

Regulating Clinician Speech in Assisted Dying: Using a Sledgehammer to Crack a Nut?

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Abstract

Since the enactment of End of Life Choice Act 2019, people suffering from terminal illness who meet specific statutory criteria have the right to request and receive assisted dying (AD) in New Zealand. However, unlike ordinary health care law that is premised upon the right of patients to receive relevant information regarding health care and treatment options, the Act expressly prohibits health practitioners from initiating *any* discussion with a person that is, in substance, about AD. This far-reaching provision abrogates the general ethical, professional and legal duty to inform patients regarding health care and treatment options. This well-established duty, which is grounded in the right of individuals to make autonomous decisions, arises from both the common law as well as New Zealand's foremost expression of patient rights promulgated under the Health and Disability Commissioner Act 2004 (the Code of Health and Disability Services Consumers' Rights). Intended as a safeguard, the prohibition is based on a perceived risk that presenting AD as an available choice may unduly influence some terminally ill patients to exercise the option of AD. While potentially well intentioned, the prohibition is far from benign. It has been criticised as hindering appropriate clinical and therapeutic communication and imposing barriers to good medical care. Ironically, the prohibition potentially risks not only contributing to inequitable access to AD, it may also increase the risk of premature death for some terminally ill individuals. This paper explores an additional criticism not previously considered in the literature, which is that the prohibition is inconsistent with section 14 of the New Zealand Bill of Rights Act 1990. Section 14 establishes the right to "freedom of expression, including the freedom to seek, receive, and impart information", which directly engages the rights of both clinician and patients in the health care context. After establishing that the prohibition cannot be demonstrably justified in a free and democratic society, this article concludes by considering two potential solutions: repeal of the prohibition completely, or alternatively, introducing a less demanding option that better achieves the objective of protecting vulnerable patients experiencing terminal illness. It favours the latter.

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I Introduction

In the year to March 2024, 37,623 people in died in New Zealand.¹ Of those, 834 (2%) applied for assisted dying (AD) under the End of Life Choice Act 2019 (EOLC Act)² with 344 people (0.9%) subsequently receiving an assisted death.³ Despite the relatively small number of people requesting AD, a substantial proportion of people who otherwise died likely had conversations with health practitioners about their inevitable demise, some of whom may have considered the option of AD if they knew it was a legitimate and available medical procedure. However, the EOLC Act expressly prohibits a health practitioner⁴ from initiating any discussion with a patient that is, in substance, about AD.⁵ This is despite evidence that when facing death and preparing to die, individuals and their families consider it important to have physicians that are comfortable talking about death and dying and who can clarify the range of available end of life options.⁶

The enactment of the EOLC Act followed a period of sustained public and political pressure to enable New Zealanders suffering terminal illness to access assisted dying.⁷ The primary purpose of the EOLC Act, in force since November 2021, is “to give persons who have a terminal illness and who meet certain criteria the option of lawfully requesting to end their lives”.⁸ A secondary purpose is “to establish a lawful process for assisting eligible persons to exercise that option”.⁹ The Act defines “assisted dying” as including both the administration of medication to an eligible person by an attending medical practitioner or attending nurse practitioner to hasten death (elsewhere termed “euthanasia”); or the self-administration of medication to hasten death (elsewhere termed “assisted suicide”).¹⁰

1 Stats NZ Info Share. New Zealand Total Deaths April 2023–March 2024. Accessed 04.10.2024.

2 *Assisted Dying Service – Ngā Ratonga Mate Whakaahuru – Annual Report To The Minister of Health* (Wellington, Ministry of Health, 2024).

3 In the first three years of AD being available in NZ, there were 2,482 requests for AD, with just over 970 of those applicants receiving an assisted death (7 November 2021–7 November 2024). Ministry of Health *Review of the End of Life Choice Act 2019* (Wellington, Ministry of Health, 2024).

4 Under the EOLC Act, “health practitioner” has the same meaning given to it by section 5(1) of 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”.

5 End of Life Choice Act 2019, s 10.

6 K Steinhäuser, N Christakis, E Clipp, M McNeilly, L McIntyre and J Tulskey “Factors Considered Important at the End of Life by Patients, Family, Physicians, and Other Care Providers” (2000) 284(19) *JAMA* 2476–2482.

7 J Snelling “Critiquing the End of Life Choice Act” (2022) 30 *New Zealand Universities Law Review*.

8 Section 3(a).

9 Section 3(b).

10 Section 4.

While an eligible person has a right to request and receive AD, this right is accompanied by multiple provisions designed to restrict AD to a narrowly defined group of terminal patients and to protect the vulnerable from coercion.¹¹ Foremost of these safeguards are the eligibility criteria.¹² Another safeguard, which is the focus of this article, is the statutory prohibition on clinicians initiating a discussion of AD with a patient.

This article critically examines the prohibition contained in section 10 of the EOLC Act. Part II begins by outlining the legislative history and the main features of the EOLC Act, before considering the provenance of the section 10 prohibition. Part III then considers the implications of prohibiting specific speech in the context of a patient-clinician relationship and whether, in directly engaging clinician's right to freedom of expression, section 10 of the EOLC Act is consistent with the New Zealand Bill of Rights Act 1990 (NZBORA). It concludes that the prohibition as currently drafted not only engages a clinician's right to freedom of expression, the rights restriction cannot be justified in a free and democratic society and is thus inconsistent with NZBORA.

II Legislative Context and Main Features of the EOLC Act

The EOLC Act, which was introduced as a member's bill by Act Party leader and Minister of Parliament David Seymour, constitutes one of the most contentious health laws to be enacted in New Zealand in recent decades. The public debate preceding its introduction was characterized by organized and vigorous lobbying by proponents on both sides of the AD divide.¹³ An additional distinctive feature of the EOLC Act is its procedurally unconventional legislative course; not only was its

11 For instance, there are three accountability oversight bodies; specific inclusion and exclusion criteria; two medical practitioners (one of whom must be an independent practitioner) must agree that a person meets the eligibility criteria; specific information must be provided by the attending medical practitioner to ensure a person understands their end-of-life options, and if found eligible that they know they can decline at any time not to receive medication; the requesting person must have capacity; and finally the attending medical/nurse practitioner is required throughout the process to ensure the person "expresses their wish free from pressure from any other person".

12 Sections 5–6.

13 For example, one group called #DefendNZ launched a public campaign to oppose the bill and advocate for the vulnerable; see www.defendnz.co.nz. Another group, "Lawyers for Vulnerable New Zealanders" claimed in an Open Statement that there were "fatal flaws" in the Bill, that it lacked safeguards, and it was not fit for purpose. See <https://lvn.org>. In addition, a coalition opposed to euthanasia and assisted suicide launched the "Care Alliance", representing "voices from across the palliative, medical, youth, elderly, disability, bioethics and faith sectors". www.Carealliance.org.nz/icare. On the other side of the divide, groups campaigning for AD included "Vote Yes for Compassion"; and the End-of-Life Choice Society of New Zealand.

introduction subject to a public referendum,¹⁴ the Select Committee members tasked with considering the Bill were unable to agree it should be passed, leading to significant late-stage amendments being introduced which circumvented usual legislative processes.

When first introduced the EOLC Bill proposed relatively broad access to AD, extending AD not only to people suffering a terminal illness likely to end their life within six months, but also to people suffering from a “grievous and irremediable” condition.¹⁵ This latter criterion does not require the presence of terminal illness or limited life expectancy, but would have enabled a person suffering from a serious illness, the effects of which could not be remediated, to access AD. Consequently, as originally drafted the Bill would have permitted access to persons with neurodegenerative conditions such as motor neurone disease or other chronic untreatable conditions associated with reduced quality of life, but with a life expectancy greater than six months. Although passing its first reading, the EOLC Bill was widely criticised as overly liberal and lacking adequate safeguards.¹⁶ Even after referral to the Justice Select Committee, the Committee was unable to agree that the Bill should be passed, exemplifying the polarized attitudes towards legalizing AD in New Zealand. Consequently, the Select Committee made only minor technical amendments to ensure the Bill was consistent with existing legislation, leaving the substantive provisions to be debated by the House at the Committee stage. On notice that the Bill as it was then drafted was unlikely to be passed, over 100 Supplementary Order Papers (SOP) were subsequently submitted to Parliament, all of which attempted to “improve” the Bill’s perceived deficiencies. When the Bill was finally debated by the Committee of the Whole House, David Seymour’s SOP (No. 259) was essentially adopted in full, introducing a range of new provisions which included narrowing the eligibility criteria and imposing additional safeguards, all of which were designed to ensure adequate parliamentary support for the Bill’s enactment.¹⁷ Significantly, none of these new provisions, including the prohibition on initiating any discussion that is in substance about AD, were vetted for consistency with the NZBORA nor subject to ordinary Select Committee processes. Ultimately the EOLC Bill as amended by SOP No. 259 passed by a majority of 69:51 following a conscience vote in Parliament. Consistent with the EOLC Act’s requirement for a referendum, the EOLC Act came into force 12 months after 65% of referendum voters in the 2020 general election supported its introduction.¹⁸

14 Andrew Geddis and Sarah Jocelyn “End of Life Choice: Coming to New Zealand by the Road Less Travelled” (2021) 95 *Australian Law Journal* 325.

15 End of Life Choice Bill 269-1 (2017), cl 4(c)(ii).

16 Snelling, above n 7.

17 Supplementary Order Paper No. 259 (released 30 July 2019) in the name of David Seymour.

18 Section 2(1).

A Eligibility and Safeguards

The EOLC Act contains multiple safeguards to ensure any request for AD is informed and made voluntarily. Before an individual may even undergo an assessment for eligibility, an extensive range of information must be provided to that person by an Attending Medical Practitioner.¹⁹ Once an application for assessment is formally made, at least two medical practitioners must find that the person suffers from a “terminal illness likely to end their life within 6 months”; and “is in an advanced state of irreversible decline in physical capacity”; and “experiences unbearable suffering that cannot be relieved in a manner that the person considers tolerable”.²⁰ Finally, to be eligible the person must have decisional capacity as defined in the EOLC Act.²¹ Significantly, this requirement for assessment of capacity reverses the presumption of capacity established by common law and under the Code of Rights, presumably due to the gravity of the decision.²² If either or both assessing clinicians are uncertain regarding an individual’s capacity, but it is considered the person otherwise meets the eligibility requirements, the Act permits an additional opinion on capacity to be sought from a psychiatrist.²³

In contrast to ordinary health law, an eligible person may not delegate decision making authority to a proxy decision maker in the event that they deteriorate and lose capacity prior to receiving AD: hence consent to AD may not be provided by an Enduring Power of Attorney under the Protection of Personal and Property Rights Act 1988,²⁴ nor may AD may be provided on the basis of an Advance Directive.²⁵ As a result, contemporaneous decisional capacity is a core principle of eligibility under the EOLC Act. Eligibility is also restricted to persons who are aged 18 years or over and who are either a New Zealand (NZ) citizen or a permanent resident.²⁶ In an attempt to ameliorate concerns that specific vulnerable groups may be at risk of coercion, and in an abundance of caution given the specific eligibility requirements, the EOLC Act expressly states that a person will not be eligible for AD by “reason *only* that the person is suffering from any mental disorder, mental illness, disability or advanced age”.²⁷

19 Section 11. An “Attending Medical Practitioner” is defined as “the person’s medical practitioner” (s 2).

20 Section 5.

21 Section 6.

22 Cf *Re T (adult: refusal of medical treatment)* [1992] 4 All ER 649; Clause 5A(3) of the HDC Code of Rights provides that s 6 of the EOLC Act overrides Right 7(2)–(5) of the Code of Rights.

23 Section 15.

24 Ordinarily an individual may appoint an Enduring Power of Attorney under the Protection of Personal and Property Rights Act 1988 to act in relation to that person’s personal care and welfare, including medical decision making, if the donor becomes mentally incapable (s 93A(1)).

25 Section 33; cf Right 7(5) of the Code of Rights.

26 Section 5(1)(a); (b).

27 Section 5(2).

To ensure that people are aware that they can change their mind at any stage, the EOLC Act also requires that the person is informed at regular and specific intervals throughout the assessment process up until the point that AD is administered that they can defer or rescind their request at any time.²⁸ Lastly, the EOLC Act requires that if at any point the attending medical practitioner or attending nurse practitioner “suspects on reasonable grounds that a person [...] is not expressing their wish free from pressure from any other person” they must not take any further action to assist the person to undergo AD.²⁹

While the EOLC Act places strong emphasis on ensuring to the greatest extent possible that any request for AD is voluntary, informed and made contemporaneously by a person with capacity, a necessary precondition for considering AD is knowing that the procedure may be an option in one’s circumstances and that it is legally available. However, the EOLC Act states:

10 Assisted dying must not be initiated by health practitioner

- (1) A health practitioner who provides *any health service to a person* must not, in the course of providing that service to the person,—
 - (a) initiate any discussion with *the person* that, in substance, is about assisted dying under this Act; or
 - (b) make any suggestion to *the person* that, in substance, is a suggestion that the person exercise the option of receiving assisted dying under this Act. (emphasis added)

The prohibition contained in section 10 is extremely broad; it applies not only to health practitioners directly involved in providing end of life care, but encompasses the range of registered health practitioners that a patient interacts with when seeking or receiving healthcare, including doctors, nurses and allied health staff.³⁰ In the absence of a patient-initiated discussion, the EOLC Act imposes a “code of silence” regarding AD. Section 10 requires patients to clearly and unambiguously indicate to a provider that they wish to receive information about AD—which presupposes an already informed individual. Given the emphasis on fully informed consent to AD in the EOLC Act, there is some irony in the fact that the EOLC Act effectively restricts access to AD to those who are sufficiently health literate and informed to know that it is now a legitimate and lawful end of life option in New Zealand in the first place. Whilst the prohibition extends across all end of life discussions, its impact is greatest for those persons who are contemplating inevitable death due to terminal illness but who are unaware that AD is now lawful in New Zealand.³¹ Included in this category are those who are less health literate, those who do not speak English or for whom English is a second

28 Sections 17(2)(e); 19(20)(e); 20(2).

29 Section 24.

30 Section 4.

31 Section 10(3)(b).

language, and those who were simply unaware of the public debate regarding AD in NZ and that it may be an option available to them.

B Section 10: Situating the Prohibition in the Context of Broader Health Law

As already indicated above, section 10 represents the antithesis of contemporary health law doctrine which establishes that health practitioners owe a legal duty to their patients to convey information that a reasonable person, in that person's circumstances, needs to be able to make informed decisions regarding their health care.³² The duty to inform, which is part of the general common law duty to exercise reasonable care and skill in the provision of professional advice and treatment, is based on the premise that patients are unable to properly exercise self-determination without being appraised of relevant information. As "knowledge-holders", clinicians are professionally, ethically and legally obliged to convey adequate information to enable their patients to exercise informed choice, and failure to do so may constitute a breach of a clinician's duty of care.³³ This common law duty has evolved over time to reflect the view that "patients are now widely regarded as persons holding rights, rather than as the passive recipients of the care of the medical profession".³⁴ The common law duty to inform is reflected, and considerably extended, in New Zealand's core patient rights instrument, the Health and Disability Commissioner (Code of Health and Disability Services Consumers' Rights) Regulations 1996 (Code of Rights) which was promulgated under the Health and Disability Commissioner Act 1994 (HDC Act).³⁵ The HDC Act establishes a Health and Disability Commissioner and an associated complaints framework to supplement the Code of Rights. The Code of Rights outlines a specific set of 10 patient rights and imposes corresponding duties on health care providers. Under the heading of "the right to be fully informed", Right 6 provides that:

- (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 ...

32 *B v Medical Council* HC Auckland HC 11; *Rogers v Whitaker* (1992) 175 CLR 479; *Montgomery v Lanarkshire Health Board* [2015] UKSC 11.

33 *B v Medical Council*, above n 32, at 17.

34 *Montgomery v Lanarkshire Health Board*, n 32 at [75].

35 Health and Disability Commissioner (Code of Health and Disability Services Consumers' Rights) Regulations 1996. Both the HDC Act and the Code of Rights were the result of recommendations made as a result of the Cervical Cancer Inquiry. See Silvia Cartwright *The Report of the Committee of Inquiry into Allegations Concerning the Treatment of Cervical Cancer at National Women's Hospital and into Other Related Matters* (Auckland, Government Printing Office, 1988).

Historically, Commissioners have taken a stringent approach to the duty to provide information regarding treatment options, particularly in the context of life-threatening illness.³⁶ However, unlike any other aspect of health care in New Zealand, the EOLC Act expressly carves out an exception to the duty to inform under the Code of Rights in relation to AD.³⁷ Although not an offence under the EOLC Act,³⁸ any provider who fails to comply with the prohibition in section 10 is liable to a complaint to the Health and Disability Commissioner, specifically for breach of Right 4(2) of the Code of Rights, which imposes a duty on health care providers to comply with relevant legal standards. Further, they may be subject to disciplinary proceedings under the Health Practitioners Competence Assurance Act 2003. Consequently, there are significant adverse implications for providers who contravene section 10. Although there was little explicit discussion regarding the rationale for adopting the prohibition contained in SOP No. 259 during the parliamentary debates, its provenance lies in the Australian state of Victoria's law on voluntary AD.

C Source of the Prohibition

Victoria was the first Australian state to legalise AD after the Victorian government appointed a Ministerial Advisory Panel on Voluntary Assisted Dying to develop a "safe and compassionate voluntary assisted dying framework".³⁹ During its deliberations, the Ministerial Panel expressed concern regarding the legalisation of AD for groups vulnerable to abuse, particularly the elderly and those with a disability. Nevertheless, it also acknowledged empirical evidence from Oregon and the Netherlands (where AD has been available since 1997 and 2002 respectively) to the effect that fears that vulnerable groups may be coerced into requesting AD in the context of rigorous request and assessment processes for AD were ill-founded.⁴⁰ Despite recommending rigorous assessment procedures and legislative safeguards, the Victorian panel ultimately considered that the inherent power imbalance between health care providers and patients meant there was coercive potential were the HP to raise AD "de novo".⁴¹ Consequently, it recommended prohibiting

36 For example, a neurosurgeon was found in breach of Right 6(1)(b) of the Code for not informing a patient diagnosed with a brain tumour that whilst in his professional opinion surgery was not a viable option (because in his view the risks outweighed any potential benefit) the option of further surgery was available elsewhere in New Zealand and Australia. See *Dr A, Neurosurgeon* (Health and Disability Commissioner, Decision 02HDC18414, 6 April 2004).

37 End of Life Choice Act 2019 Schedule Part 2: Amendments to legislative instruments 5A(3).

38 End of Life Choice Act 2019 ss 39(1); (2)(a), (b).

39 Department of Health and Human Services (Victoria). *Ministerial Advisory Panel on Voluntary Assisted Dying: Final Report* (Vic, DOH, 2017).

40 At 88.

41 At 90–91.

all registered Health Practitioners from initiating any discussion of AD to ensure that people are not “coerced or unduly influenced”.⁴² The prohibition was subsequently included in the Voluntary Assisted Dying Act 2017 (Vic).⁴³

While concern to protect vulnerable groups is at the heart of the Victorian prohibition, it must be noted that not all individuals who are unaware that AD is available are at risk of coercion or undue influence if a clinician simply references it in the course of a clinical conversation as a potential end of life option. Nevertheless, as a result of the blanket prohibition all individuals, vulnerable to “suggestion” or not, are denied access to that information. Given the wide scope of the provision, it is far from a benign legislative initiative.

Victoria’s equivalent prohibition has now been in effect for five years. Empirical evidence emerging from that state has understandably focused on health care providers’ experience of navigating the prohibition. While some Victorian AD clinicians considered the prohibition a safeguard by ensuring the decision is patient-driven, many others have voiced concerns that it could prevent patients making informed choices and that they felt “morally compromised”, “deceitful”, or “intellectually dishonest” withholding information about voluntary assisted dying.⁴⁴ Similar findings have been reported in research into the implementation of AD in New Zealand, where the prohibition has been described by some as “muzzling, stifling, censorship of clinicians”.⁴⁵

Notably, out of the five Australian states that have since introduced law permitting AD, only South Australia has adopted a similarly restrictive provision to that of the Victorian regime.⁴⁶ In contrast, Queensland, New South Wales, Western Australia⁴⁷ and Tasmania have all taken a more nuanced approach. While health care workers may not raise the topic of AD, a medical practitioner (or potentially a nurse practitioner depending

42 Victorian Voluntary Assisted Dying Bill 2017: Explanatory Memorandum (2017).

43 Any practitioner who believes another registered health practitioner has initiated a discussion about VAD or suggested it to a person is required to report that colleague to the Australian Health Practitioner Regulation Agency (AHPRA). VAD Act, s 75.

44 Lindy Willmott and others “Participating Doctors’ Perspectives on the Regulation of Voluntary Assisted Dying in Victoria: a Qualitative Study” (2021) 215(3) *Medical Journal of Australia* 125.

45 Jeanne Snelling and others “Health Care Providers Early Experiences of Assisted Dying in Aotearoa New Zealand: an Evolving Clinical Service” (2023) 22 *BMC Palliat Care* 101.

46 Voluntary Assisted Dying Act 2021 (SA), s 12.

47 Western Australia specifically rejected this constraint stating that “health practitioners have a professional obligation to ensure that their patients are fully informed about their choices at end of life, including voluntary assisted dying”. Department of Health (Western Australia) *Ministerial Expert Panel on Voluntary Assisted Dying Final Report* (WA, DOH, 2019 at 30–31.

on the jurisdiction) may initiate a conversation regarding AD *provided* that they discuss treatment and palliative care options at the same time.⁴⁸ Similarly, proposed AD legislation in the Australian Capital Territories (ACT) establishes information requirements for authorised practitioners and other health professionals who initiate discussions about AD.⁴⁹ This approach stops short of complete prohibition, but treats AD as an exception to ordinary health care services by expressly requiring that any discussion is undertaken in a balanced manner.

In summary, it may be inferred that the justification for the prohibition contained in NZ's EOLC Act is based on a presumed power imbalance between health practitioners and patients and the perceived risk of *implicit* coercion if a clinician references the option of AD. However, the prohibition has attracted a range of criticisms due to its infringement on health professional conversations and, in particular, the doctor-patient relationship. These include the professional, ethical and legal tensions created for health practitioners who are required to withhold potentially relevant information and the associated moral distress arising from suppressing what may be pertinent information for a patient;⁵⁰ the consequence of people being prevented from accessing lawful health services because of their lack of awareness; the "othering" of otherwise normal end of life conversations; and the unreasonableness that prior knowledge should be expected of people who may otherwise opt for AD.⁵¹ A slightly different concern is the perhaps unintended, though implicit, messaging that health practitioners are potentially unable to be trusted in regards to having AD discussions, so eroding confidence in the profession.⁵² This article focuses on a further underexplored criticism; which is that s 10 unjustifiably interferes with health practitioners' right to freedom of expression protected by section 14 of the NZBORA.

48 Voluntary Assisted Dying Act 2021 (Queensland) s 7; Voluntary Assisted Dying Act 2022 (NSW) s 10; Voluntary Assisted Dying Act 2019 (WA) s 10; and End of Life Choices (Voluntary Assisted Dying) Act 2021 (Tas) s 17.

49 Voluntary Assisted Dying Bill 2023 (ACT), cl 152(1).

50 Lindy Willmott and others "Restricting Conversations about Voluntary Assisted Dying: Implications for Clinical Practice" (2020) 10(1) *BMJ Supportive & Palliative Care* 105.

51 Bryanna Moore, Courtney Hempton and Evie Kendal "Victoria's Voluntary Assisted Dying Act: Navigating the Section 8 gag Clause" (2020) 212(2) *Med J Aust* 67; Jeanne Snelling, above n 7; Carolyn Johnston and James Cameron, "Discussing Voluntary Assisted Dying" (2018) 26(2) *Journal of Law and Medicine* 454; Willmott et al, above n 50.

52 Jonathan Adler, unpublished postgraduate paper (University of Otago, LAWS547: Law and Medicine, 2023). On file with authors.

III Regulating Clinician Speech: NZBORA and the Right to Freedom of Expression

The authority of the state to regulate health care professions in the interests of public health and safety is well established. Ensuring a regulatory framework that appropriately promotes competent, adequately skilled health care professionals that are fit to practice is not only a legitimate but a necessary government concern.⁵³ However, laws regulating the content of clinician speech within a therapeutic relationship trigger questions regarding the appropriate scope of state intervention in the context of professional and clinical practice.⁵⁴ Specifically, it raises issues regarding the consistency of such laws with the NZBORA which expressly affirms, protects and promotes fundamental human rights and freedoms in law. Of particular relevance in the context of regulating clinician speech is section 14, which states that:

Everyone has the right to *freedom of expression*, including the freedom to *seek, receive, and impart information* and opinions of any kind in any form. (emphasis added)

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- 53 Health Practitioners' Competence Assurance Act 2003 provides that its primary purpose is to "protect the health and safety of members of the public by providing for mechanisms to ensure that health practitioners are competent and fit to practise their professions" (s 3(1)).
- 54 In the interests of clarity, the arguments made in this article apply to what otherwise amount to reasonable and responsible professional conduct within a therapeutic relationship, but do not apply to all utterances by a clinician including statements made publicly, some of which may legitimately be subject to restriction by that clinician's regulatory body. E.g. see *Turner v Nursing Council of New Zealand* [2025] NZHC 134 where the High Court upheld the Health Practitioner's Disciplinary Tribunal (HPDT) finding that a slew of posts made by a nurse on Facebook that (1) targeted minority groups, and (2) were directed at dissuading her followers from receiving the Covid-19 vaccine (which were described by the Court respectively as hyperbolic and "highly offensive" [50]; and "ill-informed" [61]) constituted Professional Misconduct, specifically "conduct likely to discredit the nursing profession" under the Health Practitioner's Competence Assurance Act 2003 (s 100(1)(b)). The appellant unsuccessfully argued that the posts were private communications to her Facebook friends and constituted legitimate freedom of expression. However, the High Court found that neither her employer nor the HPDT breached the appellant's privacy in obtaining and examining the posts as there was no legitimate expectation of privacy in relation to Facebook posts. In addition, the Court found that the HPDT had properly distinguished between posts that could constitute legitimate political opinion, versus offensive posts likely to discredit the profession. Ultimately it affirmed that as members of a regulated profession, and subject to the Nursing Council Code of Conduct, nurses assume obligations to refrain from bringing the wider profession into disrepute, which includes an undertaking "to moderate their public utterances to ensure their duty to the wider profession is upheld" at [48].

Section 14 applies to freedom of expression in general, and hence also encompasses speech in the context of a doctor-patient relationship. Although the right to freedom of expression may be *prima facie* protected under the NZBORA, it is well established that most rights are not absolute. In some instances limiting rights may be necessary to achieve “collective goals of fundamental importance”.⁵⁵ As previously noted by NZ’s Supreme Court in *R v Hansen*, “rights are part of a social order in which they must accommodate the rights of others and the legitimate interests of society as a whole”.⁵⁶ While most NZBORA rights may legitimately subject to restrictions, they are still intended to be taken seriously. This is reflected in section 5 of the NZBORA, which provides that the rights and freedoms contained in the Act “may be subject only to such reasonable limits prescribed by law as can be demonstrably justified in a free and democratic society”. The test for determining the latter was established by the Supreme Court in *R v Hansen*. This test involves a three-part inquiry which first requires determining the objective of the rights restriction and whether that objective is sufficiently important to justify limiting the impugned right, before assessing whether the limit imposed is rationally connected to achieving that objective, and finally determining whether the resulting limit is a proportionate response to that objective.

Although the NZBORA does not have supreme status, the extent to which protected rights in the NZBORA may legitimately be overridden by Parliament is a matter of constitutional importance. Consequently, NZBORA requires that any new legislation should be assessed for consistency with the NZBORA, a function generally performed by the Attorney-General.⁵⁷ Where it appears that there is an inconsistency between the NZBORA and a particular law, the Attorney-General must “bring it to the attention of the House of Representatives” either when the Bill is first introduced if it is a Government Bill, or in any other case as soon as practicable after its introduction.⁵⁸ Post enactment, laws may be subject to challenge for inconsistency with protected rights which, if successful, may result in a senior court making a declaration of inconsistency if, applying the *Hansen* test, the relevant rights limitation is not demonstrably justified in a free and democratic society. Any

55 *R v Oakes*, 1986 CanLII 46 (SCC), [1986] 1 SCR 103.

56 *R v Hansen* [2007] NZSC 7 at [186] For instance, there are laws against perjury and false advertising, legislation permitting non-disclosure orders, and information withholding statutes; see Crimes Act 1961; Commerce Act 1986; Official Information Act 1982.

57 NZBORA, s 7.

58 NZBORA, s 7(b).

declaration of inconsistency must be notified to Parliament and a formal response provided.⁵⁹

While laws regulating clinicians' professional speech are uncommon in New Zealand, they have a longer history in other jurisdictions such as the United States (US) where some states have attempted to prohibit specific disclosures in the doctor-patient context.⁶⁰ Such laws have resulted in constitutional challenges under the US Constitution's First Amendment, which provides that Congress "shall make no law ... abridging the freedom of speech". Unlike New Zealand, the US Constitution has supreme law status; any law found by the courts to be unconstitutional may be rendered unenforceable.

A Prohibited Clinician-Patient Speech: The United States as a Comparator

A prime US example involving a constitutional challenge to restriction on clinician's freedom of speech occurred after the state of Californian decriminalised the use of medical marijuana in certain instances. Following California's partial decriminalisation, the Office of National Drug Control Policy introduced federal policy to the effect that any doctor who recommended or approved a patient's use of marijuana for medical indications could have their physicians' registration to prescribe controlled substances (which included marijuana) revoked. Subsequently patients with serious chronic illnesses, along with their treating clinicians, challenged the federal policy.⁶¹ The plaintiffs successfully obtained a permanent injunction in the US District Court, preventing any action by the federal government against clinicians. After the government appealed, the US Ninth Circuit Court of Appeals, applying the highest test of constitutional review (i.e. strict scrutiny) held that that the federal policy did not serve a compelling state interest. Contrary to arguments made by the appellants, permitting doctor-patient discussions regarding the medical use of marijuana did not impair legitimate law enforcement

59 New Zealand Bill of Rights (Declarations of Inconsistency) Amendment Act 2021 introduced new sections into NZBORA and the Human Rights Act that requires the Attorney-General to notify Parliament of a declaration of inconsistency (s 7A, NZBORA; s 92WB HRA) and requires the responsible minister to report to Parliament regarding the government's response to that declaration (s 7B NZBORA; s 92WB HRA).

60 In the US, courts have distinguished between laws that impose content-based restrictions on speech, meaning laws that apply to "particular speech because of the topic discussed or the idea or message expressed" versus content-neutral restrictions on speech. Content-based speech restrictions are subject to constitutional review. *Otto v City of Boca Raton* 981 F.3d 854 (2020) US App citing *Reed v Town of Gilbert* 576 U.S. 155 (2015). In addition, some US state laws compel the provision of specific information by clinicians, particularly in the context of abortion. See Sonia Suter "The First Amendment and Physician Speech in Reproductive Decision Making" (2014) 43(1) *Journal of Law, Medicine and Ethics* 22.

61 *Conant v Walters* 309 F.d at 637 (9th Cir. 2002).

regarding illegal drug use and the federal policy violated the First Amendment right to freedom of speech, improperly penalizing clinicians who believed medical marijuana might assist some patients.⁶² *Conant v Walters* is a paradigmatic example of “professional speech”: meaning professional advice that reflects professional knowledge. Professor of Law Claudia Haupt has cogently argued that the law should recognize and protect a category of “professional speech”, defined as speech that involves conveying “accurate, reliable and comprehensive advice that corresponds to the insights of their knowledge community”.⁶³ Significantly, in *Conant*, the court stated that “an integral component of the practice of medicine is the communication between a doctor and a patient.”⁶⁴ Further, it acknowledged the effect of the restriction on patients, observing that the rights of patients to hear *accurate information* from their doctors was also undermined by the policy, acknowledging that when it came to clinical opinion, patients have an interest in having unrestrained access to that information.⁶⁵

Subsequently, in *Wollschlaeger v Governor of Florida* (the “Docs and Glocks” case), clinicians challenged a Florida law that prevented them from asking patients “questions concerning the ownership of a firearm or ammunition”.⁶⁶ Any doctor who discussed gun safety as part of risk assessments undertaken with patients could be subject to disciplinary proceedings.⁶⁷ On appeal the eleventh circuit Court of Appeals applied the lower standard of heightened scrutiny, determining that the law was unconstitutional because the state had not demonstrated that the

62 The Court of Appeals found that the policy improperly sought to punish physicians on the basis of the content of their communications.

63 Claudia E Haupt “The Limits of Professional Speech” (2018) Yale Law Journal Forum 185 at 199. Haupt argues that a distinction may be made between professional speech and general regulation or licensing of professionals. “Professional speech ought to be protected against state interference so that professionals can give their clients and patients accurate, reliable, and comprehensive advice that corresponds to the insights of their knowledge community. Professionals’ fiduciary duties and the professional malpractice regime demand no less. Professional licensing serves the same purpose, namely, to ensure a professional’s competence to give good advice to benefit the client or patient. The First Amendment protects the content of professional speech from state interference that contradicts professional insights, but it does not prohibit the state from regulating professionals”.

64 *Conant v Walters*, above n 61 at 636.

65 At 637.

66 Firearm Owners’ Privacy Act 2-11-2012.

67 *Wollschlaeger v Governor, Fla.*, 848 F.3d 1293 (11th Cir. 2017).

restrictive law advanced a substantial government interest.⁶⁸ Whilst the decision in *Wollschlaeger* reinforced the obligation of the state to justify restrictions on clinician speech in the context of a patient-doctor consultation, the US Supreme Court has since affirmed that content-based laws curtailing clinician speech should be subject to the highest intensity of review of strict scrutiny meaning a law must “serve a compelling state interest” and be “narrowly tailored to achieve its result” to be constitutional. The burden of proof falls on the government.⁶⁹

While laws restricting health practitioners’ freedom of speech in NZ are uncommon there are two recent exceptions to this: the first being section 10 of the EOLC Act; the other involves provisions contained in the Conversion Practices Prohibition Legislation Act 2022 (CPPL Act). Unlike section 10 of the EOLC Act which was introduced in a vacuum of NZBORA analysis, policy advice was at least provided to the Government in relation to the CPPL Act prior to its introduction. Given that the CPPL Act directly engages the right to freedom of expression and encompasses health practitioners it provides a relevant comparator in this context.

B Regulating Clinician Speech in NZ: The Conversion Practices Prohibition Legislation Act 2022

The purpose of the CPPL Act is to “recognise and prevent harm caused by conversion practices”; and to “promote respectful and open discussions regarding sexuality and gender”.⁷⁰

The CPPL Act defines conversion practice as: “any practice, sustained effort, or treatment that is (a) directed towards an individual because of their sexual orientation, gender identity or gender expression; and (b) is done with the intention of *changing or suppressing* the individual’s sexual orientation, gender identity, or gender expression”.⁷¹ While the provision

68 One of the main interests that the Florida state claimed the impugned law was concerned with was protecting patients’ Second Amendment right to own and bear firearms. However, the Court held that there was no evidence that the doctors had infringed the Second Amendment. Another interest claimed to justify the restrictive law was the protection of patients’ privacy, but while the court acknowledged that the protection of privacy was a substantial government interest, it considered that given other privacy protections available to patients that interest was not enough to sustain the impugned provisions. Further, the relevant law permitted patients to decline to answer questions regarding gun ownership, thus ensuring privacy.

69 The US Supreme Court criticized the earlier view of some courts that “professional speech” is a specific category of speech that attracts the lower standard of “heightened scrutiny” rather than strict in *National Institute of Family and Life Advocates v Becerra* 585 U.S. 755, 138 SCt 2361 (2017). In that case, the Supreme Court refused to recognize professional speech as new category of speech deserving less constitutional protection.

70 CPPL Act, s 3.

71 CPPL Act, s 5.

refers to “practices” it is accepted that the CPPL Act also targets speech.⁷²

The CPPL Act creates two new criminal offences: (a) “performing a conversion practice on a person under 18 or a person lacking capacity”;⁷³ and (b) “performing a conversion practice on a person that causes serious harm to the person knowing, or being reckless as to whether, the practice would cause serious harm”.⁷⁴ The latter provision requires conducting a conversion practice that causes serious harm either knowing it will cause such harm; or, appreciating the risk of causing serious harm but proceeding regardless.⁷⁵ Serious harm is defined as any “physical, psychological, or emotional harm that seriously affects the health, safety, or welfare of the individual”. Consent by the person subject to the practice is not a defence.⁷⁶ Civil liability for performing a conversion practice is also provided under the Human Rights Act 1993.⁷⁷

Notably, the CPPL Act targets conversion practices *per se*, rather than targeting health practitioners in particular. Significantly, the CPPL Act expressly excludes any actions that a health practitioner “considers in their *reasonable professional judgement*” appropriate to take when providing a health service and that comply with “all legal, professional, and ethical standards” (emphasis added).⁷⁸ This provision directly acknowledges the capacity for professional self-regulation and reliance on professional standards to provide adequate safeguards against harmful or disrespectful practice.

Consistency of the CPPL with the NZBORA has not been tested in the courts. However, it was subject to analysis in a pre-enactment briefing to the Attorney-General, in which Crown Law expressly acknowledged that the CPPL Bill imposed a “significant” limit on the right to freedom of expression under the NZBORA.⁷⁹ Despite this, Crown Law advised that the “potentially severe consequences for the health and well-being” of the person subjected to conversion practices justified limiting the right

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- 72 At the end of s 5(2) the Act provides examples of conversion practices and includes: “using shame or coercion intending to give an individual an aversion to same-sex attractions or to encourage gender-conforming behaviour: encouraging an individual to believe that their sexual orientation, gender identity, or gender expression needs changing because it is a defect or disorder: carrying out a prayer-based practice, a deliverance practice, or an exorcism intending to change or suppress an individual’s sexual orientation, gender identity, or gender expression”.
- 73 CPPL Act, s 8. Liable on conviction to a term of imprisonment not exceeding 3 years.
- 74 CPPL Act, s 9. Liable on conviction to a term of imprisonment not exceeding 5 years.
- 75 *R v Tipple* unreported, CA 217/05, 22/12/05.
- 76 CPPL Act, s 10.
- 77 HRA, s 63A.
- 78 CPPL, s 5(2).
- 79 Crown Law “BORA Vet: Briefing to Attorney-General – Conversion Practice Prohibition Legislation Bill” (June 2021).

to freedom of expression.⁸⁰ Notably, for conversion practices performed in the adult population to constitute a criminal offence, it must be proven that any serious harm suffered by a person was knowingly or recklessly caused. However, such serious harm need not be established in relation to a conversion practice performed on persons under 18, or persons lacking capacity. In seeking to justify the unqualified criminalisation of conversion practices for this particular category of persons it was simply claimed in the pre-enactment briefing that:⁸¹

the coercion of a vulnerable person to change or suppress their sexuality or gender identity or expression is inherently harmful. The protection of those persons is a pressing social objective and the prohibition is rationally connected to it.

If the CPPL Act was subjected to scrutiny in the courts in relation to the limitation on freedom of expression, it is a certainty that the objective of protecting persons from harm arising from conversion practices, particularly for those vulnerable due to age or incapacity, would be considered a pressing and substantial objective. However, it is less apparent whether the significant limitation on freedom of expression would be found to be rationally connected to the objective of preventing harm from conversion practices *unless* the state could provide evidence to support the claims made to justify the rights infringements.⁸² In

80 At [2].

81 At [10].

82 In the United States, similar prohibitions on what have been termed “sexual orientation change efforts” (SOCE) generally in regard to minors have been enacted, with many resulting in constitutional challenges under the US Constitution’s First Amendment. However, the law in this area is far from settled in the US. In *King v Governor of New Jersey* 767 F.3d at 226–29 (2014), the third circuit Court of Appeals applied the intermediate standard of “heightened” constitutional review to the relevant SOCE law, finding that the legislature had “drawn reasonable inferences based on substantial evidence” from reputable professional and scientific organizations that SOCE had the potential to inflict harm and therefore upheld the law. However, in *Otto v. City of Boca Raton* 981 F.3d 854 (2022), the eleventh circuit Court of Appeals applied the highest level of constitutional review, i.e. test of strict scrutiny which required it to consider whether the impugned ordinances were narrowly tailored to serve compelling state interests. While the state interest in safeguarding the well-being of minors was recognised by the Court as compelling, it considered that the evidence produced by the plaintiffs constituted mere assertions and only equivocal evidence of harm being inflicted by SOCE. Ultimately, it was not satisfied that the state had established the laws furthered the claimed interest (protecting minors from harm) and were narrowly tailored to achieve it. A more recent appeal involving Washington State SOCE laws sidestepped the constitutional issue altogether by following prior precedent that SOCE laws involving minors were concerned with regulating medical conduct/treatment and any effect only on speech was only incidental, meaning the First Amendment right did not apply to the law. See *Tingley v Ferguson* (9th circ, 2022) applying *Pickup v Brown*, 740 F.3d 1209 (9th Cir. 2014).

this respect, it is significant that the claimed harms of such practices are not merely conjectural. Whilst not elaborated upon in the Briefing to the Attorney-General, the Regulatory Impact Assessment (RIA) that preceded the CPP Bill states: “the evidence base on the harms of conversion practices and lack of evidence that sexual orientation and gender identity can be changed is robust and scientific”.⁸³ Further, the RIA implies that conversion practices fall into the category of pseudoscience, claiming that conversion practices have “no therapeutic purpose or evidential basis and do not achieve their intended outcome”.⁸⁴ Overall, the RIA emphasises the lack of evidence that conversion practices are successful as well as evidence that they are potentially harmful, citing empirical research indicating that the practices “can contribute to low self-esteem, negative self-image, distress, depression, anxiety, and suicidal ideation”.⁸⁵

Although not referenced in the RIA, a Report released in 2020 by the United Nations has also recommended that states ban conversion practices on the basis of similar evidence-based harms.⁸⁶ In particular, the UN Independent Expert Report notes that “children and young people are particularly vulnerable to the impact of practices of ‘conversion therapy’”.⁸⁷

Similar law prohibiting conversion therapy had recently been introduced in Canada⁸⁸ which engages relatively comparable rights protected under the *Canadian Charter of Rights and Freedoms* including the right to freedom of expression.⁸⁹ The preamble to the Canadian Act provides that:⁹⁰

... conversion therapy causes harm to society because, among other things, it is based on and propagates myths and stereotypes about sexual orientation, gender identity and gender expression, including the myth that heterosexuality, cisgender gender identity, and gender expression that conforms to the sex assigned to a person at birth are to be preferred over other sexual orientations, gender identities and gender expressions;

And whereas, in light of those harms, it is important to discourage and denounce the provision of conversion therapy in order to protect the human dignity and equality of all Canadians.

Prior to its enactment, the Canadian Minister of Justice was required

83 See Ministry of Justice *Regulatory Impact Assessment—Prohibition of Conversion Practices* (2021) at 9.

84 At 9.

85 At 9.

86 See *Report of the Independent Expert on Protection against Violence and Discrimination Based on Sexual Orientation and Gender Identity* UN HRC, forty-fourth session, A/HRC/44/53 (2020) at [56].

87 At [57].

88 C-4: An Act to amend the Criminal Code (conversion therapy), 2021.

89 *Canadian Charter of Rights and Freedoms*, s 7, Part 1 of the *Constitution Act*, 1982, being Schedule B to the *Canada Act 1982* (UK), 1982, c 11.

90 C-4: An Act to amend the Criminal Code (conversion therapy), 2021.

to examine the new law for inconsistency with the Charter.⁹¹ The fact that conversion therapy had been denounced by medical and psychological professionals as being ineffective and harmful as well as the recommendations made in the UN report, in conjunction with the view that the new provisions were tailored to the objective of preventing established harms associated with conversion therapy, were provided as indicators that the new law was not inconsistent with the Charter rights.⁹²

Given the substantive evidence regarding harm, and the apparent lack of evidence that conversion practices achieve their desired effect, a New Zealand court might find that the specific situations in which the CPPL Act restricts freedom of expression/speech are rationally connected to achieving the CPPL Act's objective of preventing harm. However, even if it is accepted that the provisions are rationally connected to the objective, it is necessary to determine whether the restrictions are minimally impairing on the right to freedom of expression and in due proportion to the objective.

In this respect, it is likely relevant that the CCPL Act only applies to conduct that aims to "change" or "suppress" a person's sexual orientation, gender identity or gender expression. Hence it is unlikely (although not impossible) that simply disapproving of a person's choice would be captured by the definition of conversion practices.⁹³ Further, as noted above the CPPL Act limits the scope of offences under the Act to minors or those who lack capacity; or in situations involving the intentional or reckless infliction of serious harm. Most significantly for the purpose of this analysis, deliberate steps have been taken to ensure that the CPPL Act is not overbroad by limiting the scope of the Act to conduct by health practitioners that is inconsistent with professional standards or reasonable professional judgment. In contrast, when it comes to limiting clinicians' freedom of expression in relation to conversations involving AD such deference to professional standards and reasonable professional judgment is not reflected in the EOLC Act which directly targets professional speech.

91 Charter Statement: Bill C-4, Tabled in the House of Commons, December 6, 2021.

92 Charter Statement: Bill C-4, Tabled in the House of Commons, December 6, 2021. While the Canadian law does not provide a similar exception for health professionals as NZ's CPPL, the Canadian Act's definition of a conversion therapy expressly provides "that conversion therapy does not include a practice, treatment or service that relates to the exploration or development of an integrated personal identity — such as a practice, treatment or service that relates to a person's gender transition — and that is not based on an assumption that a particular sexual orientation, gender identity or gender expression is to be preferred over another".

93 However, one of the examples given that would constitute a conversion practice include "using shame or coercion intending to give an individual an aversion to same-sex attractions or to encourage gender-conforming behaviour" or "encouraging an individual to believe that their sexual orientation, gender identity, or gender expression needs changing because it is a defect or disorder".

C Regulating Clinician Speech: Section 10 and the EOLC Act

When the EOLC Bill was introduced into Parliament in its original form, the Attorney-General reported on its consistency with the NZBORA. The resulting report largely focused on the eligibility criterion that restricted access to AD to those aged 18 or over.⁹⁴ However, because section 10 was one of several late-stage amendments adopted after the EOLC Bill's second reading, the prohibition was never subject to select committee scrutiny or review for consistency with the NZBORA. This lack of scrutiny from a rights perspective constitutes a significant procedural anomaly.⁹⁵

In *Mendelssohn v Attorney-General*, it was noted that rights in the NZBORA, including the right to freedom of expression:⁹⁶

... affirm freedoms of the individual which the State is not to breach. The very nature of these rights and freedoms means that they are freedoms from state interference [...] the freedoms in issue are in general within the category often referred to as negative freedoms.

When applied to the EOLC Act, section 14 imposes a duty on the State not to interfere in what is said during a doctor-patient consultation, unless such a restriction can be otherwise justified. Significantly, the right to freedom of expression expressly includes the freedom to "seek, receive, and impart information". Consequently, it upholds the rights of not only those who would impart information, but those who might seek out that information. Indeed, it could be argued that because of the nature of the doctor-patient relationship and the established doctrine of informed consent, the State should be particularly slow to intrude on the boundaries of professional conversations.⁹⁷

As noted above, when determining whether a limit to a right is justified requires ascertaining the objective of the impugned provision and whether it is sufficiently important to warrant overriding a

94 Given that s 19 of NZBORA protects the right to freedom from discrimination on any of the prohibited grounds in the Human Rights Act 1990, and a protected ground of under the HRA includes age commencing at 16 years (s 21(1)(i)), the age-based restriction warranted scrutiny under the NZBORA. Ultimately, the A-G considered that the age-based restriction was not a reasonable limit that could be justified in a free and democratic society and was therefore inconsistent with the NZBORA. Despite this inconsistency being brought to Parliament's attention, the provision was retained throughout the legislative process. See Christopher Finlayson *C Report of the Attorney General under the New Zealand Bill of Rights Act 1990 on the End of Life Choice Bill*, 2017 s 36.

95 Judy McGregor and Margaret Wilson "Parliamentary Scrutiny of Human Rights in New Zealand: Glass Half full?" (Report to the New Zealand Law Foundation, 2 December 2019).

96 *Mendelssohn v Attorney-General* [1999] 2 NZLR 268, (1995) 5 HRNZ 1 (CA) at [14].

97 *Conant v Walters*, above n 61, at 199.

constitutionally protected right.⁹⁸ Specifically, the objective must relate to concerns which are pressing and substantial in a free and democratic society before it can be characterized as sufficiently important.⁹⁹

Admittedly, there are few things more important in society than protecting life, particularly in the case of vulnerable persons who may be susceptible to harm. This is evident in that the right not to be deprived of life (except on such grounds as are established by law and are consistent with the principles of fundamental justice) is the first protected right by the NZBORA.¹⁰⁰ Further, it has been a pervasive concern regarding legalisation of AD that some terminally ill persons may feel coerced or unduly influenced into undergoing AD due to a perception that they are a burden on society, or that their life is not worth living because they are not valued.¹⁰¹ While this concern is generally raised in relation to family members, the objective of the prohibition on initiating any discussion about AD is to prevent terminally ill persons being coerced or unduly influenced, even unintentionally, by health practitioners. Given the potentially severe consequences of even unintentional coercion, this is an important objective.

Assuming that a sufficiently important objective is established, the means chosen to achieve that objective must be “rationally connected” to the objective and not be arbitrary, unfair or based on irrational considerations. While protecting terminally ill persons from coercion by health practitioners is an important objective, it is questionable whether the current section 10 provision is rationally connected to that objective. The risk of coercion or undue influence by health practitioners is primarily based on the perceived power imbalance between patients and their doctors; however, there is no substantive evidence that coercion, even inadvertent, is actually occurring in practice. Ironically, the only evidence available regarding coercion involves clinicians attempting to dissuade patients from undergoing AD.¹⁰² Consequently, overriding a protected right may potentially be arbitrary and unnecessary in this context.

Alternatively, it could be countered that a lack of evidence of coercion by health practitioners does not establish that coercion does not occur in practice, and the severity of the consequences if it transpired warrants some form of State intervention. Conceivably it may be that the prohibition has been successful in preventing coercion. Ultimately, even if a precautionary approach is adopted, it is unclear that the prohibition would alleviate the risk of coercion or undue influence by

98 *R v Hansen*, above n 56.

99 *R v Oakes* n 55 cited in *R v Hansen*, above n 56 at [103].

100 NZBORA, s 8.

101 Maxim Institution: Submission to The Justice Select Committee for The End of Life Choice Bill. <https://maxim.org.nz/content/uploads/2021/04/EOLC-Bill-Submission-FINAL-19.02.pdf> Accessed 10.10.2023

102 See Ministry of Health, above n 3, at 87.

health practitioners in a direct and material way. Given the rigorous assessment processes and safeguards already established by the EOLC Act, including independent assessment of eligibility by two practitioners, any putative risk of coercion by health practitioners may be mitigated by other legislative provisions, such as the obligation on health practitioners to stop the AD process if they suspect “on reasonable grounds that a person [...] is not expressing their wish free from pressure from any other person”.¹⁰³ Further, the Health and Disability Commissioners’ Code of Rights already establishes that patients have right to be “free from coercion” and provides an avenue for complaint in the event of conduct that is inconsistent with professional standards or reasonable professional judgment.¹⁰⁴ Ultimately, when considering whether the limitation is rationally connected to the objective of preventing coercion of vulnerable terminally ill persons the potential for unintended, unfair and potentially harmful outcomes should be taken into account when determining whether the prohibition will in fact alleviate the risk of harm.

A direct effect of the prohibition is that terminally ill individuals who are not vulnerable to suggestion, but who are unaware that AD is legal, may not be provided with relevant information by health practitioners. In addition to instantiating inequitable access to AD, it is significant that prior to legalisation it was judicially accepted that prohibiting access to AD may result in persons suffering terminal illness who are desperate to avoid an undignified and painful death, to prematurely end their life by suicide to avoid such an outcome.¹⁰⁵ Ironically, this risk of self-inflicted death by suicide remains for those who are unaware that AD is a lawful option at the end of life remains.¹⁰⁶ In respect to this, it should be noted that section 14 contains two limbs; it not only protects the right to freedom of expression, it also protects the right to seek out and receive information. This second limb, the importance of which was recently emphasised by the Supreme Court,¹⁰⁷ was previously highlighted

103 Section 25.

104 HDC Code of Rights, right 2. In 2023, it was reported in the media that a complaint had been laid with the Health and Disability Commissioner alleging that a health practitioner had raised assisted dying with a suicidal patient. However, few facts are available, and no formal opinion has been released regarding the allegation. See Issac Davison “New Zealand Health Worker under Investigation for Raising Assisted Dying with a Suicidal Patient”. (NZ Herald, 11 July 2023). <https://www.nzherald.co.nz>

105 *Seales v Attorney-General* [2015] NZHC 1239 at [51].

106 The test for consistency with the principles of fundamental justice, as discussed by the Supreme Court of Canada in *Carter v AG* [2015] SCC 5 and subsequently applied in *Seales v AG* requires that the law must not be arbitrary, must not be overly broad as to limit rights more than necessary to achieve the legislative objective, and must not be grossly disproportionate to the law’s purpose.

107 *Moncrief-Spittle v Regional Facilities Auckland Ltd* [2022] NZSC 138 at [67]–[74]. The Supreme Court went so far as to note that, in some contexts, the right to receive information under s 14 may impose positive duties on the state to ensure that the right is respected.

in proceedings commenced in the High Court by a group of clinicians following amendments to the Contraception, Sterilisation, and Abortion Act 1977 (CSA Act). In *NZ Health Professionals Alliance v Attorney-General*, the claimant health practitioners argued that the mandatory requirement to disclose a conscientious objection to patients was inconsistent with a health practitioner's right to freedom of expression under the NZBORA.¹⁰⁸ Although that case concerned compelled, rather than prohibited, disclosure, Ellis J noted that section 14 does not solely apply to clinicians' rights to freedom of expression but may also engage the rights of persons who might seek out health-related information, citing a decision of the European Court of Human Rights (ECHR) in support of this view.¹⁰⁹ Consequently, it is relevant that section 14 not only engages the right to freedom of expression of health practitioners, it also engages the rights of terminally ill persons who may have an interest in receiving relevant information including information regarding AD, but who are denied access to that information as a result of the prohibition.¹¹⁰ Whilst the general population might consider that legalisation of AD is well known, that is not true of all, and certainly not true of less health literate groups who remain unaware that it is a lawful option.¹¹¹

What may be concluded is that even if the prohibition in section 10 is considered to be rationally connected to the objective of preventing the

108 *New Zealand Health Professionals Alliance v Attorney General* [2021] NZHC 2510.

109 Article 10.1 of the European Convention on Human Rights is expressed in similar terms to s 14 NZBORA stating that "Everyone has the right to freedom of expression. This right shall include freedom to hold opinions and to receive and impart information and ideas without interference by public authority and regardless of frontiers". In *Open Door and Dublin Well Women v Ireland* (1993) 15 EHRR 244, organizations providing pregnancy counselling services appealed a decision of the Irish Supreme Court of Ireland after the Irish Court granted an injunction restraining them from providing information to pregnant persons about abortion facilities outside Ireland. At the time, the Irish Constitution recognized "the right to life of the unborn". On appeal to the European Court of Human Rights (ECHR), it was held that restraining the provision of information to women seeking an abortion overseas was an over-broad and disproportionate limit on the right to receive information under the European Convention on Human Rights.

110 Ultimately the effect of the prohibition is that persons suffering terminal illness are treated differently from persons suffering non-terminal conditions involving chronic life-limiting illness (i.e. intra-ground discrimination) which potentially constitutes unlawful discrimination under the Human Rights Act 1993, s 21(1)(i).

111 See Ministry of Health, above n 3, at 7. Research from Australia where some states have the same prohibition indicates that restricting conversations about AD has a significant effect on public awareness and engagement with AD. B White, R Jeanneret, and L Willmott "Barriers to connecting with the voluntary assisted dying system in Victoria, Australia: A qualitative mixed method study" (2023) 26(6) *Health Expectations* 2695–2708.

risk of coercion of some terminally ill persons by health practitioners, it also undermines the rights of terminally ill persons to relevant health information; increases the risk of inequitable access to AD; and indirectly creates a risk of substantive harm in the form of premature death by persons who are unaware that AD is a legally possible option. Setting aside the equivocal evidential basis for the prohibition and the established adverse implications of section 10, even if it were accepted that there is a rational connection between the prohibition and the objective, to be a demonstrably justified limit on the right freedom of expression the limit must impair health practitioners right as “little as possible”, and be such that the limitation is proportional to the objective.¹¹²

It is clear that there are a range of less intrusive means to achieve the objective of preventing the risk of coercion or undue influence. Such alternative measures include requiring health practitioners to have mandatory AD education, including training in communication and unconscious bias; to require health practitioners to record a summary of any AD conversations with patients; to have AD practice regularly audited; or for a third party to give a person written information of a confidential number to contact if they feel coerced. Another option is to introduce a more narrowly tailored approach, similar to the Australian states that only permit health practitioners to initiate discussions about AD if treatment and palliative care options are discussed at the same time.¹¹³ Although this approach treats AD as an exceptional choice attracting additional obligations, it is less likely to bring about unintended adverse outcomes for terminally ill persons.

IV Conclusion

Tipping J sagely noted in the Court of Appeal that when Parliament creates new laws limiting rights protected under the NZBORA that “a sledgehammer should not be used to crack a nut”; in addition, all relevant issues must be considered “whether they be social, legal, moral, economic, administrative, ethical or otherwise”.¹¹⁴ Arguably, section 10 of the EOLC Act is equivalent to Tipping J’s proverbial sledgehammer. By restraining the scope of permissible communication within the immediate doctor-patient relationship regarding AD, section 10 of the EOLC Act directly engages a clinician’s right to freedom of expression

112 *R v Hansen*, above n 56, at [64].

113 Voluntary Assisted Dying Act 2021 (Queensland) s 7; Voluntary Assisted Dying Act 2022 (NSW) s 10; Voluntary Assisted Dying Act 2019 (WA) s 10; and End of Life Choices (Voluntary Assisted Dying) Act 2021 (Tas) s 17.

114 *Moonen v Film and Literature Board of Review* [2000] 2 NZLR 9 (1999) 5 HRNZ 224 (CA) at [18].

under the NZBORA, and the rights of patients to receive information.¹¹⁵ Whilst this provision has not been subjected to scrutiny for consistency with the NZBORA to date, a straightforward analysis suggests that the limit imposed on health practitioners' freedom of expression is not demonstrably justified in a free and democratic society. Not only is the evidence of coercion or undue influence by health practitioners on which the prohibition is based upon weak at best, the prohibition requires clinicians to act contrary to existing ethical principles and professional standards by denying some terminally ill persons potentially relevant end of life information. While the objective of preventing coercion or undue influence by health practitioners is important, it is not apparent that the current prohibition will achieve that objective in a direct and material way, whilst simultaneously increasing the risk of inequity and creating a risk of adverse outcomes for some terminally ill persons. Given that the rights intrusion involves not only the rights of health practitioners but also the rights of terminally ill individuals, and it is not a minimally impairing nor proportionate limitation, section 10 should be repealed. However, this is not to conclude that the concern to prevent distress, if not coercion or undue influence, does not justify imposing some restrictions on the right to health practitioners' freedom of expression in the context of AD. The range of registered health practitioners that a patient may interact with in the course of seeking or receiving healthcare is extensive, yet it is unquestionable that end of life discussions in general are often highly charged and sensitive subjects and some clinicians are better

115 A distinct category that has also triggered freedom of speech arguments involves professional speech in a public context that, whilst not necessarily constituting misinformation, is contrary to mainstream medical views. A paradigmatic example is the case of *Canaday v Medical Council* [2022] NZDC 443 involving a senior medical specialist who publicly expressed concerns regarding the safety and efficacy of the Covid-19 Pfizer vaccine. Complaints were made to the Medical Council on the grounds that information provided by a medical professional lends greater legitimacy to the claims made, and that it was dangerous information that would increase vaccine hesitancy, thereby creating a risk of harm to the public. After the Medical Council's interim suspended his licence pending investigation, Canaday appealed to the District Court (HPCAA, s 106). The District Court recognised that whilst professional speech may be associated with professional obligations imposed by a professional body, they are still subject to limits (*Orlov v NZ Law Society* [2013] NZCA 230). Even where a risk of harm to the public may be identified, limitations on freedom of speech by a professional body are only legitimate if they are rationally connected to the objective at hand and are a proportionate response to the risk identified. Ultimately, the Court held that the suspension was a "blunt instrument" to use to achieve the goal sought and would not avert the risk at the centre of the proceedings. In contrast, a voluntary undertaking to agreed terms (e.g. that his views differ from the majority of his medical peers and is contrary to Ministry of Health guidance) was both more effective in averting the harm identified, and more proportionate than the "draconian" step of suspending his licence.

qualified and equipped than others to navigate them. The availability of AD adds another dimension to such discussions. Due to the skill required to sensitively engage in discussions involving AD, including avoiding problematic assumptions regarding the value of a terminally ill person's life, or underestimating the gravity of AD for an individual and their family, it is plausible that realising the goal of protecting terminally ill persons from distressing or harmful clinical interactions is best achieved by ensuring that when clinicians initiate discussions of AD, they are conducted in a balanced manner by appropriately trained health practitioners. Consequently, the EOLC Act should be amended to impose a general restriction on initiating discussions regarding AD, except by a suitably qualified health provider in the context of end of life discussions encompassing the range of treatment options.¹¹⁶

116 This conclusion is consistent with recommendations made in the recent Ministry of Health review of the EOLC Act. The Ministry recommended amending section 10 to the effect that "health practitioners cannot raise assisted dying, *except* as part of discussions about a person's treatment and end-of-life care options". See Ministry of Health *Review of the End of Life Choice Act 2019* (Ministry of Health, 2024) at 10.