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The Case Against Euthanasia and Assisted Suicide

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Abstract

The arguments in favour of legalising voluntary euthanasia and doctor-assisted suicide initially appear convincing. We should, it is said, respect people's autonomy, euthanasia is a compassionate response to unbearable suffering, it has (supposedly) worked well in those nations that have implemented it, and so on. But on closer analysis the arguments are far less persuasive. Such a new law is unnecessary given the current legal ability of all but the most incapacitated to take their own life and the availability of palliative care. Any euthanasia law—even one carefully drafted with requisite safeguards—is susceptible to noncompliance and vulnerable to abuse. Moreover, any law would face the ineradicable reality of self-imposed pressure the vulnerable experience to "do the right thing". This article sets out ten reasons why euthanasia should not be legalised and contends that the case for decriminalising it has not been made out by the proponents of it.

I Introduction

This article sets forth the case against voluntary euthanasia (VE) in New Zealand. Should it be decriminalised? Should the related process of doctor-assisted suicide (DAS) also be rendered legal? The subject is complex and the literature voluminous. Indeed, another essay might be said to be thoroughly otiose. In defence, I offer this article because the topic is of current legislative interest and I wish to anticipate, and hopefully counter, the most common arguments in favour of VE and DAS.

Part II sets the issue in its New Zealand context. There have been two unsuccessful attempts to decriminalise VE, a third attempt by Labour MP Maryan Street, in 2013, that never got to the floor of Parliament and yet another attempt is underway. ACT MP David Seymour's End of Life Choice Bill is waiting in the wings. Perhaps it may succeed where the previous private member's bills failed. There is currently a parliamentary select committee inquiry receiving submissions in response to a petition presented by Maryan Street MP.[1] Part III sets out the major arguments against VE. I finish with some conclusions in Part IV.

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[1] The Health Select Committee "will investigate: 1. The factors that contribute to the desire to end one's life. 2. The effectiveness of services and support available to those who desire to end their own lives. 3. The attitudes of New Zealanders towards the ending of one's life and the current legal situation. 4. International experiences." <http://www.parliament.nz/en-nz/pb/sc/make-

Before proceeding it is necessary to clear the ground and define some terms. Much debate is misdirected because the proponents are at cross-purposes, critiquing something the other side is not even advocating. Euthanasia comes from the Greek words *eu* (good or noble) and *thanatos* (death), hence "good death"[2]. In the euthanasia debate there are a number of terms used more or less interchangeably—euthanasia, mercy killing, doctor (or physician)-assisted suicide, assisted dying, withdrawal of life-prolonging treatment—but the concepts are not identical.

Voluntary euthanasia means ending another person's life at his or her request.[3] The Australian and New Zealand Society of Palliative Medicine (ANZSPM) has a fuller definition:[4]

> Euthanasia is the act of intentionally, knowingly and directly causing the death of a patient, at the request of the patient, with the intention of relieving intractable suffering. If someone other than the person who dies performs the last act, euthanasia has occurred.

Euthanasia is *involuntary* where the person is able to give consent but has not done so and *non-voluntary* where the person is unable to give consent or request to end his or her life.[5] *Mercy killing* "means killing another person for motives which appear, at least to the perpetrator, to be well-intentioned, namely for the benefit of that person, very often at that persons' request."[6] *Assisted suicide* means providing someone with the means to end his or her life and *doctor–assisted suicide* is where the person providing the means, and performing the last act, is a medical practitioner.[7]

The latest New Zealand Bill adopts the umbrella and more euphemistic term "assisted dying"[8] for what is DAS. In *Seales v Attorney-General,* the applicant preferred the term

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submission/0SCHE_SCF_51DBHOH_PET63268_1/petition-of-hon-maryan-street-and-8974-others> See "Voluntary euthanasia inquiry details released", *NZ Herald*, 27 August 2015.

[2] Isabelle Marcoux, Brian L Mishara and Claire Durand, "Confusion between euthanasia and other-end-of-life decisions: Influences on public opinion poll results" (2007*)* 98 *Canadian J Public Health* 235.

[3] House of Lords, *Select Committee on the Assisted Dying for the Terminally Ill Bill*, vol 1: Report, HL Paper 86-I (4 April 2005) at 14.

[4] Australian and New Zealand Society of Palliative Medicine Inc, *Position Statement: The Practice of Euthanasia and Assisted Suicide* (31 October 2013).

[5] John Finnis, "Euthanasia and Justice" in his *Human Rights and Common Good—Collected Essays: Volume III* (Oxford University Press, Oxford, 2011) at 211.

[6] Lord Neuberger in *R (on the application of Nicklinson) v Ministry of Justice* [2014] UKSC 38 at [17].

[7] Above n 3.

[8] End of Life Choice Bill 2015, cl 3: "*Assisted dying* means the administration by a medical practitioner of a lethal dose of medication to a person to relieve his or her suffering by hastening death."

"administered aid in dying"[9]. *Withdrawal of treatment* means the cessation of treatment considered to be futile and burdensome.[10] This is *not* euthanasia. Some commentators speak of *active* versus *passive* euthanasia, but the distinction is misleading and unhelpful. Euthanasia is necessarily "active, since it needs the administration of lethal medication".[11] Passive euthanasia is "an oxymoron mistakenly applied to cases of withholding or withdrawing (potentially) life-sustaining treatment."[12]

II The Voluntary Euthanasia Debate in New Zealand

A *Legislative Attempts to Decriminalise VE and DAS*

(1) The Death with Dignity Bills 1995 and 2003

The 1995 Bill was introduced by the (then) National MP, Michael Laws, on 2 August 1995.[13] It was a Private Member's Bill and voting upon it was by way of a free or conscience vote. These twin features have been repeated in the subsequent attempts to legalise VE. A unique feature of the Bill was that it would not come into force until a majority of those voting at the next general election (in 1996) pursuant to a binding referendum had voted in favour of it. The Bill dealt with VE and set forth an elaborate five-step procedure to be satisfied before a lethal mixture of dugs or an injection could be self-administered or administered by the doctor. The Bill was defeated at the first reading stage by 61 to 29 votes.

Peter Brown, a New Zealand First MP, introduced this second Bill on 6 March 2003. Again, it involved VE and set forth a raft of protective safeguards to ensure that any request to terminate life would indeed be free, informed and non-coerced. By the narrowest of margins (60 to 58) the MPs voted not to send the Bill to a select committee.

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[9] *Seales v Attorney-General* [2015] NZHC 1239 at [5]. "Facilitated aid in dying", another term advanced by the applicant, is where the doctor provides the means whereby the patient may bring about his or her own death: ibid at [6]. Ms Lucretia Seales, dying from a brain tumour, sought a declaration that her doctor was legally allowed to assist her to die by administering a lethal drug. Her arguments that the current criminal prohibitions on DAS infringed her right to life (s 8) and her right not to be subjected to torture or cruel treatment (s 9) under the New Zealand Bill of Rights Act 1990, both failed.

[10] House of Lords, above n 3, at 23.

[11] L W Sumner, *Assisted Death: A Study in Ethics and Law* (Oxford University Press, Oxford, 2011) at 19.

[12] Ibid.

[13] See Rex Ahdar,"Religious parliamentarians and euthanasia: a window into Church and State in New Zealand" (1996) 38 *J Church & State* 569.

(2) The End of Life Choice Bills 2013 and 2015

The first End of Life Choice Bill, sponsored by Labour MP Maryan Street, follows broadly the format of the previous Bills. The Street Bill stated:

> The purpose of this Bill is to provide individuals with a choice to end their lives and to receive medical assistance to die under certain circumstances. These circumstances are:
> • that the person making the request must be mentally competent, as attested by 2 medical practitioners;
> • that the person suffers from a terminal illness which is likely to cause death within 12 months, or from an irreversible physical or mental condition that, in the person's view, render his or her life unbearable;
> • when implementing a registered End of Life Directive which is consistent with the circumstances above.

In October 2013 it was withdrawn from the Private Members' Bill ballot "out of concern a debate about euthanasia could come up in election year and become a political football."[14]

The second eponymous Bill, sponsored by the ACT leader, David Seymour MP, was lodged in the ballot of private members' bills on 14 October 2015. The Explanatory Note observes:

> The motivation for this Bill is compassion. It allows people who so choose, and are eligible under this Bill, to end their lives in peace and dignity, surrounded by loved ones.
> The Bill carefully defines those eligible for assisted dying, details a comprehensive set of provisions to ensure this is a free choice, made without coercion, and outlines a stringent series of steps to ensure the person is mentally capable of understanding the nature and consequences of assisted dying.

B *The Law*

Historically, in the West suicide was seen as self-murder and treated as a felony.[15] It is no longer a crime. It must, it seems, have been abolished in New Zealand when the Criminal Code of 1893 was passed.[16] The offence of attempting to commit suicide (s 193 of the Crimes Act 1908) was repealed in 1961.[17]

A person may refuse medical treatment and may do so even if it results in his or her death. Regarding the law of England and Wales, Lord Sumption in the important decision, *Nicklinson,* stated:[18]

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[14] Isaac Davison, "Labour: Euthanasia bill will return", *NZ Herald*, 16 October 2013.

[15] Hawkins, 1 PC, 77; David Ormerod and Karl Laird, *Smith and Hogan's Criminal Law* (14th ed, Oxford University Press, Oxford, 2015) at 667.

[16] F B Adams, *Criminal Law and Practice in New Zealand* (2nd ed, Sweet & Maxwell, Wellington, 1971) at ¶ 1209; *Seales*, above n 9, at [118].

[17] Adams, ibid at ¶1201; *Seales*, above n 9, at [118].

[18] Above n 6, at [255].

> A person who is legally and mentally competent is entitled to refuse food and water, and to reject any invasive manipulation of his body or other form of treatment, including artificial feeding, even though without it he will die. If he refuses, medical practitioners must comply with his wishes . . . A patient (or prospective patient) may express his wishes on these points by an advance decision (or "living will").

Section 11 of the New Zealand Bill of Rights Act 1990 reinforces this common law right[19] by providing that "everyone has the right to refuse to undergo any medical treatment." The ANZSPM similarly state: "Patients have the right to refuse life sustaining treatments including the provision of medically assisted nutrition and/or hydration. Refusing such treatment does not constitute euthanasia."[20]

The fact that suicide is decriminalised does not mean that it is, in the fullest sense, legal, for there is no legal right to commit suicide.[21] Lord Bingham in *Pretty v DPP* explained:[22]

> The law confers no right to commit suicide. Suicide was always, as a crime, anomalous, since it was the only crime with which no defendant could ever be charged. The main effect of the criminalisation of suicide was to penalise those who attempted to take their own lives and failed, and secondary parties. Suicide itself (and with it attempted suicide) was decriminalised because recognition of the common law offence was not thought to act as a deterrent, because it cast an unwarranted stigma on innocent members of the suicide's family and because it led to the distasteful result that patients recovering in hospital from a failed suicide attempt were prosecuted, in effect, for their lack of success.

Collins J in *Seales* noted that the New Zealand parliamentary records of the time confirm that attempted suicide was decriminalised for humanitarian reasons.[23]

Notably, decriminalisation did not extend to secondary parties. Lord Bingham in *Pretty* continued:[24]

> But while the [English] 1961 Act abrogated the rule of law whereby it was a crime for a person to commit (or attempt to commit) suicide, it conferred no right on anyone to do so. Had that been its object there would have been no justification for penalising by a potentially very long term of imprisonment one who aided, abetted, counselled or procured the exercise or attempted exercise by another of that right. The policy of the law remained firmly adverse to suicide…

Lord Bingham was summarising the English law, but the New Zealand position is the same. Thus, s 179 of the Crimes Act 1961 states

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[19] *Nicklinson*, above n 6, at [23](Lord Neuberger).
[20] Above n 4.
[21] See John Finnis, "A British 'Convention right' to assistance in suicide?" (2015) 131 *LQR* 1 at 5-6.
[22] [2001] UKHL 61; [2002] 1 AC 800 at [35]. This passage was quoted by Collins J in *Seales*, above n 9, at [131].
[23] Above n 9, at [129].
[24] Above n 22, at [35].

> Every one is liable to imprisonment for a term not exceeding 14 years who—(a) incites, counsels, or procures any person to commit suicide, if that person commits or attempts to commit suicide in consequence thereof; or (b) aids or abets any person in the commission of suicide.

Section 63 of the Crimes Act stipulates that no person can consent to being killed and any person who is a party to the intentional infliction of death is criminally culpable.[25] Furthermore, under s 151 there is a duty to provide "necessaries" to those who have the care or charge of a "vulnerable adult" who is unable to provide himself or herself with these essentials. Next, it is a criminal offence to enter into a "suicide pact". Section 180 says where two or more people enter into such a pact, and one or more of them kills himself, the survivor is guilty of being a party to a death under a suicide pact and is liable to a maximum of five years imprisonment.[26] Finally, s 41 provides a defence for those seeking to prevent someone from committing suicide.[27] These provisions all reflect the law's antipathy to the suicide as a social phenomenon whilst, nonetheless, removing the heavy weight of criminalisation from those engaging in the act itself.

Two related phenomena are often conflated with euthanasia and assisted suicide, but they are different in both medicine and law.

First, the practice of administering drugs which may hasten death where the purpose is to alleviate the patient's pain and suffering is permitted. This is known as the "double effect" principle. It is not unlawful, nor is it VE or DAS, whose purpose, to reiterate, is to terminate life. The Supreme Court in *Nicklinson* explain:[28]

> a doctor commits no offence when treating a patient in a way which hastens death, if the purpose of the treatment is to relieve pain and suffering (the so-called "double effect").
>
> Medical treatment intended to palliate pain and discomfort is not unlawful only because it has the incidental consequence, however foreseeable, of shortening the patient's life. . .

The ANZSPM state: "Treatment that is appropriately titrated to relieve symptoms and has a secondary and unintended consequence of hastening death, is not euthanasia."[29] Regarding the double effect doctrine, Professor Peter Skegg comments:[30]

> [Consider situations where] health practitioners do not kill as a means of relieving pain. Rather, they take steps to relieve pain, while knowing that this may have the incidental

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[25] See *Seales*, above n 9, at [89]-[99].
[26] See *Seales*, above n 9, at [119].
[27] See *Seales,* above n 9, at [120]-[123].
[28] Above n 6, at [18](Lord Neuberger) and [255](Lord Sumption) respectively.
[29] "Medical acts hastening death" in Peter Skegg and Ron Paterson (Gen eds), *Health Law in New Zealand* (Thompson Reuters NZ, Wellington, 2015) ch 20 at 637.
[30] "Omissions to prolong life" in Skegg and Paterson, ibid, ch 21, at 654-655.

> effect of hastening the time of the patient's death. The classical example is that of pain relief to a dying patient in a hospice, where increased doses of morphine may lead to an earlier death, either directly or from an increased probability of infection of the lungs. The propriety of the practice is widely accepted, not least by many who regard themselves as avowed opponents of euthanasia or mercy-killing. It has occurred on a vast number of occasions in New Zealand, as elsewhere. Provision of pain relief in these circumstances has never led to a charge of manslaughter, much less murder.

The High Court in *Seales* affirmed that:[31]

> if Ms Seales' doctor were to administer a lethal dose of pain relief such as morphine to Ms Seales, 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 Ms Seales with palliative relief, and provided that what was done was reasonable and proper for that purpose, even though Ms Seales' life would be shortened as an indirect but foreseeable consequence.

The protective ambit of the double effect principle is confined to doctors and thus nurses cannot claim it.[32]

The law of murder has consistently recognised there is an important difference between intending death versus merely foreseeing death. Intention could, and sometimes is, stretched to include foreseen highly likely effects: a jury *may* infer the requisite intention where foresight of a consequence (harm or death) was a virtual certainty as a result of the defendant's action.[33] But generally. such an extended meaning has been steadfastly rejected from the criminal law.[34] As the US Supreme Court in *Vacco v Quill* stated: "The law has long used actors' intent or purpose to distinguish between two acts that may have the same result. . . . Put differently, the law distinguishes actions taken 'because of' a given end from actions taken 'in spite of' their unintended but foreseen consequences."[35]

In the palliative care setting,[36] it is desirable to distinguish between meaning to cause death and being virtually certain that this consequence will ensue. As Professor Skegg cautions: "In the

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[31] Above n 9, at [106].

[32] *R v Martin* [2004] 3 NZLR 69 (HC).

[33] *R v Nedrick* [1986] 3 All ER 1; *R v Joggee; Ruddock v R* [2016] UKSC 8; [UKPC 7 at [82] and [87]. See further Glenys Williams*, Intention and Causation in Medical Non-Killing: The Impact of Criminal Concepts on Euthanasia and Assisted Suicide* (Routledge/Cavendish, New York, 2007) at 11-14 and *Adams on Criminal Law—Offences and Defences*, Vol 1 (Thomson Reuters, Wellington, 2014) at CA 20.17.

[34] See Skegg, above n 29, at 641-63.

[35] 521 US 793 at 802-03 (1997).

[36] Some commentators note that criminal law concepts of intention take on a different hue in the medical and end-of-life treatment context. "The criminal law of murder, with its emphasis on intention particularly, is an inappropriate way to deal with medical end-of life-issues", maintains Glenys Williams*,* above n 33, at 7, and the leading English cases "show how ill-equipped criminal law concepts are in dealing with medical cases where moral dilemmas are raised" (ibid at 16). Prof

context of section 167 [of the Crimes Act 1961], there are no grounds for giving [means to cause the death of the person killed] an extended meaning."[37] Similarly, Professors Simester and Brookbanks comment:[38]

> It seems that, where there is virtual certainty, the jury is *permitted* to conclude that the defendant intended the outcome and, absent any special considerations, the jury should normally so conclude; but they are entitled not to find intention should there be such considerations. For example, a doctor may know that by injecting a terminally ill patient with the morphine necessary to dull pain, it is virtually certain that she will incidentally shorten the patient's life. The doctor does not aim to shorten the patients' life, and does not intend his death in the core sense. In such a case, notwithstanding that it is virtually certain side-effect, the jury may well conclude that she does not intend his death, even indirectly.

Second, the similarly common practice of the withdrawal of futile medical assistance from a patient (for example, by turning off the artificial ventilator sustaining the life of a person in an irreversible coma), despite this action inevitably bringing about the person's death, is also legally permitted. Skegg recounts:[39]

> Over the years countless thousands of New Zealanders have been "allowed to die", without all possible steps having been taken to keep them alive. It is most unlikely that a day, perhaps even an hour, ever goes by when this does not happen in some hospital, hospice, or nursing home in New Zealand. Legal, much less criminal, proceedings are very unusual indeed.

There is a clear moral and legal distinction between the withdrawal of medical treatment and actively administering a lethal drug, between letting die and killing. The courts have "recognized the distinction between 'letting a patient die' and 'making that patient die.'"[40]

The leading UK decision is *Bland*. The House of Lords was asked to rule on the legality of withdrawing life support from Tony Bland, a victim of the Hillsborough football disaster in 1989. Lord Goff stated:[41]

> the law draws a crucial distinction between cases in which a doctor decides not to provide, or to continue to provide, for his patient treatment or care which could or might prolong his life, and those in which he decides, for example by administering a lethal drug, actively to bring his patient's life to an end. . . . the former may be lawful,

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Andrew Ashworth comments: "the courts have striven to exculpate doctors for decisions taken in medical contexts which would probably, in all other situations, lead to the imposition of criminal liability": "Criminal Liability in a Medical Context: The Treatment of Good Intentions" in A P Simester and A T H Smith (eds), *Harm and Culpability* (Clarendon Press, Oxford, 1996), 173 at 192.

[37] Skegg, above n 29, at 642-43.

[38] A P Simester and W J Brookbanks, *Principles of Criminal Law*, 4th ed (Thomson Reuters, Wellington, 2012) at109 (italics in original).

[39] Above n 29, at 651-52.

[40] *Vacco*, above n 35, at 793.

[41] *Airedale NHS v Bland* [1993] AC 789 at 865.

> either because the doctor is giving effect to his patient's wishes by withholding the treatment or care, or even in certain circumstances in which . . . the patient is incapacitated from stating whether or not he gives his consent. But it is not lawful for a doctor to administer a drug to his patient to bring about his death, even though that course is prompted by a humanitarian desire to end his suffering, however great that suffering may be. . . . So to act is to cross the Rubicon which runs between on the one hand the care of the living patient and on the other hand euthanasia—actively causing his death to avoid or to end his suffering.

Aware of the hypocrisy criticism levelled above, Lord Goff responded:[42]

> It is true that the drawing of this distinction may lead to a charge of hypocrisy; because it can be asked why, if the doctor, by discontinuing treatment, is entitled in consequence to let his patient die, it should not be lawful to put him out of his misery straight away, in a more humane manner, by a lethal injection, rather than let him linger on in pain until he dies. But the law does not feel able to authorise euthanasia, even in circumstances such as these; for once euthanasia is recognised as lawful in these circumstances, it is difficult to see any logical basis for excluding it in others.

The New Zealand position on the withdrawal of futile treatment is the same as the UK's. In *Auckland Area Health Board v Attorney General*, Thomas J was asked by the hospital if it could, with the support of the patient's parents, withdraw ventilation from a Mr L, who had Guillain-Barre syndrome. This disease meant the brain was disengaged from the body, Mr L surviving in a state of "living death", totally unable to move or communicate and with no prospect of recovery. The High Court held it could do so: "with a patient such as Mr L, where 'life' is being prolonged for no therapeutic or medical purpose or, in other words, if death is merely being deferred, the doctor is under no duty to avert death at all costs."[43] The legal position is "where the withdrawal or withholding of life-prolonging treatment is in keeping with 'good medical practice', those responsible have a 'lawful excuse' for the noncompliance with any prima facie duty to prolong life."[44] Similarly, in *Seales* the High Court observed (obiter):[45]

> doctors [are] not . . criminally culpable when they withdraw life preserving measures which artificially sustain life in circumstances which are medically futile. Doctors who withdraw ventilatory support for a patient, knowing that doing so will invariably result in the patient's death, may have a lawful excuse for doing so where to continue ventilatory support would be medically futile.

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[42] Ibid.

[43] [1993] 1 NZLR 235 at 253.

[44] Skegg, above n 29, at 673.

[45] Above n 9, at [115].

The law thus does not subscribe to "vitalism", the notion that human life must be preserved at all costs.[46]

In terms of the VE cases there have been steady number of high-profile instances to come before the courts where family members or close friends have been prosecuted for terminating the lives of their kin or beloved friends. The list includes Warren Ruscoe, John Karnon, Rex Law, Lesley Martin and, most recently, Sean Davison. The courts have usually taken a lenient approach when it comes to sentencing. For instance, in 2002, 77-year-old pensioner Rex Law killed his sick wife, Olga (aged 73 and suffering from Alzheimer's) and then attempted to commit suicide. Law said he and his wife had agreed to "do each other in" if either suffered from Alzheimer's disease. Law was sentenced to 18 months' imprisonment, served nine months and was given leave to apply for home detention. Justice Randerson stated: "The Court would be sending the wrong message to the community if it were prepared to allow the deliberate killing of someone suffering from such a disease or other affliction to go unpenalised, even in the tragic circumstances of a case like this."[47] Ms Street in her End of Life Choice Bill says it "seeks to provide a law which prevents such convictions from occurring when the request for medically assisted death comes from the express will of the person suffering." Notice that neither this, nor the Seymour DAS proposal, will protect family members (such as Rex Law) who assist their loved ones to die.

III The Case Against Voluntary Euthanasia

A *The Limits of Autonomy*

In liberal democracies it is axiomatic that the individual has the right to make his or her own life choices, to determine his or her future. That, it is argued by VE proponents, includes the right of the citizen to decide he has no future. People ought to be able to make what Maryan Street's and David Seymour's Bills call, an "end of life choice".

But the choice to do away with oneself is *already* permitted. Recall that suicide is not a crime. (Recall also that the New Zealand Bill of Rights 1990 permits a person to refuse medical treatment, including drugs, chemotherapy, cardiac surgery and so on, which would preserve that persons' own life.)

Now if suicide is available, why then is there the call for VE or DAS?

VE seems to address the situation where people cannot, physically or emotionally, end their existence by themselves; they need the assistance of someone else to end their life. Perhaps they are

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[46] John Keown in Emily Jackson and John Keown, *Debating Euthanasia* (Hart, Oxford, 2012) at 90.

[47] *R v Law* (2002) 19 CRNZ 500 at [62].

paralysed after a spinal fracture or too enfeebled by disease to do so. Perhaps the thought of using a gun, jumping off a cliff or, less violently, taking a drug overdose, is simply too ghastly. Whatever the constraint might be—physical or emotional—the person simply cannot do it by himself. Euthanasia, as Professor John Finnis points out, "is not a private act, but precisely an act in which you seek assistance from someone else, or which you are asking someone else to carry out, sharing your intent to destroy your personal life. It is no more a private act than a duel or an agreement to sell myself into slavery."[48]

Suicide is a viable option, even for the elderly or enfeebled, in all but the most rare instances of physical incapacity. Professor Paul Mullen comments:[49]

> Some effective forms of suicide have a brutal directness, such as hanging, which is difficult for the elderly and the frail. There are, however, easily available methods of self-destruction which can be accessed by all except the totally immobilised and institutionalised. *One cannot but ask why anyone physically capable of suicide should feel entitled to demand of others that they become involved in their killing.* The right to die with dignity when and where you choose is not denied currently by the law or by medicine and is available to all with the will and autonomy to suicide. Those who have the capacity but lack the will to accomplish their own end should surely be considered poor candidates for euthanasia as one can only assume a vacillation about self-destruction which vitiates their stated desire for death. Those very rare cases where self-destruction is beyond their physical capacities are the only ones with a serious claim on others with regard to their killing. The uncertainties and difficulties of suicide are exaggerated.

Returning to autonomy, "Neither Anglo-American law nor professional medical ethics have ever held that the mere fact *that* I have chosen justifies *what* I have chosen."[50] The law stoutly refuses to respect dozens of our autonomous decisions: to shoot up heroin, to beat one's spouse, to not wear a crash helmet or seatbelt. Does the claim to personal autonomy entail the right to ask that others help us realise our autonomous desires, in this instance, to assist us take our life? This is, admittedly, a right to *ask* others (specifically, medical practitioners) to assist in ending one's life, not a right to *require* a particular medical practitioner to do so. Most VE and DAS regimes will allow doctors with a conscientious objection to decline such a request.

Furthermore, does our freedom to act mean the state must provide the means for us to carry out our desires or implement our choices?[51] The Supreme Court in *Nicklinson* addresses this argument, Lord Hughes responding:[52]

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[48] "Euthanasia and the Law" in Finnis, above 5, at 258.

[49] "Euthanasia: An Impoverished Construction of Life and Death" (1995) 3 *J Law & Med* 121 at 125 (italics supplied).

[50] Keown, above n 37, at 88 (italics in original).

[51] Brian L Mishara and David N Weistubb, "Premises and evidence in the rhetoric of assisted suicide and euthanasia" (2013) 26 *International J Law and Psychiatry* 427 at 428.

[52] Above n 6, at [263]. See also Lord Kerr at [329].

> To take a simple example unconnected with the present appeals, the consumption of drugs—whether for reasons of health, pain relief, athletic performance or simple recreation —may well be an aspect of private life within the reach of article 8.1 [of the European Convention on Human Rights, providing for the right to respect for a citizen's private and family life]. But it does not follow that there is a fundamental right to take cannabis or steroids, ecstasy or cocaine, still less for others to supply such drugs to would-be users.

Baroness Hale similarly pointed out that citizens may well have a right to marry under the European Convention on Human Rights, but the state does not have to provide them with a suitable mate. At most, the state's duty is negative in that "the state's right to place obstacles in the way of a person who does wish to become a marriage partner is severely limited." [53]

This leads us to another human rights based argument. Able-bodied citizens can commit suicide. But those who are physically unable to commit suicide cannot. Is the state placing obstacles in the way of those in the latter situation by its continued ban on VE and DAS? Is there unjustified discrimination by the state occurring in respect of physically incapacitated citizens in this context? This argument was considered and rejected by the House of Lords in *Pretty,* and by Lord Mance in *Nicklinson*.[54] Lord Bingham's short reply in the former case was that the contention was "based on a misconception" as "the law confers no right to commit suicide."[55]. If that is too brief a reply, a fuller rejoinder is that given by the European Court of Human Rights in *Pretty*:[56]

> there is, in the Court's view, objective and reasonable justification for not distinguishing in law between those who are and those who are not physically capable of committing suicide. Under article 8 of the Convention, the Court has found that there are sound reasons for not introducing into the law exceptions to cater for those who are deemed not to be vulnerable. . . Similar cogent reasons exist under article 14 for not seeking to distinguish between those who are able and those who are unable to commit suicide unaided. The borderline between the two categories will often be a very fine one and to seek to build into the law an exemption for those judged to be incapable of committing suicide would seriously undermine the protection of life which the 1961 Act was intended to safeguard and greatly increase the risk of abuse.

By contrast, the Supreme Court of Canada in *Carter* recently held that that the criminal prohibition on DAS infringed the applicant's, Gloria Taylor's, right to liberty and security of the person under s 7 of the Charter[57], a similar but not identical section to our s 8 of the New Zealand Bill of Rights Act. Our section reads:

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[53] Above n 6, at [307].
[54] *Nicklinson*, above n 6, at [161].
[55] *Pretty*, above n 22, at [35].
[56] *Pretty v United Kingdom* (2002) 35 EHRR1 at [86]. See also Lord Sumption in *Nicklinson*, above n 6, at [216].
[57] It reads: "Everyone has the right to life, liberty and security of the person and the right not to be deprived thereof except in accordance with the principles of fundamental justice."

> **8. Right not to be deprived of life**—No one shall be deprived of life except on grounds as are established by law and are consistent with the principles of fundamental justice."

The Supreme Court held that the ban on DAS in Canada "had the effect of forcing some persons to take their own lives prematurely, for fear that they would be incapable of doing so when they reached the point where suffering was intolerable."[58] The prohibition left citizens like Taylor (who suffered from the fatal neurodegenerative disease, ALS) to endure pain, physical or psychological, due to the unavailability of DAS and this violated their security of the person.[59] Persons in the position of the applicant suffer from the knowledge that they lack the wherewithal to bring their lives "to a peaceful end . . . at a time and in a manner of their own choosing."[60] The ban interfered with their ability to make decisions concerning their bodily integrity and "thus trenches on liberty."[61]

The ban was also contrary to "the principles of fundamental justice" insofar as it was "overbroad". Its laudable object was to protect the vulnerable, but its absolute nature meant it caught people outside this class such as Ms Taylor—citizens who were not vulnerable, but competent, rational and uncoerced. The only justification for an absolute ban would be if doctors could not reliably assess the suitability of candidates for DAS (based on competency, voluntariness, and so on). But the state failed, in the Court's view, to provide convincing evidence that physicians lacked this ability.[62] The "sound reasons" that persuaded the European Court of Human Rights in *Pretty* to uphold an absolute ban were, in the Canadian Supreme Court's opinion, supported less by cogent evidence than by "a theoretical or speculative fear".[63]

Thus, in Canada, somewhat paradoxically, the right to life and liberty has seen the ban on assisting a person to *end* their own life struck down as an infringement of a person's right *to* life. In simple terms, one's right to life is violated by having to commit suicide earlier than one might otherwise do so.

In *Seales,* Collins J "derived assistance" from *Carter,* but also pointed out that the "broader nature of s 7" of the Charter meant "caution is required" when considering Canadian case law in the context of our s 8.[64] Unsurprisingly, the applicant argued that the reasoning in *Carter* applied equally to her situation. Collins J agreed that the right to life guarantee was engaged,[65] but

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[58] *Carter v Canada (Attorney General)* 2015 SCC 5; (20015) 384 DLR (4th) 14 at [57].
[59] Ibid at [65].
[60] Ibid at [14].
[61] Ibid at [66].
[62] Ibid at [86].
[63] Ibid at [119].
[64] Above n 9, at [157]-[158]
[65] Above n 9, at [166]

disagreed that the criminal prohibitions on DAS in New Zealand contravened the principles of fundamental justice in s 8 due to being overly broad:[66]

> In *Carter*, the Supreme Court of Canada concluded the prohibition against aiding suicide in the Canadian Criminal Code breached the "overbreadth" component of the principles of fundamental justice because the objectives of the law prohibiting assisted suicide were able to be construed more narrowly. I am not able to construe s 179(b) in that same way, when having regard to New Zealand's different legislative framework governing this country's criminal laws relating to suicide.

In *Carter,* the Supreme Court construed the counterpart of our s 179(b) to be the narrow goal of "protecting vulnerable persons from being induced to commit suicide at a time of weakness."[67] It rejected the Government's submission that the section's aim was the broader one of "the preservation of life." Collins J construed the decriminalisation of suicide, coupled with the retention of s 179 (aiding and abetting suicide), as having two objectives: the absolute protection of the lives of the vulnerable *and* "to protect, so far as is reasonably possible, the lives of those who are not vulnerable."[68] In the High Court's opinion: "The purpose of s 179 of the Crimes Act in the New Zealand context is broader than the equivalent law in Canada and is not confined to protecting the vulnerable in society."[69] Hence, the premature death as a rights violation argument, that succeeded in Canada, failed in *Seales*.

Returning more generally to the principle of autonomy, it does not stand in splendid isolation. Sometimes it clashes with the principle of the inviolability or sanctity of life. Section 8 of the New Zealand Bill of Rights Act, as the Court of Appeal in *Shortland* noted, "states the fundamental principle of the sanctity of human Life".[70] The courts have been steadfast in their defence of the sanctity of life principle. The UK Supreme Court in *Nicklinson* resoundingly did so, it being, as Lord Wilson put it by way of colloquial idiom, "hard-wired into the minds of every living person".[71] In New Zealand, Venning J in *R v Faithfull* noted:[72]

> The suggestion that there should be some relaxation of criminal liability in the case of euthanasia or mercy killings or attempted mercy killings has not been accepted by the Court. It has been rejected on every occasion raised. The Court must carefully guard the principle of the sanctity of life to ensure that the rights of the weak, the vulnerable and the handicapped are not diluted or overlooked.

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[66] Above n 9, at [186].
[67] Above n 58, at [78].
[68] Above n 9, at [132].
[69] Ibid at [132].
[70] *Shortland v Northland Health Ltd* [1998] 1 NZLR 433 at 444.
[71] Above n 6, at [199]. See also ibid at [209](Lord Sumption).
[72] HC Auckland, CRI-2007-04407451, 14 March 2008, at [8]. See also Keane J in *R v Crutchley,* HC Wellington, CRI-2007-069083, 9 July 2008, at [56].

Nonetheless, as the Court of Appeal in *Shortland* add, the final clause in s 8 of the NZ Bill of Rights Act indicates that the right is not absolute. In some situations, the principle of autonomy trumps the inviolability one. As we have seen, patients may refuse medical treatment. But, on other occasions, as Professor John Keown explains, autonomy yields to inviolability: "the law rightly holds that we have no right to be killed or to be helped to kill ourselves, whether or not we are dying or whether or not we want to die."[73]

We need to ask just whose autonomy will be exercised here? Who will really get to choose? Healthy citizens who seek euthanasia:[74]

> will find themselves being told by our reformers that, well, after all the right belongs *not* to those with an autonomy interest in defining their own concept of existence and so forth, but to people whose lives are no longer worth living—and, that means whose lives are no longer worth living *in the opinion of a court, or medical practitioners,* in the context of legislative criteria adopted by courts or legislatures from time to time. Even when you fall seriously ill . . . you will find (if the reformers are to be believed) that your right to autonomy does not give you the right to be assisted in suicide unless you are ill *enough* or suffering *enough*—in each case "enough" *in the view of somebody else.*

The irony is that what starts out as an autonomous choice ends up resting in the hands of other people.[75] "The patient autonomy that assisted suicide and euthanasia presume to protect and empower is illusory."[76]

B *Introduction of VE or DAS would avert the supposed hypocrisy and illogicality of the law*

The charge of legal hypocrisy is a recurrent one in this debate. The argument takes two forms.

One version says that the administration of pain relieving drugs to ease a patient's plight where the foreseeable consequence is shortening of life is permitted; yet administering the same drugs with the intention to kill is not. This, it is said, is hypocritical.

However, as I outlined earlier, the law consistently draws a distinction between intending death versus foreseeing death. Intention is different from foresight.

> There can be foresight of consequences without intention. . . when Field Marshall Montgomery invaded France of D-Day, he foresaw that many of the troops under his

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[73] Keown, above n 46, at 91.

[74] Finnis, above n 48, at 258 (italics added).

[75] Robert George, I G Finlay and D Jeffrey, "Legalised euthanasia will violate the rights of vulnerable patients" (2005) 331 *British Med J* 684 at 684.

[76] Edmund Pellegrino, "Compassion is not enough" in Kathleen Foley and Herbert Hendin (eds), *The Case Against Assisted Suicide: For the Right to End-of-Life Care* (Johns Hopkins University Press, Baltimore, 2002) 41 at 48.

> command would be killed on that very day. Obviously, however, he did not intend that any of them should be killed.[77]

"You intend your end (aim, purpose, sought-after outcome) and your chosen means. Consequences which you foresee even as certainties, are not intended unless they are one of your ends or your means."[78] It is morally wrong to intentionally bring about a bad outcome. By contrast, it is not wrong to intend to bring about a good outcome realising there might be bad side effects. To conflate euthanasia with double effect palliative practice is at best sloppy, and at worst mischievous. It would "not only cause confusion but would have dire consequences if adopted by the law; it would render doctors who practice palliative medicine which incidentally shortens life liable for murder."[79]

The other strand of the hypocrisy charge contends that discontinuing a patient's medical treatment or care and letting him or her die is allowed; yet bringing about the patient's death more immediately by administration of some lethal drug is not.

To be fair, not all judges or scholars are convinced by the distinction between actively killing and letting someone die (from their underlying disease). For some, it is little more than "a meaningless exercise in semantic gymnastics"[80]. Lord Brown-Wilkinson in *Bland* admitted he found it "difficult to find a moral answer" to the question of how it was lawful to allow a patient to die slowly, though painlessly, over a period of weeks, but unlawful to bring about his immediate death by a lethal injection thereby saving his family yet further ordeal.[81]

Is it a valid distinction? I believe so. The law preserves a patient's right not to have medical treatment foisted upon him or her. You have "a right to be left alone."[82] When you assert a right that someone should assist you bring about your death, you are not asking to be left alone, but rather that another person be involved in your plan. As Judge John Noonan once put it: "The difference is not of degree but of kind. You no longer seek the ending of unwanted medical attention. You seek the right to have a second person collaborate in your death."[83] It is because others are implicated that the possibility of abuse arises. The second person may harbour motives, have agendas or (in the case of medical professionals) make errors of judgment that do not advance the recipient's welfare: quite the reverse. With euthanasia there is the introduction of "an external agency of death"[84].

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[77] Keown, above n 46, at 107-8.

[78] Finnis, above n 48, at 256.

[79] Keown, above n 46, at 110.

[80] Michigan Supreme Court in *People v Kevorkian*, 527 NW 714 at 728 (1994).

[81] *Bland,* above n 78, at 885.

[82] *Compassion in Dying v State of Washington,* 49 F 3d 586 at 594 (9th Cir 1995).

[83] Ibid at 594.

[84] *Bland*, above n 41, at 832-3.

Tragic situations such as Tony Bland or Mr L are different and are not cases of euthanasia at all, because they do not involve the introduction of any external agency of death (such as a lethal injection).

C The prospect of abuse and the expansion to other situations: "slippery slopes" and "bracket creep"

The most often voiced concern is the risk of abuse. The practical operation of any system of VE or DAS is susceptible to normal human error or even deliberate, malicious exploitation. As a *New Zealand Herald* editorial pithily put it "devising a robust euthanasia regime, complete with adequate safeguards, seems hardly feasible."[85]

(1) Empirical evidence

First, an important cautionary note is in order. Citation of the relevant empirical literature and research findings is fraught with danger. Professor Jocelyn Downie et al make the following salutary comment:[86]

> It is . . . particularly important that the academic literature be rigorous so that the public policy debate can be informed by facts and *not misshapen by smoke and mirrors*. . . . The issue of the legalization of euthanasia and assisted suicide in Canada and elsewhere is complex and controversial. As various actors in the legal system contemplate reform, it is essential that they and the public they represent (in direct and indirect ways) be well-informed. *Carelessly researched and inadequately referenced or deliberately misleading professional journal articles* with the apparent legitimacy of peer-reviewed literature *must not be allowed to contaminate the debate*. There is far too much at stake.

Certain jurisdictions have decriminalised both VE and DAS: The Netherlands, Belgium, Luxembourg, while Switzerland and the US states of Oregon, Washington, Montana, Vermont and most recently, California, have legalised DAS only. The mode of legalisation takes different forms: judicial decision, legislation or prosecutorial guidelines.[87]

To take the first method, the Supreme Court of Canada in *Carter v Canada (Attorney General)* very recently held that the criminal ban on DAS infringed the Charter,[88] thus opening to

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[85] "Legal mercy killing is not feasible", *NZ Herald*, 2 April 2004.

[86] Jocelyn Downie et al, "Pereira's attack on legalizing euthanasia or assisted suicide: smoke and mirrors" (2012) 19 *Current Oncology* 133 at 134 and 137.

[87] An excellent resource is Julia Nicol and Marlisa Tiedemann, *Euthanasia and Assisted Suicide: The Law in Selected Countries* (Library of Parliament (Canada), 23 October 2015)(Publication No 2015-116-E).

[88] Above n 58.

door to the legalisation of DAS by each province in that nation.[89] Oregon, by contrast, took the second path, and passed a statute allowing DAS to be performed under strict conditions.[90] A third possible route is prosecutorial guidelines that offer some ex ante immunity from prosecution.[91]

VE has been permitted in The Netherlands since a Supreme Court decision in 1987. It was the first country to do so.[92] The Termination of Life on Request and Assisted Suicide (Review Procedures) Act 2002 further formalised the process, codifying medical practitioner guidelines that had grown up meanwhile. How well has the regime worked? Have the various procedural safeguards been effective? *Ex post facto* reporting has been disappointing, as the findings of the periodic government surveys show. In the first such survey, in 1990, a mere 18 per cent of euthanasia terminations were reported, in 1995, 41 per cent, whereas by 2005, the figure had increased to 80 per cent.[93] Yet this still leaves a significant and alarming proportion where no report was forwarded. This points to the weakness of a regime that depends upon self-reporting by busy practitioners.[94] One extremely important question is the prevalence of VE conducted *without* an explicit request by the patient. In 1990 there were 2300 cases of VE and 400 of DAS.[95] Worryingly, the survey recorded that a further 1000 patients had been given a lethal injection without having made an explicit request. By 2005, the number had halved (to 560 patients).[96] But this still represents a considerable number of persons whose life was ended without their express consent.

In Belgium, some 1.8 per cent (66) of *all deaths* (6,927) that took place in Flanders (the

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[89] Other jurisdictions to use this approach are the state of Montana (*Baxter v Montana* [2009] MT 499 (Montana Sup Ct)) and Colombia (Constitutional Claim Decision C-239/97, 20 May 1997 (Constitutional Court).

[90] As did the states of Washington (Death with Dignity Act 2008), Vermont (Patient Choice at the End of Life Act 2013) and California (End of Life Option Act 2014, which will come into force on 9 June 2016). Nations implementing VE or DAS via legislation are Belgium (Loi relative à l'euthanasie, F 2002-2141, 28 May 2002) and Luxembourg (Loi du 16 Mars 2009 sur l'euthanasie et l'assistance au suicide). In Switzerland, assisting suicide is illegal where someone does so for selfish reasons (Article 115 of the Swiss Criminal Code) leading, by implication, to the stance that assisting suicide for unselfish reasons is permitted.

[91] In *Nicklinson,* above n 6, the Supreme Court rejected the argument that the current Director of Public Prosecution's guidelines ("Policy for Prosecutors in respect of Cases of Encouraging or Assisting Suicide" (February 2010)) were inadequate on the supposed basis they afforded insufficient guidance to those wishing to assist someone to commit suicide.

[92] Ron L Berghmans and Guy AM Widdershoven, "Euthanasia in the Netherlands: Consultation and Review" (2012) 23 *King's LJ* 109.

[93] Agnes van der Heide et al, "End of life practices in the Netherlands under the Euthanasia Act" (2007) 356 *New England J Med* 1957.

[94] Keown, above n 46, at 124-8.

[95] Keown, above n 46, at 120.

[96] *Fleming v Ireland* [2013] IEHC 2 at [96]; Keown, above n 46, at 120.

Dutch-speaking part) between June and November 2007 were *without* explicit request.[97] There were 208 physician-assisted deaths (two per cent of all deaths) with an explicit request, which underscores the low take-up rate for VE and DAS generally in those nations that have decriminalised it. Returning to instances of DAS without an explicit request, the authors report that most involved patients 80 years or older and occurred in hospital; that in the majority of cases, the patient was in a coma or suffering from dementia, but that relatives and other caregivers were "often consulted."[98] The figure of 1.8 per cent had at least dropped from the 3.8 per cent of deaths without a patient's explicit consent in 1998.[99] The reporting of euthanasia by physicians in Flanders, Belgium is low—approximately half (52.8 per cent) of all estimated cases of euthanasia in 2007 were reported to the Federal Control and Evaluation Committee.[100]

In Switzerland since 1982, right-to-die organisations may assist suicides.[101] Cases of DAS undertaken without the patient's explicit request accounted for almost one per cent of all deaths. [102] Recent research by the University of Bern found that about 16 per cent of those helped by right-to-die organisations, such as Dignitas, had no underlying illness.[103]

DAS in Oregon was legalised in 1997 when the Death with Dignity Act came into force. Its utilisation has been low: from 1998 to 2015 only 1545 patients have had prescriptions written under the Act and 991 have died from ingesting the drugs,, although the numbers have been growing annually.[104] During 2015, the rate of deaths under the Act was 38.6 per 10,000 total deaths.[105] The legislation requires that patients be terminally ill (defined as having six months or less to live). One study states that no one received physician assistance in dying that was not determined by two

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[97] Kenneth Chambaere et al, "Physician-assisted deaths under the euthanasia law in Belgium: a population-based survey" (2010) 182(9) *Canadian Med Assoc J* 895.

[98] Ibid at 898.

[99] Ibid at 800; Johan Bilsen et al, "Medical end-of-life practices under euthanasia law in Belgium" (2009) 361 *New England J Med* 1119.

[100] Tinne Smets et al, "Reporting of Euthanasia in Medical Practice in Flanders, Belgium: Cross Sectional Analysis of Reported and Unreported Cases" (2010) 341 *British Med J* 5174.

[101] Nicole Steck et al, "Euthanasia and Assisted suicide in Selected European Countries and US States: Systematic Literature Review" (2013) 51 *Medical Care* 938; Rory Watson, "Luxembourg is to allow euthanasia from 1 April" (2009) *British Med J* 338.

[102] *Fleming v Ireland,* above n 96, at [99].

[103] Nicole Steck et al, "Suicide by right-to-die associations: a population based cohort study" (2014) *International J Epidemiology*.

[104] Oregon Public Health Division, *Oregon Death With Dignity Act: 2015 Data Summary* (4 February 2016) at 3. The number of prescriptions written annually increased at an average of 12.1 per cent from 1998 to 2013: ibid at 2.

[105] Ibid at 3.

physicians to be terminally ill.[106] But this conclusion is based on voluntary declarations by prescribing doctors "who are hardly likely to make such declaration if this key criterion in the assessment process for DAS has not been met."[107] The Oregon Public Health Division annual reports observe that its figures "do not include patients and physicians who may act outside the provisions of the DWDA".[108] The legal regime is characterised by confidentiality. As Keown notes: "The Oregon law relies essentially on the competence and honesty of participating doctors and as in The Netherlands, doctors who have ignored the law are unlikely to report their non-compliance or to be detected if they fail to report."[109]

One of the criticisms of the Oregon law—indeed, this applies to all operating regimes—is that it may not go far enough to prevent vulnerable people with a mental illness from committing suicide. The Oregon legislation does provide that a patient must be referred for counselling if either the attending or second physician considers that the patient may be psychologically disordered. The vast majority (94.7 per cent) of patients have not been referred for psychiatric examination.[110] Professor Linda Ganzini et al studied 58 Oregonian patients suffering from a terminal illness who requested assistance in dying.[111] Of these, 18 were given clearance to do so by the assessing physicians. Of the 18, three had treatable but undiagnosed clinical depression at the time of their assessment. The authors concluded that "most patients who request aid in dying do not have a depressive disorder. However, the current practice of the Death With Dignity Act in Oregon may not adequately protect all mentally ill patients, and increased vigilance and systematic examination for depression among patients who may access legal aid in dying are needed."[112]

(2) Heightened risk to the vulnerable

When VE and assisted dying is legalised is there a greater risk that the lives of people in groups identified as "vulnerable" will be more frequently ended? The vulnerable typically include the poor,

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[106] Margaret P Battin et al, "Legal physician-assisted dying in Oregon and the Netherlands: evidence concerning the impact on patients in 'vulnerable' groups" (2007) 33 *J Med Ethics* 591.
[107] I G Finlay and R George, "Legal physician-assisted suicide in Oregon and The Netherlands: evidence concerning the Impact on patients in vulnerable groups—another perspective on Oregon's data" (2011) 37 *J Med Ethics* 171.
[108] Oregon Department of Human Services, *Eighth Annual Report on Oregon's Death With Dignity Act* (9 March 2006) at 15.
[109] Above n 46, at 132.
[110] From 1998 -2015, 52 persons had been referred for psychiatric evaluation (5.3 per cent): Oregon Public Health, above n 108, at 6.
[111] Linda Ganzini, Elizabeth Goy and Steven Dobscha, "Prevalence of depression and anxiety in patients requesting physicians' aid in dying: cross sectional survey" (2008) 337 *British Med J* 1682.
[112] Ibid.

racial and ethnic minorities (including, in New Zealand, Maori and Pacific Peoples), the handicapped and disabled, the mentally ill and the depressed, the less-educated, the elderly, the medically-uninsured, and so on. Some research concludes that people from socio-economically deprived backgrounds were at no greater risk following the legalisation of VE and DAS in The Netherlands and DAS in Oregon: "we found no evidence to justify the grave and important concern often expressed about the potential for abuse—namely, the fear that legalised physician-assisted dying will target the vulnerable or pose the greatest risk to people in vulnerable groups."[113] However, other research questions this, pointing out that the vulnerability cannot be categorised simply by reference to race, gender, educational attainment, wealth or other socioeconomic status and that *real* vulnerability depends upon emotional fragility, communicative difficulties, having unrelieved symptoms of a distressing medical condition and so on, factors that transcend socio-economic groups.[114]

The subject of elder abuse has gained greater prominence recently. It would be naïve not to believe that if VE were legalised the elderly would not be the group most at risk of being pressured into making a "voluntary" decision to have their lives ended. Emeritus Professor David Richmond contends:[115]

> Older people are, by and large very sensitive to being thought to be a burden, and more likely than a young person to *accede to more or less subtle suggestions that they have "had a good innings."* . . . Experience overseas is that those who are less well-off, those who have no close family, and those who have fraught family relationships in older years have the most to fear. In this last case, younger members of families of long-lived elders, may feel thwarted, believing that they could utilise their older relatives' resources better but being unable to access them while they are still alive. Or it may be that care-giving has become burdensome. Those of us who work in the sector know that these things happen and that is why every District Health Board in the country has an Elder Abuse team.

(3) Slippery slopes

Many critics emphasise the unwitting extension of VE over time—the so-called "slippery slope" phenomenon. Will it eventually become a mechanism to terminate the lives of those who do *not* consent to it as well those who do, that is, will it degenerate into involuntary euthanasia? Will it be available to, and thus come to be utilised by, minors? Will it be applied to new-born infants?

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[113] Battin et al, above n 106, at 597.
[114] Finlay and George, above n 107.
[115] "Why elderly should fear euthanasia and assisted suicide" *Euthanasia-Free NZ*, 16 June 2013: http://euthanasiadebate.org.nz/84/

Slippery slope arguments come, as Professor Emily Jackson points out, in three forms.[116] The *logical* slippery slope argument says that once society accepts one form of active termination of human life restricted to a precise set of conditions, it will be difficult or impossible to confine VE to those conditions.[117] For instance, if one allows adults suffering from incurable terminal diseases then what prevents those with curable diseases from demanding this procedure? (The Street Bill already has this extended availability). If one allows adults, why should mature minors (intelligent teenagers, adolescents) be deprived of this opportunity? The *empirical* slippery slope is the claim that the track record of those countries that have introduced VE or DAS demonstrates that abuse in fact occurs. The *psychological* slippery slope is the notion that once we become accustomed to the idea of VE and DAS it becomes easier for society to take further steps to actively end the lives of those whose life has become not worth living or who deserve a dignified exit.

The logical slippery slope argument is often quickly dismissed as a weak one by supporters of VE. They counter by pointing out that human activity may be permitted by law, and boundaries placed around it, without this meaning that the boundaries *must* be pushed out further and further.[118] Logic does not demand expansion any more than it entails constriction.

But, and it is a large "but", there is one important "spoiler" here. When an activity is decriminalised there is a tendency to say that now it is not legally condemned by the state, it must be necessarily approved by society. And from there, the next step is to elevate it to a human right. Now this does not follow. What society does not condemn, it does not necessarily approve.[119] Society may decriminalise prostitution and lift most of the legal sanctions against it. But this does not bestow on us a human right to hire lap dancers.

Yet decriminalisation of VE or DAS might all too quickly follow this path. Decriminalisation could be seen as a societal endorsement of it, one worthy of the mantle and protection of a human right. And when a newly permitted activity is characterised as a "human right" there is often a constituency who will lobby to extend such a right to a greater number of persons. The American Supreme Court in *Glucksberg* commented that if assisted suicide were to be recognised as a constitutional right, it would be difficult to resist the argument that "every man and woman in the United States must enjoy it."[120] If some citizens are currently deprived of enjoying this newly minted right then "equality" and non-discrimination demand that they be granted it too.

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[116] In Jackson and Keown, above 46, at 53.

[117] See *Bland,* above n 41, at 865; George et al, above n 75, at 684.

[118] Byron J Stoyles and Sorin Costreie, "Rethinking Voluntary Euthanasia" (2013) 38 *J Med & Phil* 674.

[119] George Pilcher, *A Time to Live: The Case Against Euthanasia and Assisted Suicide* (Monarch Books, Oxford, 2010) at 34.

[120] *Washington v Glucksberg,* 521 US 702 at 733 (1997).

Why should adults alone have this right? Why should those who are terminally ill or suffering an incurable disease alone have this recourse and not those who are simply bored or tired with life? Why should those who are competent to request it alone have this option?[121]

It is plausible to believe that as society becomes used to the deliberate termination of lives or "therapeutic killing"[122] it might become willing to extend the process to new categories and situations. In The Netherlands, the prevalence of medical euthanasia has more than doubled in the decade to 2012.[123]

One might suppose that evaluating the empirical slippery slope would be straightforward. Carefully collate and analyse the studies of the actual practice of VE and DAS in the Netherlands, Belgium and so on. But here, a clear picture remains somewhat elusive. There are studies that show that abuses have occurred despite the safeguards.

A *New England Journal of Medicine* study of Dutch end-of-life practices found that in 2005 "0.4% of all deaths [in the Netherlands] were the result of the use of lethal drugs not at the explicit request of the patient."[124] A later study in *The Lancet* found that the rate of euthanasia deaths without an explicit request had dropped: "The frequency of ending of life without an explicit patient request decreased over the years (from 0·8% [45 of 5197] of all deaths in 1990 to 0·2% [13 of 6861] in 2010)."[125] The authors suggest that "one reason for this decrease might be the increased attention for palliative care over the last decade."[126] Comforting as that decrease is, it still means that 0.2% of all deaths were unlawful. I noted earlier that some one percent of all deaths that took place in Flanders between June and November 2007 were without an explicit patient request.[127]

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[121] See Daniel Callahan, "Reason, Self-determination and Physician-Assisted Suicide" in Foley and Hardin, above n 76, 41 at 62: "Consider next the person who is suffering but not competent, perhaps demented or mentally retarded. The standard argument would deny euthanasia and physician-assisted suicide to that person. But why? If a person is suffering but not competent, then it would seem grossly unfair to deny that person relief simply because he or she lacked competence. Are the incompetent less entitled to relief from suffering than the competent? Will it only be affluent, middle-class people, mentally fit and able, who can qualify?"

[122] George et al, above n 66, at 684.

[123] Bruno Waterfield, "Number of Dutch killed by euthanasia rises by 13 per cent", *Daily Telegraph*, 24 September 2013.

[124] Agnes van der Heide et al, "End of life practices in the Netherlands under the Euthanasia Act" (2007) 356 *New England J Med* 1957.

[125] Bregie Onwuteaka-Philipsen et al, "Trends in end-of-life practices before and after the enactment of the Euthanasia Law in the Netherlands from 1990 to 2010: a repeated cross-sectional survey" (2012) 380 *The Lancet* 908.

[126] Ibid at 913.

[127] Chambaere et al, above n 97; Bilsen et al, above n 99.

On the other hand, there are also studies that show abuses and slippery slopes have not eventuated.[128] One argument by supporters of VE or DAS is that there are probably more "questionable" practices in countries where all foreshortening of life is illegal. Doctors, it is said, commonly flout the law and practice VE and DAS. Decriminalisation would bring these unlawful practices "out into the open"[129]. However, there is little empirical data to support this contention.[130] UK research indicates that deaths from DAS, VE and non-voluntary euthanasia in that country are "extremely low"[131] and that instances of DAS and euthanasia without an explicit patient request "are rare or non-existent"[132].

In New Zealand there is research that found the prevalence of euthanasia or DAS that could not be described as common, but neither was it negligible. A national survey by Mitchell and Owens, published in the *British Medical Journal*, received responses from 1255 New Zealand general practitioners of which 1100 (88 per cent) reported attending a death in the past year and 693 (63 per cent) had made a medical decision that could hasten death in the last 12 months.[133] Furthermore:[134]

> In 39 (5.6%) cases, death was attributed to actions consistent with physician assisted suicide or euthanasia. In 17 of these cases there was no discussion with the patient, and in 34 (87%) palliative care services were available . . . Ninety-four respondents (13.6%) reported final actions that were taken partly with the intent of hastening death. Fifty (53%) had not discussed this with the patient beforehand. . . .Palliative care was available in over 85% of cases. Other actions were defensible under the principle of double effect—withholding or withdrawing treatment (55) or increasing medication to alleviate symptoms (373) knowing that death could be hastened . . . Thirty-nine respondents had provided some form of physician assisted death, and 226 had taken actions partly or explicitly with the intention of hastening death. These actions would be indefensible under the principle of double effect.

A more recent national study was conducted in May 2013 by Dr Phillipa Malpas et al. Of the 650 GPs who responded (a rather low 21 per cent response rate from the 3420 GPs surveyed) some 359 reported making a medical decision at the end of life (MDEL):[135]

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[128] See eg Battin et al, above n 106; Eduard Verhagen, "The Groningen Protocol for newborn euthanasia: which way did the slippery slope tilt?" (2013) 39 *J Med Ethics* 293.

[129] Keown, above n 46, at 114. Keown states the argument but does not agree with it.

[130] Mishara and Weistubb, above n 51, at 429.

[131] C Seale "National survey of end-of-life decisions made by UK medical practitioners" (2006) 20 *Palliative Med* 1.

[132] C Seale, "End-of-life decisions in the UK involving medical practitioners" (2009) 23 *Palliative Med* 198.

[133] Kay Mitchell and R Glynn Owens, "National survey of medical decisions at end of life made by New Zealand general practitioners" (2003) 327 *British Med J* 202.

[134] Ibid at 202-203.

[135] Phillipa Malpas, Kay Mitchell and Heidi Koschwanez, "End-of-life medical decision making in general practice in New Zealand—13 years on" (2015) 128 *NZ Med J* 27 at 32-33.

> The most common MDEL actioned, taking into account the probability that this may hasten end-of-life, was increasing the alleviation of pain and/or symptoms, (88% n=359), followed by withdrawal of treatment (50.1% n=359). Of 359 GPs who reported making a MDEL, 16 (4.5 percent) attributed death to a drug that had been prescribed, supplied or administered explicitly for the purpose of hastening the patient's death. . . . these [16] GPs tended to be older, and less likely to be religious. They all had access to palliative services and were more likely to live in a city (3 were rural). Gender did not factor (9 male, 7 female). . . Nurses were identified by GPs as the agent who administered the drug when this was explicitly intended to hasten the death of the patient. . .

As for bringing it out into the open, why would doctors who currently ignore the law prohibiting euthanasia be any more willing to comply with new legal guidelines for VE or DAS?[136]

(4) "Bracket creep"

Over time, the eligibility criteria for VE and DAS may be widened. In early phase of the legalisation of VE and DAS in The Netherlands—marked by a policy of "pragmatic tolerance"[137] of the practice following certain prominent judicial decisions—the prevalence of the euthanasia of children is difficult to ascertain. What is clear is that when euthanasia was codified by legislation in 2002, the statute permitted children aged 12 years or older to consent to being euthanised, provided their parents also agreed.[138] In 2013 Belgium's Senate voted to amend the euthanasia law to abolish age restrictions on those can avail themselves of euthanasia.[139] The Belgian House of Representatives, by 86 votes to 44 (with 12 abstentions), followed suit in February 2014.[140] The law applies to those under 18 (the minimum age), but they will have to satisfy certain conditions such as parental consent and psychiatric assessment. A letter from 160 Belgian paediatricians that the

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[136] Keown, above n 46, at 117.

[137] Berghmans and Widdershoven, above n 92, at 110.

[138] Termination of Life on Request and Assisted Suicide (Review Procedures) Act, s 2(4). Minors aged between 16 to 18 may make a request to be euthanised without parental or guardian consent: s 2(3). The "most controversial aspect of the legislation" was the proposal that minors as young as 12 be permitted to request euthanasia or assisted suicide: Nicol and Tiedemann, above n 87, at 12. For an empirical study of the Dutch experience with minors, see Astrid Vrakking et al, "Medical End-of-Life Decisions for Children in the Netherlands" (2005) 159 (9) *Archives of Paediatrics & Adolescent Medicin*e 802.

[139] Andrew Higgins, "Belgian Senate Votes to Allow Euthanasia for Terminally Ill Children", *New York Times*, 12 December 2013.

[140] Bruno Waterfield, "Belgian MPs vote to extend euthanasia to children of all ages", *Daily Telegraph*, 13 February 2014.

amendment was rushed and unnecessary fell upon deaf ears.[141] Opinion polls show that the extension of euthanasia to children enjoys the support of three-quarters of Belgians.[142]

The practice of neonatal euthanasia began when the Dutch legalised euthanasia.[143] According to nationwide surveys, in about one per cent of all cases of infant death under 12 months old (some 15 to 20 newborns per year) medication was administered with the explicit intention to hasten death.[144] After the introduction of the Groningen Protocol in 2005[145] there are now strict criteria governing neonatal euthanasia. Following the introduction of the Protocol the fear of a slippery slope resulting in increased numbers has not been realized. The numbers of neonatal euthanasia cases have *decreased* in the five years following the Protocol, but this may be, as the author of the study speculates, due to an increase in abortions following the introduction of free antenatal screening in 2007.[146]

In Belgium, the law permits only physicians to perform euthanasia. Yet one study found that lethal drugs were administered by nurses acting on the doctor's orders, but mostly in the doctor's absence.[147]

D *Coercion revisited*

(1) Self-imposed pressure

Coercion is undoubtedly a subtle concept. The stark contrast between requested versus unrequested euthanasia is simplistic. As Richard Doerflinger observes: "Theorists may present voluntary and involuntary euthanasia as polar opposites; in practice there are many steps on the road from dispassionate, autonomous choice to subtle coercion."[148]

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[141] BBC, "Belgium's parliament votes through child euthanasia", *BBC News*, 13 February 2014.

[142] Bruno Waterfield, "Belgium to legalise euthanasia for children", *Daily Telegraph,* 12 February 2014.

[143] See Felipe Vizcarrondo, "Neonatal euthanasia: The Groningen Protocol" (2014) 81 *Linacre Q* 388; Hilde Lindemann and Marian Verkerk, "Ending the Life of a Newborn: The Groningen Protocol" (2008) 38 *Hastings Center Report* 42.

[144] Eduard Verhagen, "The Groningen Protocol for newborn euthanasia: which way did the slippery slope tilt?" (2013) 39 *J Medical Ethics* 293 at 293.

[145] See Eduard Verhagen and Pieter Sauer, "The Groningen Protocol—Euthanasia in Severely Ill Newborns" (2005) 352 *New England J Med* 959.

[146] Verhagen, above n 144.

[147] Els Inghelbrecht et al, "The Role of Nurses in Physician-Assisted Deaths in Belgium" (2010) 182 *Canadian Med Assoc J* 905.

[148] "Assisting Suicide: Pro-Choice of Anti-Life?" (1989) *Hastings Center Report* (Special Supplement) 16.

This brings us to an important consideration: a person's *self-imposed* pressure based on the desire not to burden others:[149]

> We are dealing with a question on which ordinary folk have as good a grasp as anyone: in the new world of medical law and ethics, what conceivable legislative pronouncement, elegant preambles, government pamphlets, elaboration of hospital paperwork, physician reporting, official inquiries, and all that, could remove or even appreciably diminish the patient's subjection to *the pressure of the thought* that my being killed is *what my relatives expect of me and is in any case the decent thing to do*. . . .

Debates on VE and DAS usually focus on egotistic (in a neutral, not pejorative, sense) reasons of personal pain and suffering, on the individual's existential plight in a cruel world. Yet people often act to please others and to meet their needs—and no less so at the end of life.[150] The feeling by the terminally ill that one does not want to be a burden to others and thus "the decent thing to do" is to end one's life, cannot be underestimated. Annual reports by Oregon Public Health contain data on the numbers of patients who reported that part of their motivation to request euthanasia was because they felt a "burden on family, friends/caregiver". In the 18 years between 1998 to 2015 more than one in three patients (41.1 per cent) perceived themselves as being a burden to their nearest and dearest.[151]

If VE or DAS were permitted "many might resort to it to spare their families the substantial financial burden of end-of-life healthcare costs", wrote the US Supreme Court.[152] But this point is just as valid in New Zealand and not just the hyper-expensive American healthcare system. Elderly and ailing patients are all too aware that their increasingly expensive rest home and geriatric care is (unless the state subsidises it) steadily dissipating the inheritance that awaits their children. Sadly, the more unscrupulous and callous offspring would not be slow in pointing this out either.

In *Nicklinson,* Lord Sumption eloquently described the self-induced pressure concern and thus I cannot go past a lengthy quotation from him:[153]

> The vulnerability to pressure of the old or terminally ill is a more formidable problem. The problem is not that people may decide to kill themselves who are not fully competent mentally. I am prepared to accept that mental competence is capable of objective assessment

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[149] Finnis, above n 48, at 262 (italics supplied).

[150] Mishara and Weistubb, above n 51, at 432.

[151] Oregon Public Health, above n 108, at 6.. The leading responses (over that same period) to the 'what are your end of life concerns?' question were "losing autonomy" (91.6 %), "less able to engage in activities making life enjoyable" (89.7%) and "loss of dignity" (78.7 %).

[152] *Washington v Glucksberg*, above n 120, at 732.

[153] Above n 6, at [228](italics added). See also Lord Neuberger, ibid, at [86]: "there would be a 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."

> by health professionals. The real difficulty is that even the mentally competent may have reasons for deciding to kill themselves which reflect either overt pressure upon them by others *or their own assumptions about what others may think or expect*. The difficulty is particularly acute in the case of what the Commission on Assisted Dying called "indirect social pressure". This refers to the problems arising from the low self-esteem of many old or severely ill and dependent people, combined with the spontaneous and negative perceptions of patients about the views of those around them. The great majority of people contemplating suicide for health-related reasons, *are likely to be acutely conscious that their disabilities make them dependent on others.* These disabilities may arise from illness or injury, or indeed (a much larger category) from the advancing infirmity of old age. *People in this position are vulnerable. They are often afraid that their lives have become a burden to those around them.* The fear may be the result of overt pressure, but may equally arise from *a spontaneous tendency to place a low value on their own lives* and assume that others do so too.

Lord Kerr was unconvinced by Lord Sumption's "so-called 'pressure argument'".[154] He failed to see how the legalisation of assisted suicide by those who were physically unable to commit suicide should make those who were physically able to do so more vulnerable: "The two situations are not linked in any logical way."[155] But the link, I suggest, is not mysterious. Lord Kerr's argument ignores the fact that a newly created right of assisted suicide, accompanied by an elaborate legal and medical machinery, would now be available instead of suicide. It would in a very real sense now be easier, more clinical and more "dignified" (as proponents of VE and DAS often term such legislation) for persons contemplating ending their life to do so.

The other response is a frontal challenge: there is nothing wrong with a decision to end one's life based on the perception that one may be a burden— "one may indeed be a burden, and there may be only so much the people who care for us can do to dissuade us of this view—it may be perfectly reasonable not to want to be a burden."[156] This is the reality: "Like it or not, many people approaching the end of their lives believe themselves to be a burden to others—they may indeed be one."[157] This fact is just another one to be weighed by the competent autonomous individual; it "should not necessarily be discounted as irrelevant to one's life choices."[158]

(2) Shift in the burden of proof

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[154] Above n 6, at 349.

[155] Ibid at [350].

[156] John Shand, "A Reply to some standard objections to euthanasia" (1997) 14 *J Applied Philosophy* 43 at 44.

[157] Sheila McLean, *Assisted Dying: Reflections on the Need for Law Reform* (Routledge-Cavendish, Abingdon, 2009) at 54.

[158] Ibid.

Next, the very climate in which one exercises choice changes when VE or DAS is introduced. To quote Lord Sumption again: "The legalisation of assisted suicide would be followed by its progressive normalisation, at any rate among the very old or very ill. In a world where suicide was regarded as just another optional end-of-life choice, the pressures which I have described are likely to become more powerful." [159]

The dying are now, so to speak, put on back foot. A subtle change in the burden of proof takes place:[160]

> Elderly and disabled patients are often invited by our achievement-oriented society to see themselves as useless burdens on younger, more vital generations. In this climate, simply offering the *option* of "self-deliverance" *shifts the burden of proof,* so that helpless patients must ask themselves why they are not availing themselves of it. Society's offer of death communicates the message to certain patients that they *may* continue to live if they wish but the rest of us have no strong interest in their survival. Indeed, once the choice of a quick and painless death is officially accepted as rational*, resistance to this choice may be seen as eccentric of even selfish.*

The terminally ill, severely disabled (and chronically depressed) are forced to defend their "selfish" decision to live and to spurn the option of an easy, clinical, state-approved, death. Keown recounts the disturbing statement by the lead authors of the Dutch national surveys that it has, in their view, become the duty of patients to make it clear, while they are still competent, if they do *not* want to be euthanised should they one day become incompetent: "It is the patient who is now responsible in the Netherlands for avoiding termination of his life; if he does not wish to be killed by his doctor then he must state it clearly orally and in writing, well in advance." [161] In other words, a law passed that allowed persons to "opt in" for VE or DAS may lead to a situation where the practice becomes so normalised that it would now be up to people who did not want it to actively "opt out".

(3) Rational suicide?

The design of a VE or DAS regime is heavily premised on the clear-minded, rational person undertaking a cool cerebral choice. But how "rational" a decision can one make when one is suffering from a painful terminal disease? Mishara and Weistubb observe:[162]

> The requirements for access to euthanasia and assisted suicide overwhelmingly preclude the possibility of concluding that these decisions are likely to be rational. The typical requirement for providing access to death to a patient is that the person has interminable and unsupportable suffering. Research on human decision-making suggests that when a person

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[159] Above n 6, at [228].

[160] Doerflinger, above n 148, at 17.

[161] Keown, above n 46, at 121.

[162] Above n 51, at 431.

> is experiencing pain, decision making becomes less rational (Apkarian et al, 2004). Because of this impairment associated with experiencing pain, people may tend to engage in more impulsive and irrational decision making in periods of intense suffering.

Quite so. They continue:[163]

> This results in the paradoxical situation where proponents of legalizing euthanasia and assisted suicide insist upon the right to make a "rational" choice under circumstances where rational decision making is much less likely to occur. We contend that when advocates of euthanasia or assisted suicide say that a choice is "rational," what they mean is that the choice is understandable from the point of view of an external rational observer. This is a serious challenge for physicians who must determine whether or not to accept a request for euthanasia or assisted suicide.

One may question, as professor of palliative medicine, Baroness Finlay of Llandaff cautions, the idealised world which many advocates of VE or DAS tacitly assume:[164]

> a world in which all doctors know their patients well enough to understand their underlying fears and anxieties and to assess whether a request for euthanasia stems from firm conviction, rather than from a sense of hopelessness or obligation to others. They assume a world in which all terminally ill people know their minds clearly, are never vulnerable to any pressures, never have depressed thinking that has gone undiagnosed and that the information they have about their prognosis and future is always completely accurate. Anyone who works, day in and day out, with dying people knows that *this idealised picture simply does not reflect reality.*

Much of the debate focuses upon the pleas by exceptional individuals who are intelligent, articulate and who clearly comprehend their predicament. Yet the law will have to protect everyone—the inarticulate as well as the articulate, the impaired, gullible or naive as well as the intelligent and alert.[165] The interests of the silent but vulnerable many are lost sight of in a desire to accommodate the desire of the few to control the timing of their death.[166] Felix Cohn and Joanne Lynne express this point admirably:[167]

> But for every tragic case of individual suffering spotlighted in the media, whole categories of people suffer without similar attention. Certainly, in some particular situations, physician-assisted suicide may seems appropriate, even necessary. *However, justifying an individual act does not mean that a widespread practice can or should be justified,* What is good for a person may not be good for groups of people and may be harmful to several groups of people—as physician-assisted suicide appears likely to be. In developing policy, we must remember that physician-assisted suicide is about more than individual rights and distressing situations. Oliver Wendell Holmes reminded us. "Hard cases make bad law." Now we need

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[163] Ibid.

[164] Foreword to Pilcher, above n 119, at 13 (italics added).

[165] Iona Heath, "What's wrong with assisted dying" (2012) 344 *British Med J* e3755.

[166] Keown, above n 46, at 97.

[167] "Vulnerable people: practical rejoinders to claims in favor of assisted suicide" in Foley and Hendin, above n 76, 238 at 259-60 (italics supplied)

> a corollary about population well-being and policy. *Hard individual situations make bad policy.*

An attempt to divide suicides into those that were "rational" versus "irrational" was made in *Seales*.[168] It was unsuccessfully argued for the applicant that the prohibition on assisting suicide in s 179 applied to suicides which were irrational and the product of impaired thinking, but not to suicides that were the outcome of a rational decision to die by a mentally competent adult who was not depressed but was enduring a terminal disease.[169] Collins J declined to draw any such distinction.[170]

(4) Depression

Many who request DAS revoke that request if their depression and pain are satisfactorily treated.[171] Most VE and DAS regimes stipulate careful screening of candidates to prevent those who are depressed from ending their lives. I referred earlier to the Ganzini study that found worrying rates of depression in patients requesting DAS despite the presence of treatable but undiagnosed depression at the time of their psychiatric assessment. More recently, however, a study by Levene and Parker concluded that: "Up to half of patients requesting euthanasia/PAS may show symptoms of depression but, in the Dutch regulatory system, most patients with depression have their requests refused and the rate of depression in cases is not significantly different from that of the surrounding population." [172] The authors even question whether the presence of depression ought to be a disqualifying factor given that depression does not necessarily make patients incompetent to make medical decisions.[173] The Street Bill stipulated that the applicant must be "mentally competent", but that begs the question whether depression renders one incompetent. It also begs the question of how such depression will be recognised. Even very mild depression—of the kind that would not render a person legally incompetent—can have a marked effect on one's predisposition to live or die. Add to that the fact that virtually all patients who are facing death or an irreversible disease are depressed at some point. Under the current law, most move through this to another level. If VE or DAS is

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[168] Above n 9, at [128].
[169] *Seales,* above n 9, at [135].
[170] *Seales*, above n 9, at [140]: "The approach to the meaning of 'suicide' submitted on behalf of Ms Seales faces challenges in giving effect to s 41 of the Crimes Act. It is difficult to see how a person who intervenes to prevent a suicide can assess whether or not he or she is intervening in a case of 'rational' suicide. "
[171] Ilana Levene and Michael Parker, "Prevalence of depression in granted and refused requests for euthanasia and assisted suicide: a systematic review" (2011) 37 *J Med Ethics* 205 at 209.
[172] Ibid at 210.
[173] Ibid at 209.

allowed, many patients who would have otherwise traversed this very difficult dark phase (and found meaning in continued living) may not get that chance and will die prematurely.

E *Medical Profession Opposition*

The majority of the medical profession, both in New Zealand and in many overseas countries[174], is firmly opposed to VE and DAS. There are exceptions. Some countries, as we have seen, have allowed it. And some groups (eg Doctors for Voluntary Euthanasia Choice in Australia) and some physicians—Drs Jack Kevorkian and Philip Nitchske being the most well known—support VE and DAS. But they appear to be in the minority. Thus, in New Zealand:[175]

> The NZMA is *opposed to both the concept and practice of euthanasia and doctor assisted suicide*. Euthanasia, that is the act of deliberately ending the life of a patient, even at the patient's request or at the request of close relatives, is unethical: World Medical Association Declaration on Euthanasia, October 1987. Doctor-assisted suicide, like euthanasia, is unethical: World Medical Association Statement on Physician Assisted Suicide, September 1992. The NZMA however encourages the concept of death with dignity and comfort, and strongly supports the right of patients to decline treatment, or to request pain relief, and supports the right of access to appropriate palliative care. In supporting patients' right to request pain relief, the NZMA accepts that the proper provision of such relief, even when it may hasten the death of the patient, is not unethical. This NZMA position is not dependent on euthanasia and doctor-assisted suicide remaining unlawful. *Even if they were to become legal, or decriminalised, the NZMA would continue to regard them as unethical.*

This is a statement on behalf of the NZMA. The views of individual doctors are harder to establish. A recent survey of doctors in Waikato found that 47.3.per cent of GPs "fully or probably supported" a law permitting DAS in New Zealand; the exact same percentage who said they "totally or probably opposed" such a law.[176]

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[174] For the UK, see C Seale, "Legalisation of euthanasia or physician assisted suicide: survey of doctors' attitudes" (2009) 23 *Palliative Med* 205; Ruaidhri McCormack et al, "Attitudes of UK doctors towards euthanasia and physician-assisted suicide: a systematic literature review" (2011) 26 *Palliative Med* 23.

[175] The New Zealand Medical Association Position Statement: http://www.nzma.org.nz/policies/advocacy/position-statements/euthanasia The Australian Medical Association similarly declare: "The AMA believes that medical practitioners should not be involved in interventions that have as their primary intention the ending of a person's life. This does not include the discontinuation of futile treatment."

[176] The other 5 per cent were "unsure". See Jack H Havill, "Physician-assisted dying—a survey of Waikato general practitioners" (2015) 128 *NZ Med J* 70. The question was worded: "Given adequate safeguards against abuse, do you support the passing of a law to allow a medical practitioner to give assistance to die, on request from a competent patient, 18 years and older, where the patient has end-stage terminal disease (e.g. cancer), or is suffering from irreversible unbearable suffering (e.g. motor neurone disease, end-stage respiratory failure)?" Some 78 replies were received from 200 letters sent.

Why is there this stern opposition, at least from the associations representing doctors? The principal reason is that the role of the physician would be fundamentally altered, as would the nature of the patient-doctor relationship.[177] Finnis predicts that VE would see the emergence of "a new breed of doctors", those "directed to regard intentional killing as a therapeutic option, something good doctors quite often do."[178] In this new VE era, doctors' self-understanding would be quite different. So-called "therapeutic killing" would now be a tool in some doctors'[179] medical kitbags. The Seymour DAS Bill describes the lethal drugs to be administered as "medication".[180] VE would become "a routine management option", suggests Finnis, adding:[181]

> Oh yes, there are restrictions, guidelines paperwork. Well meant. Not utterly irrelevant. But as nothing compared with our *doctors' change in heart, professional formation, and conscience*. So our doctors would enter our sickrooms as men and women trained to be willing to kill on the occasions of their choosing, guided we trust by new professional and legal standards which shift to and fro searching for the bright line lost with the majoritarian judicial or legislative overthrow of the line between intending to kill and intending to heal, treat, alleviate, palliate…

Where does this place the ailing patients? How do they perceive their doctor? How do they view their relatives? Finnis forebodes there might be:[182]

> A new zone of silence. Can I safely speak to my physician about the full extent of my sufferings, about my fears, about my occasional or regular wish to be free from my burdens? Will my words be heard as a plea to be killed? As a tacit permission? . . .
>
> Another zone of silence. Outside the door are the relatives. What will they be telling the doctor about my condition and my wishes? What is it prudent to tell them about my suffering, my depression, my wishes? Are they interpreting my state of mind just as I would wish? Are their interests in line with mine? Many people will find that their nearest and dearest are less and less near, and less and less dear.

F Palliative Care is Sufficient

New Zealand has a well-developed network of hospices and palliative medicine is widely practiced. There are 39 hospices and 16 hospitals provide palliative care.[183] The Government recently

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[177] On the emotional effects upon physicians receiving and implementing requests to die from their patients, see G K Kimsma, "Death by request in The Netherlands: facts, the legal context and effects on physicians, patients and families" (2010) 13 *Med Health Care & Philosophy* 355.

[178] "Euthanasia and the Law", above n 48, at 260.

[179] A right of conscientious objection would be in the legislation for those who do not wish to participate: see eg cls 6-7 of the Seymour End of Life Choice Bill.

[180] Clause 15. There are four methods for the administration of the lethal dose of medication, from which the willing patient may choose the preferred one.

[181] Finnis, above n 48, at 260.

[182] Ibid.

announced it will spend an extra $76.m over four years on hospices and palliative care services.[184] There is, I suggest, no pressing need for euthanasia.

Discussions of VE and DAS are wont to present the subject in terms of a cruel dilemma. Thus, the Canadian Supreme Court in *Carter* began its long judgment as follows:[185]

> It is a crime in Canada to assist another person in ending her own life. As a result, people who are grievously and irremediably ill cannot seek a physician's assistance in dying and may be condemned to a life of severe and intolerable suffering. A person facing this prospect has two options: she can take her own life prematurely, often by violent or dangerous means, or she can suffer until she dies from natural causes. The choice is cruel.

This misstates the options and posits a false dilemma. There is a third course between unalleviated suffering and premature death by suicide: palliative care. Nearly all physical pain is treatable. Granted, *nearly* all is not all, and there is a small percentage[186] of instances where patients may have physical "refractory symptoms", defined as "symptoms that cannot be adequately controlled despite aggressive efforts to identify and utilize a therapy that does not compromise consciousness."[187] So the current situation (banning VE or DAS) "inevitably leads to optimal management being denied to some patients."[188] Yet, even here palliative sedation, is, nonetheless, available as a last resort.[189]. Palliative sedation may be defined as:

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[183] *National Health Needs Assessment for Palliative Care: Phase 2 Report—Palliative Care Capacity and Capability in New Zealand* (Cancer Control NZ, June 2013) at 138-139 (Appendix 3). This figure is at 2011.

[184] Jonathan Coleman, "$76.1m more for palliative care and hospices", *Beehive.govt.nz*, 21 May 2015.

[185] Above n 58, at [1].

[186] A figure that is difficult to quantify. One recent study observes: "Pharmacological treatment controls pain in 70 to 90% of patients and it is considered the mainstay of chronic cancer in management. . ."Augusto Caraceni et al, "Cancer pain management and palliative care" (2012) 104 (3rd series) *Handbook of Clinical Neurology* 391 at 392. For some, the size of the figure, "whether 5 per cent or 0.05 per cent", is immaterial for "no patient should be made to die in ways that, while meeting the moral or religious precepts of some, are anathema to their own." Helga Kuhse and Peter Singer, "Active Voluntary Euthanasia, Morality and the Law" (1995) 3 *J Law & Med* 129 at 130.

[187] Michael H Levy and Seth D Cohen, "Sedation for the Relief of Refractory Symptoms in the Imminently Dying: A Fine Intentional Line" (2005) 32 *Seminars in Oncology* 237 at 239.

[188] John O Willoughby, "Doctors in support of law reform for voluntary euthanasia" (2013) 198 *Med J Aust*190.

[189] Joseph A Raho and Guido Miccinesi, "Contesting the Equivalency of Continuous Sedation until Death and Physician-assisted Suicide/Euthanasia: A Commentary on LiPuma" (2015) 40 *J Med & Phil* 529 at 547: "Palliative sedation, including CSD [continuous sedation until death], usually takes place at the very end of a disease trajectory when all kinds of other approaches to relief of current pain and suffering have failed, and death is expected within hours, days, or at most two weeks."

> The intentional administration of sedative drugs and combinations required to reduce the consciousness of a terminal patient as much as necessary to adequately relieve one or more refractory symptoms.[190]

There is a debate as to whether palliative sedation is nothing more than a euphemistic term for what is really "slow euthanasia"[191] (and the critics, on that basis, prefer the term "terminal sedation"), but, in my view, the difference is clear. The intention once more is to relieve refractory symptoms and not to kill. With palliative sedation, terminally ill patients die as a result of their illness.[192] Indeed, according to Broeckaert, "palliative sedation does not hasten death (except in really exceptional cases). There are no differences in survival between sedated and non-sedated groups of patients."[193] Furthermore, the point of palliative sedation is not to render the patient unconscious (let alone end the patient's life) but to find a way to address refractory symptoms, and hence the level of sedation is adjusted ("titrated"), and the patient's consciousness affected, only as much as is needed to achieve this.[194]

A desire to die may be motivated not just by unbearable pain, but by suffering in a wider sense, including the more protean physical reactions such as nausea, vomiting shortness of breath, nightmares, delirium and so on,[195] as well as "psycho-existential symptoms" (helplessness, futility, alienation, anxiety, isolation) which may be equally refractory.[196] As Downie reminds "the

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[190] Bert Broeckhart, "Palliative Sedation, Physician-Assisted Suicide, and Euthanasia: 'Same, Same but Different?'" (2011) 11 *American J Bioethics* 62 at 63.

[191] See eg Margaret Battin, "Terminal Sedation: Pulling the Sheet over Our Eyes" (2008) 38 *Hastings Center Report* 27.

[192] Broeckhart, above n 190, at 64. The patient may also die where there has been a withdrawal of artificial nutrition and hydration (AN&H). The decision to implement palliative sedation is and should be separate from the determination about forgoing AN &H: Henk ten Have, "Palliative Sedation Versus Euthanasia: An Ethical Assessment" (2014) 47 *J Pain & Symptom Management* 123 at 131-132. Palliative sedation with cessation of AN&H is, argue some, more problematic and closer to euthanasia and thus may require stricter regulation akin to controls over VE: Soren Holm, "Terminal sedation and euthanasia: the virtue in calling a spade what it is" in Sigrid Sterckx et al (eds), *Continuous Sedation at the End of Life: Ethical, Clinical and Legal Perspectives* (Cambridge University Press, Cambridge, 2013), ch 14.

[193] Above n 193, at 62. See also Hahn who states: "The 'slow euthanasia' belief is refuted because there is no conclusive evidence that PS has life shortening effects." Michael P Hahn, "Review of Palliative Sedation and Its Distinction From Euthanasia and Lethal Injection" (2012) 26 *J Pain & Palliative Care* 30 at 33.

[194] ten Have, above n 192, at 124.

[195] Prof McLean, above n 157 at 46 (quoting CK Cassel, "Physician assisted suicide: progress or peril?" in D Thomasma and T Kushnet (eds), *Birth to death: science and bioethics* (Cambridge University Press, 1996) 218 at 218).

[196] Patrici Claasens et al, "Palliative Sedation: A review of the research literature" (2008) 36 *J Pain & Symptom Management* 310 at 311.

alleviation of physical pain is not necessarily congruent with the alleviation of suffering."[197] Interestingly, however, there is research on the actual experience of those nearing the end of life indicating that fears of dying tend to dissipate when terminally-ill patients receive good hospice or palliative care.[198] A holistic approach is thus called for, animated by the philosophy "that the care of patients with incurable illness could not be provided appropriately unless the therapeutic strategy included attention to the physical, psychological, social and spiritual domains of care."[199]

There is a concern that if VE and DAS were to be legalised the provision of palliative care might be reduced. Chambaere et al in a study of seven European countries found this *not* to be so, but add the warning that it has been only a short period since VE or DAS have been introduced—10 years—and that "trends for complex social issues such as this one may only become apparent after a longer period."[200]

G *Public support is not dispositive*

Opinion polls around the globe, or at least in liberal democracies, have usually been in favour of VE,[201] and New Zealand is no exception. The two most recent surveys asked whether euthanasia ought to be legalised. Of the 1000 respondents, 75 and 71 per cent said "yes", 21 and 24 per cent "no" and 5 per cent were undecided.[202] Public opinion polls have to be treated with caution.[203] First, the way the question is worded can be crucial. Were the respondents asked about the turning off machines linked up to persons in an irreversible coma? This is withdrawal of futile and burdensome treatment, not euthanasia. As one Quebec study concluded: "There are methodological problems in the wording of survey questions that can bias responses, and the validity of responses may be compromised by pervasive misunderstandings of what euthanasia means. [204]

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[197] *Dying Justice: A Case for Decriminalizing Euthanasia and Assisted Suicide in Canada* (University of Toronto Press, Toronto, 2004) at 104.

[198] Robert Kastenbaum, *The Psychology of Death* (3rd ed, Springer, New York, 2006); Mishara and Weistubb, above n 51, at 433.

[199] Caraceni et al, above n 186, at 391.

[200] Above n 97, at 19.

[201] See eg Joachim Cohen et al, "Public acceptance of euthanasia in Europe: a survey study in 47 countries" (2013) *International Journal of Public Health* (online version 5 April 2013); DOI 10.1007/s00038-013-0461-6

[202] "Two polls strongly support euthanasia", *Your NZ*, 27 July 2015 <http://yournz.org/2015/07/27/two-polls-strongly-support-euthanasia/>

[203] Keown, above n 46, at 113-4.

[204] Isabelle Marcoux, Brian L Mishara and Claire Durand, "Confusion between euthanasia and other-end-of-life decisions: Influences on public opinion poll results" (2007) 98 *Canadian J Public Health* 235.

Second, were the respondents presented with the alternative of well-resourced and accessible or free hospice care placed alongside VE or DAS in the questionnaire? A survey by Nicola Rae et al found that 82 per cent of the 677 respondents (a response rate of 17 per cent) said that some form of physician-assisted dying should be legal in New Zealand, but the authors add: "The response options for this questionnaire did not include palliative care treatments designed to assist patients to cope with the physical symptoms and emotional distress caused by serious illness. Therefore, it is possible that adding specific palliative options to address a wider range of patient needs may have impacted the end results."[205]

Nonetheless, when VE and withdrawal of treatment were distinguished by separate carefully-worded questions, the support for euthanasia was still high (69.6 per cent in favour of euthanasia compared to 85.8 per cent supporting treatment withdrawal). To their credit, the wording in many NZ surveys strives to delineate what kind of end-of-life action is at issue and to distinguish euthanasia from its cousins.

The larger point is that majority desire *alone* is not the touchstone of public policy. If the majority of citizens wanted to bring back the stocks or duelling that ought not to win the day. It is not unfair to note that there is a degree of "media priming" at work in the euthanasia controversy,[206] as there is in many other controversies (smacking of children, smoking, climate change and so on). The issue, in reality, is a minority one and the actual use of euthanasia affects only a tiny percentage of people, even in those nations that have legalised it. Despite this, euthanasia is promoted as if it was a matter of great importance and a policy priority.[207] It is not, and there is no urgency for Parliament to resolve the debate by legislative action.

H *To deny euthanasia is not to lack compassion*

It is often said that we put to sleep dogs and cats when they are suffering, why not our tortured, cancer-ridden mother? This is a valid argument—but only if you want to treat people the same way we treat animals. Our animals do not have human consciousness in the sense of understanding their own morality or passage of life.[208] They do not rationalise (or least we cannot ascertain whether this be so) their suffering as humans do. Rather, we have a responsibility for them, one that is entirely one-way in that our pets bear no reciprocal responsibility for us, or our feelings. The analogy

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[205] Nicola Rae, Malcolm Johnson and Phillipa Malpas, "New Zealanders' Attitudes toward Physician-Assisted Dying" (2015) 18 *J Palliative Med* 259 at 263.

[206] Megan-Jane Johnstone "Media manipulation and the euthanasia debate" (2014) 27 *Aust Nursing & Midwifery J* 32s.

[207] Ibid.

[208] Pilcher, above n 119, at 101.

between animals and human is worth developing for it does not advance the cause of VE. It is not just the loved family pets that are "put down", but those which are abandoned, unwanted or simply a nuisance. Pilcher continues:[209]

> The idea that the transfer of the system we apply to dogs would lead only to compassionate euthanasia of humans is absurd. The logical extension is that we would simply be killing off those who had become a burden we couldn't afford, or who were simply soiling the furniture.

Is not the more compassionate and caring approach to alleviate pain and suffering? The rise of palliative care and the hospice movement are compassion writ large.

I *The economic incentive for VE*

A large amount of Vote Health is spent on healthcare for the dying, demented and elderly.[210] Fewer of society's scarce resources might be consumed if a carefully crafted euthanasia regime were to be introduced. This harsh argument from economics is seldom if ever heard issuing from the lips of advocates for VE or DAS, but, as Keown suggests, it is arguably "the elephant in the room" in the debate.[211] To supporters of VE this concern might (to change metaphors) be labelled a red herring. Be that as it may, it is not unrealistic to suppose that some charged with managing the public purse might entertain the thought that "End of life care is expensive and having citizens opt for an earlier death is associated with substantial government savings."[212] Another smaller-sized "elephant" is the increasing demand for human organs suitable for transplants.[213] Macabre and distasteful as this thought might be, organ donation euthanasia facilitates the efficient supply of these commodities.[214]

J *The onus of proof, and what counts as evidence*

Euthanasia advocates have often skilfully and tactically reversed the usual onus of proving that a

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[209] Ibid at 102.

[210] Spending on long-term care constitutes approximately one-fifth of Vote Health's $15.1 billion for the 2014-2015 financial year: The Treasury, http://www.treasury.govt.nz/government/expenditure/health; and NZ Treasury, *Long-term Care and Fiscal Sustainability* (November 2012) at 3.

[211] Keown, above n 46, at 138.

[212] Mishara and Weisstubb, above n 51, at 434.

[213] Hannah Graham and Jeremy Prichard, Voluntary Euthanasia and "Assisted Dying" in Tasmania: A Response to Giddings and McKim (2013) at 20: http://www.bestcare.com.au/documents/reports/Voluntary-Euthanasia-and-Assisted-Dying-in-Tasmania-A-Response-to-Giddings-and-McKim-Oct2013.pdf

[214] Dominic Wilkinson and Julian Savulescu, "Should We Allow Organ Donation Euthanasia? Alternatives for Maximising the Number and Quality of Organs for Transplantation" (2012) 26 *Bioethics* 32.

change in the law is warranted. Roger Scruton refers to what he calls the "onus-shifting argument", whereby it is up to the cautious pessimist to prove that the customs, traditions and precedents deserve to remain intact:[215]

> Deprive common sense and custom of their authority and <u>you can prove anything or nothing, depending on your starting point</u>. Ronald Dworkin told us that it is for the opponent of abortion "rights" to show that the damage done by permitting them exceeds the damage to the mental health of women that comes from forbidding them. And of course no such thing could be *proved* in advance…

The legal strategy is to frame the claim for VE or DAS as an infringement of one's rights under the relevant rights law, thereby casting the burden of justifying the prima facie violation of one's right upon the state. However, notwithstanding upon whom the onus of proof rests as a *litigation* matter, in terms of *public policy* and legislative change, the onus is squarely upon the advocates of VE and DAS to make their case.

Turning to what counts as evidence, in *Nicklinson,* the applicants contended that their asserted rights to assisted dying[216]

> should not be sacrificed for a merely *speculative* concern about another class of persons. They say that the harmful effect that liberalising the law on assisting suicide may have on vulnerable and weak people is no more than *speculative*, because no evidence has been adduced to suggest otherwise, and because in jurisdictions where assisted suicide is permitted, there do not seem to have been any undesirable consequences for the weak and vulnerable.

Lord Kerr agreed with the applicants that[217]

> In so far as the evidence goes, it conspicuously fails to support the proposition that permitting assisted suicide will increase pressure on the vulnerable and the elderly. *Ruminations* that this may be the consequence of a more nuanced provision cannot be a substitute for evidence or, at least, some rational basis on which the two circumstances may be found to be connected.

However, as Lord Mance replied: "Whatever else may be said about the evidential position, it is not in my opinion sustainable to suggest that there is no evidence and to describe as ruminations a conclusion that permitting assisted suicide in the case of persons in [the applicants'] position would pose a relevant risk to vulnerable people."[218] Lord Neuberger explained:[219]

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[215] *The Uses of Pessimism and the Danger of False Hope* (Atlantic Books, London, 2010) at 168-9 (italics in original; underlining mine).

[216] Above n 6, at [87](italics added).

[217] Above n 6, at [351](italics added).

[218] Above n 6, at [183].

> *negative evidence is often hard to obtain*, there is only a limited scope for information given the few jurisdictions where assisted suicide is lawful and the short time for which it has been lawful there, and different countries may have different potential problems. In other words, the evidence on that point plainly falls some way short of establishing that there is no risk. The most that can be said is that the Falconer commission and the Canadian panels could find no evidence of abuse. . . . while the factual evidence in this connection is sparse, anecdotal, and inconclusive, the expert experienced and professional opinion evidence does provide support for the existence of the risk. In all the circumstances, this concern cannot, in my opinion, possibly be rejected as *fanciful or unrealistic*.

IV Conclusion

Voluntary euthanasia and physician-assisted suicide is a complex and challenging subject. Both the advocates and opponents of euthanasia are sincere and committed to what they see as the most humane and prudent policy for society.

The arguments in favour of legalising VE and DAS initially appear convincing. We should respect people's personal autonomy and free choice, euthanasia is a compassionate response to unbearable suffering, it has (supposedly) worked well in those nations that have implemented it, and so on. But on closer analysis the arguments are, in my view, far less persuasive. There is a genuine concern that any VE law—even one carefully drafted with requisite safeguards—is susceptible to noncompliance and vulnerable to abuse. "It would not be beyond the wit of a legal system", observed Baroness Hale, "to devise a process for identifying those people, those few people, who should be allowed to end their own lives."[220] I do not doubt that Ms Maryan Street's and Mr David Seymour's End of Life Choice Bills are genuine attempts to design just such an operationally safe euthanasia regime, but they have their weaknesses. These are not so much inherent problems in the operation of the statute (fuzzy definitions, unwieldy and protracted vetting procedures, second opinions by self-selecting professionals predisposed to VE, practicalities of monitoring compliance etc) but the very environment or "moral ecology"[221] in which any law would have to function. Any VE or DAS law would face the ineradicable reality of self-imposed pressure and diffuse external social pressure. Baroness Hale believed that "were there such a [carefully crafted statutory] procedure, it would appear to me to be more than sufficient to protect those vulnerable people whom the present universal prohibition is designed to protect."[222] But, in my opinion, such optimism is misplaced.

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[219] Above n 6, at [88] (italics added).

[220] *Nicklinson*, above n 6, at [314]. The Baroness then set out four essential requirements for such a procedure: ibid.

[221] See Robert George, *Making Men Moral* (Clarendon Press, Oxford, 1993) at 44-47.

[222] *Nicklinson*, above n 6, at [316].

The terminally ill and distressed will inevitably feel that euthanasia is “the right thing to do”. They will not want to be a burden to their family and friends, nor to society as a whole. With the option of an efficient and painless exit route, the terminally ill will be put in the invidious position of having to justify—both to themselves and to others—why they should not avail themselves of this state-approved option.

> The real question . . . is how much risk to the vulnerable we are prepared to accept in this area in order to facilitate suicide by the invulnerable.[223]

Voluntary euthanasia has the allure of being an enlightened and compassionate response to the plight of the suffering. But it is doubly unnecessary for (a) suicide is a realistic and socially safer course (for it involves no one else) for all but a tiny number, and (b) comprehensive palliative care is accessible for those who prefer not to end their lives but, instead, seek holistic support in their final phase of existence. Furthermore, the practical operation of VE and DAS is fraught with ineradicable risks and there are slippery slopes that are, indeed, slippery.

Yet perhaps the most ominous change is one that neither I, nor anyone, can prove will occur. There will, I venture, be an irreversible alteration to the way society and the medical professional view the demise of the elderly, the disabled, the incurably afflicted and the terminally ill. Death will be planned, coordinated and state-sanctioned in manner hitherto unknown. The era of therapeutic killing will have arrived.

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[223] Lord Sumption in *Nicklinson*, above n 6, at [368].