as follows:

> **3 Purpose of Act**
>
> The purpose of this Act is—
>
> (a) to give persons who have a terminal illness and who meet certain criteria the option of lawfully requesting medical assistance to end their lives; and
>
> (b) to establish a lawful process for assisting eligible persons who exercise that option.

[64] The medical assistance provided is ultimately through the administration of medication to hasten the person's death. The Act uses the term "assisted dying" which is defined in this way:

> ***assisted dying***, in relation to a person, means—
>
> (a) the administration by an attending medical practitioner or an attending nurse practitioner of medication to the person to relieve the person's suffering by hastening death; or

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52 Hansard, above n 45. Mr Seymour was also of the view that the provision about funding would have made it impossible for there to be a contract between a DHB and an organisation for assisted dying.

(b) the self-administration by the person of medication to relieve their suffering by hastening death

[65] To request and receive this medical assistance, a person must be "eligible". The Act defines eligibility in terms of age, New Zealand citizenship or residence, the nature and stage of an illness and the associated suffering, and competence. This is set out in s 5 which provides:

> **5 Meaning of person who is eligible for assisted dying or eligible person**
>
> (1) In this Act, ***person who is eligible for assisted dying*** or ***eligible person*** means a person who—
>
> (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 a terminal illness that is likely to end the person's life within 6 months; and
>
> (d) is in an advanced state of irreversible decline in physical capability; and
>
> (e) experiences unbearable suffering that cannot be relieved in a manner that the person considers tolerable; and
>
> (f) is competent to make an informed decision about assisted dying.
>
> (2) A person is not a person who is eligible for assisted dying or an eligible person by reason only that the person—
>
> (a) is suffering from any form of mental disorder or mental illness; or
>
> (b) has a disability of any kind; or
>
> (c) is of advanced age.

[66] The s 5(1)(f) requirement to be "competent to make an informed decision about assisted dying" is then defined in s 6 as follows:

> **6 Meaning of competent to make an informed decision about assisted dying**

> In this Act, a person is **competent to make an informed decision about assisted dying** if the person is able to—
>
> (a) understand information about the nature of assisted dying that is relevant to the decision; and
>
> (b) retain that information to the extent necessary to make the decision; and
>
> (c) use or weigh that information as part of the process of making the decision; and
>
> (d) communicate the decision in some way.

[67] The process by which a person will receive assisted dying under the Act involves the following steps:[53]

(a) the person makes a request (s 11);

(b) the person confirms the request (s 12);

(c) the "attending medical practitioner" gives a first opinion as to eligibility (s 13);

(d) an independent medical practitioner gives a second opinion as to eligibility (s 14);

(e) if competence is not established to the satisfaction of one or both medical practitioners, a psychiatrist gives a third opinion on the person's competence (s 15);

(f) if, through this process, the opinion is reached that a person is eligible for assisted dying, the attending medical practitioner must discuss and provide advice on certain matters (s 17);

(g) the person completes a form in which they choose the date and time for the administration of medication and the attending medical practitioner sends the form to the Registrar (s 18);

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53 The provisions that prescribe this process are set out in Appendix I to this judgment.

(h) before the date chosen by the person, the attending medical practitioner or an "attending nurse practitioner" writes a prescription for the medication and informs the Registrar (s 19);

(i) the Registrar advises the attending medical practitioner whether the processes in ss 11 to 18 have been complied with (s 19);

(j) at the time chosen by the person, the attending medical practitioner, or the attending nurse practitioner, asks the person whether or not they choose to proceed (s 20);

(k) if the person chooses to proceed, the attending medical practitioner, or the attending nurse practitioner, must provide the medication to the person (s 20); and

(l) the attending medical or nurse practitioner who provided the medication must report to the Registrar the details of the person's death (s 21).

[68] The process therefore starts with a "request" from a person. A discussion about assisted dying cannot be initiated by a health practitioner who provides any health service to a person, and nor may they make any suggestion to the person that they exercise the option of receiving assisted dying.[54] A health practitioner who breaches this prohibition does not commit an offence but may be found to have acted in breach of the Code and may be the subject of disciplinary proceedings.[55]

[69] At each stage of the process – making the request, determining whether the person is eligible (s 17), provisional arrangements for administration of medication (s 19), and administering the medication (s 20) – the person is told by the practitioner that they can decide not to have the medication. A person can rescind their request at

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54 Section 10. The term "health service" has the meaning given to it by s 5(1) of the Health Practitioners Competence Assurance Act 2003.

55 For professional misconduct under the Health Practitioners Competence Assurance Act 2003.

any time.[56] Further, if a person is determined not to be eligible, the reasons for this must be explained to the person.[57]

[70] In addition to the option of rescinding a request or a finding of ineligibility, the process is terminated if improper pressure is suspected on reasonable grounds. This is set out in s 24 as follows:

> **24 No further action to be taken if pressure suspected**
>
> If, at any time, the attending medical practitioner or attending nurse practitioner suspects on reasonable grounds that a person who has expressed the wish to exercise the option of receiving assisted dying is not expressing their wish free from pressure from any other person, the medical practitioner or nurse practitioner must—
>
> (a) take no further action under this Act to assist the person in exercising the option of receiving assisted dying; and
>
> (b) tell the person that they are taking no further action under this Act to assist the person in exercising the option of receiving assisted dying; and
>
> (c) complete an approved form recording—
>
> (i) that they are taking no further action under this Act to assist the person in exercising the option of receiving assisted dying; and
>
> (ii) the actions taken to comply with paragraph (b); and
>
> (d) send the form completed under paragraph (c) to the Registrar.

[71] The primary obligations under the process provided by the Act fall on the "attending medical practitioner". This, "in relation to a person, means the person's medical practitioner".[58] Medical practitioner is, in turn, defined as a person who is registered as "a practitioner of the profession of medicine" and holds a current medical certificate.[59] In other words, it refers to a doctor. The definition does not require the doctor to have any particular specialty within medicine, nor any minimum period of practice experience, generally or with the patient.

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56 Section 23.
57 Section 16.
58 Section 4.
59 Section 4.

[72] This doctor must have the discussion and provide the advice at the request stage (s 11); must be involved in completing the approved form (s 12); must form an opinion on the person's eligibility (s 13); must have the discussion and provide further advice after the process involving the independent doctor (and potentially a psychiatrist) (s 17); must be involved in completing the approved form and sending it to the Registrar (ss 17 and 18); and must provide further advice and make provisional arrangements for the medicine to be administered at the chosen time (s 19). The doctor may also be involved in administering the medicine (s 20) and reporting the death (s 21), although this may also be carried out by a nurse under instruction of the attending medical practitioner, providing the nurse has a current practising certificate and the assistance is within the nurse's scope of practice.[60] As will be discussed in more detail later, each of these steps required of the attending medical practitioner is expressed in terms of "must".

[73] These mandatory obligations are subject to a right to conscientiously object to providing the assistance required by the Act. This right is in these terms:

> **8 Conscientious objection**
>
> (1) A health practitioner is not under any obligation to assist any person who wishes to exercise the option of receiving assisted dying under this Act if the health practitioner has a conscientious objection to providing that assistance to the person.
>
> (2) Subsection (1)—
>
> (a) applies despite any legal obligation to which the health practitioner is subject, regardless of how the legal obligation arises; but
>
> (b) does not apply to the obligation in section 9(2).
>
> (3) An employer must not—
>
> (a) deny to an employee any employment, accommodation, goods, service, right, title, privilege, or benefit merely because the employee objects on the grounds of conscience to providing any assistance referred to in subsection (1); or
>
> (b) provide or grant to an employee any employment, accommodation, goods, service, right, title, privilege, or benefit conditional upon the employee providing or agreeing to provide any assistance referred to in subsection (1).

[60] See the definitions of "attending nurse practitioner" and "nurse practitioner" in s 4.

(4) A person who suffers any loss by reason of any breach of subsection (3) is entitled to recover damages from the person responsible for that breach.

(5) In subsection (3), ***employee*** includes a prospective employee.

[74] Conscientious objection is defined as meaning "an objection on the grounds of conscience".[61] What could constitute such an objection is an issue in this proceeding and is discussed below.[62]

[75] Section 8 applies to a "health practitioner".[63] This means it applies to any of the personnel on whom obligations to provide assistance are imposed under the Act. If a conscientious objection is exercised, the only obligation on the attending medical practitioner is to tell the person of their conscientious objection and of their right to ask the SCENZ Group for the name and contact details of a replacement medical practitioner.[64] The SCENZ Group is a body set up by the Act which is required, amongst other things, to make and maintain a list of practitioners willing to provide the assistance set out in the Act.[65]

[76] The ability to conscientiously object is reinforced by s 8(3)-(5). Section 8(3) prohibits an employer from disadvantaging an employee because they conscientiously object to providing the assistance provided for in the Act. Section 8(4) enables an employee to recover damages if an employer breaches this prohibition and s 8(5) extends the prohibition in s 8(3) to prospective employees. Notably, the Act does not provide that an employer may choose to employ only employees who are opposed to assisted dying and will exercise a conscientious objection if asked to assist. Nor does it provide that an employer can prohibit an employee from carrying out the tasks that would otherwise be required of the employee under the Act.

[77] Immunity from criminal liability is provided to health practitioners acting in accordance with the Act.[66] Immunity from civil liability is provided in these terms:

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61 Section 4.
62 See Questions 3 to 5 below.
63 Section 4 defines a health practitioner as having the meaning given to it in s 5(1) the Health Practitioners Competence Assurance Act 2003, which is "a person who is, or is deemed to be, registered with an authority as a practitioner of a particular health profession".
64 Section 9.
65 Section 25.
66 Section 37.

38 Immunity from civil liability

(1) A person (**A**) is immune from civil liability if A, in good faith and believing on reasonable grounds that another person (**B**) wishes to exercise the option of assisted dying,—

(a) takes any action that assists or facilitates the death of B in accordance with the requirements of this Act; or

(b) fails to take any action and that failure assists or facilitates the death of B in accordance with the requirements of this Act.

(2) Nothing in this section affects the right of any person to—

(a) bring disciplinary proceedings against a health practitioner under the Health Practitioners Competence Assurance Act 2003; or

(b) bring proceedings under section 50 or 51 of the Health and Disability Commissioner Act 1994; or

(c) apply for judicial review.

[78] Conversely, it is an offence to wilfully fail to comply with the Act or to take unauthorised actions in relation to the approved form prescribed by the Act:

39 Offences

(1) A person who is a medical practitioner, nurse practitioner, or psychiatrist commits an offence if the medical practitioner, nurse practitioner, or psychiatrist wilfully fails to comply with any requirement of this Act.

(2) A person commits an offence if the person, without lawful excuse,—

(a) completes or partially completes an approved form for any other person without that other person's consent; or

(b) alters or destroys a completed or partially completed approved form without the consent of the person who completed or partially completed the form.

(3) A person who commits an offence under this section is liable on conviction to either or both of the following:

(a) imprisonment for a term not exceeding 3 months:

(b) a fine not exceeding $10,000.

[79] The Act provides for an end-of-life review committee. It considers the reports required to be forwarded to the Registrar when a person has died pursuant to the Act's

process.[67] The Ministry of Health is required to review the Act and consider whether any amendments are necessary or desirable within three years of the Act commencing, and then at subsequent intervals of not more than five years. The Ministry provides its findings to the Minister of Health and the Minister must present the report to the House of Representatives.[68]

The Code

[80] One of the issues in this case is how the obligations on practitioners under the End of Life Choice Act fit with the Code.[69] The Code was established under the Health and Disability Commissioner Act 1994, which authorised regulations to be made prescribing a code of health and disability services consumers' rights.[70]

[81] The Code provides that:[71]

(a) every health consumer has the rights in the Code;

(b) every provider is subject to the Code; and

(c) every provider must take action to inform health consumers of their rights and enable them to exercise their rights.

[82] The rights of consumers and duties of providers set out in the Code are:[72]

(a) Right 1: the right to be treated with respect;

(b) Right 2: the right to freedom from discrimination, coercion, harassment and exploitation;

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67 Section 26.
68 Section 30.
69 The Code is set out in the Schedule to the Health and Disability Commissioner (Code of Health and Disability Services Consumers' Rights) Regulations 1996.
70 Section 74(1). The Code has "a pivotal role in many areas of New Zealand health law": Ron Paterson and Peter Skegg *Health Law in New Zealand* (Thomson Reuters, 2015) at 2.1.
71 Health and Disability Commissioner (Code of Health and Disability Services Consumers' Rights) Regulations 1996, Schedule, cl 1.
72 Rights 4, 6 and 7 are set out fully in Appendix II to this judgment.

(c) Right 3: the right to dignity and independence;

(d) Right 4: the right to services of an appropriate standard;

(e) Right 5: the right to effective communication;

(f) Right 6: the right to be fully informed;

(g) Right 7: the right to make an informed choice and give informed consent;

(h) Right 8: the right to support;

(i) Right 9: rights concerning teaching or research; and

(j) Right 10: the right to complain.

[83] Clause 5 of the Code provides that nothing in it "requires a provider to act in breach of any duty or obligation imposed by any enactment or prevents a provider from doing an act authorised by an enactment". The End of Life Choice Act, if it comes into force, will amend the Code to provide:[73]

> **5A End of Life Choice Act 2019**
>
> (1) This clause sets out how this Code operates with the End of Life Choice Act 2019 (the *EOLC Act*).
>
> (2) For Right 4(2) of this Code, contravening section 10(1) of the EOLC Act may be found or held to be providing services that do not comply with relevant legal standards.
>
> (3) Right 6(1)(b) and (c), and (2) of this Code is overridden by section 10 (assisted dying must not be initiated by health practitioner) of the EOLC Act.
>
> (4) Right 7(2) to (5) of this Code is overridden by section 6 (meaning of competent to make an informed decision about assisted dying) of the EOLC Act.
>
> (5) Under clause 5 of this Code (and without limiting that clause), nothing in this Code requires a provider to act in breach of any duty or

73 End of Life Choice Act 2019, s 41 and Schedule.

> obligation imposed by the EOLC Act or prevents a provider from doing an act authorised by the EOLC Act.

[84] Amongst other things, the Health and Disability Commissioner Act establishes the Health and Disability Commissioner to whom complaints can be made where action by a provider appears to be in breach of the Code. Complaints can lead to proceedings before the Human Rights Tribunal and, if a breach of the Code is made out, damages, declarations or other orders may be made.

Other health law regulation

[85] The provision of healthcare is regulated by other healthcare statutes and subordinate legislation. This includes the New Zealand Public Health and Disability Act 2000 which provides the legislative framework for the public funding of healthcare and provision of publicly funded health services. This Act sets out the objectives of the publicly funded health system. They include improving, promoting and protecting the health of New Zealanders and providing appropriate, effective and timely services.[74] The objectives are to be pursued to the extent that they are reasonably achievable within the funding provided.[75]

[86] Health professionals in New Zealand are regulated by the Health Practitioners Competence Assurance Act 2003. This provides for the registration of "health practitioners" within a scope of practice set by the relevant professional body. It provides mechanisms for ensuring ongoing competence and fitness to practise. The relevant professional bodies for health practitioners may issue practice standards and codes of conduct.

[87] For example, the Medical Council has issued a "*Good Medical Practice*" document as the foundation document for its standards.[76] It has also published a statement that sets standards on informed consent.[77] The Nursing Council has published practice standards for nurses as well as a Code of Conduct. Other organisations also provide guidance to practitioners. For example, the New Zealand

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[74] Section 3(1).
[75] Section 3(2).
[76] *Good Medical Practice* (Medical Council of New Zealand, December 2016).
[77] *Informed Consent: Helping patients make informed decisions about care* (Medical Council of New Zealand, September 2019).

Medical Association (NZMA) has published a Code of Ethics for the medical profession and the New Zealand Nurses Organisation has published a Code of Ethics.

[88] The Health Practitioners Competence Assurance Act also provides an accountability regime under which all complaints about patient care are forwarded to the Health and Disability Commissioner.[78] It provides for the appointment of professional conduct committees to investigate matters raising questions about the appropriateness of the conduct or the safety of the practice of a health practitioner.[79] The Act also creates the Health Practitioners Disciplinary Tribunal, which hears and determines charges brought against practitioners.[80]

Question 1

The declaration sought

[89] The first question on which a declaration is sought is:

> Question 1: A declaration that, if the End of Life Choice Act 2019 comes into force, either:
>
> A it will be lawful for an organisation such as a hospice to conscientiously object on valid grounds to Assisted Dying and to operate a 'euthanasia-free' service, explicitly promising patients and their families and whānau that it will not provide any of the services set out in the Act, without exposing their practitioners to criminal prosecution; or
>
> B it will be unlawful for an organisation such as a hospice to conscientiously object on valid grounds to Assisted Dying and to operate a 'euthanasia-free' service, explicitly promising patients and their families and whānau that it not provide any of the services set out in the Act, and / or organisations that do so will thereby expose their practitioners to criminal prosecution.

Hospice NZ's submissions

[90] Hospice NZ submits the answer to Question 1 is unclear. Its preferred answer is A. However, it is clarity that it seeks, one way or the other. Hospices wish to understand their legal obligations under the Act and the scope of the conscientious objection rights, should the Act come into force. It is important to them and the wider

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78 Health Practitioners Competence Assurance Act 2003, s 64(1).
79 Sections 67-68 and 71-83.
80 Sections 84-90.

health practitioner community to have clarity on this. Hospice NZ also says there is confusion in the community about these matters and it is important that electors vote on the basis of a correct understanding of what they are voting for.

[91] Hospice NZ discusses whether an organisation can have a right of conscience in principle. It refers to s 13 of NZBORA which affirms that "everyone has the right to freedom of thought, conscience, religion and belief". It submits the right to freedom of conscience brings with it the right to conscientious objection.[81] Section 29 of NZBORA provides that, so far as practicable, the affirmed rights apply "for the benefit of all legal persons as well as for the benefit of all natural persons". Hospice NZ says that some organisations hold core values on matters of conscience, religion and belief. Hospice NZ and its members do so and the evidence from Ms Schumacher confirms this.[82]

[92] Hospice NZ submits hospices wishing to provide a "euthanasia-free" service cannot achieve this by employing or engaging only health practitioners who hold a conscientious objection to assisted dying in all circumstances. It says this would limit the pool of available health practitioners to the potential detriment of the organisation's ability to deliver its service. It would also be discriminatory, in breach of the Employment Relations Act 2000 and the Human Rights Act 1993.[83] Yet, as Dr Donnelly put it in her affidavit filed in *Seales*, "placing the option of euthanasia

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81 Hospice NZ refers to the following authority: The UN Human Rights Committee in General Comment No 22 (1993) noted that while the Covenant does not explicitly refer to a right to conscientious objection, such a right can be derived from art 18 (equivalent to s 13 NZBORA). More recently the UNHRC decision in *Yoon v Republic of Korea* confirmed that a right of conscientious objection derives from art 18: *Yoon v Republic of Korea* CCPR/88/1321-1322/2004 (3 November 2006) at [8.3]–[8.4]. The New Zealand Court of Appeal in *Refugee and Protection Officer v CV and CW* also observed recent decisions of the UN Human Rights Committee have held that the right to conscientious objection is "inherent" in art 18: *Refugee and Protection Officer v CV and CW* [2016] NZCA 520, [2017] 2 NZLR 585 at [91]. Similar statements appear in the European Courts, as discussed, for example, in *Bayatyan v Armenia* [2011] ECHR 1095, (2012) 54 EHRR 15 at [100] (right of conscientious objection implicit to right to freedom of conscience under art 9(1) of the European Convention on Human Rights where there is a "conviction or belief of sufficient cogency, seriousness, cohesion and importance to attract the guarantees of Article 9").

82 Hospice NZ refers to Butler & Butler *The New Zealand Bill of Rights Act: A Commentary* (2nd ed: LexisNexis, 2015) at 150-151 which suggests that some organisations, such as churches and other religious associations, will be motivated by certain beliefs.

83 Employment Relations Act 2000, ss 104 and 105; the Human Rights Act 1993, s 22.

and physician assisted suicide on the table would profoundly undermine the palliative care that we deliver”.[84]

[93] If hospices sought to stipulate to health practitioners it employs or engages that assisted dying is excluded from the services that can be provided while so employed or engaged, Hospice NZ is concerned that this could conflict with the mandatory obligations on practitioners under the End of Life Choice Act. For example, a medical practitioner attending a person in a hospice may be “the attending medical practitioner” to whom a request is made under s 11. Section 11 would then require the medical practitioner to take the actions stipulated in that section, unless the medical practitioner has a conscientious objection, which they may not have.

[94] Hospice NZ submits that s 8 of the End of Life Choice Act must be given a broad interpretation to enable hospices to exercise their protected right of freedom of conscience.[85] It submits s 8 should be read so that protection from criminal prosecution extends to health practitioners who are unable to comply with the Act because they are providing services for an organisation that is exercising its right of conscientious objection. It submits it would not be contrary to the meaning of s 8 if it is interpreted as applying to collective groups of practitioners who, by their status of practising as part of that collective, are party to the exercise of the conscientious objection by the collective.[86]

[95] Hospice NZ submits this interpretation is consistent with Mr Seymour’s opposition in the House to the Hon Michael Woodhouse’s SOP.[87] This would have addressed the issue of conscientious objection rights for institutions. Mr Seymour’s view was that the proposed amendment was unnecessary given the terms of s 8.

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84 Dr Donnelly is a Wellington physician specialising in palliative medicine. Her affidavit was included in the materials before the Court by consent.

85 New Zealand Bill of Rights Act, s 6; *R v Hansen* [2007] NZSC 7, [2007] 3 NZLR 1; and *New Health New Zealand Inc v South Taranaki District Council* [2018] NZSC 59, [2018] 1 NZLR 948 at [103].

86 Hospice NZ also puts it another way. It says s 8 can be read to cover health practitioners who refuse to progress a request for assisted dying on the basis that they personally consider it right to comply with the care ethos of their employing or contracting organisation, in accordance with the agreement they made in accepting work with that organisation. Put this way, it is not a question of the organisation’s right to conscientiously object, but whether an objection by an individual health practitioner on this ground is within the scope of s 8. What can constitute a conscientious objection is discussed later.

87 Discussed above at [58]-[61].

The Attorney-General's submissions

[96] The Attorney-General submits Question 1 raises two issues:

(a) Can an organisation such as a hospice conscientiously object to providing assisted dying and operate a "euthanasia-free" service?

(b) If it does so, does this expose the health practitioners that work at such an organisation to criminal prosecution?

[97] The Attorney-General submits there is no uncertainty on this point. Organisations have no obligation under the End of Life Choice Act to provide assisted dying services and therefore no need for a right to conscientiously object. The Act's provisions concern individuals only – the rights of the person seeking assisted dying services, and the role of health practitioners who may be involved in the process. It is only medical practitioners, nurse practitioners or psychiatrists who are exposed to potential criminal liability.[88] Parliament has provided a right to conscientiously object only for those who have obligations under the Act and whose conscience may be engaged.

[98] The Attorney-General submits this is made clear from the consideration and rejection of the SOP proposed by the Hon Michael Woodhouse. He submits Hospice NZ's proposed interpretation would run counter to Parliament's intent to confine s 8 to those on whom obligations are placed.

[99] The Attorney-General also submits Hospice NZ's submission is not reasonably possible on the words of s 8.[89] That section applies to a "health practitioner" which is defined as "a person who is, or is deemed to be, registered with an authority as a practitioner of a particular health profession".[90] The Attorney submits this cannot sensibly refer to anything other than an individual natural person. He submits it is not

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88 The SCENZ Group is to make and maintain a list of pharmacists "who are willing" to dispense medication under s 20.

89 See NZBORA, s 6.

90 End of Life Choice Act, s 4; Health Practitioners Competence Assurance Act 2003, s 5(1).

necessary to do violence to the words of s 8 because a hospice or any other organisation will remain free to adopt a euthanasia-free service.

[100] The Attorney-General submits the second part of Question 2 is fact-dependent and cannot be answered in the abstract on this application for declaratory orders. It is not known, for example, whether the person requesting the services will be in a hospice facility or at home; whether the person has one or more attending medical practitioners; whether the health practitioners engaged will have a conscientious objection; what the terms of employment or engagement will provide about providing assisted dying services should a hospice patient request it; whether the health practitioner is engaged in full or part-time work for the hospice; and what, if any, practical impediments there are to health practitioners performing their obligations under the Act through putting in place arrangements separate from the palliative care services they provide for the hospice.

[101] The Attorney-General submits it will be a matter for the organisation how it goes about operating a euthanasia-free service. However, it would not be able to decline someone employment on the basis that they held different beliefs to the organisation about assisted dying. Nor could it guarantee a euthanasia-free service merely because the organisation opposes assisted dying. A health practitioner would not be able to exercise a conscientious objection because their employer directed. A hospice could regulate its services and provide that assisted dying is outside the scope of its services. There would be nothing, however, to prevent a health practitioner engaged by such a hospice providing assistance under the Act outside the hospice context (for example, by moving the person to a different organisation).

[102] The Attorney-General submits that, in the absence of clear evidence about how the Act will limit an organisation's freedom of conscience, the Court is being asked to adopt a strained meaning of s 8 to preserve that freedom. Before looking at such a meaning, the Court would need to be satisfied that any difficulty faced by an organisation in achieving a euthanasia-free service was not a justified limit on their freedom of conscience, bearing in mind the other competing rights and freedoms engaged. The Attorney submits it is not the role of the Court to come up with options for how a euthanasia-free service could be provided. The declaratory judgment

procedure is intended for a proposed and factually clear course of conduct on which the Court can pass judgment as to its legality.

My assessment

[103] I accept that an organisation may well have an entrenched moral ethos through which it operates. So far as is practicable, an organisation should have the benefit of the right to freedom of conscience and to hold its opinions free of interference.[91]

[104] I note, for example, the Australian Medical Association 2019 Position Statement on Conscientious Objection contemplates this and states:[92]

> **3. Institutional conscientious objection**
>
> 3.1 Some health care facilities may not provide certain services due to institutional conscientious objection (for example, some institutions with religious affiliations will not provide termination of pregnancy, sterilisation or IVF services). In such cases, an institution should inform the public of their conscientious objection and what services they will not provide so that potential patients seeking those services can obtain care elsewhere (for example, this information could be highlighted on the institution's website, patient brochures and on posters clearly visible at the front of the facility).
>
> 3.2 At times, a patient admitted to an institution may request a treatment or procedure that the institution does not provide due to conscientious objection. For example, a hospice patient may request access to a voluntary assisted dying service (in a jurisdiction where this is legal) but the facility does not provide such a service due to conscientious objection. In these cases, doctors should be allowed to refer patients seeking such a service to another doctor outside the facility.

[105] As discussed earlier, it is a cornerstone philosophy and ethos of hospice palliative care for Hospice NZ and its members "neither to hasten nor postpone death". Hospices with this deeply-held philosophy and ethos have the right to this belief "subject only to such reasonable limits prescribed by law as can be demonstrably justified in a free and democratic society".[93]

[106] The first issue is whether the End of Life Choice Act does in fact operate to limit hospices' right of conscience, by potentially imposing obligations on their health

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[91] NZBORA, ss 13 and 29.

[92] See also Brian Bird "The Call in *Carter* to Interpret Freedom of Conscience" (2018) 85(2) Supreme Court Law Review 107 at 123.

[93] NZBORA, s 5.

practitioners to provide assisted dying services to a hospice patient who requests them.[94] The Attorney-General submits a hospice will be able to exclude assisted dying from its services. I agree there is nothing in the End of Life Choice Act that prevents this in theory. The Attorney also submits that a hospice will be able to exclude assisted dying services from the work to be performed by the health practitioners it engages or employs. I agree with this too, with the proviso that such a term of engagement or employment could not prevent the health practitioner from his or her mandatory obligations under the Act. Does this mean in effect that a hospice's right to exclude assisted dying services from the services it provides can be overridden?

[107] Let us suppose a hospice advertises that it is a euthanasia-free service; its patients are advised of this when they come under their care; a doctor employed by the hospice accepts, as a condition of her employment, that she will not provide assisted dying services for patients under the hospice's care; a patient receiving palliative care in their home from a doctor employed by the hospice informs the doctor that she wishes to exercise the option of assisted dying; the doctor does not have a conscientious objection. The doctor must give the advice and have the discussion with the patient mandated by s 11. Can that advice and discussion be given in the person's home? Is the patient still under the hospice's care because the request was made when the doctor was at the patient's home providing palliative care services for the hospice? Is it necessary that the patient terminate her arrangements with the hospice for palliative care services before the doctor can give the advice and have the discussion under s 11? How would the patient do this? Are there practical impediments to this? Similar issues may arise where the patient makes the request of a doctor in a hospice facility.

[108] I have some information about how palliative care is provided. I do not have details that enable me to anticipate all the circumstances in which a request could be made for assisted dying by a person receiving care from an organisation with a conscientious objection and whether the mandatory obligations on health practitioners would limit the organisation's right to conscience. What is the proper approach for a Court to take in such circumstances?

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94 It is only if it does so that ss 5 and 6 of NZBORA would come into consideration.

[109] Some assistance is provided by the decision of the Supreme Court in the United Kingdom in *Greater Glasgow Health Board v Doogan*.[95] This case involved a conscientious objection provision in abortion legislation. It provided that no person was under a duty "to participate in any treatment" authorised by the legislation to which he or she had a conscientious objection.[96] Two Roman Catholic midwives, employed on a hospital labour ward as senior co-ordinators, objected to abortion on religious grounds. They did not wish to have any involvement with patients admitted to the ward for that purpose. They sought judicial review of a decision by a local health board that this provision did not confer any right to refuse to delegate to, supervise or support staff in the provision of nursing care to patients undergoing medical termination of pregnancy. Prior to this decision, it had been possible for them to work around their conscientious objection by getting someone else to do the tasks that might otherwise have fallen to them.

[110] The Supreme Court discussed the difficulty of determining whether restrictions placed by employers on employees on the exercise of their right to religious beliefs would be a proportionate means of pursuing a legitimate aim. It considered the answer would be context specific.[97]

[111] The Court went on to discuss the submissions of the parties on the consequences of taking a broad or narrow interpretation of the scope of the conscientious objection right in the provision. One side argued that a broad interpretation would put at risk the provision of a safe and accessible abortion service available to all pregnant women who needed and wanted it. It might also encourage employers to refuse to employ anyone who had a conscientious objection to abortion on the ground that it was a genuine occupational qualification for the job. The other side argued that a narrow interpretation would unreasonably restrict their fundamental right to religious beliefs and restrict the job opportunities of midwives and other healthcare practitioners.

[112] The Supreme Court said:

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95 *Greater Glasgow Health Board v Doogan* [2014] UKSC 68, [2015] AC 635.
96 Abortion Act 1967 (UK), s 4(1).
97 *Greater Glasgow Health Board v Doogan*, above n 95, at [23].

> 27 We do not have the evidence with which to resolve those arguments. … The conscience clause was the quid pro quo for a law designed to enable the health care profession to offer a lawful, safe and accessible service to women who would previously have had to go elsewhere. But we are not equipped to gauge what effect either a wider or a narrow construction of the conscience clause would have on the delivery of that service, which may well differ from place to place. Our only safe course is to make the best sense we can of what the section actually says.

[113] The Court went on to find that "treatment" covered the whole course of medical treatment bringing about the termination of the pregnancy. On the more difficult question, the Court considered "to participate in" meant taking part in a "hands-on" capacity. In reaching this view it considered that a narrow interpretation was more likely to have been in the contemplation of Parliament when the Act was passed. It regarded it as unlikely that Parliament had in mind the host of ancillary, administrative and managerial tasks that might be associated with the treatment.

[114] In the present case, it is not possible to anticipate all the circumstances that may arise. However, I am not persuaded on the information before me that an organisation's right to conscientiously object to providing assisted dying services will either invariably be limited by the End of Life Choice Act or that it will be limited in some cases. Organisations working with appropriate bodies, such as the Medical Council and the Nursing Council, may be able to put in place guidelines about how organisations' right not to provide assisted dying services can co-exist alongside the mandatory obligations on health practitioners who do not have a conscientious objection. For example, how health practitioners could comply with their obligations outside the organisation's care.

[115] As a matter of statutory interpretation, however, I can say that the proposed SOP of the Hon Michael Woodhouse would have made it clear that organisations would have the right to conscientiously object, and that they could exclude assisted dying services from the services they provide by stipulating to the health practitioners they engage or employ that these services were prohibited. But that is not to say that Parliament intended the reverse in rejecting the SOP. The SOP was rejected simply because it was considered unnecessary. It was not rejected because it was regarded as necessary that organisations sometimes be required to provide assisted dying services

to patients in their care despite it being contrary to the organisations' ethos and strongly held beliefs.

[116] As a matter of statutory interpretation, the right in s 8 is conferred on an individual health practitioner who is otherwise obligated to carry out the statutory steps in the Act. That interpretation ought not to preclude organisations and health practitioners from putting in place arrangements that will enable an organisation to exclude assisted dying from their services, while also enabling health practitioners they engage or employ to provide assisted dying services to patients who request them where the health practitioner does not have a conscientious objection under s 8. I agree with the Attorney-General that it is not for the Court to propose the arrangements for how this might be achieved.

[117] Parliament's intention is that the right of conscientious objection is a cornerstone of the End of Life Choice Act. Eligible people have the right to request assisted dying. The quid pro quo of the obligations on practitioners to take the statutory steps in response to that request is their right to conscientious objection. This was intended to ensure that no-one would be required to do anything to which they were opposed on grounds of conscience. In any particular situation that might come to the Court in the future, the Court would look to interpret the legislation consistent with this intention.

Question 2

The declaration sought

[118] The second question on which a declaration is sought is:

> Question 2: If the answer to question 1 is A, a declaration that either:
>
> A it will be unlawful for a DHB or other funding agency to decline to fund or contract with that organisation for the services it does provide, unless it also provides Assisted Dying services; or
>
> B it will be lawful for a DHB or other funding agency to decline to fund or contract with that organisation for the services it does provide, unless it also provides Assisted Dying services.

The evidence

[119] Philip Knipe, Chief Legal Advisor at the Ministry of Health, has provided an affidavit. He sets out the background of how funding in the health sector operates. He explains that the health sector is mostly funded by central government. The amount of the funding is determined each year in the national budget process.

[120] DHBs operate within geographically defined areas. Each DHB is provided a lump sum of money based on its population and demography. Each DHB determines where its funding is to be spent to meet the needs of its population, taking into account relevant service specifications and contractual obligations with the Ministry. DHBs have a broad discretion to contract for health services but must act in accordance with their objectives and functions.

[121] Palliative care may be provided as part of a person's standard clinical practice. In the community, general practice teams, district nurses, Māori health teams and aged residential care facilities all provide palliative care. In hospitals, palliative care is provided by the general ward staff as well as by staff in units caring for someone with a specific disease.

[122] Specialist palliative care is provided by health practitioners who have undergone specific training or accreditation in palliative care. Specialist palliative care may be provided by hospice or hospice-based palliative care services. Essential specialist palliative care services are funded by the Government through DHBs. Hospices are the main providers of these services.

[123] The Ministry has not yet determined how assisted dying services will be procured or funded if the referendum is successful. The Ministry would consider funding and procurement matters in the 12 months before the End of Life Choice Act comes into force. Nor has the Ministry decided if assisted dying services will be specifically funded at all. Not all health care is funded on a "fee for service" basis; some providers are funded on a capitation basis (that is, for an enrolled person). If assisted dying services fall within the ambit of DHBs, they will make provision and funding decisions in accordance with the statutory framework and government policies under which it operates.

Hospice NZ's submissions

[124] Hospice NZ submits that the answer to Question 2 should be A. It says this is a necessary protection to ensure that the rights of conscience under s 13 are not negated or overridden in practice by funding or contracting decisions by the Government or other public funding agencies such as DHBs. It says clarity is important before the referendum.

[125] Hospice NZ submits answer A can be reached by a rights-consistent interpretation of s 8(3) of the Act. It says this would be consistent with the legislative intent to provide broad protection for those who exercise rights of conscience, noting Mr Seymour's statement to the House that "nobody must do anything under this bill that they do not wish to do".[98]

[126] Hospice NZ submits there appears to be no reason why the protection in s 8(3) should be limited to health practitioners who are employees. If it is so limited, Hospice NZ says that s 8(3) would be largely redundant because of the discrimination in employment provisions in the Employment Relations Act 2000 and the Human Rights Act 1993. Hospice NZ suggests the drafters of s 8(3) may not have been aware of the wide range of funding and contracting arrangements under which health practitioners work. It says a practitioner's free exercise of their rights of conscience should not depend on whether they are directly employed, or whether they or their organisation are remunerated for their services to the public through some other form of contracting or funding arrangement. It says this would be the effect if a DHB denied funding to a group of GPs practising in partnership because they refused to provide assisted dying services on grounds of conscience.

[127] Hospice NZ submits that the references to "employer" and "employee" in s 8 can be read more widely than as referring only to those in an employment relationship as contemplated by the Employment Relations Act. It says it can be read as encompassing all types of arrangements for the remuneration for services. It says this would be consistent with the intent of s 8 and with the requirement to give preference

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[98] Hansard, above n 45.

to the meaning of a statutory provision that is consistent with an affirmed right (here, the right to freedom of conscience).[99]

The Attorney-General's submissions

[128] The Attorney-General submits the plain meaning of s 8(3) is that it relates only to individual "employee" health practitioners (natural persons). The Act is intended to focus on the requirements on individual health practitioners when assisted dying is requested and their right to conscientiously object to that assistance. Section 8(3) supports this by providing that treatment by an employer can neither be detrimental if an employee refuses to assist, nor beneficial to encourage assistance.

[129] The Attorney-General submits there is no indication in the purpose or legislative history of the Act that Parliament intended a meaning that goes beyond this plain meaning. The SOP, which proposed a specific restriction on the ability of public funding decisions to take into account the fact that an organisation had an objection to providing assisted dying, or for public funding to be offered on a condition that an organisation provide assisted dying, was rejected.

[130] The Attorney-General submits there is no obligation on an organisation to provide assisted dying services and the Ministry cannot compel them to do so. However, if an organisation does not provide assisted dying services, they will not receive any funding that is allocated for the provision of those services.

[131] Further, if a DHB determined the most efficient way to fund assisted dying services in its area was to fund a provider who is willing to provide both palliative care and assisted dying services, it must be entitled to do so. Such a decision would not be to discriminate against those holding a conscientious objection. Rather, it would be one of effective allocation of funding to service providers in accordance with the statutory requirement on a DHB that it "seek the optimum arrangement for the most effective and efficient delivery of health services in order to meet local, regional, and national needs".[100]

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99 NZBORA, ss 6 and 13.
100 New Zealand Public Health and Disability Act 2000, s 22(1)(ba).

[132] The Attorney-General submits the Ministry must be free to make those decisions. There is no indication that the Ministry would withdraw funding to an organisation simply because of a conscientious objection. A public body must exercise its contracting power in accordance with its empowering statute and, if it does not do so, it is susceptible to judicial review. The Attorney says this is the appropriate procedural mechanism for determining the lawfulness of a funding decision.

My assessment

[133] I accept the Attorney-General's submissions that s 8(3) refers to individual "employee" health practitioners. It follows in part from my view of Question 1. The Act imposes obligations on individuals subject to their right of conscientious objection under s 8. The purpose of s 8(3) is to support the right of conscientious objection for those individuals who are employees. It may be unnecessary because of the discrimination provisions in the Employment Relations Act and Human Rights Act, but it serves to emphasise the right.

[134] It is not apparent to me at this stage that there is a need to give s 8(3) the extended meaning proposed by Hospice NZ to protect an organisation's right to conscientiously object. Organisations remain free to conscientiously object by offering euthanasia-free services. Funding decisions to organisations must be made lawfully. Judicial review is the appropriate mechanism to challenge the decision if they are not. A judicial review application will enable the Court to decide the lawfulness of a particular funding decision on the facts that have arisen.

Question 3

The declarations sought

[135] The third question on which a declaration is sought is:

> Question 3: A declaration that, if the End of Life Choice Act 2019 comes into force, either:
>
> A the mandatory obligations on a health practitioner who receives a request for Assisted Dying services override the ethical, clinical or professional judgments of a practitioner and their obligations under the Code of Health and Disability Consumers' Rights in relation to that patient, such that a practitioner who refuses to undertake a task or process mandated by the

> End of Life Choice Act based on their assessment that it conflicts with one or more of those judgements and obligations acts unlawfully and may be liable to prosecution under s 39 of the Act; or
>
> B the mandatory obligations on a health practitioner who receives a request for Assisted Dying services do not override the ethical, clinical or professional judgments of a practitioner and their obligations under the Code of Health and Disability Consumers' Rights in relation to that patient, such that a practitioner who refuses to undertake a task or process mandated by the End of Life Choice Act based on their assessment that it conflicts with one or more of those judgements and obligations acts lawfully and will not be liable to prosecution under s 39 of the Act.

[136] This question is one of three related questions that concern the relationship between the mandatory obligations on health practitioners under the End of Life Choice Act and their other duties and obligations as health practitioners. It is posed at a general level. Question 4 then poses some specific examples of possible conflicts between the mandatory obligations with other duties and obligations. These anticipated conflicts then form the basis for contending under Question 5 that a broad interpretation of the right to conscientious objection is necessary.

Hospice NZ's submissions

[137] Hospice NZ submits that, as a matter of statutory interpretation, the answer to Question 3 is A, subject to whether the conflict between the End of Life Choice Act and a practitioner's ethical, clinical or professional judgement, or with the Code, would constitute a conscientious objection.

[138] In oral submissions Hospice NZ clarified that its concern is about whether the Act overrides a practitioner's clinical judgement or a practitioner's obligations in the Code (which includes the right to have services provided that comply with legal, professional, ethical and other relevant standards) where they are in conflict with the End of Life Choice Act. It submits the Act appears to be mandatory and to have this effect. This result is said to be so extraordinary that Hospice NZ seeks confirmation from the Court that the Act is to be interpreted in this way. Hospice NZ submits it is appropriate for practitioners to have clarity rather than to be "under the threat of a nightmarish criminal prosecution if they, or their advisors, prove to be in error in their

evaluation of the law or the legal process", as well as under threat of disciplinary and civil proceedings.[101]

[139] Hospice NZ gives some examples of its concern. One of them is the experience and qualifications of doctors who will be called upon by those requesting assisted dying services. It is concerned that the mandatory obligations imposed on the "attending medical practitioner" apply regardless of the practitioner's experience and scope of practice and regardless of whether the practitioner has any relationship with the patient. It submits that the Act seems to assume a "middle class" version of a doctor and patient relationship. It says that, in the real world, a retired ophthalmologist, who is without terminal illness or palliative care experience, might decide to set up a service specialising in assisted dying. Or a person who is suicidal might turn up to Accident & Emergency services saying they want to die and, if the person is over 18 years old, the doctor would have to start the process under s 11 of the Act.

[140] Hospice NZ submits there is nothing in the End of Life Choice Act that permits the Medical Council to restrict those who can provide assisted dying services. It says the Act does not require that the attending medical practitioner have any particular experience or scope of practice, nor any pre-existing relationship with the patient. The SOP that would have required this was rejected. It submits the right of patients under the Code do not apply. This is because cl 5A of the Code will provide that "nothing in the Code … prevents a provider from doing an act authorised by the EOLC [End of Life Choice] Act". Hospice NZ submits the problem of having an inappropriately experienced or qualified doctor carrying out the obligations of the attending medical practitioner under the Act is compounded by the absence of any provision permitting the doctor to seek expert medical input.[102]

[141] Another concern for Hospice NZ is where a person is in the course of difficult treatment where suicidal ideation can be very high. An experienced doctor will know that if the person can hold on while the treatment is completed, the person may change

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101 As Edward Thomas J put it in *Auckland Area Health Board v Attorney-General* [1993] 1 NZLR 235 at 242. See also, for example, *Hutt District Health Board v B* [2011] NZFLR 873.

102 Noting that s 11(h) refers only to conferring with others for the purpose of ensuring that the person expresses their wish free from pressure from any other person.

their mind. The doctor's clinical judgement would be that it is not an appropriate time for a person to decide if they wish to exercise the option of assisted dying. Hospice NZ is concerned that this clinical judgement would be overridden by the steps the doctor is required to follow under the End of Life Choice Act. It says this is contrary to the established position in New Zealand law that a patient's wishes do not prevail over a doctor's clinical judgment.[103]

[142] Hospice NZ is also concerned about the different test for informed consent and for guarding against coercion under the End of Life Choice Act as compared with the Code and the extensive requirements in the Ministry of Health's Elder Abuse Guidelines.[104]

The Attorney-General's submissions

[143] The Attorney-General submits the relationship between the End of Life Choice Act and the Code is made clear by the new cl 5A to be added to the Code by the Act. The Code will apply except to the extent that it is necessarily overridden by provisions in the Act. The Attorney submits that, where this occurs, it is to provide additional safeguards to a person who requests the option of assisted dying.

[144] The Attorney-General also submits there is nothing in the Act which overrides the requirement in ss 8 and 11 of the Health Practitioners Competence Assurance Act for doctors to perform only those health services that are within their scope of practice as specified by the Medical Council. The Attorney suggests it is unlikely that assisted dying would fall within an ophthalmologist's scope of practice for example. That will be a matter for the Medical Council, as will whether it decides to establish a scope of practice for assisting dying which specifies the level of qualification and experience required to provide this service.

[145] The Attorney-General submits the End of Life Choice Act makes provision for a situation where a medical practitioner considers they are not qualified to progress a

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103 Hospice NZ refers to *Shortland v Northland Health Ltd* [1998] 1 NZLR 433. The Attorney-General responds that this case did not hold that a doctor's clinical judgment will always be determinative and that a patient has no choice.

104 *Guidelines for health practitioners on identifying and responding to elder abuse and neglect* (Ministry of Health, 2007).

person's request for assisted dying. He submits that, in such a situation, the person would not be able to reach an opinion about whether a person was eligible for assisted dying under s 13(2) of the Act and this would trigger the involvement of a psychiatrist under s 15.

[146] The Attorney-General also submits there is some indication in the End of Life Choice Act that the attending medical practitioner might not be simply any medical practitioner involved in the patient's care to any degree. He suggests the Act assumes the attending medical practitioner is familiar with the patient's prognosis and options for end-of-life care, and their condition and relevant history. This is because, in contrast with the independent medical practitioner and the psychiatrist, there is no specific requirement that the attending medical practitioner read the person's file and examine them.[105]

PCNNZ's submissions

[147] PCNNZ submits the correct interpretation of the End of Life Choice Act, and its interrelationship with the Code, must be undertaken with reference to the State's interest in the preservation of life and the rights and freedoms affirmed in NZBORA, particularly the right in s 8 not to be deprived of life.[106] PCNNZ submits the State's interest in the preservation of human life underpins all health-related legislation, regulations and codes.

[148] PCNNZ submits that without the Code operating in tandem with the End of Life Choice Act, patients may be arbitrarily deprived of life. It is concerned that patients, who do not receive proper health care (including proper palliative care) and who do not give proper and informed consent in accordance with the Code, may

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105 Compare ss 11 and 13 with ss 14(3) and 15(3). The Attorney notes this is consistent with Mr Seymour's response to a concern raised by the Heath and Disability Commissioner that there was no express requirement for an attending medical practitioner to review patient's medical notes, nor to examine the patient. In a letter dated 30 July 2019, he replied that the attending medical practitioner, "as the patient's doctor", will already have access to and be familiar with the medical file.

106 PCNNZ also refers to the right to freedom of expression, religion, and conscience, the right not to be subjected to cruel treatment and the right to refuse to undergo medical treatment, as well as ss 5 and 6 of NZBORA.

wrongly believe they have limited options and may choose assisted dying when they otherwise would not have.

[149] PCNNZ submits a health practitioner must be able to comply with their obligations under the Code in parallel with their statutory obligations under the End of Life Choice Act. Therefore, if possible, the Court must attempt to interpret the End of Life Choice Act in a manner that achieves its two primary purposes. PCNNZ sees these as being: to deliver assisted dying services to patients who choose this on a properly informed basis; and to promote the safeguards in the Act and protect patients who would not choose assisted dying services if properly informed and cared for under the Code.

[150] PCNNZ submits there are two possible interpretations of cl 5A of the Code: an expansive interpretation whereby the Act totally overrides the Code, because the health practitioner is deemed at law to have complied with the Code if they have complied with the Act; or a narrow interpretation in which the Act does not override the whole Code. PCNNZ submits the narrow interpretation should be favoured given the Act permits a health practitioner to "participate in killing a patient" which would otherwise be totally contrary to the Code. It submits that health practitioners must fulfil their obligations under the Act in conjunction with the delivery of health care to the standards of the Code.

ANZSPM's submissions

[151] ANZSPM supports Hospice NZ's submissions. One of the particular areas of uncertainty on which it seeks clarity is as to who qualifies as an attending medical practitioner under the End of Life Choice Act. ANZSPM refers to the "somewhat tentative" submission of the Attorney-General that not all attending medical practitioners to whom an assisted dying request is made will qualify as an "attending medical practitioner" under the Act. If the Court agrees that is correct or is able to provide guidance on when a health practitioner will qualify as an "attending medical practitioner", it would greatly assist ANZSPM and its members and stakeholders.

My assessment

[152] The starting point is that the End of Life Choice Act does not say it applies to the exclusion of other health law statutes, regulations and codes. It would be a startling proposition if it did. As a matter of statutory interpretation, it is to be presumed that they co-exist to regulate a health practitioner's duties and responsibilities (etc), except where and to the extent it is expressly provided otherwise.[107]

[153] The End of Life Choice Act does say that it amends certain enactments as set out in the Schedule.[108] Relevantly for present purposes:

(a) The Health Practitioners Competence Assurance Act is not specified in the Schedule. This indicates that the requirement on doctors to only perform health services within their scope of practice continues to apply.[109]

(b) The definition of "health services" in the Health and Disability Commissioner Act is amended to include services provided to a person who has requested assisted dying under the End of Life Choice Act. This indicates that Parliament intends the Code to continue to apply and to be read side-by-side with the Act, subject to the specific provisions of cl 5A.

(c) The Code is amended to insert the new cl 5A. This "sets out how the Code operates with the End of Life Choice Act", again indicating that the two exist side-by-side in the manner set out in this clause.

[154] It is implicitly confirmed by s 38 of the End of Life Choice Act that a health practitioner providing services under the Act remains subject to the standards set by the Medical Council or the Nursing Council (as relevant). Under that section, a health

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[107] Courts will normally try to reconcile legislation to "live together" in the body of existing law. See Ross Carter *Burrows and Carter on Statute Law in New Zealand* (5th ed, LexisNexis, 2015) at 467; *Re Silver Brothers Ltd* [1932] AC 514 (PC) at 523.

[108] End of Life Choice Act, s 41.

[109] The End of Life Choice Act, s 4, makes this express in relation to attending nurse practitioners as it requires a nurse practitioner to be someone who is registered with the Nursing Council and "whose scope of practice permits the performance of nurse practitioner's functions".

practitioner has immunity from civil liability if they comply with the Act in good faith and believing on reasonable grounds that a person wishes to exercise the option of assisted dying. However, the right to bring disciplinary proceedings or proceedings for breach of the Code under the Health Practitioners Competence Assurance Act and the Health and Disability Commissioner Act expressly remains. It must follow that it is intended that health practitioners are to comply with their professional standards and with the Code except where these are expressly overridden by the End of Life Choice Act.

[155] With that background, I first consider the term "attending medical practitioner". It is defined as "the" person's medical practitioner, indicating that it is the doctor that has the care of the patient. Remembering that a person is only eligible for assisted dying if they have a terminal illness, it seems likely that often the person will be in the care of a doctor (or doctors), or at least have a doctor who has diagnosed the person's illness. This is consistent with Dr Wiseman's evidence that a majority of patients who may seek assisted dying will be receiving specialist palliative care services, and this may be in association with providers of generalist palliative care.

[156] Section 11 reinforces the assumption that the attending medical practitioner will have had some involvement in the care of the person. The section requires the attending medical practitioner to give "the prognosis for the person's terminal illness" and to ensure the person understands their other options for end-of-life care. In contrast with the independent medical practitioner and the psychiatrist who are required to "read the person's medical files" and "examine the person", s 11 presumes the attending medical practitioner is in a position to give the prognosis and to discuss the other options for the person's care.[110]

[157] Section 13 further reinforces this assumption. The attending medical practitioner is required to reach an opinion on eligibility. Section 13(2) provides only three options for the attending medical practitioner. They "must reach the opinion" that the person requesting assisted dying: "is eligible"; or "is not ... eligible"; or they "would be … eligible if it were established under s 15 that the person was competent

[110] Sections 14(3) and 15(3).

to make an informed decision about assisted dying". There is no option for the attending medical practitioner to conclude that he or she is uncertain about, or does not have the knowledge and experience to say, whether the person is eligible, except in relation to the patient's competence to give informed consent. That issue can be referred to a psychiatrist. Otherwise, it is assumed that the attending medical practitioner will be able to make the clinical judgement on a person's eligibility.

[158] That assumption follows from the fact that the doctor is likely to be involved in the care of the person's terminal illness. Apart from age, New Zealand citizenship or permanent residence, and competence to make an informed decision, the eligibility assessment requires a clinical judgment on: whether the person suffers from a terminal illness that is likely to end their life within six months; is in an advanced state of irreversible decline in physical capability; and is experiencing unbearable suffering that cannot be relieved in a manner that the person considers tolerable. Those are clinical matters all related to the person's terminal illness. If a doctor is acting within their scope of practice and has the appropriate skills and experience to be involved in the person's care, it would generally follow that they will be able to make the clinical judgement on the patient's eligibility.

[159] While the End of Life Choice Act assumes the attending medical practitioner will be able to make the necessary clinical judgement on eligibility, it anticipates the medical practitioner may not always be able to determine the person's competence to make an informed choice. It makes sense that assessing the person's mental capacity may sometimes be outside the expertise of the medical practitioner providing care to a person with a terminal illness. The Act requires a psychiatrist to give an opinion on the person's competence in this situation.[111]

[160] If the Attorney-General intended to submit that the involvement of a psychiatrist is triggered whenever the attending medical practitioner or the independent practitioner is not qualified to progress or assess a person's request for assisted dying, I do not agree. The Act assumes that the attending and independent medical practitioners are both qualified to make the assessment on eligibility, with the

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111 Similarly, a psychiatrist's opinion is required if the independent medical practitioner has not reached an opinion on the person's competence to make an informed consent.

possible exception of the person's competence to make an informed consent. It is only in determining a person's competence to make an informed consent that a psychiatrist may be involved.

[161] What happens when, in a particular case, the attending medical practitioner does not have the knowledge and experience to provide the advice required under s 11 or to make the eligibility assessment under s 13? As in any doctor/patient situation where this can arise, the doctor may need to consult with, or refer or transfer the patient's care, to a practitioner who has the relevant knowledge and experience.[112]

[162] The End of Life Choice Act does not prevent this. As a matter of statutory interpretation, it does not follow that, because a doctor is expressly permitted to confer with the others about whether the person is expressing their wish free from pressure, a doctor is not permitted to confer with others on clinical matters relating to the person's eligibility. Nor, as a matter of statutory interpretation, is a doctor required to carry out the steps under the Act if they do not have the skill or experience to do so. The attending medical practitioner will be a doctor who has the necessary skill and experience to carry out those steps. If that means a doctor needs to consult with colleagues, or refer or transfer the patient's care, then that can and should happen.

[163] The Act would not permit a doctor, in response to a request under s 11, claiming that he or she is not the attending medical practitioner simply to avoid taking the steps that the Act requires of the attending medical practitioner. The purpose of the Act is to give eligible persons the option of assisted dying. Doctors to whom the request is appropriately made (because they qualify as "the attending medical practitioner" and do not need to refer or transfer the person's care to another doctor because the advice is outside their competence) will be required to facilitate that request, by carrying out the steps required of them under the Act, unless they have a conscientious objection.

[164] Issues may arise when a person who seeks assisted dying has more than one doctor who is providing care to them. Hospice NZ submits the evidence before the

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112 The Medical Council's "Good Medical Practice" (Medical Council of New Zealand, December 2016) expects doctors to: "recognise, and work within, the limits of [their] competence"; and "consult and take advice from colleagues when appropriate". It also sets out guidance on referring patients and on transferring their care.

Court is that palliative care is provided collectively, by multi-disciplinary teams. If the team has more than one doctor involved in the care, then are each of the doctors in that team potentially the "attending medical practitioner" so that the obligations under the Act will fall on the first person to whom the request is made? What about when a person is under the care of a GP as well as a specialist? What about when a person does not have a doctor involved in their care (even though they have a terminal illness) but wishes to request assisted dying?

[165] Whether the person to whom a request is made is "the person's medical practitioner" will be fact-dependent. If the End of Life Choice Act comes into force, it may be that the Medical Council will issue practice standards about this or provide guidelines. The Act would not prevent this, providing the standards facilitate the Act's purpose "to give persons who have a terminal illness and who meet certain criteria the option of lawfully requesting medical assistance to end their lives".[113]

[166] I now consider cl 5A of the Code which, as noted earlier, is about how the Code "operates with" the End of Life Choice Act. Clause 5A(2) concerns how Right 4(2) of the Code operates with the Act. Right 4(2) provides that consumers have the right to services that comply with "legal, professional, ethical, and other relevant standards". Clause 5A(2) provides that contravening s 10(1) of the End of Life Choice Act (which prohibits a health practitioner from initiating a discussion about, or suggesting, the option of assisted dying) can amount to providing services that do not comply with the relevant legal standards.

[167] Clause 5A(2) is, therefore, an instance of the Code and the End of Life Choice Act working alongside each other. Clause 5A(2) ensures that the patient may have rights for a breach of Right 4(2) if s 10(1) of the Act is contravened. In doing so, cl 5A(2) complements s 10(3) of the Act, which provides that a health practitioner who contravenes s 10(1) may be found to have acted in breach of the Code and may also be subject to disciplinary proceedings under the Health Practitioners Competence Assurance Act.

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113 Section 3.

[168] Importantly, cl 5A(2) does not override Right 4(2) and nor does it purport to affect the other rights that comprise Right 4. They are all aspects of the right to services of an appropriate standard. As the Attorney-General put it, they are about "how" services are provided, not "what" services are provided. These rights are generally compatible with the services required of an attending medical practitioner or the other health practitioners involved in the assisted dying steps set out in the Act, with the possible exception of Right 4(4).[114] Where there is inconsistency, cl 5A(5) will apply.

[169] Clause 5A(3) provides that Rights 6(1)(b) and (c) and (2) of the Code are overridden by s 10 of the End of Life Choice Act. This is necessary to reinforce the prohibition in that section on health practitioners initiating a discussion about, or suggesting, assisted dying to a person. The scheme of the Act is that a request can only be initiated by the person who wishes to exercise the option. It is necessary to override these rights because:

(a) Right 6(1)(b) provides the right to "an explanation of options available";

(b) Right 6(1)(c) provides the right to "an estimated time within which a service will be provided"; and

(c) Right 6(2) provides the right to information that a reasonable consumer needs to make an informed choice or give informed consent.

[170] But for cl 5A(3), the prohibition in s 10 would or could be inconsistent with these rights. Apart from remedying this inconsistency, cl 5A(3) does not purport to override these rights in any other way. Nor does it override the other rights that come with Right 6. To the extent they are consistent with the End of Life Choice Act, they

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114 Right 4(4) provides the right to services "in a manner that minimises the potential harm to, and optimises the quality of life of, that consumer". Depending on one's philosophy, assisted dying may be regarded as harming a person and not optimising the person's quality of life in accordance with the palliative care ethos. The effect of cl 5A(5) is that taking the steps required under the Act will not constitute a breach of this right.

apply alongside the process it mandates. Where they are inconsistent, cl 5(5) will apply.

[171] Clause 5A(4) provides that Rights 7(2)-(5) are overridden by s 6 of the End of Life Choice Act. It does so for consistency with the enhanced protections under the Act. Specifically:

(a) Right 7(2) presumes a consumer to be competent to give informed consent unless there are reasonable grounds for believing that the consumer is not competent. That is overridden by s 6, which is prescriptive about the meaning of competence. No presumption applies under the Act. Competence must be actually assessed in accordance with the prescriptive test in s 6.

(b) Right 7(3) provides that a person with diminished competence has the right to make informed choices and give informed consent. That is overridden for assisted dying because the End of Life Choice Act requires that a person be competent in order to be eligible.

(c) Right 7(4) permits services to be provided to a person who is not competent to give informed consent and no other person is entitled to give consent on their behalf in certain circumstances. This is overridden for assisted dying because the scheme of the Act is to permit this option only if the person requesting it is competent.

(d) Right 7(5) permits a consumer to give an advance directive. This is overridden because the End of Life Choice Act only permits assisted dying in accordance with the step-by-step process set out in the Act.

[172] Clause 5A(4) does not override any other of the provisions that make up the right to make an informed choice and give informed consent. To the extent they are compatible with the End of Life Choice Act, they apply alongside the process mandated by it. Where there is inconsistency, cl 5A(5) will apply.

[173] The leaves cl 5A(5). Its meaning becomes clear when cl 5 of the Code is considered. The two clauses complement one another. Clause 5 provides that:

> Nothing in this Code requires a provider to act in breach of any duty or obligation imposed by any enactment or prevents a provider from doing an act authorised by any enactment.

[174] Clause 5A(5) is the mirror image of this provision. It provides:

> Under clause 5 of this Code (and without limiting that clause), nothing in this Code requires a provider to act in breach of any duty or obligation imposed by the [End of Life Choice] Act or prevents a provider from doing an act authorised by the [End of Life Choice] Act.

[175] Clause 5 does not mean that the Code does not apply because there are duties and obligations imposed or acts authorised under other legislation. It means that the Code does not override duties, obligations or acts authorised under other legislation. The Code sits alongside those duties, obligations or authorised acts and applies, except to the extent they are inconsistent. Clause 5A simply makes it express, for the purposes of cl 5, that this is also the case with duties, obligations and authorised acts under the End of Life Choice Act.

[176] Hospice NZ accepts that many of the rights in the Code can sit alongside the End of Life Choice Act.[115] It considers this may not be so with others. It compares s 24 of the Act with the Code under which a provider is required to take action to enable consumers to exercise their rights (Right 1(3)), and consumers have rights to be free from coercion (Right 3) and to make an informed choice and to give informed consent (Right 7). It describes s 24 of the End of Life Choice Act as narrow and specific and quite different from requiring that the practitioner be satisfied that the person is in fact exercising their own free will.

[177] In my view consumers will continue to have the right to be free from coercion and to give informed consent under the Code. The Act complements but does not replace these rights:

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115 For example, the right to be treated with respect (Right 1), the right to freedom from discrimination, coercion, harassment, and exploitation (Right 2), the right to dignity and independence (Right 3), the right to effective communication (Right 5), the right to support (Right 8), the right in respect of teaching or research (Right 9) and the right to complain (Right 10), can co-exist with the requirements on practitioners under the End of Life Choice Act without difficulty.

(a) Section 11(h) complements the right to be free from coercion by requiring a practitioner to do their best to ensure a person is expressing their wish free from pressure and authorising certain steps for doing so.[116] Section 11(h) does not purport to limit other steps the doctor would take to comply with Rights 1(3) and 3.

(b) The End of Life Choice Act does not alter a consumer's right to be provided with services "only if that consumer makes an informed choice and gives informed consent" (Right 7(1)). As discussed, it only overrides the presumption of competence to make an informed choice and give informed consent under Right 7(2) (because competence must actually be determined), and the rights under Right 7 that would allow services to be provided when a consumer has diminished competence or is not competent.

(c) Section 24 is complementary to these rights by expressly permitting a doctor or nurse to take no further action if they suspect on reasonable grounds that a person is not expressing their wish free from pressure. It does not purport to replace either Right 1(3), Right 3 or Right 7(1).

[178] Because the End of Life Act does not override these rights, they can co-exist with the Act, alongside the Medical Council standard on informed consent, as well as other complementary guidelines issued by relevant bodies (for example, on elder abuse) providing these standards and guidelines are not inconsistent with the Act and its purposes.[117]

[179] Lastly, I discuss Hospice NZ's concern that a doctor may be required to carry out the steps under the Act even though, in their clinical judgment, the person might

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116 It provides for an attending medical practitioner to confer with health practitioners who are in regular contact with the person (for example, a nurse who may have more day-to-day contact with the person) or with members of the person's family.

117 Hospice NZ submitted the Act was inconsistent with the Medical Council's standard because s 6 merely required some things but not others. This was not elaborated further. I have therefore not considered this in detail, except to note that some of the matters in the standard are about "how" to go about obtaining informed consent (for example, it is good practice to check if the patient would like to involve others close to them in the informed consent process) are not inconsistent with the End of Life Choice Act.

not make the same choice if they wait until a particular course of treatment is completed. The first point is that the attending medical practitioner is required to discuss the person's prognosis and their other options for end of life care. A discussion about the effects a particular treatment may be having and when those effects might pass could be part of this where it is relevant.

[180] Secondly, there are a number of steps that need to happen between when a person makes the request for assisted dying and when the medication is administered. This may allow the effects of treatment causing suicidal ideation to pass before the final step under the Act is taken. The Act makes it clear that at any stage a person can change their mind and the attending medical practitioner is required to advise the person of this when responding to their request (s 11(d)), after their eligibility has been determined (s 17(2)(e)), when making the provisional arrangements for the administration of medication (s 19(2)(c)) and when administering the medication (s 20(2)) (or the attending nurse practitioner must do so).

[181] The Act therefore has protections to ensure assisted dying is a considered decision by a person competent to make that decision. If they make that decision, then the health practitioner must carry out the steps required of them in the Act subject only to the right to conscientiously object.

[182] Contrary to Hospice NZ's submissions about this, this is not contrary to established law in New Zealand that a doctor's clinical judgement must prevail. As it is put in *Health Law in New Zealand*:[118]

> Judges have often emphasised the importance of decisions being made in a patient's best interests. …
>
> Any implication that a patient's priorities, values, and wishes have no bearing on the determination of best interests would be disturbing, and contrary to a good deal of judicial opinion. …
>
> …
>
> In cases without the complicating factors of *Shortland v Northland Health Ltd*, the patient's wishes may well be crucial. …

[118] *Health Law in New Zealand*, above n 70, at 21.4(5). See also *R(Burke) v General Medical Council* [2005] QB 544 at [213(r)].

[183] Under the End of Life Choice Act, providing the Act's processes are complied with and the health practitioner does not have a conscientious objection, then the patient's choice prevails.

[184] It follows that the answer to Question 3 is fact-dependent and cannot be answered in the form it is asked. However, in the main, the obligations on a practitioner under the End of Life Choice Act and the Code sit side-by-side and cl 5A provides how they operate alongside each other.

Question 4

The declaration sought

[185] The fourth question on which a declaration is sought is:

> Question 4: Following on from question 3, declarations as to whether a refusal by a health practitioner to undertake a task or process mandated by the End of Life Choice Act for each of the following reasons would or would not be lawful. The reasons are where the practitioner:
>
> A considers that they are not competent due to their specialisation or experience to undertake a task required under the Act; or
>
> B considers that they have insufficient information or familiarity with the requesting person to competently undertake a task required under the Act; or
>
> C has concerns about the patient's level of competence to provide informed consent, even though the patient meets the threshold prescribed in s 6 of the Act; or
>
> D has concerns about the level of freedom of choice being exercised by the requesting person, where such concerns fall short of the threshold prescribed in s 24 of the Act; or
>
> E forms a clinical judgement that Assisted Dying is not the best option for the patient at the time; or
>
> F for any other reason, believes that they are unable to undertake the task in a way that does not conflict with their ethical, clinical or professional judgments or their obligations under the Code of Health and Disability Consumers' Rights.

Submissions

[186] As discussed under Question 3, Hospice NZ is concerned that the End of Life Choice Act overrides a practitioner's clinical judgement and their obligations under the Code.

[187] The Attorney-General submits:

(a) If a doctor is within the examples of A and B, they may not have obligations under the Act because they may not be the attending medical practitioner. If, however, they are the attending medical practitioner, then a broad meaning of the right to conscientiously object is available.

(b) Examples C and D essentially amount to a conscientious objection to the process of assisted dying as provided for in the Act. It is foreseeable that there may be health practitioners who are not opposed to assisted dying in principle, but consider the standards and processes in the Act provide insufficient safeguards (whether generally or in the particular case) and therefore could conscientiously object to participating in it.

(c) Example E will depend on whether in the particular circumstances the health practitioner has a conscientious objection.

(d) Example F is a catch-all, effectively repeating Question 3.

My assessment

[188] The discussion in relation to Question 3 responds to examples A and B. Examples C and D are expressed too generally to be able to provide a clear answer. It may depend on the health practitioner's concerns and whether they are able to carry out further enquiries to satisfy their concerns. As the Attorney-General submits, it may be because the health practitioner holds a conscientious objection to providing assistance under the Act because they are deeply unsatisfied with the safeguards the

Act provides and considers that to assist someone on the basis of these safeguards is contrary to their moral values. Examples E and F have been discussed above.

Question 5

The declarations sought

[189] The fifth question on which a declaration is sought is:

> Question 5: Following on from question 4, a declaration that if the End of Life Choice Act 2019 comes into force, either:
>
> A it is open to a practitioner to exercise a right of conscientious objection under s 8 of the Act on the basis that he or she holds as a core value that they must not act in a way that is contrary to their ethical, clinical or professional judgment and/or their obligations under the Code of Health and Disability [Services] Consumers' Rights in relation to that patient, and this provides a lawful excuse for a practitioner to refuse to undertake a task or process mandated by the End of Life Choice Act; or
>
> B it is not open to a practitioner to exercise a right of conscientious objection under s 8 of the Act on the basis that he or she holds as a core value that they must not act in a way that is contrary to their ethical, clinical or professional judgment and/or their obligations under the Code of Health and Disability [Services] Consumers' Rights in relation to that patient, and this does not provide a lawful excuse for a practitioner to refuse to undertake a task or process mandated by the End of Life Choice Act.

[190] Question 5 assumes the health practitioner would be acting unlawfully if they decline to undertake the task under Questions 3 and 4 unless the right to conscientiously object applies.

Hospice NZ's submissions

[191] Hospice NZ says the orthodox view of what constitutes a conscientious objection in medical practice is different from ethical, clinical and professional judgements. It submits the orthodox view should not apply in the unique context of the End of Life Choice Act. It says a wider than usual meaning is necessary to off-set the breadth of the mandatory obligations under the Act and to protect the right of freedom of conscience (s 13 NZBORA) and the right not to be deprived of life (s 8 NZBORA). It submits a conscientious objection would arise where the practitioner

holds a core value that they must not act in a way that is contrary to their ethical, clinical or professional judgement or their obligations under the Code.

The Attorney-General's submissions

[192] The Attorney-General submits that if a health practitioner, having followed the legal process under the Act, maintains a view that assistance should not be provided, then this would be a personal view and the question would be whether it was a personal conscientious objection under ss 4 and 8 of the Act. He submits that if a health practitioner genuinely believes assisting in the process is wrong because the proposed action would breach ethical, clinical or professional standards, that would be a conscientious objection.

[193] The Attorney-General agrees that conscientious objection in the context of the Act can be given a broad meaning. He submits there is nothing in the Act that suggests a conscientious objection can only arise from an inherent, personal moral compass, without being informed by external guidance and standards. For example, a belief that conduct would be contrary to the law would be a belief that the conduct was wrong. Whether any ethical, clinical or professional judgement would amount to a conscientious objection will depend on the circumstances of the case, including whether the judgement is genuinely held.

PCNNZ's submissions

[194] PCNNZ supports Hospice NZ's submissions on the answer to Question 5.

ANZSPM's submissions

[195] ANZSPM supports Hospice NZ's submissions. It seeks clarity on the scope of the right to conscientiously object, noting that the interpretation advanced by Hospice NZ is different from that concept in current medical practice. It refers to the evidence of Dr Wiseman about this (discussed below). ANZSPM poses the example of where taking forward a request for euthanasia against a clinician's professional judgement would provoke significant moral distress in that practitioner. Would the statutory right to "conscientious objection" be engaged?

[196] ANZSPM also seeks clarity on whether a health practitioner who holds a blanket opposition to assisted dying, that does not change from patient to patient, is protected by the statutory right to conscientious objection. It says that, if it is always necessary for a health practitioner to assess this on a patient-specific basis, this may involve a change to clinicians' thought processes.

My assessment

[197] I start first with considering what is meant by conscientious objection in medical practice. Dr Wiseman says this:

> "Conscience" is different from ethical, clinical or professional judgement. As a medical practitioner, my ethical, clinical and professional judgements are informed by my training, expertise, evidence-based research and international standards. My conscience reflects my personal values. If a person should not proceed with an assisted dying application because they are in the midst of a pain crisis, that is a matter of clinical judgment not conscience. If an Emergency Department physician does not take forward a request for assisted dying because they are inexperienced in this area, that is a matter of competence, not conscience.

[198] The distinction between clinical judgement and a conscientious objection is also made in the Australian Medical Association's (AMA) Position Statement, which provides:[119]

> 1.1 Doctors (medical practitioners) are entitled to have their own personal beliefs and values as are all members of the community.
>
> 1.2 A conscientious objection occurs when a doctor, as result of a conflict with his or her own personal beliefs or values, refuses to participate in, a legal, legitimate treatment or procedure which would be deemed medically appropriate in the circumstances under professional standards.
>
> 1.3 A conscientious objection is based on sincerely-held beliefs and moral concerns, not self-interest or discrimination.
>
> …
>
> 1.8 A refusal by a doctor to provide, or participate in, a treatment of procedure for legitimate medical or legal reasons, does not constitute a conscientious objection. For example, where a patient requests a treatment or procedure that is of no medical benefit, outside the doctor's skill or scope of practice, illegal or where the doctor believes the patient has impaired decision making.

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[119] *Position Statement – Conscientious Objection* (Australian Medical Association, 2019).

[199] The distinction drawn by Dr Wiseman and the AMA is consistent with academic commentary on what is meant by conscience as compared with a clinical or professional judgement in clinical practice. Stephen Smith, an academic in the United Kingdom, has written a series of articles about the role of conscience in healthcare decisions.[120] He argues that a doctor's decision-making in any case involves the following four questions:[121]

> (a) Is this particular treatment option *possible or feasible?* (the technical medical skill question).
>
> (b) Is this particular treatment option *generally acceptable* in these cases? (the professional regulation question).
>
> (c) Is this particular treatment option good for *this particular patient?* (the best interests question).
>
> (d) Can I *provide* this treatment *consistently with my own conscience?* (the conscience question).

[200] Smith says the answers to one question will influence the others although they are separate questions with different purposes and foci.[122] He argues that treatment decisions are rarely just decisions on one of these questions. Instead, decisions about treatment involve a doctor making a complex judgment about what treatments are clinically available and allowed by professional regulations in light of what is best for the patient and what the doctor feels individually able to provide in terms of their conscience.[123]

[201] Smith discusses conscience as follows:[124]

> Conscience claims are about my moral choices and decisions, not what I necessarily think others are required to do. More specifically, conscience, in the way we generally use it, is a feeling or attitude, or belief, which is frequently but not necessarily based on religion, about whether doing something is right or wrong …
>
> Conscience also does not have to be correct … . It means only the individual in question *believes* it to be …

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[120] Stephen Smith "The Responsibilities of Conscience in Healthcare Decisions: Moving Towards a Collaborative Framework" (2020) 79(1) Cambridge Law Journal 120; "Individualised Claims of Conscience, Clinical Judgement and Best Interests" (2018) 26 Health Care Analysis 81; "A Bridge Too Far: Individualised Claims of Conscience" (2015) 23 Medical Law Review 283.

[121] Smith (2018).

[122] At 89.

[123] At p 88 and 89.

[124] Smith (2015), above n 120, at 286-287.

> Conscience then is the doing or failing to do something on the basis of our beliefs about the rightness or wrongness of the conduct in question. … A claim of conscience requires that the reason be a moral one, but it need not be a rule-based reason. One can have a moral qualm about performing a particular action in one case without it necessitating that the individual be able to articulate a rule as to why. This may be because the claim is based on a moral hunch, but it might also be because there are a number of ethical rules at play in a particular case …

[202] Smith describes a conscientious objection as a "legally enforceable right to object to providing treatment which goes against the conscience of the individual". He describes conscience as "an internal mental process focussed on an inward-looking choice to engage in particular behaviour on the basis of a moral value".[125] It provides "'the inner voice' which helps to determine whether the conduct in question is good or bad and whether we ought to do it".[126]

[203] Smith explains:

(a) Describing conscience as an internal mental process helps to avoid issues relating to the origins of conscience and its substantive content. Conscience need not be limited to individuals with specific religious views. Conscience might arise from anywhere (for example, it might be influenced by social culture and upbringing) but it must be an internal mental process.[127] It does not matter if others think something is right or wrong. What matters is that the person claiming conscience has "a deeply felt belief".[128]

(b) The second component is a choice relating to behaviour. A person can choose to follow their conscience or to do something else. Conscience concerns the rightness or wrongness of things that we either do or fail to do.

(c) The third component is for the choice to be based upon "moral" values. It is not simply a choice based upon values. That is too broad as it

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125 Smith (2020), above n 120, at 124.
126 At 131.
127 At 124-125.
128 At 131.

could, for example, capture aesthetic or cultural values. It must be based upon some set of moral values but it is not required to be any specific set of moral values.[129]

(d) The fourth component, that it be inward facing, means that conscience is only capable of binding our own conduct and not the conduct of others. In other words, conscience can only provide a reason for an individual to do or to refrain from doing something. It is an insufficient reason for someone else to do or refrain from doing something.[130]

[204] Smith discusses that a person may oppose a course of action in all cases of that kind (for example, to provide an abortion or to assist euthanasia) or only in specific circumstances. He discusses that healthcare regulation provides legally enforceable conscientious objections in very specific circumstances and this is crucial. Otherwise, they would have the potential to dictate treatment for patients and limit their choices.[131]

[205] Another academic commentator, José Miola, agrees that decisions of conscience differ from clinical judgments.[132] He says:

> I consider a doctor to be using her conscience whenever she makes, and is free to make, a decision that is non-technical in nature…
>
> … The use of conscience in my view, involves personal values rather than professional judgement…

[206] He goes on to discuss that personal values tend not to relate to:[133]

> *how* something is done (which would generally be a matter of clinical judgment), but *whether* it would be right to do so, which is a different category of decision involving personal values rather than professional judgment…

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129 At 127.
130 At 127.
131 At 129.
132 *Making Decisions About Decision-Making: Conscience, Regulation, and the Law* (2015) 23(2) Medical Law Review 263.
133 At 265. As discussed earlier, Smith takes the view that "values" is too broad, and that it is necessary that they be based upon some set of moral values.

[207] Another commentator, Brian Bird, discusses what the right to freedom of conscience in the Canadian Charter of Rights and Freedoms might entail in the context of physician assisted death following the Supreme Court of Canada's decision in *Carter v Canada (Attorney-General).*[134] Bird argues that in this context "freedom of conscience … protects physicians – whether they are atheist, agnostic or religious – who refuse to assist with a patient's death because in their view it is immoral".

[208] The closest interpretation to the one proposed by Hospice NZ that I have found is discussed by Robert Card.[135]

> A great number of medical providers such as physicians and nurses view their practice of medicine as constitutive of their identity; because their core moral values are also part of their self-constitution, their moral values are thereby imported into their practice.

[209] Finally, I note that, although clinical judgement is to be distinguished from claims of conscience, clinical judgement may potentially influence the claim on a doctor's conscience. An example of this is a case discussed by Smith.[136] Treatment was clinically available to a patient and could have prolonged his life. The patient did not have capacity to make the decisions for himself but the patient's family wanted him to have the treatment in order to prolong his life. The doctors involved in his care were opposed to providing it because it would cause the patient to constantly shiver, possibly for the rest of his life. The doctors did not feel able to allow this distressing consequence and considered it to be "deeply inappropriate for me as a clinician and the rest of my colleagues to offer these treatments".[137] Smith argues that the doctors' resistance to the treatment may have been more moral than clinical, in which case it was about the doctors' conscience.

[210] Against this background, I do not consider it appropriate for the Court to provide a comprehensive of interpretation of the right to conscientious objection in the End of Life Choice Act. Suffice it to say that I do not consider the case has been made

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134 *Carter v Canada (Attorney-General)* [2015] 1 SCR 331; Bird "The Call in *Carter* to Interpret Freedom of Conscience", above n 92.

135 Robert Card *A New Theory of Conscientious Objection in Medicine* (Routledge, 2020) at 82.

136 Stephen Smith "A Bridge Too Far: Individualised Claims of Conscience" (2015) 23(2) Medical Law Review 283, discussing *Aintree University Hospitals NHS Foundation Trust v James* [2013] UKSC 67.

137 Above at [19].

at this stage for an atypically broad interpretation that does not fit with its more usual meaning in medical practice to enable me to answer Question 5 as it is posed. Certainly it will encompass when a doctor or nurse holds a deeply-felt belief that it is wrong for them to provide the assistance for personal, moral reasons internal to them. The question of whether a broader interpretation is available should be decided on specific facts where it is said to be necessary.

[211] As to whether a health practitioner can hold a blanket conscientious objection, I consider s 8 permits this. If a health practitioner is opposed to assisting anyone to die on grounds of conscience, then the health practitioner will have “a conscientious objection to providing that assistance to the person” who wishes to exercise the option under s 8. This was also the view of the Attorney-General in his submissions.

Conclusion

[212] I accept the premise of Hospice NZ’s application that there are aspects of the End of Life Choice Act that are causing confusion amongst those involved in palliative care and more generally. I also accept that, if the Court is able to clarify areas of confusion by interpreting the legislation, then it should do so even though there may be limits to their binding effect. The unique constitutional position whereby voters will decide whether legislation in a form that has received Royal Assent will come into force supports this.[138]

[213] However, I am not able to make the declarations in the form they are sought. The questions posed for declaratory relief involve hypotheticals, without sufficiently certain factual bases to answer them in the form in which they are asked, or which will depend on the particular circumstances that may give rise to the concerns the questions posed seek to address in advance.

[214] However, there are some matters on which the Court can assist. These are matters of statutory interpretation that are not fact-dependent. They are as follows:

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138 In *Shark Experience v PauaMAC5*, above n 31, the Supreme Court said, at [117]: “We acknowledge that in some cases the public interest may be so great as to outweigh the countervailing considerations we have identified”.

(a) The End of Life Choice Act does not require hospices or other organisations to provide assisted dying services. They are entitled to choose not to provide these services. This does not depend on a hospice or other organisation having a conscientious objection, although that may often be the reason, and allowing hospices or other organisations not to offer assisted dying services is consistent with the right to freedom of conscience under s 13 of NZBORA.

(b) Hospices or other organisations that choose not to offer assisted dying services may employ or engage health practitioners on the basis that these services are not provided by the hospices or organisations, but it will also be necessary to have arrangements for how health practitioners can comply with their objections under the End of Life Choice Act if a request is made of them by a person in the hospice or organisation's care.

(c) The End of Life Choice Act does not exclude the operation of the Code, except to the extent that it is expressly overridden by the Act or cannot apply alongside the requirements of the Act.

(d) The End of Life Choice Act does not exclude the professional obligations of health practitioners as set by the Medical Council and the Nursing Council. Health practitioners required to take steps under the End of Life Choice Act may only do so if they have the competence to do so in accordance with their professional standards. "[T]he attending medical practitioner" is the patient's medical practitioner, whose scope of practice permits them to provide the services required of them under the Act and who has the necessary competence to provide those services.

(e) The right to conscientiously object encompasses its usual meaning in medical practice. It will encompass when a doctor or nurse holds a deeply-felt belief that it is wrong for them to provide the assistance for personal, moral reasons, internal to them.

[215] I make declarations in accordance with these conclusions. In making these declarations I do not exclude the possibility that broader interpretations of some of the Act's provisions may be available if or when circumstances come before the Court that test the parameters of the Act. But at this stage I am not able to say that such broader interpretations, if available, will be necessary to protect NZBORA rights, nor whether any limitations on NZBORA rights will be demonstrably justified in a free and democratic society.

[216] If there is any issue as to costs, the parties have leave to file brief submissions within 14 days of the date of this judgment.

Mallon J

Appendix I: End of Life Choice Act 2019 provisions

[217] The definitions in the End of Life Choice Act include:

> **attending medical practitioner**, in relation to a person, means the person's medical practitioner
>
> **attending nurse practitioner** means a nurse practitioner who is acting under the instruction of an attending medical practitioner (or replacement medical practitioner)
>
> **independent medical practitioner** means a medical practitioner who,—
>
> (a) in relation to a person who has requested to exercise the option of receiving assisted dying, is independent of the person and of the person's attending medical practitioner (and any replacement medical practitioner); and
>
> (b) has held, for at least the previous 5 years, a practising certificate, or the equivalent certification from an overseas authority responsible for the registration or licensing of medical practitioners
>
> **medical practitioner** means a health practitioner who—
>
> (a) is, or is deemed to be, registered with the Medical Council of New Zealand continued by section 114(1)(a) of the Health Practitioners Competence Assurance Act 2003 as a practitioner of the profession of medicine; and
>
> (b) holds a current practising certificate
>
> **nurse practitioner** means a health practitioner who—
>
> (a) is, or is deemed to be, registered with the Nursing Council of New Zealand continued by section 114(1)(a) of the Health Practitioners Competence Assurance Act 2003 as a practitioner of the profession of nursing and whose scope of practice permits the performance of nurse practitioner functions; and
>
> (b) holds a current practising certificate

[218] The obligations on an attending medical practitioner when a request is made are as follows:

> **11 Request made**
>
> (1) A person who wishes to exercise the option of receiving assisted dying must inform the attending medical practitioner of their wish.
>
> (2) The attending medical practitioner must—
>
> > (a) give the person the following information:

(i) the prognosis for the person's terminal illness; and

(ii) the irreversible nature of assisted dying; and

(iii) the anticipated impacts of assisted dying; and

(b) personally communicate by any means (for example, by telephone or electronic communication) with the person about the person's wish at intervals determined by the progress of the person's terminal illness; and

(c) ensure that the person understands their other options for end-of-life care; and

(d) ensure that the person knows that they can decide at any time before the administration of the medication not to receive the medication; and

(e) encourage the person to discuss their wish with others such as family, friends, and counsellors; and

(f) ensure that the person knows that they are not obliged to discuss their wish with anyone; and

(g) ensure that the person has had the opportunity to discuss their wish with those whom they choose; and

(h) do their best to ensure that the person expresses their wish free from pressure from any other person by—

(i) conferring with other health practitioners who are in regular contact with the person; and

(ii) conferring with members of the person's family approved by the person; and

(i) record the actions they have taken to comply with paragraphs (a) to (h) in the first part of the approved form that requests the option of receiving assisted dying.

[219] The process for confirming a request, and the obligations on an attending medical practitioner at this stage are:

12 Request confirmed

(1) This section applies after the attending medical practitioner complies with section 11.

(2) If the person requesting to exercise the option of receiving assisted dying (**A**) wishes to proceed, the attending medical practitioner must give A the approved form referred to in section 11(2)(i).

(3) A must—

(a) sign and date the second part of the form; or

(b) be present when the second part of the form is signed and dated as described in subsection (4).

(4) The second part of the form may be signed and dated by another person (**B**) if—

(a) A cannot write for any reason; and

(b) A requests B to sign and date it; and

(c) B notes on the form that they signed the second part of the form in the presence of A; and

(d) B confirms on the form that B is not—

(i) a health practitioner caring for A; or

(ii) a person who knows that they stand to benefit from the death of A; or

(iii) a person aged under 18 years; or

(iv) a person with a mental incapacity.

(5) The attending medical practitioner must—

(a) be present when—

(i) subsection (3)(a) is complied with; or

(ii) subsections (3)(b) and (4) are complied with; and

(b) collect the form; and

(c) send the completed form to the Registrar.

[220] When a request has been confirmed, the first attending medical practitioner is required to reach an opinion on eligibility as follows:

13 First opinion to be given by attending medical practitioner

(1) This section applies after the attending medical practitioner complies with section 12(5)(c).

(2) The attending medical practitioner must reach the opinion that—

(a) the person requesting the option of receiving assisted dying is a person who is eligible for assisted dying; or

(b) the person requesting the option of receiving assisted dying is not a person who is eligible for assisted dying; or

(c) the person requesting the option of receiving assisted dying would be a person who is eligible for assisted dying if it were established under section 15 that the person was competent to make an informed decision about assisted dying.

(3) The attending medical practitioner must—

(a) complete an approved form recording their opinion; and

(b) send the completed form to the Registrar.

[221] After this, the independent medical practitioner provides a second opinion:

14 Second opinion to be given by independent medical practitioner

(1) This section applies if the attending medical practitioner reaches the opinion described in section 13(2)(a) or (c).

(2) The attending medical practitioner must—

(a) ask the SCENZ Group for the name and contact details of an independent medical practitioner; and

(b) ask the independent medical practitioner for their opinion on whether the person requesting the option of receiving assisted dying is a person who is eligible for assisted dying.

(3) The independent medical practitioner must—

(a) read the person's medical files; and

(b) examine the person; and

(c) reach the opinion that—

(i) the person is a person who is eligible for assisted dying; or

(ii) the person is not a person who is eligible for assisted dying; or

(iii) the person would be a person who is eligible for assisted dying if it were established under section 15 that the person was competent to make an informed decision about assisted dying.

(4) The independent medical practitioner must—

(a) complete an approved form recording their opinion; and

(b) send the completed form to the Registrar; and

(c) send a copy of the completed form to the attending medical practitioner.

[222] A psychiatrist's involvement is as follows:

15 Third opinion to be given by psychiatrist if competence not established to satisfaction of 1 or both medical practitioners

(1) This section applies if—

(a) the following situation exists:

(i) the attending medical practitioner reaches the opinion described in section 13(2)(a); and

(ii) the independent medical practitioner reaches the opinion described in section 14(3)(c)(iii); or

(b) the following situation exists:

(i) the attending medical practitioner reaches the opinion described in section 13(2)(c); and

(ii) the independent medical practitioner reaches the opinion described in section 14(3)(c)(i); or

(c) the following situation exists:

(i) the attending medical practitioner reaches the opinion described in section 13(2)(c); and

(ii) the independent medical practitioner reaches the opinion described in section 14(3)(c)(iii).

(2) The medical practitioners must jointly—

(a) ask the SCENZ Group for the name and contact details of a psychiatrist; and

(b) ask the psychiatrist for their opinion on whether the person requesting the option of receiving assisted dying is competent to make an informed decision about assisted dying.

(3) The psychiatrist must—

(a) read the person's medical files; and

(b) examine the person; and

(c) reach the opinion that—

(i) the person is competent to make an informed decision about assisted dying; or

(ii) the person is not competent to make an informed decision about assisted dying.

(4) The psychiatrist must—

(a) complete an approved form recording their opinion; and

(b) send the completed form to the Registrar; and

(c) send a copy of the completed form to—

(i) the attending medical practitioner; and

(ii) the independent medical practitioner.

[223] If the opinion is reached that the person is eligible for assisted dying, the following applies:

17 Opinion reached that person is eligible for assisted dying

(1) This section applies if—

(a) the following situation exists:

(i) the attending medical practitioner reaches the opinion described in section 13(2)(a); and

(ii) the independent medical practitioner reaches the opinion described in section 14(3)(c)(i); or

(b) the following situation exists:

(i) a psychiatrist is asked for their opinion under section 15(2)(b); and

(ii) the psychiatrist reaches the opinion described in section 15(3)(c)(i).

(2) The attending medical practitioner must—

(a) advise the person requesting the option of receiving assisted dying that the person is a person who is eligible for assisted dying; and

(b) discuss with the person the progress of the person's terminal illness; and

(c) discuss with the person the likely timing for the administration of the medication; and

(d) give the person an approved form for the person to complete by choosing the date and time for the administration of the medication; and

(e) advise the person that at any time after completing the approved form referred to in paragraph (d) the person may decide—

(i) not to receive the medication; or

(ii) to receive the medication at a time on a later date that is not more than 6 months after the date initially chosen for the administration of the medication.

(3) The attending medical practitioner must—

(a) complete an approved form recording the actions taken to comply with subsection (2); and

(b) send the completed form to the Registrar.

[224] The next step is the provisional arrangements for administering medication:

19 Provisional arrangements for administration of medication

(1) This section applies after the attending medical practitioner complies with section 18(2).

(2) Before the date chosen by an eligible person for the administration of the medication, the attending medical practitioner must—

(a) advise the person about the following methods for the administration of the medication:

(i) ingestion, triggered by the person:

(ii) intravenous delivery, triggered by the person:

(iii) ingestion through a tube, triggered by the attending medical practitioner or an attending nurse practitioner:

(iv) injection administered by the attending medical practitioner or an attending nurse practitioner; and

(b) ask the person to choose one of the methods; and

(c) ensure that the person knows that they can decide, at any time before the administration of the medication, not to receive the medication or to receive the medication at a time on a later date that is not more than 6 months after the date initially chosen for the administration of the medication; and

(d) make provisional arrangements for the administration of the medication on the chosen day and time.

(3) At least 48 hours before the chosen time for the administration of the medication, the attending medical practitioner, or an attending nurse practitioner, must—

(a) write the appropriate prescription for the eligible person; and

(b) advise the Registrar of the method and of the date and time chosen for the administration of the medication.

(4) The Registrar must check that the processes in sections 11 to 18 have been complied with.

(5) If the Registrar is satisfied that the processes in sections 11 to 18 have been complied with, the Registrar must notify the attending medical practitioner accordingly.

[225] The next step is the administration of medication:

20 Administration of medication

(1) This section applies after the attending medical practitioner has received notification from the Registrar under section 19(5).

(2) At the chosen time for the administration of the medication, the attending medical practitioner, or an attending nurse practitioner, must ask the eligible person if they choose—

(a) to receive the medication at that time; or

(b) not to receive the medication at that time, but to receive the medication at a time on a later date that is not more than 6 months after the date initially chosen for the administration of the medication; or

(c) not to receive the medication at that time, and to rescind their request to exercise the option of assisted dying.

(3) If the eligible person chooses not to receive the medication at the chosen time, the attending medical practitioner, or an attending nurse practitioner, must—

(a) immediately take the medication away from the eligible person; and

(b) complete an approved form recording the action taken to comply with paragraph (a); and

(c) send the completed form to the Registrar.

(4) If the eligible person chooses to receive the medication, the attending medical practitioner, or the attending nurse practitioner, must—

(a) provide the medication to the person, for administration by either of the methods described in section 19(2)(a)(i) and (ii); or

(b) administer the medication by either of the methods described in section 19(2)(a)(iii) and (iv).

(5) The attending medical practitioner, or the attending nurse practitioner, must—

(a) be available to the eligible person until the person dies; or

(b) arrange for another medical practitioner or attending nurse practitioner to be available to the person until the eligible person dies.

(6) For the purposes of subsection (5), the attending medical practitioner or attending nurse practitioner ***is available to the eligible person*** if the medical practitioner or attending nurse practitioner—

(a) is in the same room or area as the person; or

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

Appendix II: The Code

[226] The Health and Disability Commissioner (Code of Health and Disability Services Consumers' Rights) Regulations 1996 sets out consumers' rights.

[227] These include Right 4, which is in the following terms:

Right to services of an appropriate standard

(1) Every consumer has the right to have services provided with reasonable care and skill.

(2) Every consumer has the right to have services provided that comply with legal, professional, ethical, and other relevant standards.

(3) Every consumer has the right to have services provided in a manner consistent with his or her needs.

(4) Every consumer has the right to have services provided in a manner that minimises the potential harm to, and optimises the quality of life of, that consumer.

(5) Every consumer has the right to co-operation among providers to ensure quality and continuity of services.

[228] Right 6 is in the following terms:

Right to be fully informed

(1) Every consumer has the right to the information that a reasonable consumer, in that consumer's circumstances, would expect to receive, including—

(a) an explanation of his or her condition; and

(b) an explanation of the options available, including an assessment of the expected risks, side effects, benefits, and costs of each option; and

(c) advice of the estimated time within which the services will be provided; and

(d) notification of any proposed participation in teaching or research, including whether the research requires and has received ethical approval; and

(e) any other information required by legal, professional, ethical, and other relevant standards; and

(f) the results of tests; and

(g) the results of procedures.

(2) Before making a choice or giving consent, every consumer has the right to the information that a reasonable consumer, in that consumer's circumstances, needs to make an informed choice or give informed consent.

(3) Every consumer has the right to honest and accurate answers to questions relating to services, including questions about—

(a) the identity and qualifications of the provider; and

(b) the recommendation of the provider; and

(c) how to obtain an opinion from another provider; and

(d) the results of research.

(4) Every consumer has the right to receive, on request, a written summary of information provided.

[229] Right 7 is in the following terms:

Right to make an informed choice and give informed consent

(1) Services may be provided to a consumer only if that consumer makes an informed choice and gives informed consent, except where any enactment, or the common law, or any other provision of this Code provides otherwise.

(2) Every consumer must be presumed competent to make an informed choice and give informed consent, unless there are reasonable grounds for believing that the consumer is not competent.

(3) 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.

(4) Where a consumer is not competent to make an informed choice and give informed consent, and no person entitled to consent on behalf of the consumer is available, the provider may provide services where—

(a) it is in the best interests of the consumer; and

(b) reasonable steps have been taken to ascertain the views of the consumer; and

(c) either,—

(i) if the consumer's views have been ascertained, and having regard to those views, the provider believes, on reasonable grounds, that the provision of the services is consistent with the informed choice the consumer would make if he or she were competent; or

(ii) if the consumer's views have not been ascertained, the provider takes into account the views of other suitable persons who are interested in the welfare of the consumer and available to advise the provider.

(5) Every consumer may use an advance directive in accordance with the common law.

(6) Where informed consent to a health care procedure is required, it must be in writing if—

(a) the consumer is to participate in any research; or

(b) the procedure is experimental; or

(c) the consumer will be under general anaesthetic; or

(d) there is a significant risk of adverse effects on the consumer.

(7) Every consumer has the right to refuse services and to withdraw consent to services.

(8) Every consumer has the right to express a preference as to who will provide services and have that preference met where practicable.

(9) Every consumer has the right to make a decision about the return or disposal of any body parts or bodily substances removed or obtained in the course of a health care procedure.

(10) No body part or bodily substance removed or obtained in the course of a health care procedure may be stored, preserved, or used otherwise than—

(a) with the informed consent of the consumer; or

(b) for the purposes of research that has received the approval of an ethics committee; or

(c) for the purposes of 1 or more of the following activities, being activities that are each undertaken to assure or improve the quality of services:

(i) a professionally recognised quality assurance programme:

(ii) an external audit of services:

(iii) an external evaluation of services.