

THE CASE FOR ALLOWING AID IN DYING IN NEW ZEALAND

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Many of us would prefer not to think about the issue of how and when we will die until we are compelled to do so. Should we turn our minds to such matters, understandable fears and emotions quickly can crowd out our higher reasoning facilities. But it is not necessary to embrace Plato's assertion that "those who pursue philosophy aright study nothing but dying and being dead"¹ in order to confront the necessary implications of our mortality: even though we may wish to ignore death, it most assuredly will not ignore us. Uncomfortable and upsetting as they may be, questions about the ending we might want for our particular life story and thus what choices we think ought to be permitted in end of life situations are not something that we can or should avoid confronting with clear eyes and an open mind.

In fact, debates over such matters — more particularly, whether and when persons suffering as the result of an incurable and/or terminal medical condition ought to be allowed to end their lives with the active assistance of others — have become increasingly common around the world. The laws of six countries currently permit such practices,² as do six states within the United States of America.³ Parliaments in both the United Kingdom⁴ and Scotland⁵ recently have voted down legislative proposals to join this group. In contrast, last year a parliamentary committee in the Australian State of Victoria recommended that it should adopt such a law,⁶ with legislation to deliver on that recommendation set to enter the State Parliament in 2017. And in New Zealand, the High Court determined in *Seales v Attorney-General* that our criminal law presently prohibits a doctor from actively assisting a terminally ill patient to die.⁷ Following that judgment, the House of Representatives' Health Committee commenced a wide-ranging inquiry into "all the various aspects of the issue, including [its] social, legal medical, cultural, financial, ethical and philosophical implications", while a Bill in the name of David Seymour MP currently in the members' ballot proposes that our Parliament legislate to allow for such "end of life choice".⁸

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¹ Plato "Phaedo" in *Plato in Twelve Volumes* (William Heinemann, London, 1966) vol 1 at 64a.

² Belgium, Canada, Colombia, Luxembourg, The Netherlands and Switzerland.

³ California, Colorado, Montana, Oregon, Vermont and Washington.

⁴ Assisted Dying (No 2) Bill (2015-16) (UK).

⁵ Assisted Suicide (Scotland) Bill 2015.

⁶ Legal and Social Issues Committee *Inquiry into End of Life Choices: Final Report* (Victorian Government Printer, Melbourne, 2016).

⁷ *Seales v Attorney-General* [2015] NZHC 1239, [2015] 3 NZLR 556.

⁸ See End of Life Choice Bill 2015. In addition, Louisa Wall has publicised a draft Member's Bill, the Authorised Dying Bill, but has chosen not to submit this to the ballot. See Phil Taylor "Lecretia

In this article I argue that New Zealand's law should be amended to allow at least those competent and consenting adult persons:

- experiencing unbearable physical or mental suffering;
- as the result of an incurable and terminal medical condition;
- where the best medical advice is that death will occur in the next six months;

to directly request that a willing doctor actively help end their life.⁹ To avoid repetition, I will refer to those in such a situation as being "relevant persons". I focus on the case of relevant persons because it provides the strongest grounds for the proffered proposition; if anyone should be able to receive such help to die, it is they. Conversely, I accept that if the argument fails in respect of such relevant persons, then it fails in all other cases as well. The question whether, if successful for relevant persons, the argument then ought to apply to *other* classes of person — or, indeed, if it is possible to limit the argument's reach at all — will be addressed in the article's final part.

There are two reasons for writing this article now. First, as just noted, the issue is very much a current issue of public policy in New Zealand. Second, my colleague at Otago, Professor Rex Ahdar, recently has published a carefully reasoned article arguing that our present law on the issue should *not* be changed.¹⁰ A clear statement of the general argument in favour of this law reform is thus doubly warranted. As with Professor Ahdar's critique, this article does not closely describe the particular features of current proposals to allow medical help to die in New Zealand; rather, it seeks to establish the general principle that *some* law change should occur to allow it.

I begin in part one with an initial clarification of the various terms used by those involved in this debate. Part two outlines the intertwined moral grounds for allowing medical help to die — recognition of individual autonomy and avoidance of cruelty — and responds to some arguments that these do not justify taking such a step. Part three turns to examine current medical practice, arguing that there is no good reason to distinguish actively helping a relevant person to die from the various end of life choices presently permitted to patients. Part four then considers and responds to two of the most common arguments against permitting such medical help: that determining who may qualify for it results in arbitrary and unprincipled distinctions and that allowing such help will result in a "slippery slope" whereby an ever increasing range of individuals will feel compelled to request it. I then conclude in part five by arguing that the time for a law change is now in that a large proportion of the New Zealand public has repeatedly shown that it supports such a reform.

Seales knew exactly what she was asking for: Louisa Wall" *The New Zealand Herald* (online ed, Auckland, 19 November 2016).

⁹ I assume and accept that actively helping a patient to die should be a matter of individual conscience. Current legislative proposals for allowing aid in dying also do so; see End of Life Choice Bill, cl 6; Authorised Dying Bill, cl 10.

¹⁰ Rex Tauati Ahdar "The Case Against Euthanasia and Assisted Suicide" [2016] NZ L Rev 459.

I. AN INITIAL BRIEF NOTE ON TERMINOLOGY

A preliminary problem when discussing matters of end-of-life choice is that there are a number of different practices that may be called different things by those taking each side of the debate. Consequently, it is worth clarifying at the outset what particular terms refer to. The withdrawal (or withholding) of life-sustaining treatment commonly is described as *passive euthanasia*,¹¹ while the positive act of intentionally causing the death of another person on compassionate grounds is termed *active euthanasia*. A further distinction is drawn between *voluntary euthanasia*, where consent first is obtained, and *non-voluntary euthanasia*, where express consent is not acquired, such as where a person is in a persistent vegetative state or otherwise lacks the capacity to decide.

The common feature in all such cases is that an external party takes a step that directly leads to death, either by consciously choosing to withhold or withdraw treatment or deliberately administering a dose of fatal medication or the like. As discussed further below, passive voluntary euthanasia is lawful in New Zealand whenever a competent person decides upon it. Passive non-voluntary euthanasia also is lawful where a doctor believes that further treatment or intervention is not in a patient's best interests. However, active euthanasia is unlawful in all cases, amounting to culpable homicide.¹² Finally, *indirect euthanasia* (also called the "double effect doctrine") covers the administration of drugs with the primary purpose of relieving a terminally ill patient's pain and suffering, despite a doctor knowing that this treatment likely will have the incidental effect of hastening that person's death.¹³ This practice is lawful in New Zealand.¹⁴

The concept of euthanasia is then very closely related to that of suicide. *Suicide* itself involves an individual actively and directly ending her own life, while *assisted suicide* involves a person taking active steps to aid another individual in committing suicide. A specific form of such assistance is *physician-assisted suicide*, which involves a doctor prescribing a lethal substance to a patient knowing that they intend later self-administration. In New Zealand, committing or attempting suicide is not a criminal offence. However, it is an offence for any person to "aid[] or abet[] any person in the commission of suicide".¹⁵ The High Court has declared that this provision applies to anyone, whether a health professional or otherwise, that supplies even a terminally ill patient with lethal

¹¹ Professor Ahdar denies that such a concept exists, labelling it "misleading and unhelpful" at 461. I simply will note here that the term is both widely used and defensible; see, e.g., Richard Sainsbury "End of life issues" in I M St George (ed) *Cole's medical practice in New Zealand* (12th ed, Medical Council of New Zealand, Wellington, 2013) 107 at 110; E Garrard and S Wilkinson "Passive euthanasia" (2005) 31 J Med Ethics 64.

¹² *Airedale NHS Hospital Trust v Bland* [1993] 1 All ER 821 (HL); *R v Martin (no 2)* HC Wanganui CRI-2003-083-432B, 24 March 2004; Seales, above n 7, at [112]–[114].

¹³ E Emanuel "Euthanasia: historical, ethical and empiric perspectives" (1994) 154 Arch Int Med 1890.

¹⁴ *Auckland Area Health Board v Attorney-General* [1993] 1 NZLR 235 (HC) at 250–251; Seales, above n 7, at [106].

¹⁵ Crimes Act 1961, s 41(1)(b).

medication for the purpose of subsequently ending her own life.¹⁶ Indeed, even informing a person about how to end one's own life painlessly is an offence, if done knowing and intending that the recipient will act on the information supplied.¹⁷

Further complicating matters is the fact that the very use of the terms "euthanasia" and "suicide" are deeply contested in this context, with the phrase "aid in dying" increasingly used in their place.¹⁸ In this parlance, active euthanasia is termed *assisted aid in dying* while physician-assisted suicide is called *facilitated aid in dying*. These descriptors are claimed to be less emotively fraught, given the historical connection between the term euthanasia and the actions of the Nazi regime (which murdered over 100,000 men, women and children who were physically and/or mentally disabled, or otherwise considered "genetically inferior"), as well as the psychological differences between those who commit suicide and those who seek to end their lives voluntarily to escape unbearable suffering.¹⁹ I have preferred these latter terms in previous writings on this topic.²⁰ If for no other reason than the sake of consistency, I shall do so in this article as well. The ultimate question is not what we call the actions in question, but whether they ought to be permitted. To that question I now turn.

II. IT IS MORALLY DESIRABLE TO PERMIT AID IN DYING

As intimated above, the current legal status of aid in dying in New Zealand is reasonably clear. In *Seales v Attorney-General*,²¹ the High Court refused to declare that providing either assisted or facilitated aid in dying is not an offence under the Crimes Act 1961 punishable (at least in theory)²² by extremely long terms of imprisonment.²³ Proponents of aid in dying believe that this current state of our criminal law is morally wrong and should be changed to permit a willing doctor to give such assistance to (at least) relevant persons. The

¹⁶ *Seales*, above n 7, at [147]. See also *R v Davison* [2011] NZHC 1677; *R v Mott* [2012] NZHC 2366. But see Ahdar, above n 10, at 477.

¹⁷ Crimes Act 1961, s 41(1)(a) and (2). See also *R v Tamatea* (2003) 20 CRNZ 363 (HC).

¹⁸ See Kathryn Tucker "At the Very End of Life: The Emergence of Policy Supporting Aid in Dying Among Mainstream Medical and Health Policy Associations" (2009) 10 Harv Health Pol Rev 45 at 45.

¹⁹ Gina Lopes *Dying with Dignity: A Legal Approach to Assisted Dying* (Praeger, Santa Barbara, California, 2015) at 10.

²⁰ Kathryn Tucker and Andrew Geddis "Litigating for the right to die" [2015] NZLJ 172; Andrew Geddis and Colin Gavaghan "Aid in dying in New Zealand: Recent legal developments" (2016) 23 JLM 849.

²¹ *Seales*, above n 7, at [9]. See also Geddis and Gavaghan, above n 20, at 853–857.

²² In practice, recent sentences for individuals who provide aid in dying have ranged from a discharge without conviction to home detention. See, e.g., *R v Ruscoe* (1992) 8 CRNZ 68 (CA); *R v Law* [2002] 19 CRNZ 500 (HC); *R v Faithfull* HC Auckland CRI 2007-044-007451, 14 March 2008; *R v Crutchley* HC Hamilton CRI 2007-069-83, 9 July 2008; *R v KJK* HC Christchurch CRI 2009-009-14397, 18 February 2010; *R v Davison* HC Dunedin CRI 2010-012-4876, 24 November 2011; *Mott*, above n 16.

²³ The sentence for culpable homicide is up to life imprisonment (Crimes Act 1961, s 172(1); s 177(1)), whilst aiding or abetting suicide attracts a potential sentence of 14 years' imprisonment (Crimes Act 1961, s 179(1)).

argument for doing so then rests on two primary propositions.²⁴ First, relevant persons ought to be permitted to choose for themselves how and when they will die. This claim is derived from notions of individual autonomy: the right of such individuals to decide for themselves the time and manner of their life's end demands our collective respect (even if not our agreement). Second, there is no good reason for society to deny relevant persons this choice and thereby require that they continue to suffer against their will. Laws that prevent relevant persons receiving voluntarily provided aid in dying are unnecessarily cruel. And a society that denies individuals their autonomy in a way that is unnecessarily cruel is morally deficient. Establishing the claim that aid in dying ought to be permitted requires both propositions be considered in greater depth.

A. The Argument from Autonomy

The first autonomy-based claim derives from our society's core liberal individualist commitments. We generally presume competent adults to be the superior judges of what is best for them in the particular situation they are confronted with and so should respect their decisions about what actions they do or do not want to take in response. Thus, it is a foundational principle of medical practice that informed consent must be obtained for any procedure on or treatment of a patient who is capable of giving such consent.²⁵ Liberal-individualist presumptions also underpin wider societal decisions as to what people are permitted to do. We collectively allow people to climb up mountains despite the inevitable numerous fatalities that result,²⁶ accept political protests we disagree with at the cost of significant disruption and irritation,²⁷ and even tolerate others listening to *Creed* songs notwithstanding their lack of any musical value whatsoever.²⁸ Indeed, our laws steadily are being reformed to better reflect this basic worldview. Not only were homosexual acts decriminalised in 1986,²⁹ the right of same-sex couples to claim marital status since has been affirmed.³⁰ The solicitation of payment for sex has been decriminalised, with prostitution now recognised as a lawful profession.³¹ Making or publishing a statement that expresses a seditious intention is no longer an offence.³² Students

²⁴ See Glanville Williams "Euthanasia Legislation: A Rejoinder to the Non-Religious Objections", in AB Downing (ed) *Euthanasia and the Right to Die* (Peter Owen, London, 1969) 134 at 134–135; Stuart Beresford "Euthanasia, The Right to Die and the Bill of Rights Act" [2005] Hum Rts Research 3 at 7.

²⁵ Health and Disability Commissioner (Code of Health and Disability Services Consumers' Rights) Regulations 1996, reg 2, Right 7.

²⁶ There have been, for example, more than 230 known fatalities in the Aoraki/Mount Cook National Park alone, including 78 from climbing Aoraki itself.

²⁷ *Brooker v Police* [2007] NZSC 30, [2007] 3 NZLR 91; *Morse v Police* [2011] NZSC 45, [2012] 2 NZLR 1.

²⁸ See "Readers' Poll: The Top Ten Worst Bands of the Nineties" (9 May 2013) Rolling Stone <www.rollingstone.com/music/pictures/readers-poll-the-ten-worst-bands-of-the-nineties-20130509/1-creed-0736783>.

²⁹ Homosexual Law Reform Act 1986.

³⁰ Marriage (Definition of Marriage) Amendment 2013.

³¹ Prostitution Reform Act 2003.

³² Crimes (Repeal of Seditious Offences) Amendment Act 2007.

may study at university without having to be a member of a students' association.³³ And so on.

Of course, a claim that individual autonomy is a fundamental precept of our society does not equate to everybody being allowed to do everything they want. Society can and still does impose numerous collective limits on individual choice through the criminal law. We do not let people take some kinds of recreational drugs.³⁴ We do not let people sell their bodily organs.³⁵ We do not let people claim to be entitled to wear medals that they were not properly awarded.³⁶ And so on. While acknowledging the factual existence of such wide-ranging restrictions on personal liberty, an immediate question is whether they are morally defensible. Because pointing to *other* existing laws that are *themselves* an illegitimate infringement of individual autonomy does not really counter the claim that relevant persons should be permitted to receive aid in dying. Doing so is like a bank robber who defends his actions by saying he also robs post offices, pharmacies and toy stores. Instead, we need to examine the applicability of general justifications for society placing collective limits on the individual exercise of decisional freedom. There are three such justifications, none of which (I will argue in the course of this article) apply to the case of aid in dying.

The first is where we judge an individual's exercise of autonomy to be vitiated by some form of cognitive bias or other reasoning defect, such that her decision cannot be trusted to reflect a properly considered understanding of what is best for her. In such circumstances, society may decide to impose a paternalistic fetter on an individual's decisional freedom for that individual's own good. However, in an earlier article Professor Ahdar sounded an appropriate note of caution about this justification for restraining individual action:³⁷

... the range of situations in which such condescending paternalistic claims hold true (on average, over time and allowing for the costs of imposing views on others) is ... fairly limited. It is *not* that the notion that I know better than you what will further your welfare is always false or indefensible. Rather, the point is that experience indicates that as a rule it is *usually* false.

I will argue in more detail below that the claim actually is false in respect of aid in dying, as there simply is no reason for us to assume that collectively we have a superior understanding of what are the true best interests of relevant persons. We cannot honestly say a person is "foolish" or "short-sighted" or "delusional" for wanting to end her life rather than continue a necessarily truncated existence marred by pain and suffering. We know this because we *already* respect such individuals' decision to die. As shall be seen, our law and medical practices treat as sacrosanct a competent patient's decision to end treatment or remove life support, even where such a choice results in her inevitable death. So if we see

³³ Education (Freedom of Association) Amendment Act 2010.

³⁴ Misuse of Drugs Act 1975.

³⁵ Human Tissue Act 2008, s 56.

³⁶ Military Decorations and Distinctive Badges Act 1918, s 4A.

³⁷ Rex Ahdar and James Allan "Taking Smacking Seriously: The Case for Retaining the Legality of Parental Smacking in New Zealand" [2001] NZ L Rev 1 at 18 (internal citation omitted).

no reason to impose paternalistic constraints on these sorts of end-of-life decisions, then there is no reason to do so with respect to a relevant person's decision to seek aid in dying.

A second reason for imposing limits on individual autonomy is that its exercise may result in harm to others. Most of our criminal law reflects a desire to prevent some forms of action immediately and directly impacting negatively on others' interests. Concern about the indirect effect of the exercise of choice on others then underpins much of the criminal law's remaining limits. For example, we legislate against some apparently "victimless crimes" in order to undermine a market that we believe will result in harm to more vulnerable individuals.³⁸ With respect to aid in dying, it is argued that should the practice be permitted for relevant persons, it inevitably will result in incompetent or non-consenting individuals also being coerced into ending their own lives. Alternatively, a slippery slope will develop that leads to its application to an ever-increasing range of individuals and situations, inevitably resulting in pressure on the vulnerable to avail themselves of the option. I will again argue in more detail below that such claims regarding potential harm are both not supported by evidence and at odds with current end of life practices. In particular, there is now sufficient experience from overseas jurisdictions to counter fears about the inevitability of any particular consequences of permitting aid in dying. Furthermore, the very broad decisional freedom we already give to individuals at life's end is inconsistent with claims that allowing aid in dying must result in harm to others. Simply put, if letting people choose how they will die inexorably leads to the vulnerable being pressured to end their lives early, then opponents of aid in dying must explain why it is that current forms of passive euthanasia are not routinely abused in hospitals, rest homes and hospices.

Finally, there is a somewhat nebulous set of constraints imposed on individual freedom of choice out of irreducibly moral judgments regarding the nature of certain acts.³⁹ Most pertinently, the Crimes Act 1961, s 63 states: "No one has a right to consent to the infliction of death upon himself or herself". Thus, even a fully informed, non-coerced decision to (say) voluntarily offer oneself up for human sacrifice to Odin⁴⁰ is overridden by society's collective judgment that human life is too valuable for an individual to agree to permit another to take it from her. It may thus be argued that the provision of aid in dying is a fundamentally wrongful act and our laws should uphold "the sanctity of life" absolutely by allowing no exceptions to the bar on actively participating in another person's desire to die.⁴¹ At this point we may reach an irreconcilable gulf

³⁸ Examples of this are the prohibition on personal possession of illegal drugs, the selling of bodily organs and the viewing of digitally created child pornography.

³⁹ Such constraints seek to combat what Joel Feinberg describes as "free-floating evils"; see Joel Feinberg *The Moral Limits of the Criminal Law Vol 4: Harmless Wrongdoing* (Oxford University Press, Oxford, 1990) at 20–25.

⁴⁰ See, e.g., "Sacrifice" *Vikings* (season 1, episode 8).

⁴¹ Ahdar, above n 10, at 475–476.

in perspectives. Those holding such a core moral belief, be it for religious⁴² or secular⁴³ reasons, are unlikely to be swayed⁴³ by any form of contrary argument.

In contrast, while proponents of aid in dying do not deny that society generally should affirm and protect the value of human life, we think this position ought to be qualified in respect of (at least) relevant persons. For such individuals, the best medical advice is that their medical condition will kill them in the very near future. As such, they are not really choosing *to* end their lives through aid in dying, but rather *how* and *when* their death will occur. And as Eugene Debs poetically expressed the matter a century ago:⁴⁴

Human life is sacred, but only to the extent that it contributes to the joy and happiness of the one possessing it, and to those about him, and it ought to be the privilege of every human being to cross the River Styx in the boat of his own choosing, when further human agony cannot be justified by the hope of future health and happiness.

So proponents of aid in dying do not claim that society should treat the general phenomena of suicide, much less the active euthanasia of incompetent persons, as morally neutral matters. Both our laws and our general societal attitudes should remain opposed to these practices, just as they should continue to prohibit activities such as voluntary human sacrifice to Nordic gods. But proponents of aid in dying believe a general commitment to life's value ought not to harden into a duty on all people to continue to live, no matter their individual circumstances. In particular, we endorse the observations of Collins J in his judgment in *Seales v Attorney-General*:⁴⁵

... the consequences of the law against assisting suicide as it currently stands are extremely distressing for Ms Seales and ... she is suffering because that law does not accommodate her right to dignity and personal autonomy.

Our view is that it is morally wrong to for the law to require that (at least) relevant persons must experience further distress and suffering. Valorising the importance of human life at such a cost is inhumane, involving the improper application of rigid principle over basic human compassion. And we ought not to treat the harm done to relevant persons as merely the sad but necessary collateral damage of our unrelenting moral convictions. Rather, we should change our laws to avoid it.

B. The Prohibition on Aid in Dying Is Unnecessarily Cruel

For some relevant persons, the process of dying is not particularly pleasant to contemplate. It can be extended, be painful and strip a person of the

⁴² See, e.g., John Sutherland Bonnell "The Sanctity of Human Life" (1951) 8 *Theology Today* 194 at 201; Sacred Congregation on the Doctrine of the Faith *Declaration on Euthanasia* (5 May 1980).

⁴³ See, e.g., Immanuel Kant *Grounding for the Metaphysics of Morals* (Hackett, Indianapolis, 1993) at 422; Neil M Gorsuch *The Future of Assisted Suicide and Euthanasia* (Princeton University Press, Princeton (NJ), 2006) at 159.

⁴⁴ Quoted in V Robinson "A symposium on euthanasia" (1913) 19 *Med Rev of Reviews* 143.

⁴⁵ *Seales*, above n 10, at [192].

independence and dignity to which she is accustomed. Take, as an example, the irreversible progression of Motor Neuron Disease (MND), which annually claims some 100 lives in New Zealand:⁴⁶

... eventually individuals will not be able to stand or walk, get in or out of bed on their own, or use their hands and arms. Difficulty swallowing and chewing impair the person's ability to eat normally and increase the risk of choking. Maintaining weight will then become a problem. Because cognitive abilities are relatively intact, people are aware of their progressive loss of function and may become anxious and depressed. ... In later stages of the disease, individuals have difficulty breathing as the muscles of the respiratory system weaken. They eventually lose the ability to breathe on their own and must depend on ventilatory support for survival.

It is easy to urge those suffering such end stage symptoms to follow Dylan Thomas' injunction to "rage, rage against the dying of the light." Undoubtedly some MND sufferers find it within themselves to do so or, alternatively, make their peace with their situation and calmly resign themselves to their fate. But for others the promise of months of slow wasting away until finally their body ceases to function is an utterly horrifying prospect that they would rather avoid by way of a swift and painless end. Similarly, other relevant persons facing comparably bleak end of life circumstances also may wish to receive aid in dying rather than continue to suffer the inescapable effects of their particular condition. Lecretia Seales, when unsuccessfully seeking a declaration that aid in dying is permitted under New Zealand law, expressed the matter thus:⁴⁷

I have lived my life as a fiercely independent and active person. I have always been very intellectually engaged with the world and my work. For me a slow and undignified death that does not reflect the life that I have led would be a terrible way for my good life to have to end.

I want to be able to die with a sense of who I am and with a dignity and independence that represents the way I have always lived my life. I desperately want to be respected in my wish not to have to suffer unnecessarily at the end. I really want to be able to say goodbye well.

For proponents of aid in dying, using the criminal law to deny relevant persons such a final outcome is unnecessarily cruel.

Of course, we do not label as "cruel" *every* societal denial of choice that results in individual suffering. Laws prohibiting sexual contact with minors likely create significant mental anguish for pedophiles, but we would not say that they are treated cruelly as a result. Equally, it is not cruel for Pharmac to decide against paying for some new medication that can cure a medical condition because the organisation's limited funding can better be used buying drugs that relieve the affliction of a greater number of others. In such cases the suffering caused by the legal rule or policy choice is outweighed by some demonstrably greater social good. However, it *is* cruel to tell relevant persons that they must continue to live in pain and anguish against their will *for no good reason*. In the rest of this

⁴⁶ National Institute of Neurological Disorders and Stroke "Amyotrophic Lateral Sclerosis (ALS) Fact Sheet" (2016) <www.ninds.nih.gov/disorders/amyotrophiclateralsclerosis/detail_ALS.htm>.

⁴⁷ *Seales*, above n 7, at [29].

section I consider two arguments to the effect that the law's prohibition on aid in dying does not actually mean that relevant persons must suffer at the end of their lives. The rest of this article then contends that such suffering is unnecessarily cruel because it is imposed without good reasons for doing so.

(i) Current Laws Do Not Provide Sufficient End of Life Choice

It may be argued that laws permitting aid in dying are unnecessary because relevant persons already can take steps to end their lives without having to involve any other person.⁴⁸ As Professor Ahdar notes, the Crimes Act no longer makes it an offence to attempt or succeed at committing suicide, and so "[it] is a viable option, even for the elderly and enfeebled in all but the most rare instances of physical incapacity".⁴⁹ Cashed out fully, that argument must go something as follows. There is no need to change our criminal law to enable relevant persons to receive a lethal dose of medicine from a doctor at a time of their own choosing while surrounded by their loved ones, because such individuals instead can go off on their own and cut their wrists, overdose on paracetamol or jump in front of a train. I do not regard this as an overly compelling claim, for the following reasons.

First, it elides a relevant person's end of life choice with "committing suicide". And while our law presently does not outright *prohibit* suicide, it also does not positively *permit* it.⁵⁰ The Crimes Act 1961, s 41 provides a general defence for anyone who uses "such force as may be reasonably necessary in order to prevent the commission of suicide ... or in order to prevent any act being done which he or she believes, on reasonable grounds, would, if committed, amount to suicide". So current law does not say that relevant persons have a right to actively end their own lives; rather, it says that anyone who wants to can actively stop a relevant person from doing so.⁵¹ The real world consequences of this legal situation recently became apparent when the police served a number of search warrants on elderly people in the Wellington and Nelson regions as well as set up a breath alcohol checkpoint to gather information about those who might be considering an exercise of end-of-life choice.⁵² Far from leaving relevant persons free to end their own lives through suicide, our present criminal law aggressively seeks to prevent this in both theory and practice.

Second, there are important practical differences between how life ends with aid in dying and through suicide. Aid in dying involves a doctor providing, or directly administering, a fatal cocktail of medicines that render a person unconscious before death peacefully occurs. However, it is unlawful to possess such medicines unless prescribed by health professionals, meaning that without legal access to aid in dying a relevant person must turn to other methods. These

⁴⁸ Ahdar, above n 10, at 470–471.

⁴⁹ At 471.

⁵⁰ A point Professor Ahdar recognises at 472–473.

⁵¹ See Colin Gavaghan "Stopping Suicide After *Seales*" [2016] NZCLR 4.

⁵² See Andrew Geddis "Sing me to sleep" (27 October 2016) Pundit <<http://pundit.co.nz/content/sing-me-to-sleep>>.

methods are messy and potentially painful in themselves, with someone then required to cut down the resultant hanging corpse, clean up the shotgun splatter or deal with the train driver's emotional trauma. Furthermore, such methods run a significant risk of failure, which can leave the individual in a worse state than they were in before. Simply put, a cancer sufferer with end stage symptoms who takes an overdose of paracetamol has a non-zero risk of awakening in a hospital bed with not only their cancer symptoms but liver or kidney failure as well.

Finally, the current law on aiding and abetting suicide means that relevant persons cannot safely involve anyone else in their end of life choice. This has two consequences. It means that a person may feel compelled to end their life at a point earlier than they otherwise would, for fear that their deteriorating condition will leave them physically unable to do so later on. This claim is not purely speculative. Extensive evidence that it occurs was presented to the High Court in *Seales v Attorney-General*,⁵³ with Collins J expressly accepting that "the offence provisions of the Crimes Act ... may have the effect of forcing Ms Seales to take her own life prematurely, for fear that she will be incapable of doing so when her condition deteriorates further."⁵⁴ In such cases, the failure to permit aid in dying effectively robs an individual of a quantum of their life; they die earlier than otherwise would be the case. The second consequence is that a relevant person necessarily must end her life alone. The mere presence of anyone else in the room when death occurs opens that person up to investigation and possible subsequent prosecution by the police. By contrast, where aid in dying is permitted, relevant persons can surround themselves with family and friends, recount memories and say goodbyes before taking the medication that will end their life.⁵⁵ Only the most hard-hearted, it seems to me, could consider that these two circumstances are readily interchangeable.

(ii) Palliative Care Is Not a Sufficient Alternative to Aid in Dying

A second argument against the claim that prohibiting aid in dying is unnecessarily cruel is that good and proper palliative care can provide a sufficient guarantee against the end of life experience of pain.⁵⁶ The problem with this assertion is that it is deeply contested at best, simply not true at worst and in any case misdirected. As Collins J concluded from the voluminous evidence presented in *Seales v Attorney-General*, existing palliative care could not guarantee Ms Seales would not suffer pain during the dying process,⁵⁷ while "many of the experts, including those relied upon by the Attorney-General accept that palliative care

⁵³ *Seales*, above n 7, at [51]–[52]. See also *R (Nicklinson) v Ministry of Justice* [2014] UKSC 38, [2014] 3 WLR 200 at [96] (per Lord Neuberger); *Carter v Canada (Attorney-General)* [2015] SCC 5, [2015] 1 SCR 331 at [15].

⁵⁴ *Seales*, above n 7, at [166]. See also *Carter v Canada*, above n 53, at [57].

⁵⁵ For an account of such an ending under California's aid in dying law, see Lindsey Bever "A terminally ill woman had one rule at her end-of-life party: No crying" *Washington Post* (online ed, Washington DC, 16 August 2016).

⁵⁶ Ahdar, above n 10, at 497–500.

⁵⁷ *Seales*, above n 7, at [37]–[38].

may not be able to address Ms Seales' psychological and emotional suffering".⁵⁸ This final point is significant, as evidence from the United States indicates that a fear of physical pain is less important to those who choose aid in dying than is a desire to retain control over their end of life situation.⁵⁹ So although the provision of aid in dying should never be regarded as a replacement for good palliative care, the High Court's factual finding is that current practices are unable to provide a general guarantee of a peaceful, painless, dignified ending for all.

A refinement of this argument is that while *current* forms of palliative care may be unable to provide such guarantees, a properly funded and universally available system of care could do so. Therefore, rather than permit aid in dying, societal efforts and resources ought to be spent on improving and expanding existing arrangements. Of course, that argument treats the availability of aid in dying and improved palliative care as necessarily incompatible choices, rather than twin policy goals that can be pursued together. I simply note here that there is no evidence that this is the case. As two opponents of aid in dying admit:⁶⁰

In 2011, the [European Association for Palliative Care] published a report on palliative care development in countries with a euthanasia law. The report highlighted that there has been substantial development in palliative care services in these countries, and that it was not possible to conclude that the development of palliative care had either been hindered or promoted by the legalization of elective death options.

More broadly, suggestions that a universally available and properly funded future system of palliative care will be able to sufficiently alleviate end-of-life suffering in all cases display a remarkably hubristic view of what medical practice can deliver. It also seems strange to argue it is necessary to criminalise a practice because there purportedly are superior alternatives for people to choose instead. Or, rather, if palliative care really can deliver all that is claimed for it, why is it thought that anyone would instead want to avail herself of aid in dying? Because

⁵⁸ At [44].

⁵⁹ In Oregon, 91.6% of individuals who received aid in dying between 1998-2015 cited "losing autonomy" as a reason for doing so, compared to 25.2% who cited "inadequate pain control or fear of it". See *Oregon Death With Dignity Act: 2015 Data Summary* (Oregon Public Health Division, 4 February 2016) at 6. This report is available at: <<https://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Documents/year18.pdf>>. In Washington state, 87% of individuals who received aid in dying in 2014-2015 cited "losing autonomy" as a reason for doing so, compared to 37% who cited "inadequate pain control or fear of it". See *Washington State Department of Health 2015 Death with Dignity Act Report Executive Summary* (Washington State Department of Health, 2016) at 7. This report is available at: <www.doh.wa.gov/portals/1/Documents/Pubs/422-109-DeathWithDignityAct2015.pdf>.

⁶⁰ Lars Johan Materstvedt and Georg Bosshard "Euthanasia and Palliative Care" in Nathan Cherny et al (eds) *Oxford Textbook of Palliative Medicine* (5th ed, Oxford University Press, Oxford, 2015) at 318. See also Kenneth Chambaere and Jan L Bernheim "Does legal physician-assisted dying impede development of palliative care? The Belgian and Benelux experience" (2015) 41 *J Med Ethics* 657 at 660; Bryn Nelson and Terence J Colgan "In debating the right to die, a shift in tone among physicians: As laws legalizing physician-assisted suicide gain ground in Canada and elsewhere, physicians readjust their stance to retain a say" (2015) 123 *Cancer Cytopathology* 327.

if even a handful of individuals would rather a quick end to their existence than a lingering one protected by the best care that palliative medicine may provide, it is cruel to deny that preference for no other reason than that we think it the “wrong” one to hold. Consequently, while improved palliative care ought to be a societal goal irrespective of any arguments about aid in dying, even the promise of such enhanced care does not nullify the arguments that without full end of life choice some individuals will continue to suffer in an unnecessarily cruel manner.

III. AID IN DYING IS CONSISTENT WITH CURRENT END OF LIFE PRACTICES

This article argues for amending our law to permit a particular form of end of life choice: assisted or facilitated aid in dying, which involves a doctor’s voluntary but active participation in her patient’s decision. As such, it is not *solely* an exercise of a relevant person’s individual autonomy in that it necessarily involves another person in the process. Such involvement, while a matter of conscience for individual doctors, nevertheless would represent a change in what currently is permitted in the doctor-patient relationship. Opponents of aid in dying view this development as “cross[ing] a fundamental legal and ethical Rubicon”, representing “a change of monumental proportions both in the law and in the role of doctors”.⁶¹ In this section I argue that this claim misrepresents the nature of the proposed law reform. The provision of aid in dying actually is quite consistent with the sorts of choices currently available to a patient at the end of her life. And while it would represent an extension of current practices, that extension poses no unmanageable new risks or challenges, while entirely fitting the modern doctor-patient relationship.

A. The Range of Existing End of Life Choices

At present, our law recognises patient autonomy by allowing a competent adult person to choose to die in a variety of ways.⁶² Section 11 of the New Zealand Bill of Rights Act 1990 affirms the right to decline any form of treatment without having to provide a reason. Such refusals must be respected even if the treatment would be effective in prolonging life:⁶³

A person with operable cancer, for instance, who is able to make a decision on what should happen is quite entitled to reject surgery and accept the consequences of not undergoing it, even though on an objective view the surgery would improve the quality of the patient’s life, if not extend or save it.

Neither is the right to decline treatment restricted to what is sometimes called “extraordinary” or “heroic” treatment. Even the provision of food and hydration may be refused,⁶⁴ leading to death by starvation or dehydration. In order to relieve the end of life symptoms of a patient who refuses food or hydration,

⁶¹ Justin Welby “Why I believe assisting people to die would dehumanise our society for ever” *The Guardian* (online ed, London, 5 September 2015).

⁶² See generally Peter Skegg “Medical Acts Hastening Death” in Peter Skegg and Ron Paterson (eds), *Health Law in New Zealand* (Thomson Reuters, Wellington, 2015) at 623.

⁶³ *Re K* (2002) 22 FRNZ 349 (FC) at 356.

⁶⁴ *Chief Executive of the Department of Corrections v All Means All* [2014] NZHC 1433.

“palliative sedation” — the application of increasing amounts of analgesics and sedatives to render the patient unconscious — may take place until death occurs. A patient also may insist that life-prolonging interventions be stopped:⁶⁵

It has been held overseas, and would accord with my thinking, that [the New Zealand Bill of Rights Act 1990, s 11] enables a patient, properly informed, to require life support systems to be discontinued.

Finally, a patient may be indirectly euthanised by the provision of life-shortening medication under the doctrine of double effect:⁶⁶

... if [a] doctor were to administer a lethal dose of pain relief such as morphine to [a patient], the doctor’s actions may not be an unlawful act within the meaning of s 160(2)(a) of the Crimes Act if the doctor’s intention was to provide [the patient] with palliative relief, and provided that what was done was reasonable and proper for that purpose, even though [the patient’s] life would be shortened as an indirect but foreseeable consequence.

In addition, a number of life-ending choices may be made for patients who are not presently competent to express an autonomous choice. A patient may make an anticipatory refusal of treatment by means of an advance directive.⁶⁷ Medical staff also may elect to withhold or withdraw life-prolonging treatment on behalf of an incompetent patient if they believe that such treatment would not be in the patient’s best interests. The High Court has, for example, permitted the removal of ventilatory support from a patient who, while still believed to be aware, was “unable to communicate by even elementary means”,⁶⁸ and similar decisions have been reached by UK courts.⁶⁹ Against this background, the law’s current failure to permit relevant persons to receive aid in dying is deeply anomalous. The question then is whether there are any morally relevant reasons to distinguish between the broad autonomy accorded to patients when *refusing* any further life sustaining treatment or interventions and the complete denial of such autonomy when it comes to *requesting* active forms of aid in dying.

B. Alleged Problems of Consent and Competence Already Exist

It commonly is claimed that difficulties in determining the competence of a relevant person making a request for aid in dying undermines the autonomy argument for permitting it. How can we be sure she “really” wants to end her suffering by dying?⁷⁰ Alternatively, might not a relevant person’s ostensibly

⁶⁵ *Auckland Area Health Board*, above n 14, at 245.

⁶⁶ *Seales*, above n 7, at [106].

⁶⁷ Health and Disability Commissioner (Code of Health and Disability Services Consumers’ Rights) Regulations 1996, reg 2, Right 7(5).

⁶⁸ *Auckland Area Health Board*, above n 14, at 238. See also *Re G* [1997] 2 NZLR 201 (HC); *Auckland Healthcare Services Ltd v L* (1998) 5 HRNZ 748 (HC).

⁶⁹ For example, *Re AK (Medical Treatment: Consent)* [2001] 1 FLR 129 (Fam).

⁷⁰ See, e.g., Affidavit of Baroness IG Finlay, 6 May 2015 at [34] (“To end your life is the biggest decision that you could make and is cognitively demanding. But detecting cognitive impairment is very difficult.”). This affidavit is available at: <http://lecretia.org/wp-content/uploads/2015/10/affidavit_of_finlay.pdf>.

voluntary decision really be the result of pressure from others, whether direct or inferred? For example, members of the UK Supreme Court expressed a:⁷¹

... direct concern about weak and vulnerable people in the same unhappy position as Applicants, who do not have the requisite desire (namely “a voluntary, clear, settled and informed decision to commit suicide”), but who either feel that they have some sort of duty to die, or are made to feel (whether intentionally or not) that they have such a duty by family members or others, because their lives are valueless and represent an unjustifiable burden on others.

While such concerns are valid, they fail to offer credible reasons to distinguish aid in dying from the withdrawal of life-preserving treatment or interventions. For all the risks and perils often suggested to accompany aid in dying already arise in the context of existing end of life choices. In particular, the dangers of vulnerability, incapacity, coercion and misinformation are all present in the sorts of routine decisions that doctors and nurses caring for dying patients currently must take. Those decisions necessitate a determination of competence and consent,⁷² and it is not apparent why such a determination would be less reliable in the aid in dying context than in the context where a patient refuses dialysis treatment, food and hydration or a blood transfusion. The difficulty of making such determinations is not then thought to provide an ethical basis for a blanket ban on all life-ending decisions; on the contrary, healthcare professionals are routinely trusted with them.

A recent English Court of Protection case provides an illustration of the approach taken by courts to the question of end of life competence in common law jurisdictions.⁷³ Following an attempt at suicide that destroyed her kidney function, the patient (“C”) sought to refuse life-saving dialysis in spite of medical advice that she could expect to live for a significant further period with it. C’s reasons for refusal included:⁷⁴

... that she believed she may need dialysis for the rest of her life, saw a bleak future if she could not have a life of socialising, drinking and partying with friends, that getting old scared her both in terms of illness and appearance.

The Court’s consideration of these reasons is illustrative of the approach taken to treatment refusals more generally:⁷⁵

The decision C has reached to refuse dialysis can be characterised as an unwise one. That C considers that the prospect of growing old, the fear of living with fewer material possessions and the fear that she has lost, and will not regain, ‘her sparkle’ outweighs a prognosis that signals continued life will alarm and possibly horrify many ... C’s decision is certainly one that does not accord with the expectations of many in society. Indeed, others in society may consider C’s decision to be unreasonable, illogical or even immoral within the context of the sanctity accorded to life by society in general. None of this however is

⁷¹ *R (Nicklinson)*, above n 53, at [86] (per Lord Neuberger). See also at [228] (per Lord Sumption).

⁷² *Sainsbury*, above n 11, at 107–108.

⁷³ *Kings College Hospital NHS Foundation Trust v C* [2015] EWCOP 80.

⁷⁴ At [74].

⁷⁵ At [97].

evidence of a lack of capacity. ... As a capacitous individual C is, in respect of her own body and mind, sovereign.

There is no real doubt that such a patient would be deemed competent to make the same choice in New Zealand. That people may make unwise, idiosyncratic or morally questionable decisions about the value of their lives is not presently accepted as a reason to deny them control over life and death decisions.⁷⁶ Neither is the fact that capacity assessments are not infallible.

Concerns that relevant persons may seek aid in dying on the basis of a perceived "duty to die" also are not really new. After all, we respect the decision of a Jehovah's Witness who tells a doctor she refuses consent to a life-saving blood transfusion because she does not wish to betray the religious beliefs she shares with her family and wider congregation. But if a perceived duty to die is believed to fatally undermine an individual's decisional capacity, why should a doctor refrain from providing treatment in this situation? Equally, we valorise the so-called "altruistic suicides" of individuals like Captain Oates, who actively end their lives in order to benefit others. Such behaviour is seen as the epitome of Christ's injunction that "*Greater love hath no man than this, that a man lay down his life for his friends.*"⁷⁷ It seems odd, then, to conclude that a relevant person's concern about how her condition may impact on the lives of her loved ones automatically vitiates their autonomy, such that we cannot trust the basis of their end of life decisions. Or, rather, if such other-regarding concerns do have this effect, not only does our understanding of capacity in wider end of life situations need revisiting but also our very understanding of what is noble and praiseworthy is flawed.

Therefore, insofar as the mechanisms we currently possess are deemed adequate to distinguish competent from incompetent treatment or intervention refusals, there is no reason why they would be inadequate to distinguish competent from incompetent requests for aid in dying. Insofar as aid in dying poses risks, they are risks that already exist in our end of life decision-making practices. And so if those risks are considered by opponents of aid in dying to be intolerable in respect of that practice, then it is incumbent on such opponents to explain why they are not presently resulting in widespread errors or abuses in current end of life situations. Furthermore, it is important to note that current legislative proposals to permit aid in dying in New Zealand would impose far more rigorous safeguards than exist under current medical practice. Before permitting a relevant person to receive aid in dying, David Seymour's End of Life Choice Bill would require a minimum seven day waiting period;⁷⁸ the certifying medical practitioner to encourage the applicant to consult with his or her family or a close friend about the request, and seek professional counselling;⁷⁹ the mandatory agreement of a second practitioner;⁸⁰ and scrutiny by the Registrar.⁸¹

⁷⁶ See, e.g., *All Means All*, above n 64.

⁷⁷ "John Chapter 15" King James Bible Online www.kingjamesbibleonline.org/John-Chapter-15/.

⁷⁸ End of Life Choice Bill 2015, cl 7(2)(c).

⁷⁹ At cl 8(2).

⁸⁰ At cl 10.

Louisa Wall's draft Authorised Dying Bill proposes an even more extensive authorisation procedure, requiring a specially constituted ethics committee to review and assent to any individual request for aid in dying.⁸² With such mechanisms in place, we can be far more certain that any successful request for aid in dying represents a genuinely consented, non-coerced choice than we can with regard to already permitted patient demands to discontinue life sustaining treatment or refuse further medical procedures.

C. The Act Versus Omission Distinction Is Illusory

Another attempt to distinguish current end of life choices from the provision of aid in dying is through contrasting actions with omissions to act.⁸³ On this view, it is morally permissible — indeed, morally required — for a doctor to refrain from treatment or intervention where a competent adult patient demands this, even if death results. However, it is not ever morally permissible for a doctor to actively and intentionally cause her patient's death, even if requested to do so by a competent adult. The patient's autonomy right thus forms a negative shield from unwanted interference, rather than a positive ground for obtaining aid from another.⁸⁴ Equally, the doctor's forbearance from acting is said simply to allow the patient's condition to take its "natural" course, whereas the provision of aid in dying operates as the immediate cause of death. Thus, there is a relevant moral distinction to be drawn between letting someone die and killing her.

The moral significance of this act-versus-omission distinction has been subject to extensive criticism over many years. For as James Rachels notes: "There is nothing wrong with being the cause of someone's death if his death is, all things considered, a good thing. And if his death is *not* a good thing, then *no* form of euthanasia, active or passive, is justified."⁸⁵ Furthermore, it simply is not true that current end of life practices require only forbearance on the part of health professionals. For example, a patient's request for the discontinuance of respiratory assistance involves a doctor physically removing a breathing tube from the patient's throat. The disabling of a cardiac implantable electronic device requires the positive step of reprogramming its operation, or even operating to remove it altogether. And so on. While the law then treats such procedures as being an "omission" for the purpose of avoiding criminal liability on the doctor's part, this is a legal fiction designed to enable what we regard as morally desirable practices to occur.⁸⁶ We know that this is the case because the exact same *conduct* carried out by another — say, the removal of a breathing tube by a greedy relative anxious to inherit a patient's wealth — would be deemed an

⁸¹ At cl 24.

⁸² At cls 12–21.

⁸³ See, e.g., *Seales*, above n 7, at [143] ("In my assessment, there is an important distinction between those who end their lives by taking a lethal drug and those who decline medical services and die from natural causes.").

⁸⁴ Ahdar, above n 10, at 477.

⁸⁵ James Rachels *The End of Life: Euthanasia and Morality* (Oxford University Press, Oxford, 1986) at 115 (emphasis in the original).

⁸⁶ *Seales*, above n 7, at [115].

“act” to which criminal liability attaches.⁸⁷ The act versus omission distinction thus ultimately rests on a judgment reached on quite separate moral grounds as to whether the behaviour in question should be allowed, rather than anything intrinsic to the nature of that behaviour itself.

The distinction is then *completely* elided in respect of indirect euthanasia, where the double effect doctrine is invoked. This practice involves a doctor giving increasing doses of opioids to a terminally ill patient for the purposes of relieving her pain, while knowing that doing so could depress the patient’s respiratory system and so hasten death. In *Seales v Attorney-General* it was accepted that such practices constitute an act causing death, but Collins J also opined that “the doctor’s actions may not be an *unlawful act*”⁸⁸ as the primary purpose is the relief of suffering. A narrow and a broad point can be made here. First, under this analysis there is a strong argument that facilitated aid in dying likewise should not be viewed as an unlawful act.⁸⁹ For why can the double effect doctrine not extend to a doctor who provides a patient with a dose of fatal medication without intending that the patient actually use this to end her life, but rather wanting only to relieve the suffering caused by the patient’s lost sense of control in their end of life situation?⁹⁰ The broader point is that the practice of palliative sedation fatally undermines any claim that our law ought to strictly uphold the sanctity of life. It patently does not do so. Rather, it condones the positive actions of doctors who cause the death of their patients, so long as their primary intention is deemed to be the easing of suffering rather than a desire to end their patients’ lives. But as the easing of suffering is *precisely* what a relevant person seeks through aid in dying, the distinction in intention becomes morally irrelevant. For how is a doctor who knows her actions in relieving suffering will bring about the end of a relevant person’s life any different to a doctor who brings about the end of a relevant person’s life knowing this will relieve that person’s suffering?

D. Providing Aid in Dying Is Consistent with Medical Ethics

Although I have argued above that aid in dying cannot meaningfully be distinguished from existing forms of end of life choice, it must be acknowledged that a current majority of the medical community does not appear to agree. The professional associations representing New Zealand’s doctors and nurses are united in opposing a law change to permit aid in dying, while international medical associations express similar views at the global level. This view is that intentionally causing a patient’s death, even the death of a relevant person, is

⁸⁷ See, e.g., *Airedale NHS Hospital Trust v Bland* [1993] AC 789 (HL) at 812 (per Lord Goff).

⁸⁸ *Seales*, above n 7, at [106].

⁸⁹ Colin Gavaghan and Mike King “Can facilitated aid in dying be permitted by ‘double effect’? Some reflections from a recent New Zealand case” (2016) 42 J Med Ethics 361.

⁹⁰ Retention of autonomy is the main reason given for requesting aid in dying in those US jurisdictions that permit the practice, see above n 59. Furthermore, in those jurisdictions around 40% of individuals prescribed with aid in dying elect not to make use of it — they consider having the option available to them sufficient to ease their end of life concerns.

fundamentally inconsistent with a health professional's ethical role.⁹¹ However, there is reason to believe that this apparently implacable opposition is less solidly grounded than surface appearances suggest.

We may begin by noting that medical ethics are not a set of fixed and unchanging edicts written in tablets of stone. Take the original Oath of Hippocrates, often cited as the basis for the idea of medicine as a moral community.⁹² Although it required of its taker that "I will neither give a deadly drug to anybody who asked for it, nor will I make a suggestion to this effect", it also committed him "to teach [medicine to others] — if they desire to learn it — without fee and covenant", whilst stating "I will not give to a woman an abortive remedy". The apparent ethical obligation to provide free teaching is something current debt-stricken medical students may be surprised to discover, whilst the injunction against performing an abortion is now treated as a matter of conscience for individual practitioners. By the same token, currently routine end of life practices were themselves deeply controversial only a matter of decades ago. Although the right of competent patients to refuse life prolonging medical treatment and interventions is now treated as absolute, it once was the subject of serious legal and ethical debate.⁹³ However, over time doctors first accepted the withdrawal of respirators from patients in persistent vegetative states; then it became acceptable to stop any kind of medical intervention, including artificial nutrition and hydration, from patients in any condition. The once untenable became ethically unremarkable.

Furthermore, the (largely)⁹⁴ unified views of professional bodies mask real differences of opinion and even practice amongst individual members of the profession.⁹⁵ While I have until now focused on relevant persons' autonomy interests, the prohibition on aid in dying also impacts upon those providing end of life care. As Glanville Williams noted some 50 years ago:⁹⁶

It is the doctor's responsibility to do all he can to prolong worth-while life, or, in the last resort, to ease his patient's passage. If the doctor honestly and sincerely believes that the best service he can perform for his suffering patient is to accede to his request for euthanasia, it is a grave thing that the law should forbid him to do so.

⁹¹ See, e.g., *Code of Ethics for the New Zealand Medical Association* (New Zealand Medical Association, 2014) <www.nzma.org.nz/publications/code-of-ethics>.

⁹² See, e.g., Edmund D Pellegrino "The Medical Profession as a Moral Community" (1990) 66 *Bull NY Acad Med* 221.

⁹³ See, e.g., Norman L Cantor "A Patient's Decision to Decline Life-Saving Medical Treatment: Bodily Integrity Versus The Preservation of Life" (1972) 28 *Rutgers L Rev* 228; Robert M Byrn "Compulsory Lifesaving Treatment for the Competent Adult" (1975) 44 *Fordham L Rev* 1.

⁹⁴ There are some doctors groups that adopt a neutral position on aid in dying (for example, the California Medical Association and the American Academy of Hospice & Palliative Medicine) or even support the practice outright (for example, the American Public Health Association and The American Medical Student Association).

⁹⁵ See, e.g., K Mitchell and R Glynn Owens "National survey of medical decisions at end of life made by New Zealand general practitioners" (2003) 327 *BMJ* 7408; J H Havill "Physician-assisted dying—a survey of Waikato general practitioners" [letter] (2015) 128 *NZ Med J* 1409.

⁹⁶ Williams, above n 24, at 135.

Although such doctors may at present form a minority of the profession both in New Zealand and globally, they are by no means an insignificant segment of it. Indeed, in some areas of practice they may well now be in the majority. I have outlined above the end stage effects of MND. Having repeatedly seen these circumstances first hand, a recent survey of 231 Canadian MND doctors and allied health providers reported that some 80 percent believe patients with moderate to severe symptoms should be eligible to seek aid in dying, with only 8 percent not supporting its availability at any stage of the disease.⁹⁷ In regards this particular condition at least, it may be the opponents of aid in dying who are in the minority of medical opinion.

Opponents then have to fall back on general claims that allowing aid in dying even in patient-doctor relationships where both parties accept it is in a relevant person's best interests will create negative consequences for the wider practice of medicine. John Finnis, for instance, warns that aid in dying risks undermining "patient trust" in doctors or creating a "change in heart" in medical practitioners.⁹⁸ However, the limited evidence that has been gathered on such claims fails to substantiate them.⁹⁹ For at its core, medical opposition to aid in dying really seems driven by an underlying, somewhat conservative understanding of the practice of medicine:¹⁰⁰

... the [traditional] professional ideal of the physician-patient relationship held that the physician directed care and made decisions about treatment; the patient's principal role was to comply with 'doctor's orders.' ... When faced with what appeared to be a patient's irrational choices or preferences, physicians were encouraged by this approach to overlook or override them as not being in the patient's true interests.

Such a model of medical care is now quite out of step with all other aspects of the modern patient-doctor relationship. Or, as one US doctor puts it:¹⁰¹

We always listen to the patient. We never tell a patient: "This is what you have to do. You have no choice." Yet at the moment when their life is ending—when they say, "I don't want to live in this bed for the next three weeks waiting to die"—it's an odd change in the consent procedure. Suddenly they become wrong and we become right. That does not make sense to me. Dying should not be completely separate from everything else we do in medicine.

⁹⁷ Agessandro Abrahao et al "Physician-assisted death: A Canada-wide survey of ALS health care providers" (2016) 87 *Neurology* 1152. See also M Maessen "Euthanasia and physician-assisted suicide in amyotrophic lateral sclerosis: a prospective study" (2014) 261 *J Neurol* 1894.

⁹⁸ John Finnis *The Collected Essays of John Finnis, Vol 3, Human Rights and Common Good* (Oxford University Press, Oxford, 2011) at 260.

⁹⁹ See, e.g., M Hall, F Trachtenberg and E Dugan "The impact on patient trust of legalising physician aid in dying" (2005) 31 *J Med Ethics* 693; Anna Lindblad, Rurik Löfmark and Niels Lynöe "Would physician-assisted suicide jeopardize trust in the medical services? An empirical study of attitudes among the general public in Sweden" (2009) 37 *Scand J Public Health* 260; KA Smith and others "Quality of death and dying in patients who request physician-assisted death" (2011) 14 *Jnl Palliat Med* 445.

¹⁰⁰ Dan W Brock and Steven A Wartman "When Competent Patients Make Irrational Choices" (1990) 322 *N Engl J Med* 1595 at 1595.

¹⁰¹ Dr Lonnie Shavelson, quoted in Jennifer Medina "Who May Die? California Patients and Doctors Wrestle with Assisted Suicide" *New York Times* (online ed, New York, 9 June 2016)

Proponents of aid in dying concur with this view. The provision of aid in dying should not be seen as inconsistent with the role of a doctor. It is, rather, something that can be accommodated within the physician's role without undermining the ethical obligation to care for her patients' welfare and interests.

IV. ON LINE DRAWING AND SLIPPERY SLOPES

Beyond objections to aid in dying in principle, there are two commonly made practical objections to its adoption in any form. The first relates to deciding who should be able to access it and the problems associated with distinguishing those who can do so from those who cannot. It is argued that if aid in dying proponents are true to their principles, they cannot limit the scope of aid in dying to relevant persons alone. The second objection relates to potential future effects of adopting even the most limited form of aid in dying. Opponents claim that even if it were possible to create a restricted form of aid in dying that does not threaten to harm vulnerable individuals (which they in any case deny),¹⁰² that model will over time move in an ever more liberal direction. As it does so and aid in dying is practiced in a commonplace fashion, pressure on the elderly, disabled and the otherwise "burdensome" to avail themselves of the option will intensify. In this section I address and rebut both of these claims.

A. On Line Drawing

This article has argued that relevant persons – that is, those suffering unbearably as the result of an incurable and terminal medical condition where death is predicted to occur in the next six months – ought to be permitted access to aid in dying provided by a willing doctor. As noted in its introduction, if the argument is to be successful for anyone, then it will be for this class of persons. Conversely, if the argument is not successful for this class of persons, then it will not be for anyone. However, it may be objected that limiting the argument in this way artificially draws the circle too narrowly. For why should persons suffering from non-terminal but untreatable medical conditions be prevented from accessing aid in dying? Surely their autonomy claim also ought to be respected in that it is even crueler to force them to live in pain and anguish for an indeterminate future length of time? Indeed, it may be argued that if individual autonomy is regarded as so vital, why are *any* limits be placed on it at all?¹⁰³ To return to the case of "C" discussed earlier, why should a person who rejects the "prospect of growing old, the fear of living with fewer material possessions and the fear that she has lost, and will not regain, 'her sparkle'" be barred from receiving a doctor's aid to end her life?

The short answer to this challenge is to admit that any proponent of aid in dying who does not advocate a general right to assisted suicide for everyone inevitably must engage in a line drawing exercise. The reason for doing so is recognition that human life has an inherent value such that not *every* reason for seeking to

¹⁰² Ahdar, above n 10, at 482–483.

¹⁰³ At 476; 484–485.

end it should be accorded the same respect. And amongst those who believe that ending some forms of human suffering ought to outweigh “the sanctity of life” there will be disagreements over who ought to qualify to receive aid in dying. I have argued the minimal case here: that relevant persons at least should be permitted to access aid in dying. In contrast, David Seymour’s Bill would permit individuals suffering “a grievous and irremediable medical condition” to access aid in dying,¹⁰⁴ whilst Louisa Wall’s alternative proposal restricts access to aid in dying to suffering persons whose death is predicted within 12 months. There is thus a degree of potential arbitrariness involved in any decision on qualifying criteria, for a person prohibited from accessing aid in dying under any given regulatory regime always may ask “if them, why not me?”

However, the fact that proponents of aid in dying must engage in creating disputable and perhaps seemingly arbitrary boundaries does not doom the exercise. First of all, a world in which relevant persons *at a minimum* can access aid in dying is *more* morally just than one in which they are not permitted to do so, even if it is not considered *optimally* just by some. Therefore, society ought to respect the right of at least relevant persons to access aid in dying and then seriously consider what other groups (if any) should also qualify. Second, the problem of line drawing exists for those on both sides of the aid in dying debate. For opponents of the proposition either must argue in favour of radically rolling back currently accepted medical practices¹⁰⁵ or else have to justify why certain existing end of life choices (removal of respiratory assistance, palliative sedation, refusal of sustenance, etc) are permitted whilst others (assisted or facilitated aid in dying) are forbidden. The practical application of currently permitted choices then generates its own potential absurdities. For example, a patient with advanced cancer who also has a pacemaker fitted may quickly end their suffering by requiring that it be deprogrammed, whilst another cancer patient without a pacemaker cannot. So at present a person’s right to exercise end of life choice under current law depends upon the particular condition that they happen to suffer from, just as would be the case if aid in dying were to be permitted for some class of persons but not for others.

Finally, problems associated with line drawing are not regarded as a reason for outright prohibiting other practices. Take, for example, the case of a girl aged 16 years and one day who engages in sexual intercourse with a boy aged 15 years and 364 days. Current law deems the girl to have committed a crime punishable by up to 10 years imprisonment,¹⁰⁶ but not the boy. That absurdity may provide

¹⁰⁴ End of Life Choice Bill 2015, cl 4(c)(ii).

¹⁰⁵ As, for example, was attempted in the UK through the Medical Treatment (Prevention of Euthanasia) Bill 2000, cl 1, which proposed that: “It shall be unlawful for any person responsible for the care of a patient to withdraw or withhold from the patient medical treatment ... if his purpose or one of his purposes in doing so is to hasten or otherwise cause the death of the patient.”

¹⁰⁶ Crimes Act 1961, s 134(1).

a reason to revisit exactly how we regulate the age of consent,¹⁰⁷ but no one would seriously argue that we should avoid all line drawing problems in this area by criminalising anyone who engages in sexual intercourse with anyone else. Equally, there is no reason to respond to difficulties in deciding who qualifies to access aid in dying by saying that no one at all may do so. Rather, the better response is to engage in a serious debate about what we see as being the value of life and what particular circumstances so undermine it that an individual ought to be able to decide that they no longer wish to experience it. Only that conversation can tell us where the right line for our society lies.

B. On Slippery Slopes

This article has argued that New Zealand law should be changed to allow competent adult persons to directly request aid in dying where the prognosis of their medical condition is death within six months. Consequently, concerns about such a law change's effect on vulnerable groups — children, the elderly, the disabled, incompetent persons, etc — are misplaced as they simply would not qualify to receive aid in dying. Nevertheless, opponents of such a change argue that the law will slip over time in the direction of permitting ever-wider access to aid in dying. Such slippage, it then is alleged, will increase the threat that aid in dying will pose to vulnerable groups.¹⁰⁸ For as it becomes more available and is practiced in a commonplace fashion, pressure on the elderly, the disabled and the otherwise "burdensome" to avail themselves of the option will intensify.¹⁰⁹ Whatever initial safeguards are adopted will then prove ineffective in protecting the vulnerable, as the practice becomes normalised, even expected. Almost inevitably, such slippery slope claims are accompanied by reference to jurisdictions such as the Netherlands or Belgium and the alleged practices that occur under their regulatory regimes.¹¹⁰

One response to this claim is to look at those jurisdictions where aid in dying is permitted and note that there is no one global, common practice.¹¹¹ Different countries instead have established quite different regimes that permit different classes of individuals to access different methods of aid in dying. As Professor Ahdar also recognises,¹¹² this fact should make us somewhat cautious when drawing "lessons" about the practice of aid in dying from any particular jurisdiction. We instead would be wise to heed Penney Lewis' warning:¹¹³

¹⁰⁷ By, for example, introducing a "Romeo and Juliet exception" to age of consent laws for young adults close in age; see Steve James "Romeo and Juliet were Sex Offenders: An Analysis of the Age of Consent and a Call for Reform" (2009) 78 UMKC L Rev 241.

¹⁰⁸ Ahdar, above n 10, at 485.

¹⁰⁹ At 489–491.

¹¹⁰ At 485, 487–489. Although it should be noted that Professor Ahdar accepts at 486 that "there are also studies that show abuses and slippery slopes have not eventuated [in these places]".

¹¹¹ A second response is to note that Professor Ahdar has not always been so convinced by "slippery slopes" arguments; see Ahdar and Allan, above n 37, at 23–24 (rejecting the argument that permitting the physical discipline of children inexorably leads to child abuse).

¹¹² Ahdar, above n 10, at 478–479.

¹¹³ Penney Lewis, *Assisted Dying and Legal Change* (Oxford University Press, Oxford, 2007) at 188.

Slippery slope arguments, whether logical or empirical, often make distinctly unhelpful contributions to debates over legalization [of aid in dying]. ... Instead, we should learn from the experience in jurisdictions which have legalized assisted dying, while recognizing that because of different social contexts and baseline rates of covert practices, and the use of diverse mechanisms of legal change, those experiences do not translate directly to other jurisdictions.

However, what even a cursory examination of overseas jurisdictions does reveal is that there are examples both of nations that have over time increased the availability of aid in dying and jurisdictions that have remained stable. North America exemplifies the latter case. For some 20 years, Oregon has permitted aid in dying only for individuals suffering a terminal illness and a prognosis of six months to live without changing the qualifying criteria.¹¹⁴ The five US states that then have followed in Oregon's wake all have adopted similarly restrictive qualifying criteria, as has Canada when it recently legislated to regulate aid in dying. This experience is in direct contradiction to any claim that the introduction of aid in dying somehow inevitably results in its application to an ever-widening group of individuals.

Admittedly, the Netherlands and Belgium exemplify the opposite trajectory. Both countries have, over time, expanded the range of individuals who may access aid in dying. However, the particular reasons why they have done so need to be understood. Aid in dying first was allowed in the Netherlands from the 1980s as the result of judicial rulings that permitted the practice in situations other than where an individual is suffering a terminal illness. Consequently, when the Netherlands' Parliament came to enact legislation on the matter, it did so against the backdrop of an already existing, comparatively expansive regulatory regime. A recent discussion of the development of aid in dying in the Benelux nations also points to the particular cultural circumstances that applied in the Netherlands:¹¹⁵

... four salient features of the Dutch legal, cultural, and medical systems ... have affected the debate and attendant legalization of aid in dying in the Netherlands: the notion of "legal tolerance" or "forbearance" (*gedoogbeleid*); the Dutch indisposition toward taboos, or their understanding that everything should be freely discussed (*bespreekbaarheid*); their historically unparalleled trust in physicians; and the Dutch ethos of 'conflict avoidance'.

The Netherlands experience then had a marked impact on its near (and culturally quite similar) neighbours. In other words, the Benelux nations form a cluster of socially and politically similar societies that have adopted a broadly consistent approach to the matter. There is no reason to assume that other nations that do not share those social and political similarities will act likewise. Furthermore, in both the Netherlands and Belgium it has been the country's elected legislature — following a process of open public deliberation — that has decided to define (and then redefine) the criteria that must be met before aid in dying may be accessed.

¹¹⁴ It also is worth noting that Professor Ahdar could not locate any research conclusively demonstrating that these criteria have either been ignored or misapplied in that period. See Ahdar above n 10, at 481–482.

¹¹⁵ Lopes, above n 10, at 142.

At any point in time, the elected legislature in each of those countries could say that it did not wish to make that change. So the fact that the Dutch and/or the Belgians have chosen to do so means little in respect of how we here in New Zealand might decide to address those matters in the future.

V. IN CONCLUSION – THE PUBLIC GETS WHAT THE PUBLIC WANTS

The conclusion to this article is its shortest and most straightforward part. Aid in dying should be introduced into New Zealand because, irrespective of any uncertainties or posited risks, the people of the country support it being a part of our law. Repeated opinion polls over the last couple of years report a steady majority of some 65-75% of respondents support the legalisation of "euthanasia".¹¹⁶ Perhaps most notably, in 2015 some 15,259 participants in Auckland University's New Zealand Attitudes and Values Survey answered the question, "Suppose a person has a painful incurable disease. Do you think that doctors should be allowed by law to end the patient's life if the patient requests it?" Using a Likert scale of 1-7,¹¹⁷ the mean response was 5.6, with some 66 per cent answering 6-7, 21.7 per cent 3-5 and 12.3 per cent 1-2.¹¹⁸ The study authors then confidently assert, "Because we have such a national representative sample of New Zealanders, findings of our study are likely to reflect what the general New Zealand public over the age of 18 think about this issue."¹¹⁹ As such, the data demonstrates that New Zealanders not only are comfortable with the idea of aid in dying occurring in their society, but also positively want their law to allow it to do so.

Opponents of aid in dying then have two standard responses to such indications of public opinion. The first is to call into question the meaningfulness of such polls, citing problems in the way questions are worded or alleging that respondents do not really understand the issues at stake.¹²⁰ I simply will note the consistency of reported views across multiple surveys involving differently worded questions and suggest that were the results reversed, concerns about methodology or participant understanding likely would vanish. The second approach is to deny that aid in dying really is the sort of issue that public opinion

¹¹⁶ Research New Zealand "Should euthanasia be legalised in New Zealand?" (9 April 2015) <<http://researchnz.com/pdf/Media%20Releases/Research%20New%20Zealand%20Media%20Release%20-%2008-04-15%20-%20Euthanasia.pdf>>; Colmar Brunton "One News Colmar Brunton Poll" (19 July 2015). <www.colmarbrunton.co.nz/images/150803_ONE_News_Colmar_Brunton_Poll_report_11-15_July_2015.pdf>; Patrick Gower "Poll: Kiwis want euthanasia legalised" (27 July 2015) 3 News <www.newshub.co.nz/home/health/2015/08/poll-kiwis-want-euthanasia-legalised.html>; Research New Zealand "Should euthanasia be legalised in New Zealand?" (17 October, 2017) <<http://researchnz.com/pdf/Media%20Releases/2016/Research%20New%20Zealand%20Media%20Release%20-%202016-10-28%20Euthanasia.pdf>>.

¹¹⁷ Where a response of "1" means "definitely NO" and "7" means "definitely YES".

¹¹⁸ Carol HJ Lee, Isabelle M Duck and Chris G Sibley "Demographic and psychological correlates of New Zealanders' support for euthanasia" (2017) 130 NZ Med Jnl 9 at 13.

¹¹⁹ Lucy Warhurst "Most New Zealanders Support Euthanasia, Study Suggests" (22 January 2017) Newshub <www.newshub.co.nz/home/health/2017/01/most-new-zealanders-support-euthanasia-study-suggests.html>.

¹²⁰ Ahdar, above n 10, at 501.

ought to decide. Consequently, Professor Ahdar argues, “majority desire *alone* is not the touchstone of public policy”.¹²¹ That claim certainly is true; we can all think of some proposed law that we would regard as unjust even if a majority of the population expressed support for it. However, I have argued that far from being unjust, changing the law to permit aid in dying for at least relevant persons would be a moral advance for us as a society. It also happens to be a law change that a large majority of New Zealanders supports. Therefore, its continuing prohibition by way of the criminal law thus reflects the moral qualms of a small (and apparently shrinking) subset of society.

And, I would contend, it simply is wrong for our criminal law to privilege those minority views at the cost of imposing cruel outcomes on those relevant persons who wish to end their lives on their own terms. That is, at its core, the case for permitting aid in dying in New Zealand.

¹²¹ At 501 (emphasis in the original).