

Mōku anō ēnei rā: The End of Life Choice Act and its Compliance with Te Tiriti o Waitangi

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I Introduction

Assisted dying has always been a controversial topic, having long been accused of contributing to the normalisation of suicide and clashing with religious beliefs and cultural practices. Some fear it could be particularly detrimental to disabled people, the elderly, and the vulnerable, putting pressure on them to consider assisted dying in order to avoid feeling they are burdens. It has also been criticised for “leav[ing] grey areas between terminal illness and chronic conditions”.¹ To date, four bills have been proposed to New Zealand’s Parliament on assisted dying, two of which were successfully introduced and considered by the House.² The latest of these bills has passed its Third Reading, received the Royal Assent, and will be going to referendum later this year.³ This is the furthest that such a bill has progressed. However, whilst there are valid arguments for supporting the establishment of a euthanasia regime, particularly when one considers (patient) autonomy to be of paramount importance, there is good reason to hold this statute back to some degree.

This article will argue that, currently, the End of Life Choice Act 2019 (ELCA) is not compliant with te Tiriti o Waitangi. Compliance is crucial because death is an extremely tapu concept to Māori. Part II provides a brief overview of the ELCA and public

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1 Wendi Wicks “New Zealand’s euthanasia bill is a step into the unknown for disabled people” *The Guardian* (online ed, London, 14 November 2019).

2 Death with Dignity Bill 1995 (not introduced); Death with Dignity Bill 2003 (37-1); End of Life Choice Bill 2012 (withdrawn from ballot in 2013); and End of Life Choice Bill 2017 (269-3). See also New Zealand Parliamentary Service *Assisted Dying: New Zealand* (Parliamentary Library Research Paper 2018/06, 20 December 2018) at 1–2.

3 See New Zealand Parliamentary Service, above n 2, at 1; and “End of Life Choice Bill” (27 November 2019) New Zealand Parliament <www.parliament.nz>. See also Wicks, above n 1.

perceptions of assisted dying. Part III discusses the omission of any mention of te Tiriti in the Act, let alone any attempt at compliance — a potential breach of Article 3 of te Tiriti. It shows that the ELCA does not comply with the principles of the Treaty of Waitangi. It also explains how the Act fails to properly provide for the inconsistency between assisted dying and tikanga Māori — a breach of Article 2 of te Tiriti. This is not to say that assisted dying should not be legalised. It is simply that the ELCA should not progress without properly addressing Māori concerns. Part IV argues that assisted dying can become a procedure acceptable in tikanga Māori through an individualised interpretation of mana motuhake (self-determination and autonomy). Part V lays out several recommendations to make the ELCA more compliant with te Tiriti.

Throughout the article, I use “Treaty” to refer specifically to the English version of te Tiriti. This is because the terms of the Treaty are weaker than te Tiriti and the Treaty principles are a Western creation. Though the Treaty principles are simplistic and detract from te Tiriti’s literal interpretation, the Act does not even meet this lower bar.

II Background

Introduced by David Seymour MP of the ACT Party, the ELCA is intended to “give persons who have a terminal illness and who meet certain criteria the option of lawfully requesting medical assistance to end their lives”.⁴ Assisted dying is defined as “the administration by an attending medical practitioner or an attending nurse practitioner”, or “the self-administration by the person”, of “medication to relieve [the person’s] suffering by hastening death”.⁵

The End of Life Choice Bill (ELCB) attracted approximately 40,000 submissions — “the highest number of submissions a select committee [had] ever received”, indicating

4 End of Life Choice Act 2019, s 3.

5 Section 4.

“the significance of this complex issue to so many New Zealanders”.⁶ Although around 90 per cent of the submissions that “contained a discernible view” were against the Bill itself, and only approximately 8.5 per cent supported it,⁷ the majority of the general population actually supports the legalisation of assisted dying, and this number is increasing.⁸ A 2018 Newshub Reid Research poll showed that approximately 71 per cent of the country supported passing a euthanasia law,⁹ up from 66 per cent in a 2015 Curia Market Research poll¹⁰ and 57 per cent in 2013.¹¹ Some submissions by those who were seriously ill, as well as their families, commented on how having this option would save them from intense suffering in the future.¹² The ELCA would operate on a compassionate level by averting such “unbearable suffering and indignity”, which has often been described as “inhumane” and even “the equivalent of torture”.¹³ But, perhaps more importantly, it would allow people to exercise bodily autonomy and to die with dignity. Assisted dying provides people with *choice*. Not only do many supporters consider “individual autonomy and self-determination” as “foundations of modern New Zealand society”, some even see the option of assisted dying as a human right.¹⁴

In addition to the frequently-cited reasons for opposition and hesitation — such as preserving the sanctity of life, the difficulty of discerning coercion and full mental capacity, and the potential normalisation of suicide — there were also strong cultural concerns. Submissions cited inconsistencies with tikanga Māori, breaches of te Tiriti, and additional detriment to Māori and Pasifika communities who already experience high suicide rates and prejudice within the healthcare system.¹⁵

6 Justice Committee “End of Life Choice Bill hearings to begin 21 May 2018” (press release, 16 May 2018). See also New Zealand Parliamentary Service, above n 2, at 2.

7 End of Life Choice Bill (269-2) (commentary) [ELCB commentary], at 10.

8 New Zealand Parliamentary Service, above n 2, at 9.

9 Emma Hurley and Lloyd Burr “Newshub poll: Most New Zealanders support euthanasia” (3 February 2018) Newshub <www.newshub.co.nz>.

10 New Zealand Parliamentary Service, above n 2, at 10.

11 At 10.

12 ELCB commentary, above n 7, at 13.

13 At 15.

14 At 14.

15 At 19.

III The ELCA's compliance with Te Tiriti

The ELCA is not compliant with te Tiriti. First, it contains no clause expressly providing for te Tiriti concerns, let alone any mention of te Tiriti. Secondly, the Act does not even comply with Treaty principles, which set lower standards than te Tiriti itself. Finally, the Act is inconsistent with tikanga Māori and the value that Māori place on the collective. I will address each of these concerns in turn.

A Absence of a Treaty Clause

Many pieces of relatively recent New Zealand legislation make some reference to the Treaty, or at least its principles.¹⁶ However, the ELCA has no Treaty clause and does not refer to te Tiriti at all. Disappointingly, the Waitangi Tribunal recently found in its *Hauora Report on Stage One of the Health Services and Outcomes Kaupapa Inquiry* that “the legislative, strategy and policy framework that administers the primary health care sector ... fails to consistently state a commitment to achieving health equity outcomes for Māori”.¹⁷

Although the Crown has “social policy responsibilities toward Māori under Article 3 [of te Tiriti]”,¹⁸ the ELCA fails to comply with them. Article 3 sets out that “the Government ... will protect all the ordinary people of New Zealand and will give them the same rights and duties of citizenship as the people of England”.¹⁹ Although Māori are overrepresented in “terminal illness and chronic sickness rates”²⁰ which “suggest strongly that Māori will be disproportionately affected by the availability of a regime of euthanasia”, the ELCA fails to include provisions which address such issues.²¹

16 See, for example, Resource Management Act 1991, s 8; Oranga Tamariki Act 1989 (Children’s and Young People’s Well-being Act 1989), s 7AA; Marine and Coastal Area (Takutai Moana Act) 2011, s 7; and Heritage New Zealand Pouhere Taonga Act 2014, s 7.

17 Waitangi Tribunal *Hauora Report on Stage One of the Health Services and Outcomes Kaupapa Inquiry* (Wai 2575, 2019) [*Wai 2575 Report*] at xiii.

18 Sophie Bateman and Anna Bracewell-Worrall “Lawyers denounce End of Life Choice Bill as ‘threat to Māori’” (9 April 2019) Newshub <www.newshub.co.nz>.

19 IH Kawharu “Appendix” in Michael Belgrave, Merata Kawharu, and David V Williams (eds) *Waitangi Revisited: Perspectives on the Treaty of Waitangi* (Oxford University Press, Melbourne, 2005) 388 at 392.

20 Bateman and Bracewell-Worrall, above n 18.

21 Supplementary Order Paper 2019 (384) End of Life Choice Bill (269-2) (explanatory note) at 4.

This precludes Māori from having the same rights as those with “greater resources, access and social capital”.²² Coupled with inadequacies in cultural safety and funding, which “actively disadvantage Māori primary health organisations and providers”, this failure could even be recognised as an indication of the institutional racism faced by Māori within the healthcare system.²³

Socioeconomic factors, which are known to have great impacts on Māori health inequity as “cumulative effects of colonisation”,²⁴ have also been shown in other jurisdictions to influence a person’s choice to end their life or not. A 2018 report on the Oregon Death with Dignity Act 1997 (DWDA) showed that the majority of DWDA deaths were persons on Medicare or Medicaid insurance, suggesting lower income brackets.²⁵ This is particularly troubling information in light of Māori being disadvantaged across all socioeconomic indicators, including income, unemployment, education, rented accommodation and household crowding, as well as facing racial discrimination.²⁶ With no reference to te Tiriti, and bearing in mind the “severity and persistence of [Māori] health inequity”,²⁷ the ELCA fails to take any substantial steps to achieve Māori health equity in this area. This is not compliant with Article 3 of te Tiriti.

During the *In Committee* debate of the ELCB on 25 September 2019, amendments proposed by Alfred Ngaro MP and Harete Hipango MP of the National Party to add a Treaty clause into the ELCB were quickly ruled out for relating to an already-debated part of the Bill.²⁸ Mr Seymour dismissed the notion of Treaty clauses to address cultural competency in the ELCB on the basis that such provisions would imply that medical professionals would not be “expected to carry out duties of cultural competency in other settings”.²⁹

22 Bateman and Bracewell-Worrall, above n 18.

23 *Wai 2575 Report*, above n 17, at 156 and 151.

24 At 20.

25 Oregon Public Health Division, Center for Health Statistics *Oregon Death with Dignity Act: 2018 Data Summary* (Oregon Health Authority, February 2019) at 6.

26 Ministry of Health “Ngā awe o te hauora: Socioeconomic determinants of health” (2 August 2018) <www.health.govt.nz>.

27 *Wai 2575 Report*, above n 17, at 151.

28 (25 September 2019) 741 NZPD (End of Life Choice Bill – In Committee).

29 (25 September 2019) 741 NZPD (End of Life Choice Bill – In Committee, David Seymour).

I do not agree with Mr Seymour — Treaty references in legislation are important. Matthew Palmer notes that they serve both symbolic and instrumental value.³⁰ Palmer argues that symbolism legitimises the constitutional Māori-Crown relationship and is “the most important, and most undervalued, function of legislation”.³¹ However, it is difficult to see symbolism as the “most” important function given that many Treaty clauses (when actually present) are more comparable to vague, tokenistic gestures. Indeed, many such clauses require mere consideration of Treaty principles, or are limited to the consultation, contribution or participation of Māori.³²

Genuine avenues for Māori to have effective influence or decision-making power are rare. The Waitangi Tribunal’s analysis of the s 4 Treaty clause in the New Zealand Public Health and Disability Act 2000 gives substance to this notion (at least, in the health sector).³³ Despite the provision of “mechanisms to enable Māori to contribute to decision making on, and to participate in the delivery of, health and disability services”,³⁴ the Tribunal found that the Treaty clause has not allowed Māori “as Treaty partners to be fully involved in the co-design, control, or delivery of the primary health care system” and, thus, “proved ineffective in practice”.³⁵

Without Treaty references, Parliament can too easily forgo its obligations under te Tiriti to Māori and, sadly, it cannot be trusted to proactively act in good faith, particularly considering its history of oppression and repeatedly failing Māori. Parliament’s irresponsibility is illustrated by two rather recent examples: the closure of Napier Hospital, the establishment of which had been a term of the Ahuriri land transfer, without consulting Ahuriri Māori; and the disestablishment of Te Kete Hauora, the Māori health business unit, in 2016 — an incident described by Janice Kuka,

30 Matthew Palmer “The Treaty of Waitangi in Legislation” [2001] NZLJ 207 at 209.

31 At 209.

32 See, for example, Crown Research Institutes Act 1992, s 10; Resource Management Act 1991, s 8; Education Act 1989, s 181; Local Government Act 2002, s 4; Land Transport Management Act 2003, s 4; and Public Records Act 2005, s 7.

33 *Wai 2575 Report*, above n 17, at 75.

34 New Zealand Public Health and Disability Act 2000, s 4.

35 *Wai 2575 Report*, above n 17, at 78.

chief executive of Ngā Mataapuna Oranga, as “weaken[ing] the voice of Māori decision making and advocacy for primary health”.³⁶

To mitigate such issues, Jack Oliver-Hood has suggested that all legislation should have an overarching implied Treaty principles clause, requiring Parliament to use clear, express words when it intends to infringe Treaty principles.³⁷ Though not particularly radical, it is doubtful that the government would embrace such an approach at this moment, considering its continuous breaches of Treaty obligations and principles. Such an approach likely has a causal link to statistics such as 44 per cent of Māori having low trust in Parliament (compared with 29 per cent for the general population) and 47 per cent of Māori feeling that the public has little-to-no influence on government decision-making.³⁸

B Non-Compliance with Treaty Principles

The government laid out three Treaty principles in its Māori health strategy, *He Korowai Oranga*: partnership, participation, and protection.³⁹ These principles aim to support whānau and maximise Māori health. The government did admit that the “three Ps” oversimplified the Treaty principles but attempted to justify this as “an attempt to create a common language for use by a large workforce”.⁴⁰ Nonetheless, there is no attempt at fostering partnership with, or participation of, Māori within the ELCA, and thus no protection of Māori. Under the *Accountability* part of the Act, s 25 establishes the Support and Consultation for End of Life in New Zealand (SCENZ) Group to which the Director-General will appoint “members who the Director-General considers have, collectively, knowledge and understanding of matters relevant to the

36 Gabrielle Baker “Summer health series: Treaty partnership and decision making” (23 January 2018) The Spinoff <www.thespinoff.co.nz>; Waitangi Tribunal *The Napier Hospital and Health Services Report* (Wai 692, 2001); and *Wai 2575 Report*, above n 17, at 144.

37 Jack Oliver-Hood “Our Significantly Indigenous Administrative Law: The Treaty of Waitangi and Judicial Review” (2013) 19 Auckland UL Rev 53 at 70.

38 Stats NZ “Kiwis perceive high political trust but low influence” (26 January 2018) <www.stats.govt.nz>.

39 Ministry of Health *He Korowai Oranga: Māori Health Strategy* (November 2000).

40 *Wai 2575 Report*, above n 17, at 79; and Janine Hayward “Principles of the Treaty of Waitangi – ngā mātāpono o te tiriti” (20 June 2012) Te Ara — the Encyclopedia of New Zealand <www.teara.govt.nz>.

functions of the SCENZ Group”. Section 26 requires the Minister of Health to “appoint an end-of-life Review Committee consisting of (a) a medical ethicist ... and (b) 2 health practitioners”. There are no Māori branches or members, or guarantees that te Tiriti or tikanga will be considered, within either of these bodies, despite their duties, including:⁴¹

... in relation to the administration of medication under section 20,—

- (i) to prepare standards of care; and
- (ii) to advise on the required medical and legal procedures; and
- (iii) to provide practical assistance if assistance is requested.

and:⁴²

... to report to the Registrar whether it considers that the information contained in an assisted death report shows satisfactory compliance with the requirements of this Act.

The ELCA also fails to meet other Treaty principles, such as *good faith* and *exchange*. Good faith would require the Crown to ensure that the ELCA is not inconsistent with principles of the Treaty. The duty to act in “the utmost good faith” flows from the partnership created between Pākehā and Māori with the signing of te Tiriti.⁴³ The Waitangi Tribunal has even held that “[b]ecause the Crown is in the more powerful position as the government in this partnership, the Crown has a fiduciary obligation to protect Māori interests.”⁴⁴

Mirroring the principle of good faith is the principle of exchange, which refers to the Crown’s obtainment of kāwanatanga in exchange for protecting Māori tino rangatiratanga over “lands, villages, and all their treasures”.⁴⁵ In the case of the ELCA, health could be considered in and of itself a taonga. Because “the Treaty

41 End of Life Choice Act 2019, s 25(3)(g).

42 Section 26(2)(b).

43 *New Zealand Maori Council v Attorney-General* [1987] 1 NZLR 641 (CA) at 643.

44 Waitangi Tribunal *Te Maunga Railways Land Report* (Wai 315, 1994) at 68.

45 Hayward, above n 40, at 4; and Kawharu, above n 19, at 392.

goes beyond Western concepts of property”,⁴⁶ taonga encompasses intangible and non-material “dimensions of a tribal group’s estate”, and can include things such as “ancestral lore and whakapapa (genealogies)”.⁴⁷ Mark Barrett and Kim Connolly-Stone have argued that an application of Article 2 of te Tiriti to health would not only “change the discourse from one of needs, to one of Māori rights to health”, but would indicate a right to self-determination in healthcare provision.⁴⁸ The protection of this tino rangatiratanga would oblige the Crown to ensure Māori have effective influence and decision-making power over their own healthcare. Failure to do so exemplifies the “inconsistency between [the g]overnment’s official statements on the Treaty and the application of Treaty principles at an operational level”.⁴⁹

The Treaty principles already provide lower standards than the literal terms of te Tiriti. If they are not used, they are also unable to create a common language. I argue that using the Treaty principles is already an indirect, inadequate and reductionist approach by the Crown to fulfil its obligations to Māori under te Tiriti, even if it is a well-intentioned attempt to acknowledge the Māori-Crown relationship.

The failure to have even one voice for Māori on the bodies created by the Act is concerning, particularly considering that the tikanga around death differs between iwi, thus making “wide-ranging consultation ... important”.⁵⁰ It is difficult to see how any of the aforementioned Treaty principles would be meaningfully satisfied by mere consultation, when legislators can choose not to act on submitters’ concerns.

Some submitters had felt the ELCB would breach te Tiriti and its “underlying principle of tiaki (protection) of Māori values and ... the concept of the taonga (treasure) of life”.⁵¹ Some voiced concerns about the written submission process itself, fearing that

46 Mark Barrett and Kim Connolly-Stone “The Treaty of Waitangi and Social Policy” (1998) 11 Social Policy Journal of NZ 29 at 31.

47 Waitangi Tribunal “Translation of the te reo Māori text” (19 September 2016) <www.waitangitribunal.govt.nz>.

48 Barret and Connolly-Stone, above n 46, at 37.

49 At 37.

50 ELCB commentary, above n 7, at 20.

51 At 19.

it “may not obtain fully representative views from [non-Western cultural] groups”.⁵² And yet, iwi were not consulted. No Treaty clause was added to the Act. Tino rangatiratanga was not protected.

Simply noting the concerns raised in the submissions process and then failing to respond to them is a travesty of Māori influence in decision-making. Merely “influencing decisions or participating in making them is not the same as making decisions”.⁵³ The concept of death plays such a crucial part in Māori life and the treasure of tikanga, and yet Māori have had no real involvement in the reform of the law on assisted dying. The ELCA is not compliant with the principles of te Tiriti.

C Inconsistency with Tikanga

Death and the processes surrounding death are tapu, one of the most sacred concepts in tikanga Māori. Death is heavily “influenced by connections to ... tūpuna (ancestors), whānau (nuclear and extended family) and whenua (land)”.⁵⁴

Assisted dying has been accused of “erod[ing] cultural processes” and being inconsistent with aspects of tikanga on the basis that maintaining the mana of the individual by caring for them until their natural death “is important for the wellbeing of the whole whānau”.⁵⁵ Whanaungatanga is a central concept in both tikanga Māori and Māori health, referring to “relationship, kinship, sense of family connection ... a relationship through shared experiences and working together which provides people with a sense of belonging.”⁵⁶

To many indigenous cultures, the family/collective are of utmost significance.⁵⁷ As Green Party co-leader Marama Davidson MP has explained: “in Te Ao Māori, no

52 At 20.

53 *Wai 2575 Report*, above n 17, at 80.

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

55 At 545.

56 Māori Dictionary “Whanaungatanga” <www.maoridictionary.co.nz>. See also Lee Stoner and others “The indigenous health gap: raising awareness and changing attitudes” (2015) 135(2) *Perspectives in Public Health* 68 at 68.

57 Malpas and others, above n 54, at 545.

decisions can be seen as individuals making decisions in isolation of whānau and community”.⁵⁸ Because “health services in Western countries are generally designed and delivered based on Western values”, such as liberalism, which venerates the individual, there can be “inequities in service delivery and health outcomes for indigenous people”.⁵⁹ Mason Durie, for example, has described familial involvement in issues related to health as “a very traditional and culturally necessary attitude which must be recognised in the management of the whole patient and not just [their] impaired organ”.⁶⁰ Familial involvement is deemed especially important for Māori as hospitalised Māori patients can experience particular anxiety and depression because illness is viewed as a transgression of tapu.⁶¹

Durie also illustrates how uniquely Māori notions of illness, such as mākutu and mate Māori, were ascribed by Western-trained psychiatrists and medical anthropologists to mental and psychic realms, diminishing their relevance in the contemporary medical sphere.⁶² The concept of historical trauma stemming from colonisation, combined with the present trauma of racism, have also been found to be causal factors of indigenous ill-health.⁶³ Studies in Australia have concluded that policy decisions and exploitation have contributed to chronic disease, depression, and so-called diseases of poverty (for example, rheumatic fever, heart disease, tuberculosis and trachoma) suffered by indigenous Australians.⁶⁴ These examples demonstrate that “[c]olonisation is a determinant of health and requires appreciating that it is not a ‘finished project’”.⁶⁵

Assisted dying is premised on the exercise of individual autonomy. If the ELCA comes into force without full consideration of Māori concerns, it could be taken as the

58 (26 June 2019) 739 NZPD (End of Life Choice Bill – Second Reading, Marama Davidson).

59 Malpas and others, above n 54, at 545.

60 Mason Durie *Whaiora: Māori Health Development* (2nd ed, Oxford University Press, Auckland, 1998) at 67.

61 At 67.

62 At 66.

63 Yin Paradies “Colonisation, racism and indigenous health” (2016) 33(1) *Journal of Population Research* 83 at 86.

64 Juanita Sherwood “Colonisation – It’s bad for your health: The context of Aboriginal health” (2013) 46(1) *Contemporary Nurse* 28 at 31.

65 At 30.

imposition of these Western, liberal notions — perhaps even as an extended limb of colonisation. The legalisation of assisted dying could erode whanaungatanga and the importance of the collective for Māori.

The 1970s saw a push for a model of health to reflect this non-individualistic approach in Māori health, which recognised the whole patient and their surroundings, rather than just the Western perception of “the absence of sickness”.⁶⁶ It was from this that Te Whare Tapa Whā emerged, a Māori health framework proposed by the Ministry of Health and consisting of four cornerstones: taha tinana, taha hinengaro, taha whānau, and taha wairua — physical, mental, family, and spiritual health.⁶⁷

Wairua (spirit, soul) is extremely important in the tikanga around death. Certain procedures must occur “so that the wairua of the dying person could be released appropriately”.⁶⁸ Because death is so tapu, following kawa (protocols, ceremony) becomes crucial. Assisted dying has also long been wrongly compared to suicide which, for Māori, can be “considered an imbalance ... of wairua ... and whakapapa”.⁶⁹ In tikanga Māori, whakapapa (genealogy) is a person’s connection between the spiritual and physical worlds, referring to the genealogical relations between people and helping to prescribe behavioural norms and accountability.⁷⁰ Suicide may mean that the individual who committed it is “no longer taking their place as part of whānau, hapū and iwi” unreasonably.⁷¹ The family’s condemnation of the person’s suicide might be reflected in a shortened one-day tangi,⁷² a prohibition against bringing the body onto the marae, burying the body outside the urupā (cemetery) and “even burying the

66 Durie, above n 60, at 68; and Stoner and others, above n 56, at 68.

67 Ministry of Health “Māori health models – Te Whare Tapa Whā” (18 May 2017) <www.health.govt.nz>.

68 Malpas and others, above n 54, at 550.

69 Ngaropi Cameron “He waipuna koropupū: Taranaki Māori wellbeing and suicide prevention” (2017) 2(2) *Journal of Indigenous Wellbeing* 105 at 107.

70 Miriama Kahu (1995) as cited in Keri Lawson-Te Aho “Whāia te Mauriora: In Pursuit of Healing” (PhD Thesis, Victoria University of Wellington, 2013) at 19.

71 At 19.

72 Tangihanga generally take three days, though this is not a strict rule and they can last much longer. Elton Smallman “Understanding a tangi” (3 May 2013) Stuff <www.stuff.co.nz>.

person upside down”.⁷³ There may also be a sense that the suicide brings whakamā (shame) upon the whānau (though the tikanga of many iwi have shifted and since become more accepting).⁷⁴

Making assisted dying the choice of the individual, when Māori health models do not focus on the individual, could be seen as bringing about an imbalance in wairua and whakapapa in the way that suicide is considered to do so. As is the case with suicide, assisted dying may be considered unacceptable under tikanga as “many lives are impacted by the actions of one and [those many] are all accountable for that one”.⁷⁵

Clear inconsistencies between tikanga and assisted dying can be identified. Article 2 of te Tiriti promises that the Crown would protect taonga — which includes tikanga. To push forward with an Act that could violate aspects of tikanga might in turn violate te Tiriti. This renders the ELCA non-compliant with te Tiriti.

IV Making Assisted Dying Acceptable in Tikanga

While, for the reasons set out above, the ELCA does not comply with te Tiriti, this is not to say that assisted dying itself should not be legalised in New Zealand. Rather, it is my contention that the Act should not move forward without the proper involvement of Māori. Though there are elements of assisted dying which are inconsistent with tikanga, tikanga is known to adapt to contemporary circumstances. I propose that Māori adopt an individualised interpretation of mana motuhake to re-evaluate assisted dying as a procedure that can be acceptable according to tikanga.

Māori worldviews are not static. There is no one single Māori worldview. Take, for example, the tangi of Māori academic Ranginui Walker, who chose to be cremated and have his tangi away from his marae — even livestreamed.⁷⁶ More Māori are becoming

73 “He Koha Aroha: A study in the area of Māori suicide prevention strategies” University of Otago <www.otago.ac.nz> at 40; and Chris Barton “Michael Naera” Speaking Out about Suicide <www.speakingoutaboutsuicide.com>.

74 At 40.

75 Kahu, above n 70, as cited in Lawson-Te Aho, above n 70, at 19.

76 “Assisted dying – nurses face the contentious issues” (2017) 23(9) Kai Tiaki Nursing New Zealand 13.

organ donors.⁷⁷ Acceptance is growing for holding tangi for those who were cremated and those who committed suicide — the kawa around burials are changing.⁷⁸ Though some worry that kawa on marae will need to change to accommodate assisted dying,⁷⁹ tikanga has already adapted many times and it can adapt again.

It is also important to add that there is some historical precedent for euthanasia in Māori culture, through: *tuku wairua* (the exercise of freeing one's spirit); leaving the person outside without food or water, and then in a *wharemate* (house of mourning) if they did not die immediately; and, as explained in one *kaumātua's* anecdotal account, by the breaking of the neck.⁸⁰ *Tuku wairua* involves the recital of prayers or incantations by a *tohunga* or a minister of a church in order to release the *wairua* from the body “while the person is still alive ... when there is no hope of recovery and when the patient has begun the process of dying”.⁸¹

The procedure of *tuku wairua* may thus be comparable to assisted dying through the concept of brain death. Interestingly, the *wairua* is said to “[begin] its existence” or “is activated” when the eyes of a foetus form, when “new life develops ‘rudimentary powers of thought’”.⁸² Similarly, New Zealand law and the medical community define legal death, not in a cardiopulmonary sense, but in relation to the brain — “when irreversible brain damage is diagnosed and ... none of the vital centres in the brain stem are still functioning”.⁸³

77 At 14.

78 Cleo Fraser “Marae protocol may change if euthanasia legalised” (16 January 2018) Newshub <www.newshub.co.nz>.

79 John Boynton “Reverend questions euthanasia bill’s impact on te ao Māori” (15 January 2018) RNZ <www.rnz.co.nz>.

80 Te Karere TVNZ “Precedent for euthanasia in Māori culture exists, says tikanga expert” (video, 13 December 2017) YouTube <www.youtube.com>; Meriana Johnsen “Is there tikanga around euthanasia?” (19 November 2019) RNZ <www.rnz.co.nz>; Māori Dictionary “Wharemate” <www.maoridictionary.co.nz>; and Malpas and others, above n 54, at 548. The *kaumātua's* affiliations are Ngai Tūhoe, Ngāti Porou and Ngāti Maniapoto.

81 Hirini Moko Mead *Tikanga Māori: Living by Māori Values* (2nd ed, Huia Publishers, Wellington, 2013) at 85.

82 At 83.

83 *Auckland Area Health Board v Attorney General* [1993] 1 NZLR 235 at 246.

It is after *tuku wairua* has occurred that “the *whānau* take up a vigil and ... wait for the moment when the *mauri* departs”, evidenced by the person’s last breath.⁸⁴ *Parihaka* *kuia* *Maata Wharehoka*, who runs a *whānau* business providing traditional Māori burial services, *Kahu Whakaterere Tūpāpaku*, has even stated that assisted dying may “help the *wairua* of the person dying”, allowing it to “leave the world faster with less pain and suffering”.⁸⁵

Older attitudes towards suicide are also being re-evaluated. It is noted that “traditional Māori tribal pedagogies” indicate that:⁸⁶

... the death of an individual by suicide was not considered ... shameful or cowardly ... rather it was viewed in its full context ... [S]uicide was considered a human tragedy and loss of potential ... thus treated with understanding, compassion and *aroha*.

Indeed, *Michael Naera* suggests that negative perceptions of suicide “are a result of transference of ... Christian beliefs into Māori protocol”.⁸⁷

Attitudes are changing. Some people, including *Willie Jackson* MP of the Labour Party, have suggested that personal experiences of seeing family members suffer justifies more *kōrero* on assisted dying.⁸⁸ Some even deem it a right, despite the inconsistencies with *tikanga* and the Māori distrust of the healthcare system and government, stemming from New Zealand’s oppressive history.⁸⁹

The concept of *mana motuhake* is commonly used in a collective sense, encapsulating the self-determination and autonomy of Māori as a whole. However, I propose an interpretation of *mana motuhake* which looks towards the individual. I emphasise that, as someone who is non-Māori, my aim is not to undermine *tikanga* in favour of

84 Mead, above n 81, at 85.

85 Johnsen, above n 80.

86 *Tepora Emery, Candy Cookson-Cox, and Ngāmaru Raerino “Te Waiata a Hinētītama—Hearing the Heartsong: Whakamate i roto i a Te Arawa—A Māori suicide research project” 2015 11(3) AlterNative 225 at 225.*

87 Barton, above n 73.

88 (26 June 2019) 739 NZPD (End of Life Choice Bill – Second Reading, *Willie Jackson*).

89 *Malpas and others*, above n 54, at 547.

something which may be rooted in Western ideology. My aim is merely to suggest viewing the concept of mana motuhake in a way that reflects the growing acceptance and support of assisted dying in the Māori community. It is to mirror the evolution of tikanga which is protected in Article 2 of te Tiriti.

The scope of mana motuhake has been shifted before, from the self-determination of Māori generally to the self-determination of those who would choose the avenue offered by assisted dying.⁹⁰ Ms Davidson extended this to individuals in a way that does not compromise the collective sense of mana motuhake but instead runs in parallel to it. Ms Davidson argued that:⁹¹

... that level of mana motuhake as a person is also a valid, well celebrated aspect of Te Ao Māori ... our stories are full of individual achievement, celebrations, and success, and examples of mana motuhake, but that ... does not ever have to separate how that impacts on the wider inclusion of whānau and community in being able to be an informed part of these decisions that we make.

Moreover, this interpretation of mana motuhake is consistent with the Treaty principle of *options*, which “protects Māori in their right to continue their way of life according to their indigenous traditions and worldview while participating in British society and culture, as they wish”.⁹² A suggestion is for Parliament to add provisions into the ELCA that make assisted dying more palatable in the eyes of tikanga, such as arranging a karanga of farewell and allowing assisted dying to happen in places other than hospitals (which may seem foreign and lack the spirituality required for such a tapu procedure).⁹³ Of course, iwi and hapū differences must be acknowledged, and different tikanga and approaches developed.

90 (26 June 2019) 739 NZPD (End of Life Choice Bill – Second Reading, Marama Davidson); and “Assisted dying – nurses face the contentious issues”, above n 76.

91 (26 June 2019) 739 NZPD (End of Life Choice Bill – Second Reading, Marama Davidson).

92 *Wai 2575 Report*, above n 17, at 35.

93 “Assisted dying – nurses face the contentious issues”, above n 76; and Permindar S Sachdev “Mana, Tapu, Noa: Maori cultural constructs with medical and psycho-social relevance” (1989) 19 *Psychological Medicine* 959 at 967.

On the whole, allowing the option of assisted dying in a manner which better accommodates Māori would be an evolution of tikanga. Such an approach would protect tikanga as a taonga under Article 2 of te Tiriti, as well as make the ELCA more compliant with te Tiriti.

V Making the ELCA More Compliant with Te Tiriti

I recommend that, at the very least, the ELCA needs a Treaty clause that requires consistency and compliance with te Tiriti for the stronger protection of Māori. The duty to act and perform any duties in a manner consistent with te Tiriti should be extended to any bodies created by the Act, such as the SCENZ Group and the end-of-life Review Committee, and their members. I agree with the submission of Mr Hipango which contends that a similar duty should apply as well to “[a]ny organisation that is accorded a duty or responsibility under this Act”.⁹⁴

Prohibiting inconsistency with the Treaty principles may also have the desired result of reducing Māori health inequities in the area of assisted dying. However, as discussed above, the principles — though well-intended — are an indirect and reductionist approach to the Crown’s obligations to Māori. We need euthanasia legislation that is not limited to the consultation, contribution or participation of Māori. Considering that death is such a tapu and significant concept in tikanga Māori, the Act should give Māori actual decision-making powers — or at the minimum, *effective* influence in decision-making.

Another suggestion to make the ELCA more consistent with tikanga and te Tiriti would be to establish Māori branches of the SCENZ Group (in s 25) or the end-of-life Review Committee (in s 26), or at least require them to have a number of Māori members. I would recommend that the Māori members have different tribal affiliations or are empowered to convene hui with relevant iwi before making their decisions. This would allow for the more effective consideration of different approaches that are compatible

94 Supplementary Order Paper 2019 (384), above n 21, at 27B(1).

with different tikanga. These bodies (and any responsible organisations) should have an extensive list of Tiriti duties, including to:⁹⁵

... develop strategic partnerships with iwi and Māori organisations, including iwi authorities, in order to provide opportunities to, and invite innovative proposals from, those organisations to improve outcomes for Māori who seek services under this Act.

If Parliament chooses not to take such courses of action, ss 25 and 26 should at least be amended to require qualifications in knowledge of te ao Māori and tikanga Māori to be considered for membership.

From an international law perspective, Māori, as the indigenous people of New Zealand, have the right to self-determination which includes the free pursuit of “their economic, social and cultural development”.⁹⁶ Indigenous peoples also have “the right, without discrimination, to the improvement of their economic and social conditions, including ... health” and “the right to be actively involved in developing and determining health ... programmes affecting them and, as far as possible, to administer such programmes through their own institutions.”⁹⁷ As a State Party to the United Nations Declaration on the Rights of Indigenous Peoples (UNDRIP), New Zealand’s apathy and inaction towards Māori concerns in the assisted dying regime has the effect of making our commitments to such international agreements appear to be mere window-dressing or a sham.⁹⁸ The above recommendations would help to more closely align New Zealand with its international commitments and obligations.

VI Conclusion

The ELCA in its current form is not compliant with te Tiriti. It neither mentions te Tiriti nor the Treaty principles. Moreover, there has been no effort to address the Act’s

95 At 27B(2)(c)(i).

96 United Nations Declaration on the Rights of Indigenous Peoples GA Res 61/295 (2007), art 3.

97 Articles 21 and 23.

98 *Tavita v Minister of Immigration* [1994] 2 NZLR 257 (CA) at 266.

inconsistencies with tikanga. Further research in this area could involve exploring how other countries have balanced indigenous rights and assisted dying legislation (if at all), the extent to which the ELCA is consistent with international law (particularly the UNDRIP) and how attitudes overseas, particularly in Asia, have changed to be more accepting of assisted dying despite continuing to hold on to strong family values.

Though it can take several years of parliamentary sessions for a bill to be passed into law, with only a little over seven months between April 2019, when the ELCA was referred to the Select Committee, and November 2019, when the Act was granted the Royal Assent,⁹⁹ the ELCA appears to have hurtled through the legislative process. The ELCA should not progress, and should not have progressed, with such haste without fully considering and addressing Māori concerns. The Crown has endlessly failed Māori in so many aspects of life — must it also fail Māori in assisted death?

99 “End of Life Choice Bill”, above n 3.