Analysis of the End of Life Choice Amendment Bill under the New Zealand Bill of Rights Act 1990

17 February 2026

ethos

Advocates for conscience and belief

Section 7 of the New Zealand Bill of Rights Act 1990 ("NZBORA") is an important safeguard. It says that the Attorney-General must warn Parliament if a proposed bill is inconsistent with the fundamental rights and freedoms in the NZBORA.

Because we want to help MPs when they consider the End of Life Choice Amendment Bill, Ethos has produced our own section 7 analysis.[1] While the Attorney-General considers all the rights in the NZBORA, we have focused on the rights that are relevant to our mission to promote freedom of thought, conscience, religion and belief.

BACKGROUND TO THE BILL

The history

The End of Life Choice Act 2019 ("the Act") introduced assisted dying to New Zealand. Assisted dying can take two forms: euthanasia, where a doctor or nurse practitioner administers lethal medication to end a patient's life, or assisted suicide, where a patient self-administers the lethal medication provided by a doctor or nurse practitioner. Patients are eligible for assisted dying if, among other things, they suffer from "a terminal illness that is likely to end the person's life within 6 months".[2]

Parliament passed the Act, but provided that the new law would not come into force unless a majority of voters in a referendum said 'yes' to this question: Do you support the End of Life Choice Act 2019 coming into force? In a referendum the following year, 65 percent of voters answered 'yes' and the Act came into force in 2021.[3]

The Act's operation is reviewed periodically.[4] The first of these reviews was completed in November 2024 by the Ministry of Health and recommended a number of changes to the Act.[5]

Todd Stephenson, an ACT MP, has lodged a member's bill, the End of Life Choice Amendment Bill ("the Bill"). The Bill's stated objectives are to "improve the operation of the Act" by adopting the recommendations of the Ministry of Health's review, and "to reflect Australian and Canadian law" and "new evidence" by removing the "temporal requirement" (the 6 month limit) and allowing assisted dying in some cases where a patient has lost competence.[6]

The Ministry's recommendations included new restrictions on conscience rights.

---

[1] This analysis was prepared by our CEO, Alex Penk. Previously Alex worked at one of New Zealand's largest law firms and in public policy. He has a Master of Law from Cambridge University. Ethos is a registered charity that offers advice, advocacy and education to promote the rights of conscience, religion and belief: www.ethosalliance.nz.

[2] Section 5(1)(c) of the End of Life Choice Act 2019.

[3] Electoral Commission, "Referendum results – End of Life Choice Referendum," https://electionresults.govt.nz/electionresults_2020/referendums-results.html.

[4] Section 30 of the End of Life Choice Act 2019.

[5] Ministry of Health, "Review of the End of Life Choice Act 2019" (Wellington: Ministry of Health, 2024).

[6] Explanatory Note, General policy statement, End of Life Choice Amendment Bill, https://bills.parliament.nz/v/1/10b121dd-830b-4dc2-177e-08ddec07b3c1?lang=en. The Bill would state that patients authorised to receive assisted dying must be competent when the lethal medication is provided or administered, unless they knew they were likely to lose competence before then. In that case, they could waive the requirement for their final consent. See clause 20 of the End of Life Choice Amendment Bill, inserting new section 17B.

Explaining the Bill

The Bill would expand eligibility for assisted dying. Rather than patients needing to suffer from a terminal illness likely to end their life within 6 months, they would be eligible if they were:[7]

> *diagnosed with a condition that is advanced, progressive, and, either on its own or in combination with 1 or more other diagnosed conditions, is expected to cause death.*

The other eligibility requirements in the Act would be unchanged.[8]

The Bill would also change the Act's conscience provisions. At present, the Act says that:

- An "attending medical practitioner" (usually the doctor responsible for the patient) who has a conscientious objection to providing assisted dying must tell a patient who asks for assisted dying that they have this objection, and that the patient has a right "to ask the SCENZ Group for the name and contact details of a replacement medical practitioner."[9]

- Apart from this, a "health practitioner" (which includes doctors, nurses, psychiatrists, and pharmacists) "is not under any obligation to assist any person who wishes to exercise the option of receiving assisted dying under this Act" if that conflicts with their conscience, regardless of any other legal obligation, and an employee cannot be discriminated against because of this conscientious objection.[10]

Individual conscience

The Bill would repeal these provisions and would instead provide the following in relation to individual conscience:

- A health practitioner who has a conscientious objection to assisted dying would be excused from:[11]
  - acting as one of the doctors who provide assisted dying;
  - supplying, prescribing, or administering the lethal medication; or
  - being present at the time the medication is administered.

- However, a health practitioner:
  - if asked for information about assisted dying, would have to "provide the person with the contact details of the assisted dying service as soon as practicable";[12]

---

[7] Clause 5 of the End of Life Choice Amendment Bill.

[8] To be eligible for assisted dying, a patient must also be aged at least 18, a citizen or permanent resident, "in an advanced state of irreversible decline in physical capability", experiencing "unbearable suffering that cannot be relieved in a manner that the person considers tolerable," and competent: section 5 of the End of Life Choice Act 2019.

[9] Section 9 of the End of Life Choice Act 2019. The SCENZ Group is the Support and Consultation for End of Life in New Zealand Group established by section 25 of the Act. It maintains a list of replacement medical practitioners who are willing to provide assisted dying to patients who have requested it.

[10] Section 8 of the End of Life Choice Act 2019.

[11] Clause 29 of the End of Life Choice Amendment Bill, inserting new section 24C(1).

[12] Clause 9 of the End of Life Choice Amendment Bill.

  - if told by a patient that they want assisted dying, would also have to provide that patient with the contact details for the assisted dying service, or "contact or arrange for another person to contact the service on the person's behalf", even if they conscientiously objected;[13]
  - if they hold "relevant health information" about a patient who has requested assisted dying would, if asked by a doctor involved in that process, have to share that information.[14]

- A health practitioner's conscientious objection would not override their obligation to "act in accordance with the Code of Health and Disability Services Consumers' Rights".[15]

The Bill would maintain the prohibition on discriminating against an employee because they conscientiously object to assisted dying.[16]

Institutional conscience

In addition, the Bill would introduce new provisions affecting institutional conscience in the form of obligations on "care facility operators". Care facilities would be facilities where a temporary or permanent resident receives "health services", or "personal care services" such as support with "bathing, showering, personal hygiene, toileting, dressing, undressing, or meals," "assistance with mobility problems" or with "administering medicine," or "substantial emotional support." Care facilities would include hospitals, hospices, "a residential aged care facility", "a disability residential care facility," nursing homes, and rest homes.[17]

If a resident told a care facility operator that they wanted information about or access to euthanasia or assisted suicide, the operator would have to:

- Provide the contact details for the assisted dying service or allow someone else to provide that information to the resident.[18]

- Arrange for assisted dying to take place at the facility or allow someone else "reasonable access" to the resident to provide assisted dying at the facility,[19] unless the resident agreed to be transferred to another facility to receive assisted dying.[20] However, if the resident's doctor believed that a transfer would cause "serious harm", "undue delay" or "prolonged suffering", the operator would have to allow assisted dying to take place at their facility.[21] A facility operator would not be allowed to refuse their services to a resident or potential resident solely because they were likely to ask for assisted dying or had asked for it.[22]

---

[13] Clause 11 of the End of Life Choice Amendment Bill.

[14] Clause 9 of the End of Life Choice Amendment Bill.

[15] Clause 29 of the End of Life Choice Amendment Bill, inserting new section 24C(2)(a).

[16] Clause 40 of the End of Life Choice Amendment Bill, inserting new section 38B.

[17] Clause 29 of the End of Life Choice Amendment Bill, inserting new Part 2B.

[18] Clause 29 of the End of Life Choice Amendment Bill, inserting new section 24E.

[19] Clause 29 of the End of Life Choice Amendment Bill, inserting new section 24F.

[20] Clause 29 of the End of Life Choice Amendment Bill, inserting new section 24G(1) and (2).

[21] Clause 29 of the End of Life Choice Amendment Bill, inserting new section 24G(3).

[22] Clause 29 of the End of Life Choice Amendment Bill, inserting new section 24H.

The Bill does not provide institutions with any conscientious objection rights.

ANALYSING THE RELEVANT RIGHTS

There are three stages to a section 7 enquiry: first, does the proposed legislation engage a right that the NZBORA protects? If so, does the bill limit that right? If it does, can the limit be justified?

As will be explained, the Bill engages the NZBORA rights to freedom to manifest religion and belief, and freedom of expression.

However, before considering those rights it is helpful to understand the meaning and importance of conscientious objection in the Act.

Conscientious objection in the Act

Conscience is integral to health care. The practice of medicine "is characterised by a multiplicity of ethically complex situations" which means that health practitioners have to "foster a capacity for sound ethical judgment."[23] What they do is inextricably linked with who they are.[24] Undue limitations on conscience therefore have much wider ramifications than the individual procedure they relate to; they can affect the provision of health care as a whole.

The Bill maintains the Act's definition of "conscientious objection" as "an objection on the ground of conscience".[25] Neither the Act nor the Bill define "conscience," but in *Hospice New Zealand v Attorney-General*, the High Court held that it "will encompass when a doctor or nurse holds a deeply-felt belief that it is wrong for them to [assist with euthanasia or assisted suicide] for personal, moral reasons internal to them."[26]

This definition applies most obviously to individuals. However, the Court also considered 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."[27] This was reinforced by section 29 of the NZBORA, which provides that its rights and freedoms "apply, so far as practicable, for the benefit of all legal persons as well as for the benefit of all natural persons." As a result, organisations should be permitted to "[put] in place arrangements that will enable [them] to exclude assisted dying from their services".[28]

The right to conscientious objection has been described as a "cornerstone" of the Act. The architect of the Act, Hon David Seymour MP, used this term during Parliamentary debate when rejecting an amendment that would have created an explicit right to institutional conscientious

---

[23] X. Symons, *Why Conscience Matters* (Oxon: Routledge, 2023), 66.

[24] "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." R. Card, *A New Theory of Conscientious Objection in Medicine* (Routledge, 2020), 82, cited in *Hospice New Zealand v Attorney-General* [2020] NZHC 1356, [208].

[25] Section 4 of the End of Life Choice Act 2019.

[26] *Hospice New Zealand v Attorney-General*, [210].

[27] *Hospice New Zealand v Attorney-General*, [103].

[28] *Hospice New Zealand v Attorney-General*, [116].

objection. Arguing that the amendment was unnecessary, he said, "nowhere in this bill is any institution required to do anything."[29] The High Court said:[30]

> *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.*

The Court also noted that the way in which the Act had come into force was "constitutionally unique".[31] The enabling referendum asked voters to approve the Act specifically. It did not ask them to respond to a general proposition about assisted dying. This perhaps indicates that extra weight should be given to such a fundamental feature of the law, and that Parliament should be slow to disturb the particular balance the Act strikes between patients' ability to request assisted dying and health practitioners' ability to conscientiously object to assisting with it.

The right to freedom to manifest religion and belief

Section 15 of the NZBORA provides:

> *Every person has the right to manifest that person's religion or belief in worship, observance, practice, or teaching, either individually or in community with others, and either in public or in private.*

This right protects religious and non-religious beliefs when they are "manifested", a term that in ordinary usage means that they are expressed or revealed.[32] The beliefs in question can be understood as the "external manifestations" of a person's conscience.[33]

They must also be manifested in particular types of conduct—"worship, observance, practice, or teaching"—which requires "a sufficiently close and direct nexus" between the belief and the conduct in question so that they are "intimately linked."[34]

A health practitioner who objects to assisted dying because of their conscience—that is, because of "personal, moral reasons internal to them"—necessarily reveals their belief when they decline to be involved. Prima facie that is a manifestation of their belief. The Bill would remove the explicit requirement for a patient's doctor to state that they have a conscientious objection, but a health practitioner who objects to euthanasia and assisted suicide will still have to express this in some way. Otherwise, for example, if they are the patient's doctor, they will be expected to facilitate the process of assisted dying as the "attending practitioner".

---

[29] *Hospice New Zealand v Attorney-General*, [61].
[30] *Hospice New Zealand v Attorney-General*, [117].
[31] *Hospice New Zealand v Attorney-General*, [46].
[32] The Cambridge Dictionary defines "manifest" as "to show something clearly, through signs or actions": https://dictionary.cambridge.org/dictionary/english/manifest. The Collins Dictionary defines it as "to show plainly; reveal or display": https://www.collinsdictionary.com/dictionary/english/manifest.
[33] G. Palmer, "A Bill of Rights for New Zealand" (Wellington: Government Printer, 1985), 78.
[34] *New Zealand Health Professionals Alliance v Attorney-General* [2021] NZHC 2510, [103], [109].

Similarly, a care facility that objects to facilitating assisted dying on their premises because of their ethos is manifesting their belief. They may reveal that belief when they advertise their services. They will certainly reveal it if they invoke the Bill's procedure to discuss a possible transfer with a patient who has requested assisted dying.

The conscientious belief that is manifested must amount to "observance" or "practice". This is likely to be the case when the relevant actions "express the beliefs concerned" or are otherwise carried out because of that belief.[35] Showing that there is a sufficient nexus between the underlying belief and the refusal will be a question of fact in each case, but it seems inevitable that there will be cases where this requirement is met.

In *New Zealand Health Professionals Alliance v Attorney-General*, Ellis J considered that doctors who objected to providing information about how to access an abortion had not proved that their objection was "intimately linked" to their (Christian) beliefs as opposed to merely "motivated" by them.[36] Presumably different evidence could have led to a different result but, in any case, Cooke J in a different case straightforwardly accepted that opposition to vaccines which may have been tested on cells derived from aborted foetuses "is grounded in a core principle of the particular Christian religion and the objection to abortion." Unlike Ellis J, he held that "[t]he fact that others observing the same religion do not agree with the stance does not mean that the stance does not involve the observance of a religious belief."[37] And, in the *Hospice* case, the evidence clearly established that "[t]he ethos of hospice and palliative care … is that it 'intends neither to hasten nor postpone death'", that this was "a defining value of Hospice NZ and its members" and, by necessary implication, that these beliefs were the basis of the organisations' objection to assisted dying.[38]

The right is therefore engaged both for individual health practitioners and for institutions that qualify as "care facilities" who are unable to facilitate or participate in assisted dying because of their beliefs.

Does the Bill limit the right?

Starting with the individual right, the Bill would narrow the scope of the current protection in the Act.

Presently, a doctor responsible for a patient wanting assisted dying must tell the patient they have a conscientious objection and that the patient has a right to contact the SCENZ Group for the name and contact details of a replacement practitioner. Apart from this, they have no other obligations. Any other health practitioner can refuse to assist someone who wants to access assisted dying, where "assist" is a broad term that may extend to involvement in day-to-day care. For example, a doctor who is part of a team caring for a patient in a hospital, or a senior doctor supervising a junior doctor, could decline to be involved if the patient was receiving

---

[35] P. Rishworth et al, *The New Zealand Bill of Rights* (South Melbourne: OUP, 2003), 294-295.
[36] *New Zealand Health Professionals Alliance v Attorney-General*, [103]-[104].
[37] *Yardley v Minister for Workplace Relations and Safety* [2022] NZHC 291, [49].
[38] *Hospice New Zealand v Attorney-General*, [13], [105], [214(a)].

assisted dying and they considered this would involve them in the provision of assisted dying. This ability to decline to assist applies "despite any [other] legal obligation".[39]

The Bill would only allow health practitioners to object to a narrower range of specified activities: acting as one of the doctors who provide assisted dying; supplying, prescribing, or administering the lethal medication; or being present at the time the medication is administered. It would also require all health practitioners, not just attending medical practitioners, to provide the contact details of the assisted dying service in response to inquiries. And it would introduce new requirements. Health practitioners would be required to respond to requests for information from the doctors involved in the assisted dying process, and the Code of Health and Disability Services Consumers' Rights would override their right to conscientious objection.[40]

The Bill would also require an objecting health practitioner to cooperate with a doctor providing assisted dying by sharing information about the patient. Health practitioners may very reasonably see this as being compelled to help facilitate the process of assisted dying. For example, the Ministry said that experience had shown that conscience issues were likely to arise "when an assisted dying practitioner requests information from another health practitioner to inform an assessment of eligibility".[41]

Different practitioners may reach different conclusions about whether these actions would compromise their conscience. One may object to providing information and another may not. That is inherent in the nature of conscience, which is personal to each individual. Respecting conscience and upholding the associated rights therefore means respecting this potential variation in views.

Turning to the institutional right, the *Hospice* case established that institutions are entitled to exclude euthanasia and assisted suicide and that they should have the benefit of the right to freedom of conscience "so far as is practicable". The Bill, by contrast, would require care facility operators to provide contact details for the assisted dying service (or allow someone else to provide them), arrange for assisted dying on their premises (or allow someone else to provide it) unless the resident agreed to be transferred, but even if the resident agreed their doctor could block the transfer if they believed it would cause serious harm, undue delay, or prolonged suffering. A care facility could not refuse to admit even a temporary resident on the basis that they were likely to ask for assisted dying or had asked for it.

Is the limit justified?

If a limit on a right can be justified, the Bill is not inconsistent with the NZBORA. A limit is justified only if it can be "demonstrably justified in a free and democratic society".[42] The Supreme Court has said a provision will meet this standard if:[43]

1. the provision that creates the limit serves a "sufficiently important" objective;

---

[39] Section 8(2) of the End of Life Choice Act.

[40] Clause 29 of the End of Life Choice Amendment Bill, inserting new section 24C(2)(a).

[41] Ministry of Health, "Review of the End of Life Choice Act 2019", 86.

[42] Section 5 of the New Zealand Bill of Rights Act 1990.

[43] *Hansen v R* [2007] NZSC 7, [103]-[104], [121]-[124] per Tipping J.

2. the limit is proportional to that objective, meaning it is:
    a. rationally connected to the objective;
    b. limits the right or freedom no more than is reasonably necessary to sufficiently achieve the objective;
    c. in due proportion to the importance of the objective.

Is the objective sufficiently important?

To be "sufficiently important," the objective of the limiting measure "must relate to societal concerns which are pressing and substantial in a free and democratic society."[44]

As noted earlier, the Bill's stated objectives include to "improve the operation of the Act" by adopting the recommendations of the Ministry of Health's review. (The Bill's other objective is not relevant here.)

The Ministry considered that "assisted dying is a health service, and as such, the provision of assisted dying must uphold health consumers' rights in a similar manner to other health services". However, "the provision of assisted dying must also uphold relevant rights and interests addressed in the Act, such as the right of individuals to conscientiously object".[45] This creates a tension:[46]

> *Conscientious objection interacts with health consumer rights under the Code, where health practitioners' rights to act according to their moral or ethical beliefs must be balanced with the health consumer's right to receive appropriate care, continuity of care, and cooperation between providers.*

In fact, the Ministry considered that "the provisions in the Act enable practitioners to prioritise their right to conscientious objection over the rights of health consumers." In addition, the Ministry said, "People seeking assisted dying who live in care facilities face particular barriers to access, as people in these facilities rely on staff for information and continuity of care, and are limited in their ability to seek information elsewhere."[47] Thus the Ministry recommended amending the Act's conscience provisions in similar terms to the Bill.

By implication, the Bill's objective regarding conscience protection is to prioritise the rights of health consumers over those of health practitioners, in order to improve access to information and to assisted dying itself. It would do this by constraining health practitioners' ability to dissent—effectively, requiring them to toe more lines than before.

These objectives are contentious. MPs were given a conscience vote on the Act itself precisely because reasonable people can come to very different views on these questions. Since the Act has been in force, few doctors have registered as assisted dying providers, indicating that the majority of the medical profession does not support assisted dying.[48] Survey evidence collected

---

[44] *R v Oakes* [1986] 1 SCR 103 (SCC), cited in *Hansen v R* [2007] NZSC 7, [103] per Tipping J.
[45] Ministry of Health, "Review of the End of Life Choice Act 2019", 82.
[46] Ministry of Health, "Review of the End of Life Choice Act 2019", 83.
[47] Ministry of Health, "Review of the End of Life Choice Act 2019", 87.
[48] Ministry of Health, "Review of the End of Life Choice Act 2019", 104.

by the Ministry of Health also shows that most doctors oppose euthanasia and assisted suicide.[49] Submitters to the Ministry's review told it "overwhelmingly" that assisted dying does not align with the health system.[50] And the Ministry itself concedes that "assisted dying must also be recognised as a service that is particular and distinct from other services in the health system."[51] All these points suggest that a "free and democratic society" should be hesitant to limit health practitioners' consciences in this area.

Although the Ministry speaks of health consumers' rights, patients do not in fact have any right to require health practitioners to provide any health service in general or assisted dying in particular. Therefore the Bill cannot be characterised as supporting a right. At most, there is a right to request information about or access to assisted dying, which may or may not be able to be provided depending on various factors.[52] It is arguable whether this is a "pressing and substantial concern". Information about assisted dying, including the contact details of the assisted dying service, is easily accessible with a simple internet search. The Bill would also give doctors permission to initiate conversations about assisted dying with patients, and support the Ministry and Health New Zealand to provide public information about assisted dying.[53]

As noted earlier, few doctors have been willing to register as assisted dying providers, and this could raise concerns about patients' ability to access assisted dying. On the other hand, it is arguable that in a free and democratic society, it is the state's responsibility to make up for any lack of provision—given that it was the state that legalised assisted dying—rather than conscripting doctors against their will.

The Bill's limits on individual and institutional conscience do not, therefore, serve a sufficiently important objective.

Is there a rational connection between the objective and the limit?

In order to be rationally connected to their objective, "[limiting] measures must be fair and not arbitrary, carefully designed to achieve the objective in question".[54]

The Bill's limits on conscience rights are rationally connected to its objective to improve access to information and to assisted dying itself. It is logical that making it harder for objecting health practitioners and care facilities to act consistently with their beliefs will make it easier for patients who want assisted dying.

---

[49] The Ministry conducted a workforce survey prior to implementation of the Act in 2021. It found that 53.1 percent of health professionals opposed assisted dying in principle (for medical practitioners other than psychiatrists, i.e. doctors, the figure was 56 percent opposed), with 51.5 percent unwilling to provide assisted dying and 18.8 percent unlikely to do so (results for doctors were 55.4 percent and 19.3 percent respectively). See A. Dehkhoda et al, "Health professionals' understanding and attitude towards the End of Life Choice Act 2019: a secondary analysis of Manatū Hauora – Ministry of Health workforce surveys" (2023) 136 *New Zealand Medical Journal* 11.

[50] Ministry of Health, "Summary of Online Submissions Received on the End of Life Choice Act" (Wellington: Ministry of Health, 2024), 43.

[51] Ministry of Health, "Review of the End of Life Choice Act 2019", 81.

[52] *Hospice New Zealand v Attorney-General*, [117].

[53] Clause 8 of the End of Life Choice Amendment Bill.

[54] *R v Oakes* [1986] 1 SCR 103 (SCC), cited in *Hansen v R* [2007] NZSC 7, [103] per Tipping J.

Does the limit impair the right no more than is reasonably necessary to achieve the objective?

Here, the question is whether the limit is within "the range of reasonable alternatives" that could achieve the objective. The mere fact that a different approach would be less rights-limiting does not mean that the limit fails the minimal impairment test. However, if the limit restricts rights more than is "reasonably necessary to achieve the objectives", it will not be within the range of reasonable alternatives.[55]

It is not obvious that the Bill's limits on conscience are reasonably necessary to achieve its objectives. To begin with, the Act already says that a doctor caring for a patient as an "attending medical practitioner" must give that patient information about how to access assisted dying (by telling them they can contact the SCENZ Group) if the doctor does not want to assist with providing euthanasia or assisted suicide. While it does not say that an institution like a care facility must do this, any attending medical practitioner caring for a resident at the facility will have to comply with this requirement if the resident asks them for assisted dying.[56]

There are other ways to achieve the Bill's objectives which would not impair the right and would make the proposed limit on conscience unnecessary. Available alternatives include making it easier for government agencies to advertise information about assisted dying, and increasing the supply of willing practitioners by allowing nurse practitioners as well as doctors to act as attending practitioners. Both of these measures are in the Bill. Further, it could be left to care facilities to decide for themselves whether they will allow assisted dying on their premises. One hospice has already chosen to do this.[57]

Nor does it appear that the Bill's limits on conscience are within the range of reasonable alternatives.

First, the Ministry of Health recommended that care facilities should only have to provide information about assisted dying, or allow access to the procedure, for permanent residents or inpatients. This was on the basis that the care facility was their home.[58] By contrast, the Bill would extend this to include temporary residents, and would prohibit facilities from refusing admission to someone who they suspected intended to access assisted dying on their premises. Temporary residents could enter a facility like a hospice for a very short stay at the end of their life fully intending to access euthanasia or assisted suicide, which would constitute a serious limit on these facilities' ability to act consistently with their ethos.

Second, the Bill would compel health practitioners to provide patient information to doctors carrying out assisted dying. When discussing the recommendation containing this change, the Ministry referred to "improv[ing] the timeliness and ease of access to assisted dying for people seeking the service."[59] But requiring practitioners to share information to enable someone to be assessed for euthanasia or to receive it would be a significant imposition on their freedom

---

[55] *Ministry of Health v Atkinson* [2012] NZCA 184, [151]-[154]. See also McGrath J in *Hansen v R* [2007] NZSC 7, [217]: "The inquiry here is into whether there was an alternative but less intrusive means of addressing the legislature's objective which would have a similar level of effectiveness".

[56] *Hospice New Zealand v Attorney-General*, [106], [116].

[57] Tōtara Hospice, "Assisted Dying," https://hospice.co.nz/whanau-support-services-2/.

[58] Ministry of Health, "Review of the End of Life Choice Act 2019", 95.

[59] Ministry of Health, "Review of the End of Life Choice Act 2019", 94.

of conscience. Again, individual practitioners may very reasonably see this as making them complicit in a series of events causing an outcome that they fundamentally object to.

Third, the Bill would also remove the Act's permission for practitioners to decline to assist patients receiving assisted dying, perhaps as part of a team caring for that patient. Requiring doctors to be involved in a process that violates their most important beliefs may cause them significant moral injury and, indeed, may compromise the care that the patient receives.

Is the limit in due proportion to the importance of the objective?

This limb requires an assessment of "the balance of social advantage against harm to the right"[60] or "whether the practical benefits to society of the limit under consideration outweigh the harm done to the individual right or freedom".[61] In fact, "the more severe the deleterious effects of a measure, the more important the objective must be."[62]

Limiting health practitioners' conscience rights would have a significant impact on them. It would treat doctors as mere deliverers of state-sanctioned healthcare objectives. As discussed earlier, medicine and healthcare require the constant exercise of not only clinical but ethical reasoning about complex situations. Undermining practitioners' ability to employ and develop this reasoning would undermine the foundation of healthcare itself.

There would also be a significant impact on care facilities. As the *Hospice* case noted, many of these facilities are founded on an ethos that is incompatible with the provision of assisted dying. Forcing these facilities to facilitate access to information about assisted dying, or to assisted dying itself, could place them in an untenable position. They may choose to shut down their in-patient units or even to close entirely rather than be complicit in an activity that conflicts with the reason they exist. The social costs of losing these facilities would be extremely high, especially when the public health system is already stretched and would struggle to accommodate their displaced residents.[63]

Lastly, the Bill prioritises the desires of those who want to access assisted dying, but does not consider the interests of those who might want to be cared for in euthanasia-free spaces. Patients who are already vulnerable may be made more so if there is nowhere where they can be sure that assisted dying will not be on the agenda.

Conclusion: the Bill unjustifiably limits this right

In summary, the Bill's limits on conscience are rationally connected to its objective to improve access to information about assisted dying and to assisted dying itself. However, this objective is not sufficiently important in a free and democratic society, and the limits would impair

---

[60] *Multani v Commission scolaire Marguerite-Bourgeoys* [2006] 1 SCR 256 (SCC), cited in *Hansen v R* [2007] NZSC 7, [120] per Tipping J.

[61] *Hansen v R* [2007] NZSC 7, [123] per Tipping J.

[62] *R v Oakes* [1986] 1 SCR 103 (SCC), cited in *Hansen v R* [2007] NZSC 7, [103] per Tipping J.

[63] For example, see RNZ, "What's gone wrong with New Zealand's health system?", 14 August 2024, https://www.rnz.co.nz/news/national/523686/what-s-gone-wrong-with-new-zealand-s-health-system.

conscience rights more than is reasonably necessary. They would also have disproportionate negative social impacts.

The Bill unjustifiably limits the right to freedom to manifest belief.

The right to freedom of expression

Section 14 of the NZBORA provides:

> *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.*

This right "also protects the freedom *not* to express oneself in any particular context or manner."[64]

The Bill would require health practitioners either to supply information about assisted dying—namely, the contact details of the assisted dying service—to a patient or to arrange for someone else to do so. "Expression" is defined widely,[65] and both these options will be captured by that definition. The Bill would also require health practitioners to share patient information with doctors involved in assisted dying. The Bill therefore engages health practitioners' right to freedom of expression.

Similarly, the Bill would require care facility operators to supply this information about assisted dying to residents or to allow someone else to do so. This may engage an individual's right to freedom of expression—that is, the person who is actually responsible for supplying or arranging the provision of the information. To the extent that organisations are to be given the benefit of the NZBORA rights, it may also engage the right in respect of the legal entity that operates the care facility.

However, the Bill would remove the current requirement in the Act for an attending medical practitioner to tell a patient that they have a conscientious objection. Health practitioners would not be required to give any particular reason for declining to participate in assisted dying.

Does the Bill limit the right?

The Bill clearly limits the right when it would require information to be provided. It is explicit that this requirement would override a health practitioner's conscientious objection. It would apply to care facilities regardless of whether they are founded on an ethos that is incompatible with assisted dying.

The limit would go beyond the current requirement in the Act, which only applies to attending medical practitioners and says that they must tell a person asking for assisted dying that they

---

[64] P. Rishworth et al, *The New Zealand Bill of Rights*, 333.

[65] The Court of Appeal has held that "expression" is "as wide as human thought and imagination": *Moonen v Film & Literature Board of Review* [2000] 2 NZLR 9 at [15]. The same Court said that, "conduct as well as speech will fall within the scope of s 14," in *R v Morse* [2009] NZCA 623 at [87].

have a right to ask the SCENZ Group for the name and contact details of a replacement medical practitioner (and that they have a conscientious objection).

Is the limit justified?

Is the objective sufficiently important?

The Bill's objective—to prioritise the rights of health consumers over those of health practitioners, in order to improve access to information and to assisted dying itself—has already been discussed.

The Act already contains an obligation on a doctor caring for a patient to provide information about accessing assisted dying. This obligation applies equally to doctors caring for residents of care facilities.

For this and other reasons discussed earlier, the objective of this limiting measure is not "pressing and substantial".

Is there a rational connection between the objective and the limit?

The Bill's limits on freedom of expression are rationally connected to its objective to improve access to information and to assisted dying itself. It is logical that compelling health practitioners and care facilities to provide information will make it easier for patients to receive that information.

Does the limit impair the right no more than is reasonably necessary to achieve the objective?

As discussed earlier, existing measures in the Act are sufficient to achieve the objective of this limit. And other changes proposed by the Bill—allowing nurse practitioners as well as doctors to act as attending practitioners, and making it easier to publish information about assisted dying—demonstrate that the objective can be achieved in other ways that would not impair the right.

This limit therefore fails the minimal impairment test.

Is the limit in due proportion to the importance of the objective?

Compelling health practitioners to provide information against their better judgment undermines their role as reasoning, ethical professionals. As discussed earlier, this undermines the foundation of healthcare, with potentially wide-ranging consequences. Similarly, compelling care facilities to provide information that conflicts with the reason they exist jeopardises the continuing existence of those facilities and their services.

Conclusion: the Bill unjustifiably limits this right

In summary, the Bill's limits on freedom of expression are rationally connected to its objective to improve access to information about assisted dying and to assisted dying itself. However, this objective is not sufficiently important in a free and democratic society, and the limits would impair freedom of expression more than is reasonably necessary. They would also have disproportionate negative social impacts.

The Bill unjustifiably limits the right to freedom of expression.

THE BILL IS INCONSISTENT WITH THE NZBORA

The Bill is inconsistent with the right to manifest religion and belief—it engages and limits that right, and the limit cannot be justified.

Similarly, the Bill is inconsistent with the right to freedom of expression—it engages and limits that right, and the limit cannot be justified.

The "constitutionally unique process for deciding whether the End of Life Choice Act will come into force" also suggests that Parliament should be slow to disturb the limits on rights already approved by the electorate.