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STOPPING SUICIDE AFTER *SEALES*

COLIN GAVAGHAN*

Suicide occupies an anomalous position in New Zealand law. Although it is not a crime to attempt suicide, the provision of assistance in such an attempt remains an offence. Furthermore, s 41 of the Crimes Act allows for the use of force to prevent another's suicide.

The case brought by Lecretia Seales in 2015 focused on the legal status of assisting suicide. During the course of those proceedings, however, attention turned to the defence under s 41. In this article, I consider the approach taken in Seales towards that provision. I will argue that the wide scope accorded to that defence by Collins J is not the only manner in which that section could be interpreted, and argue in favour of an alternative, more restricted, interpretation.

I. INTRODUCTION

The law around end of life decisions in New Zealand comprises a complex and uneven tapestry of legislative provisions and court decisions, involving both civil and criminal law. The ad hoc development of these provisions often makes it difficult to find consistency between them, and courts charged with ruling on one of those aspects must keep one wary eye on the potential impact on others.

It was against this trying background that, in May of last year, the High Court was charged with ruling on certain criminal provisions relating to 'aid in dying'.[1] The litigation brought by Lecretia Seales constituted the first challenge to the legal status of 'aid in dying' in New Zealand.[2] The decision by Collins J to reject all of the plaintiff's legal submissions (he did recognise certain factual contentions; see Part 1) has been well documented. The future of the legality of assisted dying is now firmly back with the legislature.[3]

The main points of that decision have been discussed in detail elsewhere.[4] In this article, I want to concentrate on a somewhat tangential issue that arose in the course of oral arguments. The status – and indeed, the definition - of 'suicide' in

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[1] I use the terminology adopted by the plaintiff, rather than the more question-begging 'assisted suicide'.

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

[3] The Health Select Committee is currently considering submissions on the topic of medically-assisted dying, in response to a petition initiated by former MP Maryan Street: <http://www.parliament.nz/en-nz/pb/sc/make-submission/0SCHE_SCF_51DBHOH_PET63268_1/ petition-of-hon-maryan-street-and-8974-others>. ACT MP David Seymour has also introduced an End of Life Choice Bill into the members' ballot.

[4] Andrew Geddis and Colin Gavaghan "Aid in dying in New Zealand: recent legal developments" Journal of Law and Medicine, forthcoming 2016.

New Zealand law was an important strand to Ms Seales' case, but the approach Collins J adopted to that question seems likely to have important implications for situations other than those in which Ms Seales found herself. In particular, his broad interpretation of s 41 of the Crimes Act 1961 – which allows for the use of force to prevent suicide - could also have implications for those who attempt to end their own lives *without* assistance.

In the Part II of this article, I will outline the main claims advanced by the plaintiff in *Seales*, and show how the definitional question around 'suicide' came to play an important role in the judgment. In Part III, I will explain the approach taken to that question by the judge, Collins J, and argue that the approach he adopted has potentially problematic implications for a range of circumstances not limited to those in the case before him.

In the final section, I will offer an alternative interpretation of s 41. I will propose that, contra Collins J, the decision-making competence of the person attempting suicide should be of considerable significance in this area. In so doing, however, I will argue that a wide margin of protection should be afforded for those who intervene in circumstances when they cannot be certain whether the attempter is in fact competent.

II. *SEALES V ATTORNEY-GENERAL*

In 2011, Lecretia Seales – a lawyer working for the Law Commission – was diagnosed with an advanced form of brain cancer. While treatment extended her life several years beyond her initial gloomy prognosis, by late 2014 it had become evident that anything other than palliative treatment was futile, and her death was imminent. Her attention, then, turned to the timing and manner of that death. The precise manner in which Ms Seales' tumour would progress was impossible to predict with certainty, but some of the possible outcomes were unacceptable to her. 'For me,' she explained, 'a slow and undignified death that does not reflect the life that I have led would be a terrible way for my good life to have to end.'[5]

In the hope of securing herself against the possibility of such a fate, and faced with the prospect of increasingly severe physical disability, Ms Seales sought to be permitted to receive assistance in taking her own life, should her circumstances worsen to the extent that she no longer considered life to be tolerable. Her general practitioner had provisionally agreed to provide her with the means of taking her own life should the need arise, but only on the condition that s/he had an assurance that she would not face criminal charges for so doing.

To that effect, Ms Seales sought two declaratory orders from the High Court. The first asked the Court to declare that, in the circumstances of Ms Seales' condition,[6]

[5] *Seales v Attorney-General* at [29].

[6] These circumstances were specified as being that Ms Seales was "a competent adult who: (i) clearly consents ...; and (ii) has a grievous and terminal illness that causes enduring suffering that is intolerable to her in the circumstances of her illness..." At [8].

it would not be a breach of either s 160 ("culpable homicide") or s 179 ("assisting suicide") of the Crimes Act for a doctor to provide her with 'aid in dying'. In the event that the Court felt unable to grant this declaration, Ms Seales sought an alternative declaration, to the effect that those provisions are, in the circumstances of Ms Seales' condition, inconsistent with her rights under the New Zealand Bill of Rights Act 1990 (NZBORA).

As is widely known, Collins J declined to issue either declaration. Although this outcome was inevitably disappointing to supporters of reform, whose hopes had been raised by bolder rulings in Canada[7] and South Africa,[8] Collins J's reluctance to make such a radical change in such a contentious area is perhaps not entirely surprising. As he explained, [9]

> The changes to the law sought by Ms Seales can only be made by Parliament. I would be trespassing on the role of Parliament and departing from the constitutional role of Judges in New Zealand if I were to issue the criminal law declarations sought by Ms Seales.

On the other hand, it has been argued that avenues were available to him that would have led to a bolder outcome.[10] For the purposes of this article, however, I want to focus on a particular aspect of the ruling. The issue of preventing suicide arose only tangentially to Ms Seales case. No-one had proposed to prevent her taking her own life, should she choose to do so, and she was not asking the Court to prevent any such future intervention. Rather, the issue arose in the context of discussion as to whether the sort of death that she sought to be allowed was properly to be regarded as 'suicide' at all. If it was not, then it seemed to follow that anyone assisting her with that death could not be said to be 'assisting suicide' for the purposes of s 179. With the Crimes Act offering no definitional assistance, the issue of what precisely counts as 'suicide' for those purposes was one for the Court to determine. In particular, it required Collins J to address the vexing question of whether some self-chosen deaths could be regarded as non-suicidal.

Collins J began his evaluation of this area by noting that, historically, the common law had long treated both successful and unsuccessful suicidal attempts as criminal offences. In the thirteenth century, the English jurist Henry de Bracton wrote that '[j]ust as a man may commit felony by slaying another so may he do so by slaying himself',[11] and writing some 400 years later, Sir William Blackstone noted that the law regarded suicide as 'among the highest crimes'.[12]

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[7] *Carter v Canada* [2015] SCC 5, [2015] 1 SCR 331.

[8] *Stransham-Ford v Minister of Justice and Correctional Services and Others* (27401/15) [2015] ZAGPPHC 230.

[9] *Seales v Attorney-General*, above note 2, at [13].

[10] Geddis and Gavaghan, above note 4.

[11] Bracton on Laws and Customs of England, 423 (f. 150).

[12] Sir William Blackstone, "Of Homicide," in *Commentaries on the Laws of England* (18th ed, Sweet, Pheney, Maxwell, Stevens & Sons, London, 1829), at 188.

Penalties for those who attempted suicide were often harsh; according to Glanville Williams, it was once a capital offence.[13] Various imaginative means were derived to punish even successful suicides, including the confiscation of the deceased's estate and the denial of Christian burial; indeed, funeral rites for suicides were often accompanied by grotesque ritual, including 'throwing lime over the body and driving a stake through it'.[14] The Methodist John Wesley had argued for even more public displays of disapproval, suggesting that the bodies of suicides be gibbeted and left to rot in full public view.[15]

A movement for a more humane approach to suicide appears to have grown throughout the eighteenth and nineteenth centuries, possibly driven in part by the perception that, while ordinary people were subject to the full wrath of law and the Church, the suicides of wealthy and educated people more commonly avoided stigma or legal sanctions by classifying the deceased as insane.[16]

By the late Victorian and Edwardian eras, suicide seems to have come to be viewed more as a social stigma rather than a sin, while particular examples of self-sacrificing conduct seem to have been heralded as heroic, e.g. Captain Lawrence Oates, who is thought to have sacrificed his life in an (ultimately futile) attempt to save fellow Antarctic explorers (see Part III of this article).

Probably as a result of this changing of attitude, coupled with a growing recognition that such penalties did not actually offer much of a deterrent, and perhaps informed by the large numbers of traumatised and 'shell-shocked' men returning to Britain during the First World War, a more lenient approach came to be adopted in England:[17]

> As long ago as 1916 the Metropolitan Police adopted, with the approval of the then Secretary of State, the practice of preferring a charge of attempted suicide only where there is no responsible person able or willing to take charge of the individual concerned, or where special circumstances, such as threats of renewed attempts of suicide or positive indications of insanity suggest that the individual should be kept in custody for his own protection. In 1921 the Metropolitan practice was brought to the notice of provincial forces. In the great majority of cases no proceedings are taken ...

Nonetheless, suicide remained technically a crime – both in England and Wales and in New Zealand – until 1961, when the Suicide Act (England and Wales) and

[13] Glanville Williams explained the rationale behind such a punishment thus: "If, as is sometimes supposed, suicide is a form of self-murder, then, but for the accident that the culprit is beyond the jurisdiction, he might be punished for his wicked self-destruction by being destroyed." *The Sanctity of Life and the Criminal Law* (Faber and Faber Ltd, London, 1958) at 246.
[14] Barbara Gates *Victorian Suicide: Mad Crimes and Sad Histories* (Princeton University Press, Princeton, New Jersey, 1988).
[15] Michael MacDonald and Terence R Murphy *Sleepless Souls: Suicide in Early Modern England* (Clarendon Press, Oxford, 1990).
[16] Donna T Andrew "The Secularisation of Suicide in England 1660-1800" Past and Present, No 119 (May 1988), 158-165.
[17] Gwilym Lloyd George, Secretary of State for Home Department. HC Deb 20 December 1956 vol 562 cc1432-3.

the Crimes Act (New Zealand) respectively formally abolished the offence. This is not, however, to say that the law recognized any sort of 'right to suicide.' For one thing, both pieces of legislation contained specific offences of assisting suicide (s 2 of the Suicide Act, s 179 of the Crimes Act), punishable by up to 14 years imprisonment. Furthermore, the Crimes Act made specific provision for those who use force to prevent suicide. Section 41 of the Crimes Act provides that:

> Every one is justified in using such force as may be reasonably necessary in order to prevent the commission of suicide, or the commission of an offence which would be likely to cause immediate and serious injury to the person or property of any one, 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.

This provision was based on s 72 of the Crimes Act 1908, which provided for 'using such force as may be reasonably necessary in order to prevent the commission of an offence … the commission of which would be likely to cause immediate and serious injury to the person or property of any one…' The interesting difference is that the defence was expanded to encompass the prevention of an act – suicide – which was no longer criminal. Section 41, then, placed suicide in a unique position; a non-criminal act which anyone could use force to prevent.

III. Justice Collins' Approach

The manner in which this section became relevant to the Seales case perhaps merits some further explanation. Central to Ms Seales' case was the contention that the offence of assisting suicide would not be committed by someone who assisted her, for example, by providing her with a lethal prescription. There is, she contended, 'a distinction between suicide which … is "irrational and a product of impaired thinking" and a "rational decision to die" by a mentally competent adult who is not depressed but is enduring a terminal illness.'[18] Some support for this approach could be found in United States case law,[19] though Collins J was quick to discount that authority as "provid[ing] little assistance".[20]

In evaluating this claim, Collins J looked to the origins and context of the various statutory provisions around suicide, and investigation that led him to discern no basis for any such distinction:[21]

> Section 41 of the Crimes Act does not distinguish between the vulnerable and those who might commit a "rational suicide". If s 41 is to have any effect, it must apply to all suicides.

It may seem, then, that Collins J simply followed the well-trodden path of refusing to depart from the plain meaning of s 41. Whether this would be sufficient to reflect legislative intention, or to pay sufficient heed to the New Zealand Bill of Rights Act, are both arguable propositions. Nonetheless, faced with such a socially divisive area of law, there is much that could be said for such judicial humility.

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[18] *Seales v Attorney-General*, above note 2, at [135].
[19] *Baxter v Montana* 2009 MT 449 (Mont 2009) at [71].
[20] *Seales v Attorney-General*, above note 2, at [142].
[21] At [128].

In reality, however, Collins J went some way beyond that approach, in two respects. First, while declining to distinguish 'rational' from 'irrational' acts of self-killing, he did recognise several other distinctions which required a somewhat imaginative approach to the bare text of the section. Secondly, he offered an opinion to the effect that s 41 could not practically function were it to be interpreted in the manner proposed by Ms Seales. It is with both of these claims that I take issue in this section.

The Crimes Act offers no definition of 'suicide.' In *Seales*, Collins J referred to '[o]rdinary dictionary definitions of suicide [which] say that suicide is "the intentional killing of oneself"'.[22] In reality, both he and other judges have sought to distinguish 'truly' suicidal acts from other decisions and actions that are either intentionally or knowingly oriented towards the death of the individual.

In *Chief Executive of the Department of Corrections v All Means All* – which concerned a prisoner undertaking a hunger strike – Panckhurst J had taken the view that '[s]uicide is an intentional killing of oneself. Death is the desired and intended end result.'[23] The supplementing of 'intent' with 'desire' may be seen as somewhat surprising in this regard, especially given attempted suicide's history as a criminal offence. If attempting suicide had remained a crime, it is interesting to speculate whether a desire requirement would have remained an element of that offence, given the general reluctance of New Zealand courts to conflate intention with purpose or motive.[24]

Moreover, it may be seen to add a complicating element for the purposes of s 41, which sits awkwardly with Collins J's apparent desire for simplicity from the perspective of the intervener.[25]

In *Seales*, Collins J also sought to distinguish different categories of self-killing behaviour. He referred, for example, to:[26]

> ...the soldier who sacrifices his or her own life on a battlefield by falling onto a grenade to save his or her comrades is generally regarded as a hero rather than a person who has committed suicide. In that case, the soldier's death is not branded as an act of suicide because he or she has acted altruistically, in the greater good to save others.

As with the requirement that the death be 'desired', a definition of 'suicide' that excludes 'altruistic' self-killing certainly involves going some way beyond the wording of the Crimes Act, and also beyond common dictionary definitions. Furthermore, it is presumably possible for someone to intend to kill them self for

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[22] At [134].
[23] *Chief Executive of the Department of Corrections v All Means All* [2014] NZHC 1433, [2014] 3 NZLR 404 at [44].
[24] In *Police v K*, the Court referred to 'the principle that the law has law recognized the need to define criminal intent in a way which does not oblige the prosecution to prove that the prohibited outcome represented the defendant's purpose or motive.' [2011] NZCA 533 at [28].
[25] See next section.
[26] *Seales v Attorney-General*, above note 2, at [137].

an altruistic motive, in a manner that would commonly be regarded as suicide – as in the case where someone takes their life so that their family may benefit from the insurance pay out. That death may not be their *ultimate* objective is generally not relevant as to whether it is an intended result. Where X is an indispensable means to the accomplishment of Y, it is common to regard both X and Y as intended.

The hand grenade example could, however, at least arguably be distinguished on grounds of intent without entering into the murky terrain of ultimate and instrumental objectives. It is plausible, after all, that the soldier falling on the grenade anticipates that his objective – saving his comrades – might be accomplished without his actually dying. It is not unknown for those who dive onto grenades to survive the experience, albeit that severe injury is almost inevitable. The extent to which 'intent' should encompass foreseen side effects is a matter of considerable jurisprudential debate, but on at least some approaches, the soldier's death could be deemed unintended. Applying the so-called 'test of failure'[27] would allow us to conclude that the heroic soldier did not intend to die at all (even though he recognised that he might well die, his purpose could well have been satisfied had he survived), and hence, could be said not to have intended suicide.

More difficult, from this perspective, is the example of the insurance suicide. Or perhaps the well-known case of Captain Oates, referred to earlier in this article. While it is certainly true that neither of those parties sought death *for its own sake*, both pursued an objective in which death was not only a virtually certain outcome, but an indispensable step toward their desired goal. To regard those deaths as other than intended is to proceed some way down the road towards conflating intention and motive. It would also sit awkwardly with the approach of the New Zealand courts in other contexts. In an oft-cited passage, Fisher J described the position of "oblique" intent in New Zealand law:[28]

> In a legal context 'intention' is normally taken to embrace both ultimate (desired) consequences and incidental (undesired but foreseen) consequences so long as the latter are foreseen with sufficient certainty when the course of action is deliberately embarked upon… If it is clear that the intended course of action will result in both, both are said to be intended.

Furthermore, it would seem to restrict very substantially the class of deaths that could be deemed 'truly' suicidal. Lecretia Seales, after all, did not seek death for its own sake, but as a means to escape a quality of life that she might deem intolerable. Had she characterised her death as being intended to spare her family the ordeal of watching her further decline, would that have elevated the choice into the realm of altruistic self-sacrifice, rather than suicide properly so called?[29]

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[27] Suzanne Uniacke "The Doctrine of Double Effect" in Ashcroft, Dawson, Draper, McMillan (eds) *Principles of Health Care Ethics* (2nd ed, Wiley, 2007) 1052 at 1053. Colin Gavaghan and Mike King "Can facilitated aid in dying be permitted by 'double effect'? Some reflections from a recent New Zealand case" (2016) 42(6) *Journal of Medical Ethics* 361-366.

[28] *R v Wentworth* [1993] 2 NZLR 450 (HC) at 453.

[29] It is also, perhaps, interesting to reflect on the extent to which 'altruistic' suicides are truly autonomous. In the context of the wider debate around assisted dying, the prospect of elderly or

The claim that 'altruistic' self-sacrifice should not be regarded as 'suicide', then, is controversial in several senses: first, in that it involves going beyond the stated meaning of the text, and indeed, of the standard definitions of 'suicide' to which Collins J alluded; second, because it did so on the basis of considerations of motive or desire, considerations which generally have a very limited role in New Zealand criminal law; and third, because it may be seen to rest on unarticulated normative assumptions about the moral status of these acts.

The second of Collins J's contentious distinctions at least has more of an established pedigree in case law.[30]

> In my assessment, there is an important distinction between those who end their lives by taking a lethal drug and those who decline medical services and die from natural causes.

This approach, as Collins J pointed out, is consistent with the approach adopted by the English courts, most significantly, by the House of Lords in *Bland*.[31] Perhaps more importantly for New Zealand purposes, it may have been intended to allow the defence in s 41 to be reconciled with s 11 of the New Zealand Bill of Rights Act, which provides that 'Everyone has the right to refuse to undergo any medical treatment.' Yet it is not an approach without problems. In particular, it seems to place very considerable significance on the precise means chosen by the individual to end their life, a significance that seems detached from the practical and ethical concerns that surround end of life choices.

Before exploring those, I should acknowledge that there are certainly cases where a refusal of life-prolonging treatment may be seen as non-suicidal. One such may be the hunger-striking prisoner in *All Means All*. As with the heroic soldier diving onto the grenade, the more plausible reason for deeming the prisoner's conduct to be non-suicidal may lie with his intent, rather than the means adopted. As Panckhurst J explained in that case:[32]

> Mr All Means All is undertaking a protest. Whether his cause is sensible or not is beside the point. 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.

For All Means All, then, his objective could have been achieved without his death resulting. It was neither his ultimate nor his instrumental objective, but rather, at

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disabled people opting for such deaths out of a sense of duty to 'not be a burden' is often advanced as a reason to be cautious of reform. The concern, presumably, is that their autonomous will risks being overborne by the sense of obligation to others. Yet from other philosophical perspectives, actions derived from a sense of duty are the only truly autonomous actions.

[30] *Seales v Attorney-General*, above note 2, at [143].

[31] 'I wish to add that, in cases of this kind, there is no question of the patient having committed suicide, nor therefore of the doctor having aided or abetted him in doing so. It is simply that the patient has, as he is entitled to do, declined to consent to treatment which might or would have the effect of prolonging his life, and the doctor has, in accordance with his duty, complied with his patient's wishes.': *Airedale NHS Trust v Bland* [1993] AC 789 per Lord Goff at 864.

[32] *Chief Executive of the Department of Corrections v All Means All*, above note 23, at [44].

most, a foreseen possibility that he was willing to risk but hoped to avert. It is at least plausible to conclude that death was not his intent, and therefore, that his hunger strike was not an attempt at suicide.

More problematic would be deaths like those of Auckland woman Margaret Paige. whose refusal of food and hydration seems to have been adopted entirely as means to end her life.[33] If death was not her intent, then it is difficult to see what was. Even more clearly than in the earlier examples of Captain Oates and the insurance suicide, death was precisely what she desired – not only as a means, but as an end in itself. It is difficult to think of any plausible approach to intent that would deem this death to have been unintended, but some imaginative attempts have been made. Margaret Ottlowski has been dismissive of some such attempts:[34]

> There has been a tendency to rationalize this conclusion on the basis that a patient who refuses life-saving treatment would really prefer to live, free of his or her afflictions. This is a patent absurdity which, if followed through to its logical conclusion, would mean that a person deliberately taking his or her life would not be committing suicide if he or she wished it were not necessary.

Yet to interpret s 41 so as to allow her to be forcibly fed would have very fundamentally weakened the effect of s 11 NZBORA. Indeed, it would have required that section to be read as saying something like 'Everyone has the right to refuse to undergo any medical treatment, provided their intent in so doing is not to die.' It is presumably in order to avoid this weakening of s 11 that New Zealand courts have followed their English counterparts in declaring that such refusals will not be regarded as suicidal, apparently regardless of the patients' intent or desire.

Most problematic of all would seem to be those cases where someone survives an initial attempt at suicide, but in an injured state that requires treatment if their subsequent death is to be avoided. This was precisely the situation faced by the English Court of Protection in a recent relatively high profile case.[35] Following an overdose, the patient was told that she required a period of dialysis. Her prognosis with this treatment was good, without it her death almost certain. The patient declined the treatment, making it entirely clear that her reason for doing so was a desire to die. As the Court heard from one independent expert witness, she had stated:[36]

> I know that I could get better; I know that I could live without a health problem, but I don't want it; I've lost my home; I've lost everything I'd worked for; I've had a good innings; it's what I have achieved.

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[33] "Margaret Paige dies in rest home after 16 days", *Dominion Post*, 31 March 2010. It should perhaps be noted that Ms Paige's death is the subject of an ongoing Coroner's inquest, though the legality of respecting her refusal of feeding and hydration does not seem to be in doubt.

[34] Margaret Ottlowski *Voluntary Euthanasia and the Common Law* (Oxford University Press, Oxford, 1997), at 70.

[35] *Kings College Hospital NHS Foundation Trust v C and Another* [2015] EWCOP 80.

[36] At [79].

Were such a case to arise in New Zealand, a question might arise as to whether treatment might be forcibly administered to such a patient. Would s 41 provide a defence for those who forcibly treat? Or would s 11 allow the patient to decline that treatment? Peter Skegg has argued that s 11 does not necessarily preclude intervention in such cases:[37]

> Viewed in its entirety, the NZBORA provides no warrant for this aspect of s 41 ... being restricted entirely to interventions in advance of the apparent attempt.

This would seem to place New Zealand law out of line with that in England. It would also arguably draw a fairly arbitrary distinction between those who – like Margaret Paige – choose from the outset to die by omission, and those who – like the patient in the Kings College Hospital case – make the mistake of first attempting by active means. Given that the stated desire of both patients is for their life to be over, it is difficult to see what public interest or ethical value would justify forcibly keeping the latter alive, while allowing the former to starve herself to death.

Margaret Ottlowski has argued that treatment refusals can be distinguished from 'active' suicides on the following basis:[38]

> In the medical context, the refusal of treatment by a patient is usually a considered and rational decision, based on their medical condition and the circumstances of their continued existence. The State's legitimate interest in the prevention of irrational self-destruction clearly does not arise in these circumstances.

On that basis, she concludes that:[39]

> Because of the special features of the refusal of treatment cases, upholding a patient's right to refuse treatment (even though that refusal may be tantamount to suicide), does not necessarily imply a *general* right to commit suicide free of State intervention.

While this may be true as an empirical observation, it seems to provide a more questionable basis for maintaining a clear distinction on this basis. For one thing, the courts have been clear that patients may decline life-saving treatment even if their reason is irrational,[40] unreasonable or foolish.[41] That being so, it is difficult to accept rationality as the basis for the distinction. Even if it were to be accepted, however, there seems no reason why an exception could not be made for 'considered and rational' suicides by active means – as may well have been the case for Lecretia Seales, had she elected to follow that path.

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[37] Peter Skegg and Ron Paterson, eds. *Health Law in New Zealand* (Thomson Reuters, Wellington, 2015), at 297.

[38] Ottlowski, above note 34, at 75.

[39] Ibid.

[40] *Re T (Adult: Refusal of Treatment)* [1993] Fam 95, at 102.

[41] "An individual patient must, in my view, always retain the right to decline operative investigation or treatment however unreasonable or foolish this may appear in the eyes of his medical advisers." *Smith v Auckland Hospital Board* [1965] NZLR 191 (CA) at 219.

Kay Wheat has suggested that such a distinction may be justified on the basis of the differing forms of intervention required:[42]

> We might say that in both cases there is a suicide attempt, but in the case of a refusal of food or medical treatment, the indignity of enforced treatment is too much of an infringement of bodily integrity to be justified.

It is not entirely clear, however, that prior attempts will always be less undignified or intrusive than subsequent attempts. Would physically restraining Ms C, or perhaps forcing the pills from her mouth before she could swallow them, necessarily be less intrusive than forced 'medical treatment'? Were an intervener to force their fingers down her throat to induce vomiting before the pills could be ingested, would that fall under s 41, or s 11? Would seizing the wrist of a knife-wielding suicidal person, or twisting the knife from their grasp, be inherently less dignified or intrusive than forcibly seizing or binding their wrist to staunch the blood flow once the incision was made?

What, then, if s 41 were read as applying only to interventions in advance of the attempt? That too would give rise to some anomalous positions. Patient C could be forcibly restrained from taking the overdose. But were she to succeed in swallowing the pills, any intervener would have to desist in the life-saving attempt and watch her die. The wrist-cutting example perhaps looks even more anomalous; the attempter could be physically restrained when attempting to cut, but the intervener must desist the moment the cut is made.

IV. An Alternative Approach To Section 41

My argument, then, is that the attempts to plot a course between s 41 and s 11 have brought the law to an uneasy and unclear compromise position. Competent adults may choose to die, and no-one may intervene to save them, unless their actions are classified as suicidal, whereupon anyone may use such force as is necessary to stay their hand. In the absence of a statutory definition of what makes a chosen death 'suicide', the courts have been left to draw a series of ad hoc and seemingly arbitrary distinctions that seem to reflect nothing of ethical or practical importance.

I wish to propose an alternative reading of s 41, one that I think better reconciles it with s 11 while avoiding the perverse and anomalous outcomes detailed in the previous section. In proposing this, I do not mean to beg the question as to whether it was really open to Collins J to interpret the section in this manner. Much in this regard may depend on how bold we wish our judges to be in interpreting legislative provisions, and this is not an article about that.

[42] Kay Wheat, "The Law's Treatment Of The Suicidal" (2000) 8(2) Med Law Rev 182. My thanks to Jonathan Herring, who raised a similar point for my consideration.

I do, however, feel on more solid ground in taking issue with Collins J's apparent conclusion that s 41 can only work on an all-or-nothing basis:[43]

> 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.

My argument is that s 41 could be interpreted in a manner that affords a wide protective scope for those who act without being sure of the rationality of the attempt. In so doing, I will assume that – in the great majority of cases of attempted suicide - it is highly desirable for would-be interveners not to be deterred by the prospect of later criminal charges.

The rationale for such a wide protective scope may be thought to derive from the strong societal interest in preserving life. While there is a certain appeal to this approach, it remains somewhat difficult to reconcile with the presumption of competence that allows individuals to decline life-saving treatment unless shown to be incompetent.[44]

A more plausible basis for the presumption in favour of intervention might derive from an empirical assumption – that as a matter of fact, those attempting suicide are not typically rational, or perhaps even competent.[45] If that assumption is reliable, then it seems that there is considerable justification to allow intervention on the basis that the attempter is not rational.

This presumption forms the basis for an approach proposed by Margaret Ottlowski:[46]

> where a person is found attempting to commit suicide, and nothing is known about his or her state of mind, it would be reasonable to assume that the attempt is evidence of mental disorder and it would be quite justifiable for concerned persons or members of the medical profession to take whatever steps were necessary to prevent the death of that person.

Such an approach would also see the defence available when the intervener is subsequently shown to have been mistaken about the mental state of the attempter. Indeed, that very possibility of a mistaken intervention is explicitly acknowledged in s 41, which provides the defence where the intervener "believes, on reasonable grounds" that the act being undertaken would amount to suicide. In that respect, as the Court of Appeal has noted, "a reasonable mistake may still attract the protection of s 41."[47]

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[43] *Seales v Attorney-General*, above note 2, at [140].

[44] HDC Code of Health and Disability Services Consumers' Rights Regulation 1996, Right 7(2).

[45] I have adopted the language of "rational suicide" from *Seales*. However, it should be noted that, in common law, the relationship between rationality and competence is not straightforward. It has been held, for example, that an irrational refusal of life-saving treatment may nonetheless be competent. See *In Re T* [1992] 3 WLR 782; *Re MB* [1997] 2 FLR 426. Were rationality to be required of attempted suicides, then, it should be noted that this would be to set a considerably higher bar than for those seeking to end their lives by omission. That being so, it may be worth considering whether "competent suicide" may in fact be the preferable term.

[46] Ottlowski, above note 34, at 85.

[47] *Russo v R* [2011] NZCA 79, [2011] NZAR 123 at [12].

Admittedly, the error being discussed in that case was as to whether suicide was being attempted at all, and not to the state of mind of the individual making the attempt. Nonetheless, it is not clear why the same scope for reasonable error could not apply to both issues. A passer-by who witnesses what appears to be an attempt at suicide, and who uses force to prevent that apparent attempt, may avail them self of the defence, even if it subsequently transpires either that no attempt was being made, or that the attempt was being made by a competent and rational adult.

Like most presumptions, though, this one would be open to rebuttal. Let us imagine, for instance, that Lecretia Seales had made it known that, having been denied the right to legal assisted dying should she become more profoundly incapacitated, she intended to consume a quantity of drugs that she had been stock-piling, with the intent of ending her own life while she retained the ability. On Collins J's reading, it seems that any passing stranger could forcibly restrain her from so doing – notwithstanding that the High Court had just deemed her to be 'not vulnerable', and her request for aid in dying to be 'a rational and intellectually rigorous response to her circumstances.'[48]

My proposed alternative approach would mean that, in rare circumstances such as this, where the attempter is known to be competent and rational, the defence under s 41 would cease to be available. There would be no more justification for forcibly retraining such a person than for forcibly feeding a competent patient who is declining medical treatment, or feeding and hydration. Just as in those cases – and contra Collins J's conclusion regarding Parliament's intent – the principle of individual autonomy would indeed prevail over the sanctity of life, just as it does in the context of treatment refusal.

This would bring such cases into closer alignment with cases such as that of Margaret Paige, and Ms C in the recent English case discussed above. In all cases where individuals adopt courses of conduct oriented towards ending their own lives, the primary question for any prospective intervener would be whether the individual has the capacity to make such a decision, rather than on arbitrary and spurious distinctions based on the precise form of the conduct. Determining capacity for decisions of such magnitude can be far from straightforward, even for courts. Those intervening in acute situations will have even less scope for considered decisions. This, however, is equally true regardless of whether the decision is to tackle someone attempting suicide, to treat someone who has attempted suicide, or indeed to treat someone who has succumbed to some other injury. In all of those cases, an argument can be made for a wide – though not infinitely wide – margin for error. In none of those cases can a persuasive argument be made for overcoming the will of someone known to be a competent adult.[49]

[48] *Seales v Attorney-General*, above note 2, at [81].

[49] Kay Wheat has also sought to distinguish treatment refusals from (other) cases of suicide on the basis of the opportunity for reflection afforded in the former. 'In the context of suicide, it can be argued that, in contrast with the person who refuses treatment because of a wish to die, the person who takes steps to end his own life immediately will have no opportunity to reflect upon what he

V. CONCLUDING REMARKS

Whether it was open to Collins J – or remains open for any future court – to read s 41 in that manner is, I concede, arguable. It is easy to have a measure of sympathy with judicial reluctance to read more into the defence than Parliament explicitly provided. It is also important to consider what my proposed, slightly restricted reading of s 41 would mean for the context in which it arose in *Seales*. Could a rational life-ending action by a competent adult be regarded as 'not suicide' for the purposes of s 41, but still 'suicide' for the purposes of the assisting offence in s 179? A court adopting my suggested approach to preventing suicidal actions could, if it did not proceed very carefully, end up effectively decriminalising many cases of what might currently be assisting suicide. Unpicking one part of the patchwork of end-of-life laws will at very least tug on threads leading to others.

If, however, courts feel able to supplement the notion of suicide by requiring that death be desired, or by excluding deaths caused by refusing treatment, or deaths motivated by altruism, then my contention is that the door is already some way open to the sort of reading I propose here.

With regard to the implications for s 179, it may be that the New Zealand courts have already conceded rather a lot in this regard. If altruistic acts of self-sacrifice are not to count as 'suicide', then it seems to follow that someone who incites, counsels, procures, aids or abets such acts is not guilty under s 179. It may be difficult to imagine such a case arising in the context of the heroic grenade-diving soldier, but if altruistic motives can be expanded to, for example, the insurance case I discussed earlier, then the possible difficulty becomes more apparent. Only a very restrictive, and probably arbitrary, definition of 'altruistic' seems likely to keep open the option of prosecution in such cases.

Likewise, if those who starve themselves to death, in the manner of Margaret Paige, are not 'committing suicide', then someone inciting them to do so will not be committing an offence. Can it really have been Parliament's intention to treat different acts of incitement so differently, depending only on the means the incited party chooses to bring about their death? Again, it is hard not to wonder what public interest or ethical value is reflected in that distinction.[50]

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is doing and change his mind'. While this may helpfully distinguish some cases of treatment refusal from some cases of suicide, it seems unlikely to function effectively across the board. It is possible, after all, that one person may make their decision to take their own life many weeks or months in advance, while someone refusing treatment after an acute incident will have no opportunity for reflection. There is perhaps something to be said for the argument that a truly autonomous decision to die must involve a 'cooling off' period – indeed, several proposals to permit assisted dying have included exactly this. But it is unclear why this should be required of cases of 'true' suicide, but not of treatment refusals. Wheat, above note 42, at 182.

[50] Pamela Ferguson has speculated as to whether the mother of the acutely ill Jehovah's Witness patient in *Re T (Adult: Refusal of Treatment)* [1992] 4 All ER 649, who is thought to have impressed on her daughter her obligation to decline a blood transfusion, may have been guilty of an offence under analogous English law provisions. "Killing 'without getting into trouble'? Assisted Suicide and Scots Criminal Law" (1998) 2(3) Edinburgh Law Review 288-314.

It is possible that much of this inconsistency could be rectified should Parliament elect to reform the law around assisted dying. If some provision is made for others to assist in an individual's death, then it seems inevitable that this will require some modification to s 41 as well; it would seem bizarre to allow X to assist with Y's suicide, while at the same time allowing Z to physically prevent it.[51] In the meantime, however, it will fall to the courts to impose whatever logic and consistency is to be found in this area, within the confines of limited and sometimes ambiguous authority. Their task is not enviable.

[51] In this article, I do not address the related issue of whether certain persons or institutions (such as prisons or hospitals) may have *duties* to prevent suicide, but of course, this too would require careful consideration if the law in this area is to be reformed.