

# Litigating for the right to die

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Modern medicine can extend life to an extent that a patient dying of a terminal illness may feel trapped. Suffering can become unbearable. Some patients want to obtain medication from their doctor that they could ingest to achieve a peaceful death, an option known as aid in dying.

However, a lack of clarity in New Zealand law presents an obstacle to dying patients who wish to obtain such assistance in this country. Under the Crimes Act 1961, s 179:

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.

A doctor who respects a competent, terminally ill patient's right to make end of life choices and provides aid in dying thus risks prosecution and conviction if the patient's act to achieve a peaceful death is considered "suicide" (see, for example *R v Mott* [2012] NZHC 2366; *R v Davison* [2011] NZHC 1677). The lack of clarity in the law creates an uncertain legal environment making it very difficult for competent, terminally ill persons to die as they prefer: peacefully, on their own terms, with help from a medical professional, avoiding the final cruel bit of suffering caused by their illness.

A significant majority of New Zealanders support empowering patients suffering from terminal illnesses or unbearable pain to have access to aid in dying, with polls ranging from 60–82% approval. Reports of such strong public support for this compassionate option have been consistent for some fifteen years.

Unfortunately, public support for providing a clear legal path for patients wishing to access aid in dying has not translated into parliamentary action. On two occasions, in 1995 and 2003, members' bills designed to permit "Death With Dignity" were defeated on their first readings. More recently, the Labour MP Ian Lees-Galloway was pressured into withdrawing the End of Life Choice Bill from the members' ballot. And while Prime Minister John Key has expressed his personal support for permitting aid in dying, there appear to be no government moves to introduce legislation permitting it.

The result is that there are no legislative vehicles currently available to deliver New Zealanders the legal clarity they appear to want. It is in this vacuum that Lecretia Seales, a woman suffering from a terminal form of brain cancer, has asked the High Court for a declaratory judgment to the effect that it is not an offence under s 179 for a doctor to provide her with aid in dying (*Seales v Attorney General* [2015] NZHC 828).

While the authors have provided Ms Seales' counsel with some general advice, we have not seen the pleadings in her case. As such, we do not know precisely how the matter has been presented to the Court. Our purpose in this article is to review how such cases have been litigated in the United States, before outlining how a similar approach may be argued in New Zealand.

## AID IN DYING IN THE UNITED STATES

There is, as yet, no constitutionally recognised "right to die" in the United States under its Constitution. When invited to find that liberty and equality guaranteed by the Fourteenth Amendment to the Constitution protects the right of an individual to choose aid in dying, the Supreme Court of the United States declined to find a federal constitutional right at the time. However, it carefully reserved the possibility it might do so in future and invited the "laboratory of the States" to grapple with the issue in the meantime (*Vacco v Quill* 521 US 793, 797–99 (1997); *Washington v Glucksberg* 521 US 702, 707–09 (1997)). The benefit of such an approach in a nation comprised of fifty states is that one or more states can address the matter while the others can watch and learn from their experience.

The "laboratory" opened in Oregon shortly after the Supreme Court's decision, with implementation of Oregon's voter approved Death with Dignity Act, which permits aid in dying. Oregon law requires doctors providing aid in dying to collect and report a vast amount of data about the patients who request it to the Oregon Health Authority, which publishes an annual statistical report presenting this information. This substantial body of data allows us to evaluate the impact of an open practice of aid in dying upon both patients and medical practice.

Concerns about whether an open practice of aid in dying would harm patients, vulnerable populations, or the delivery of medical care to dying patients – the main reason for the opposition to a "right to die" before the United States Supreme Court – have been put to rest by the experience in Oregon, and more recently a number of other states. Despite the speculation and conjecture of those opposed to aid in dying, none of the dire predictions of harm raised by opponents have been realised.

Indeed, the passage of the Death with Dignity Act led to a greater effort by physicians and hospice care professionals to ensure adequate pain and symptom management (Schneiderman "Physician-Assisted Dying" (2005) 293 J Am Med Assn 501). Once aid in dying becomes openly available, experience shows that physicians work harder to improve end-of-life care, improve their knowledge of pain and symptom management, and their ability to recognise depression and other psychiatric disorders. Referrals to hospice care increase and are often made earlier in the course of the patient's illness.

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Since Oregon's initial move, Washington and Vermont have joined it in enacting legislation that permits aid in dying; the "laboratory of the States" has served its intended purpose.

### EXPANDING END OF LIFE CHOICE THROUGH U.S. COURTS

In the United States, the Federal Constitution sets a floor for the rights of citizens; the states may choose to confer more protections to citizens within their borders through state constitutions. Many states have done so. This opens another avenue for advocates seeking to expand end of life choice: litigation in state courts, typically raising both statutory and state constitutional claims.

Montana provided the first success for this strategy. Robert Baxter, a seventy-five year-old former U.S. Marine dying of lymphocytic leukemia, and a number of doctors sued the State of Montana to establish the right of a competent, terminally ill citizen to choose aid in dying (*Baxter v. State* 224 P3d 1211 (Mont 2009)). The challenge was run on two grounds. First, this choice is worthy of protection under the Montana State Constitution's explicit guarantees of privacy and dignity (this was the basis of a lower court ruling in the plaintiff's favour). Alternatively, doctors who provide aid in dying could not be subject to prosecution, because the patient seeking aid in dying would have consented to the conduct that resulted in death and such a death would not conflict with public policy. In other words, physicians were not within reach of the state's criminal prohibition of aiding another person to precipitate their death.

The Montana Supreme Court declined to decide the constitutional issues, choosing to resolve the case on the alternative, statutory ground. It held that Montana's statute empowering citizens with the ability to direct medical care through an advance directive reflects the policy of the state to vest patients with broad autonomy over medical decision making. Since the state had expressed such policy, a decision of a competent patient for aid in dying was not against public policy, and thus the "consent" of the patient to the doctor's provision of aid in dying precluded prosecution (*Baxter* at 1215).

Under this ruling, doctors may provide aid in dying to mentally competent, terminally ill patients without fear of prosecution. Montana doctors are not subject to the statutory frameworks established in states with legislation governing the practice. However, the Montana Supreme Court recognised certain boundaries which are similar to some of the statutory limits in states with permissive legislation: the patient must be terminally ill, mentally competent, and the doctor is limited to providing a prescription for medication which a patient may ingest to achieve a peaceful death (*Baxter* at 1217). In Montana, beyond the bounds set by *Baxter*, the practice of aid in dying is developing subject to the medical profession's own best practices. This is as it should be: medicine is not commonly governed by statute, but rather by evolving practices which physicians refine as they learn from treating patients. The "best practices" become adopted by practicing physicians. This evolution of best practices is an organic process, quite different from the rigid structure of a statutory scheme.

Following the success in Montana, similar cases were brought in New Mexico (*Morris v New Mexico* No D-202-CV 2012-02909 slip op (NM Dist Ct Jan 13, 2014) (appeal argued 1/26/15)), New York (*Myers et al v Schneiderman et*

*al* Supreme Court of the State of New York, County of New York No 151162/15 (filed 2/4/15)), and California (*Brody et al v Harris et al*, Superior Court of the State of California City and County of San Francisco No CGC-15-544086 (filed 2/11/15)) raising statutory and state constitutional claims to establish access to aid in dying. The focus of this article is on the statutory scope argument, as that sort of claim could open access to aid in dying in New Zealand, as discussed below. The cases are brought by terminally ill patients with cancer, motor neuron disease and AIDS, and doctors who provide care to patients with such conditions.

These cases assert that decades old (New Mexico's law is 50 years old, California's 140 years old and New York's more than 200 years old) legislative enactments criminalising "assisting suicide" say nothing in the text or legislative history about a doctor providing care to dying patients seeking a peaceful death, and so do not reach the conduct of a doctor providing aid in dying. Indeed, when these statutes were enacted medicine was not as advanced as it is today. Death typically came swiftly; where an extremely protracted dying process once was rare, now it is common (see A Gawande *Being Mortal: Medicine and What Matters in the End* (Metropolitan Books, New York, 2014)).

The plaintiffs in these cases accept that the challenged statutes have a proper application and scope; for example, to prohibit someone from handing a lovesick teenager a gun when the teen, distraught over the ending of a romantic relationship, declares life is no longer worth living (this fact pattern was presented in *People v. Duffy* 79 NY 2d 611 (1992)). However, the plaintiffs argue that the choice by a dying patient of a peaceful death is fundamentally and starkly different from such situations, urging the courts to recognise as much and hold that should the state desire to outlaw this choice it must do so with more specific language. This has been done in a number of states, including, for example, Arkansas (Ark Code Ann, s 5-10-106 (making illegal the act of a "physician ... wilfully prescribing any drug, compound, or substance for the express purpose of assisting a patient to intentionally end the patient's life")).

In these cases, plaintiffs are aided by the fact that mental health professionals, including the national and some state psychological associations, have recognised that suicide and aid in dying are fundamentally different and ought not to be conflated. For example, the New Mexico Psychological Association filed an amicus brief in *Morris*, discussing the critical difference between suicide and aid in dying and urging the court to find that the New Mexico statute prohibiting assisting suicide does not reach the conduct of a physician providing aid in dying. This brief cites a statement adopted by the American Psychological Association (Brief of Amicus Curiae Coalition of Mental Health Professionals at 17, *Gonzales v Oregon*, 126 S Ct 904 (2006) (No 04-623):

It is important to remember that the reasoning on which a terminally ill person (whose judgments are not impaired by mental disorders) bases a decision to end his or her life is *fundamentally different* from the reasoning a clinically depressed person uses to justify suicide.

### ARGUING THE MATTER IN THE NEW ZEALAND COURTS

Ms Seales' application for a declaratory judgment makes much the same statutory scope argument that has been advanced in the United States. Her case turns upon the

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proper understanding of the Crimes Act 1961, s 179. It states that anyone who “incites, counsels, or procures any person to commit suicide”, or “aids or abets any person in the commission of suicide”, commits a criminal offence. Whether those provisions cover the case of a doctor who supplies Ms Seales with aid in dying is the question. This is a matter of statutory interpretation. Key to that process is the New Zealand Bill of Rights Act 1990 (NZBORA), s 6:

Wherever an enactment can be given a meaning that is consistent with the rights and freedoms contained in this Bill of Rights, that meaning shall be preferred to any other meaning.

To simplify, s 6 requires a two-step approach (*R v Hansen* [2007] NZSC 7; Paul Rishworth “Human Rights” [2012] NZ L Rev 321 at 330–331). First, does an “ordinary” or “plain meaning” interpretation of s 179 that criminalises the conduct of a doctor who assists a competent, terminally ill patient to achieve a peaceful death via aid in dying unjustifiably limit any of the rights and freedoms contained in the NZBORA? If so, can the word “suicide” in s 179 be given an *alternative* meaning that is consistent with the NZBORA?

We need not spend too much time on the first point, as a recent unanimous decision of the Supreme Court of Canada, *Carter v Canada (Attorney General)* [2015] SCC 5, provides extremely strong persuasive authority that it does so. It found that (at [57]):

The right to life is engaged where the law or state action imposes death or an increased risk of death on a person, either directly or indirectly. Here, the prohibition deprives some individuals of life, as it has the effect of forcing some individuals 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.

Consequently, the Canadian criminal law’s blanket prohibition on aiding suicide (which the parties in *Carter* assumed, for the purposes of the case, reached the act of doctor providing aid in dying) limits an individual’s right to life guaranteed under the Canadian Charter of Rights and Freedoms, s 7.

Furthermore, the Supreme Court found that this limit is not consistent with the s 7 requirement that a person only may be deprived of their right to life in ways that are “consistent with the principles of fundamental justice”. A ban on aid in dying imposes a limit that is overly broad (*Carter* at [86]):

... the limitation on ... rights is in at least some cases not connected to the objective of protecting *vulnerable* persons. The blanket prohibition sweeps conduct into its ambit that is unrelated to the law’s objective.

In reaching this conclusion, the Supreme Court cited the extensive evidence reviewed by the trial court from jurisdictions around the world which permit physician assisted dying (*Carter* at [104]). In particular, drawing on the significant body of empirical data that has emerged from the Oregon “state laboratory”, the trial court found that when assisted dying is available there is no evidence of harm to patients or to vulnerable populations (*Carter* at [25]).

Consequently, the Supreme Court found that Canada’s effective prohibition on aid in dying breaches the Canadian Charter, rendering the law invalid to the extent it prohibits a doctor providing a means of a peaceful death to a competent adult who (at [127]):

(1) clearly consents to the termination of life and (2) has a grievous and irremediable medical condition (including an illness, disease, or disability) that causes enduring physical or psychological suffering that is intolerable to the individual in the circumstances of his or her condition.

It then stayed this finding for twelve months to permit the federal Parliament to enact reasonable safeguards, should it opt to do so.

Although the Canadian Charter’s “supreme law” status ultimately was rejected in New Zealand, it still provides the model for our NZBORA. Unsurprisingly, therefore, s 8 of the NZBORA guarantees each individual’s right to life in terms virtually identical to the Canadian Charter. Furthermore, as Ms Seales’ husband notes, the same issue of premature death arises here in New Zealand (<[www.lecretia.org/on-suicide/](http://www.lecretia.org/on-suicide/)>):

What Lecretia faces are the horns of a dilemma: kill herself now and rob herself, me and her family of precious moments together, or risk waiting until death takes her, which could be weeks or months of needless, potentially agonising suffering.

### THE MEANING OF “SUICIDE”

Consequently, it seems almost certain that a New Zealand court, considering the *Carter v Canada* precedent, would find that a reading of s 179 that prevents Ms Seales access to aid in dying is inconsistent with the NZBORA (see also *Stransham-Ford v Minister of Justice And Correctional Services and Others* (27401/15) [2015] ZAGPPHC 230). That leads to the second required step under s 6: is the word “suicide” in s 179 able to be given an alternative meaning that is consistent with the NZBORA? For where such a meaning *can* be given, then the Court *shall* prefer it.

This alternative meaning would distinguish between the sorts of intentional self-inflicted deaths we ordinarily think of as being “suicide” (the lovesick teen, the family breadwinner facing financial crisis, and so forth) and the act of a competent, terminally ill person who is seeking (as in Ms Seales’ case) to choose a more peaceful death when brought to death’s door by the advance of disease and enduring unbearable suffering. Are these scenarios distinguishable from each other, and can that distinction be given effect under the specific wording of the Crimes Act?

Here the evidence proffered in the United States context seems very relevant. The fact that mental health professionals, including state psychological associations, have recognised that suicide and aid in dying are fundamentally different and ought not be conflated should make us realise that focusing on the similar *outcome* when considering whether a competent, terminally ill patient who acts to precipitate a peaceful death is committing “suicide” is to completely misunderstand what is going on. They are two quite different phenomena, undertaken for different reasons and under different circumstances.

That leads to the next issue. Even if terminally ill patients choosing a more peaceful death are engaging in an act that is different in nature to what we ordinarily consider to be suicide, *can* the word “suicide” in the Crimes Act be read in a way that excludes them?

We may start by asking why exactly Parliament made it a crime to incite, procure, counsel, aid or abet “suicide”. Originally, it was because taking one’s own life itself was viewed as an unforgivable sin — up until 1961 it was a crime

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in itself to attempt suicide — and so facilitating anyone to do so was just as unforgivable. However, societal views have since shifted, in that we no longer regard trying to deliberately end your own life as being so morally abhorrent that it is of itself deserving of criminal sanction.

Consequently, criminalising actions that contribute to another's suicide now must reflect a desire to protect those who are deeply vulnerable and so prone to take a deeply misguided action that cannot then be undone (see *Carter v Canada* at [29]). If you do something to facilitate such a self-inflicted death, then you are committing a wrong that the State should sanction you for because you have contributed to another's irretrievable action that no properly thinking person would want to undertake.

But, of course, those wishing to access aid in dying are not vulnerable in this way. Choosing to suffer less before death arrives can be an entirely rational response to a horrific situation that cannot be remedied. No matter how fervently they may wish to live, their illness has robbed them of that option. The only question is how much suffering will be endured before death arrives. Suffering can be multifactorial, and indeed the experience in jurisdictions where aid in dying is openly available demonstrates this: those who choose aid in dying typically express that they do so because of the cumulative burden their illness imposes. These burdens may include: loss of ability to engage in activities which give life joy and meaning; progressive and inexorable loss of bodily function and integrity; increasing dependence on others for all personal care needs; pain that cannot be relieved; extreme fatigue; severe nausea and vomiting; acute shortness of breath and sensation of suffocation; open wounds with foul-smelling discharge.

Choosing a less brutal death ought not to be considered suicide. Indeed, acting to precipitate impending death and avoid further suffering may be a kind of preservation of the self, a way to allow the last bit of life to involve an exercise of autonomy, which for some is crucially important to their sense of self, and coherent with the life lived. As Ronald Dworkin eloquently states (*Life's Dominion* (Knopf, New York, 1993) at 199):

We live our whole lives in the shadow of death, we die in the shadow of our whole lives. ... [W]e worry about the effect of life's last stage on the character of life as a whole, as we might worry about the effect of a play's last scene or a poem's last stanza on the entire creative work.

Therefore, interpreting "suicide" in s 179 as excluding the act of competent, terminally ill patients, like Ms Seales, who wish to achieve a peaceful death when disease has brought them to death's door, is consistent with Parliament's purpose of preventing individuals from intentionally cutting short an otherwise viable life. Furthermore, a reading of "suicide" that excludes Ms Seales' situation *better* fits the rest of the Crimes Act 1961 than does one that encompasses it. Consider s 41:

Every one is justified in using such force as may be reasonably necessary in order to prevent the commission of suicide ... or in order to prevent any act being done which he or she believes, on reasonable grounds, would, if committed, amount to suicide or to any such offence.

Imagine that someone like Ms Seales were to publicly announce that in light of the advance of incurable brain cancer she is going to ingest medication at a particular time, on a particu-

lar day, in her bed at home while surrounded by her loved ones, in order to achieve a peaceful death and avoid further horrific suffering. Should everyone in New Zealand then be permitted to "us[e] such force as may reasonably be necessary" to stop her from doing so? If her choice were to be deemed "suicide" under the Crimes Act, then apparently they can.

Or, consider s 180, which criminalises "suicide pacts". Imagine a situation where a couple both find themselves facing some terminal condition and decide that, rather than drift slowly to the end of their diseases, they wish to end their time together while they can recognise and appreciate each other. So they lie down on a bed together with their favourite music playing and each take an assumedly fatal dose of drugs — but it fails to end the life of one of them.

Should the survivor be considered guilty of a criminal offence under s 180(2), such that he or she could be imprisoned for up to five years? If you treat the couple's joint choice as being a "suicide" under the Crimes Act, then he or she is.

**A REASONABLE ALTERNATIVE MEANING?**

In the context of the Crimes Act, an alternative meaning for "suicide" that does not encompass those in Ms Seales' situation, more effectively fits the text and purpose of the legislation (Interpretation Act 1999, s 5(1)). Would a court then be prepared to adopt it? They already have been called on to consider what kinds of intentional taking of one's own life constitute a suicide. In the case of *Chief Executive of Department of Corrections v All Means All* [2014] NZHC 1433, the High Court was asked whether prison officials and health authorities had any legal power to force-feed a prisoner who was threatening to starve himself to death as a form of protest. Justice Pankhurst found they did not, as the prisoner's decision to (potentially) end his own life should not be equated with suicide (at [44], emphasis added):

His intention is to bring pressure to bear on the person who he believes is guilty of misconduct. Death is an unwanted end result of the means Mr All Means All has adopted, *but it is certainly not his desire, nor his intention.*

Accordingly, the High Court already has recognised that not all cases of conduct that result in one's own death are to be treated as "suicide". It also distinguished Mr All Means All's decision to (potentially) end his life on grounds similar to those argued by individuals seeking aid in dying. They, too, do not "desire" or "intend" death *qua* death; given the choice between a pill that cures them of their terminal condition or aid in dying, the former is what they really want. However, their imminent death is a fact that they now cannot avoid, leaving them with only the possibility of some element of control over the circumstances in which that inescapable event takes place. Their intention is not *to* die, but to control *how* they die.

Furthermore, the Courts have performed similar interpretative moves in other legislative contexts. In the case of *Re AMM & KJO* [2010] NZHC 977, the High Court accepted that the word "spouse" in the Adoption Act 1955 could be read to include "an unmarried couple in a long term de facto relationship". Even though the Parliament that enacted the legislation clearly would not have intended the word to cover such persons, the Court was prepared to adopt a NZBORA consistent interpretation because (at [50]):

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Although not the meaning that was intended at the time of enactment, it is a meaning that is consistent with the purposes of the Act, is not a strained meaning of "spouse", and is workable within the other parts of the Act. It will have quite limited consequences beyond the area of adoption.

Change the word "spouse" to "suicide" and the word "adoption" to "aid in dying" and it seems entirely reasonable for a court to reach the same conclusion in Ms Seales' case.

One last hurdle remains, however. Under New Zealand law, a court's decision whether to grant the declaration is purely discretionary (Declaratory Judgments Act 1908, s 10). Courts have been reluctant to grant such declarations as to whether or not certain conduct amounts (or will amount) to the commission of a criminal offence (see *Imperial Tobacco v Attorney-General* [1981] AC 718 (HL); *Ambrose v Attorney-General* HC AK CIV 2011-404-7392 23, November 2011). Doing so, the courts fear, "risks usurping the function of the criminal court (including the function of a Judge or a jury to find the facts)" (*Ambrose* at [36]).

However, this reluctance is not the same as a jurisdictional bar (*Auckland Area Health Board v Attorney-General* [1993] 1 NZLR 235 (HC); *R v Sloan* [1990] 1 NZLR 474 (HC)). The courts have, on occasion, given such declarations as to the legal rights and duties of individuals under criminal statutes where there is no factual dispute at issue. In particular, the courts have been quite prepared to make declarations regarding the legal responsibility of health providers to provide treatment (see, for example *Hutt District Health Board v B* [2011] NZFLR 873; *All Means All* at [70]–[71]). There

seems no reason, therefore, that a court should not make a declaration as to whether a doctor who provides Ms Seales, or another mentally competent terminally ill patient, with the means of precipitating a peaceful death (if she so chooses) runs afoul of s 179.

#### **WHO SHOULD DECIDE?**

There are those who will argue, no doubt, that this is no place for the courts and that it should be left to Parliament to address matters in this arena.

Two points may be made about this claim. First of all, this *is* the courts' business in that Parliament has specifically given it the task of interpreting and applying laws in ways that are consistent with the individual rights under the NZBORA. Using that interpretative power to clarify the scope of the challenged law is a perfectly respectable judicial function, authorised by Parliament; indeed it is a quintessential *judicial* duty and responsibility.

Second, a declaration that s 179 of the Crimes Act does not cover aid in dying does not necessarily end the matter. If Parliament really thinks that aid in dying ought to be a crime, then it can respond by amending the Crimes Act to make it clear that a doctor providing aid in dying is a criminal. Of course, were it to do so, Parliament would be doing something in conflict with the views of the great majority of New Zealanders. But if it really wants to do it, it can.

Consequently, we believe that there is a very strong case for recognising that existing law does not reach the conduct of a physician providing a mentally competent terminally ill patient in New Zealand with means to achieve a peaceful death. We hope for Ms Seales' sake, and that of others who find themselves in her position, that we are correct. Now we wait to see if Collins J agrees with us in the High Court. □