

Killing Me Softly

Should Euthanasia Be Legalised?

by Professor Rex Ahdar

Report to Family First New Zealand 2014



About the Author

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Executive Summary

1. Voluntary euthanasia (VE) is the act of intentionally and directly causing the death of a patient, at the request of the patient, with the intention of relieving intractable suffering. It is illegal, as is physician-assisted suicide (PAS). The administration of drugs with the intention to relieve pain, but with the effect of shortening the life of the patient (the “double effect” principle), is lawful. Withdrawal of life-preserving medical treatment is also lawful where the ongoing treatment is, according to the best medical opinion, futile and burdensome. Neither of these situations constitutes euthanasia.

2. One of either VE or PAS has been legalised in only a small handful of nations: the Netherlands, Belgium, Luxembourg and Switzerland, as well as four US states – Oregon, Washington, Montana and Vermont. New Zealand has had two unsuccessful attempts to introduce VE and the third and most recent one, the End of Life Choice Bill sponsored by Labour MP Maryan Street, was withdrawn from the private member’s bill ballot in 2013. It is almost certain to resurface after the 2014 General Election.

3. The potential for abuse and flouting of procedural safeguards is a strong argument against legalisation. A very small percentage of *all* deaths in the Netherlands and Belgium were cases of euthanasia implemented *without* the patient’s request (i.e., *involuntary* euthanasia). But as a percentage of *terminated* deaths, through euthanasia or assisted suicide, the figure is more alarming. A recent study found that 32 percent of all physician-assisted deaths in the Flemish region of Belgium in 2007 were done without an explicit request from the patient (Chambaere: 2010). The requirement to report euthanasia has not been fully complied with in those nations either.

4. Is there a “slippery slope” whereby VE gradually gets extended to other, less acceptable, situations? There is some empirical evidence from those nations that have authorised VE that the availability and application of euthanasia does expand to situations initially ruled out as beyond the pale. So, for example, euthanasia has been extended to enable minors to avail themselves of it (albeit with parental consent) in the Netherlands and, most recently, Belgium. Interestingly, Labour MP Maryan Street has commented: “Application for children with terminal illness was a bridge too far in my view at this time. That might be something that may happen in the future, but not now” (Fleming 2013).

5. Procedural safeguards that require the patient’s consent look convincing in theory. The Street bill has a raft of mandatory conditions, vetting processes and reporting duties. But in practice such safeguards can only go so far. Coercion is subtle. The everyday reality is that terminally ill people *and* those afflicted with non-terminal but irreversible and unbearable physical or mental conditions are vulnerable to self-imposed pressure. They will come to feel it (euthanasia) would be “the right thing to do”, they have “had a good innings”, they do not want to be “burden” to their nearest and dearest.

6. Simply offering the possibility of VE or PAS shifts the burden of proof, so that patients must ask themselves why they are not availing themselves of it. Society’s offer of an easy death communicates the message to certain embattled and hurting 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 stubborn, eccentric or even selfish.



7. The highest appellate courts in the United States, Canada, the United Kingdom and Ireland, as well as the European Court of Human Rights, have upheld the current criminal laws in each jurisdiction that declare VE and PAS to be unlawful.

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The availability and application of euthanasia does expand to situations initially ruled out as beyond the pale.

8. Opinion polls in New Zealand have been consistent: the majority support the legalisation of VE and PAS. But the questions asked have sometimes been misleading in that they conflate the “double effect” principle and withdrawal of treatment situations (which are currently lawful) with euthanasia. More importantly, however, while the public’s views are always important in a liberal democracy, key social policy ought not to be determined by such polls alone.

9. The majority of the medical profession and national medical associations around the world have been resolutely against the introduction of VE or PAS. The role of the doctor would be, at times, irrevocably changed from healer to killer, from caring professional who saves lives to one who takes them. “Therapeutic killing” would have arrived. Inevitably, patient trust would be eroded.

10. Legalisation of euthanasia would represent an irreversible alteration to the way society and the medical professional view the demise of the elderly and the terminally ill. Death would become planned, coordinated and state sanctioned in a manner hitherto unknown.

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I. Introduction

This report considers the case for voluntary euthanasia in New Zealand. Should it be decriminalised? Should the related processes of physician-assisted suicide and advance medical directives be also rendered legal? The observation by Lord Steyn below (*Pretty v DPP* [2001] UKHL 61 at [54]) captures the complexity of the topic:

The subject of euthanasia and assisted suicide have been deeply controversial long before the adoption of the Universal Declaration of Human Rights in 1948 . . . The arguments and counter arguments have ranged widely. There is a conviction that human life is sacred and that the corollary is that euthanasia and assisted suicide are always wrong. This view is supported by the Roman Catholic Church, Islam and other religions.

There is also a secular view, shared sometimes by atheists and agnostics, that human life is sacred. On the other side, there are many millions who do not hold these beliefs. For many the personal autonomy of individuals is predominant. They would argue that it is the moral right of individuals to have a say over the time and manner of their death.

On the other hand, there are utilitarian arguments to the contrary effect. The terminally ill and those suffering great pain from incurable illnesses are often vulnerable. And not all families, whose interests are at stake, are wholly unselfish and loving. There is a risk that assisted suicide may be abused in the sense that such people may be persuaded that they want to die or that they ought to want to die.

Another strand is that, when one knows the genuine wish of a terminally ill patient to die, they should not be forced against their will to endure a life they no longer wish to endure. Such views are countered by those who say it is a slippery slope or the thin end of the wedge.

It is also argued that euthanasia and assisted suicide, under medical supervision, will undermine the trust between doctors and patients. It is said that protective safeguards are unworkable.

The countervailing contentions of moral philosophers, medical experts and ordinary people are endless. The literature is vast . . . It is not for us, in this case, to express a view on these arguments. But it is of great importance to note that these are ancient questions on which millions in the past have taken diametrically opposite views and still do.

The terminally ill and those suffering great pain from incurable illnesses are often vulnerable. And not all families, whose interests are at stake, are wholly unselfish and loving.

Part II of this report sets the issue in its New Zealand context. There have been two unsuccessful attempts to decriminalise voluntary euthanasia (VE) and a third attempt is looming. Labour MP Maryan Street's End of Life Choice Bill is waiting in the wings. It may yet succeed where the previous private member's bills—by Michael Laws in 1995 and Peter Brown in 2003—failed.

Part III examines the major arguments in favour of VE.

Part IV discusses several objections that proponents of VE tend to overlook or downplay.

Part V finishes with conclusions and recommendations.

II. The Euthanasia Debate in NZ

1. Terminology

Euthanasia comes from the Greek words *eu* (good) and *thanatos* (death), hence “good death” (Marcoux 2007). In the euthanasia debate there are a number of terms used more or less interchangeably – euthanasia, mercy killing, physician-assisted suicide, assisted dying, withdrawal of life-prolonging treatment – but the concepts are not identical.

Voluntary euthanasia (VE) means ending another person’s life at his or her request (House of Lords 2005: 14). The Australian and New Zealand Society of Palliative Medicine (ANZSPM 2013) has a fuller definition:

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 (Finnis 2001b: 211; CMA 2007). **Assisted suicide** and **assisted dying** means providing someone with the means to end his or her life and **physician-assisted suicide (PAS)** is where the person providing the means is a medical practitioner. Again, the ANZSPM definition is helpful:

Assisted suicide is the act of intentionally, knowingly and directly providing the means of death to another person, at the request of the patient, with the intention of relieving intractable suffering, in order that that person can use that means to commit suicide. If the person who dies performs the last act, assisted suicide has occurred.

Withdrawal of treatment means the cessation of treatment considered to be futile and burdensome (House of Lords 2005: 23). 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” (Sumner 2011: 19). Passive euthanasia is “an oxymoron mistakenly applied to cases of withholding or withdrawing (potentially) life-sustaining treatment (ibid).” In withdrawal of treatment cases, the question of intention is left open; as is the cause of death. By contrast, with euthanasia or assisted suicide, the immediate and primary intent of the person administering the lethal medication is to kill (albeit to relieve suffering) and the direct cause of death is the lethal injection or medication.

2. Legislative Attempts to Decriminalise VE

The Death with Dignity Bill 1995



This Bill was introduced by the then National MP, Michael Laws, on 2 August 1995 (see Ahdar 1996). It was a private member’s bill and voting upon it was by way of a free or conscience vote, twin features of the successors to it. The Northern Territory’s Rights of the Terminally Ill Act 1995 (NT) was the model for the Law’s bill. 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 thrust of the bill was articulated by Laws in his introductory speech in the House:

There are a number of terms used more or less interchangeably – but the concepts are not identical.

Withdrawal of treatment means the cessation of treatment considered to be futile and burdensome. This is not euthanasia.

The Death with Dignity Bill 1995 was defeated by 61 to 29 votes.

The Death with Dignity Bill provides choice and opportunities to persons suffering from terminal or incurable illnesses, and who believe their quality of life to be seriously and permanently impaired, to manage their own inevitable death. It also provides for those persons who have made advance directives or living wills to appoint a representative to carry out their wishes, should they be mentally incapacitated and unable to activate the bill themselves.

By the narrowest of margins (60 to 58 and one abstention) the MPs voted not to send the 2003 bill to a select committee.

The bill dealt with VE and set forth an elaborate five-step procedure to be satisfied before a lethal mixture of drugs or an injection could be self-administered or administered by the doctor. The bill was defeated by 61 to 29 votes.

The Death with Dignity Bill 2003



Peter Brown, a NZ First MP, introduced this bill on 6 March 2003. Again, it involved voluntary euthanasia 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 and one abstention) the MPs voted not to send the bill to a select committee.

The End of Life Choice Bill 2013



Sponsored by Labour MP Maryan Street, this bill follows broadly the format of the previous bills. 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" (Davison 2013). The draft bill states:

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 circumstance. 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.

The End of Life Choice Bill 2013 was withdrawn from the private members' bill ballot.

3. The Law

Historically, suicide in the West was seen as self-murder and treated as a felony. It is no longer a crime. It must, it seems, have been abolished in New Zealand when the Criminal Code of 1893 was passed (Adams 1971: 325). The offence of attempting to commit suicide (s 193 Crimes Act 1908) (Garrow 1927: 100) was repealed in 1961.

A person may refuse medical treatment and may do even if it results in his or her death (Skegg et al 2006: 230, 534). Section 11 of the New Zealand Bill of Rights Act 1990 reinforces this common law right by providing that "everyone has the right to refuse to undergo any medical treatment." The Australian and New Zealand Society of Palliative Medicine (ANZSPM 2013) 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."

The fact that suicide is decriminalised does not mean that it is, in the fullest sense, legal. There is no legal right to commit suicide. Lord Bingham in *Pretty v DPP* [2001] UKHL 61 at [35] explained:

Everyone has the right to refuse to undergo any medical treatment.

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. 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, as section 2(1) [s 179 of the NZ Crimes Act] makes clear (bold added).

There is no legal right to commit suicide.

Lord Bingham is summarising the English law but the New Zealand stance is the same. Thus, s 179 of the Crimes Act 1961 (NZ) states that "Everyone 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." Furthermore, under s 151 there is a duty to provide "necessaries" of life 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. Finally, s 41 provides a defence for those who seek to prevent someone from committing suicide. 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.

At common law euthanasia is the offence of murder.

4. Two Different Things: The administration of pain relief hastening death and the withdrawal of burdensome and futile life-prolonging treatment

The English Court of Appeal in an important recent decision, *Nicklinson v A Primary Care Trust* [2013] EWCA Civ 961 at [25] and [26], explains:

At common law euthanasia is the offence of murder, unlawfully taking the life of another . . . The courts have not hitherto been willing to accept that it is any defence to euthanasia that the deceased consented to, or even actively sought, his or her own death, or that the defendant acted out of compassion or familial love. . . A "mercy killing", as it is sometimes termed, even at the request of the deceased, remains unlawful homicide. None of this is contentious.

It is not, however, unlawful for a doctor to prescribe medical treatment which will necessarily hasten death **where the purpose is to relieve pain and suffering**. This is known as **the double effect principle**. . . this has nowhere been the subject of a specific decision but seems to have been generally assumed to be the law by criminal practitioners.

Nor is it unlawful to withdraw medical assistance from a patient even though the inevitable result is to bring about that person's death: that was the principle enunciated by the House of Lords in the Bland case itself.

The law has drawn a clear and consistent line between withdrawing medical support, with the consequence that the patient will die of his own medical condition, and actually bringing about the patient's death by a positive act. It reflects the position succinctly described by the poet Arthur Clough in his satirical

The practice of administering drugs which will hasten death where the purpose is to alleviate pain and suffering is permitted.

poem on the Ten Commandments, "The Latest Decalogue": "Thou shalt not kill; but needst not strive officiously to keep alive" (bold added).

Two different matters often wrongly called euthanasia, and thus erroneously confused with it, are not unlawful.



First, the practice of administering drugs which will hasten death where the purpose is to alleviate pain and suffering is permitted. This is known as the "double effect" principle. The Australian and New Zealand Society of Palliative Medicine (ANZSPM 2013) states: "Treatment that is appropriately titrated to relieve symptoms and has a secondary and unintended consequence of hastening death, is not euthanasia."

Second, the similarly common practice of the withdrawal of futile medical assistance from a patient, despite this action inevitably bringing about the person's death, is also legally permitted. The court in the case above summarises the English law, but the same holds in New Zealand. Professor Peter Skegg of Otago University, in the leading text, *Medical Law in New Zealand* (2006: 519) explains:

[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 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 in these circumstances has never led to a charge of manslaughter, much less murder.

The defence of double effect is confined to doctors and thus nurses cannot claim it (*R v Martin* [2004] 3 NZLR 69).

On the withdrawal of medical treatment (for example, by turning off the artificial ventilator sustaining the life of a person in an irreversible coma), Skegg (2006: 534) recounts:

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 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 exceptional indeed.

There have been very few cases where the withdrawal issue has ever been examined by the NZ courts. From the two main cases (*Auckland Area Health Board v Attorney General* [1993] 1 NZLR 235; *Shortland v Northland Health Ltd* [1998] 1 NZLR 433) Skegg (at 546) summarises: "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."

5. Notorious Cases

There have been a steady number of high-profile cases where family members have been prosecuted for terminating the lives of their kin. The list includes John Karnon, Rex Law, Lesley Martin and, most recently, Sean Davison.

The withdrawal of futile medical assistance from a patient is also legally permitted.

The defence of double effect is confined to doctors and thus nurses cannot claim it.

The Table below summarises the leading instances in chronological order.

NAME	YEAR	CHARGE	VERDICT	RELATION TO VICTIM	VICTIM'S CONDITION	SENTENCE
Roger Stead	1991	murder	manslaughter (s 171)	mother	severe depression	3.5 years' jail
Warren Ruscoe	1992	aiding & abetting suicide (s 179)	guilty	close friend	tetraplegia	1 year supervision
Janine Albury-Thomson	1998	murder	manslaughter	daughter (aged 17)	autism	18 months' imprisonment
John Karnon	1999	manslaughter	guilty	wife	shingles, psoriasis, tinitis and Parkinson's disease	2 years' supervision
Chris Simpson	2000	murder	manslaughter, on grounds of provocation	mother	bowel cancer	3 years' jail
Rex Law	2002	murder	guilty	wife (73)	Alzheimer's	18 months' jail with leave to apply for home detention
Louise Bell	2002	attempted murder (s 173)	guilty	friend	depression	1 year imprisonment
B	2003	murder	criminal proceeding stayed permanently	wife (78)	dementia and physically crippled with arthritis	criminal proceeding stayed permanently against 89 year-old, cancer-ridden defendant
W	2004	murder	acquittal of murder and manslaughter	daughter (5 months)	brain damaged	discharged without conviction
Lesley Martin	2004 2005	attempted murder	guilty	mother (69)	bowel cancer	15 months' imprisonment with leave to apply for home detention
Lloyd Faithfull	2008	attempted murder	guilty	wife	pancreatic cancer	home detention for period of 12 months
Ian Crutchley	2008	attempted murder	guilty	mother (77)	stomach cancer	6 months' community detention plus 150 hours community work
KJK	2010	aiding attempted suicide (s 179), and failing to provide necessaries of life (s 152(2))	guilty of aiding attempted suicide charge	son (15)	depression	18 months' supervision plus 200 hours' community work. Convicted and discharged re failure to provide necessaries
Sean Davison	2011	attempted murder	counselling and procuring attempted suicide (s 179a)	mother (85)	cancer	5 months' home detention
Evans James Mott	2012	assisting suicide (s 179b)	guilty	wife (55)	primary progressive multiple sclerosis	discharged without conviction

(The section numbers are to the Crimes Act 1961).

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 9 months and was given leave to apply for home detention. Justice Tony Randerson stated (*R v Law* (2002) 19 CRNZ 500 at [62]): "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."

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 this VE proposal will not protect family members (such as Rex Law) who assist their loved ones to die.

The Court would be sending the wrong message to the community if it were prepared to allow the deliberate killing of someone.

III. The Case For Euthanasia

1. Autonomy

"It's my life and what right do you have to tell me what I can do with it? The state does not own my body, I do!"

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 private member's bill calls, an "end of life choice".

But the choice to do away with oneself is *already* permitted. Recall that suicide is not a crime. No one, to put it crassly, is stopping you from throwing yourself off the Huka Falls or drinking a bottle of Janola. Recall also that the NZ Bill of Rights permits you to refuse medical treatment, including treatment (drugs, chemotherapy, cardiac surgery) which would preserve your own life. VE addresses situations where you cannot end your existence yourself; you need the assistance of someone else to end your life. Perhaps you are now senile, suffering from Alzheimer's, paralysed after a spinal fracture or too enfeebled by disease to do so. Whatever the constraint might be, you simply can't do it alone (Stoyles and Costreie 2013: 682). Euthanasia, as Finnis (2011b: 258) 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.

My choice...but so what?

"Neither Anglo-American law nor professional medical ethics have ever held that the mere fact *that* I have chosen justifies *what* I have chosen" (Keown 2012: 88). The law stoutly refuses to respect dozens of our autonomous decisions: to shoot up heroin, to beat my spouse, to not wear a crash helmet or seatbelt. What about the right to demand that others help us take our life? Furthermore, being free to act does not mean the state must provide the means for everyone to realize their desires or implement their choices (Mishara & Wiestubb 2013: 428). I have the right of free speech, but that does not require the government to provide me with a printing press or a radio frequency.

The inviolability or sanctity of life



Here, the principle of autonomy clashes with the principle of the inviolability or sanctity of life. "This historic principle, foundational to Western criminal law and professional medical ethics, holds that it is wrong intentionally to kill other people" (Keown 2012: 89). In *Airedale NHSTrust v Bland* [1993] AC 789 at 831, Hoffmann LJ said: "the sanctity of life entails its inviolability by an outsider. Subject to

exceptions like self-defence, human life is inviolate even if the person in question has consented to its violation. That is why, although suicide is not a crime, assisting someone to commit suicide is."

Section 8 of the NZ Bill of Rights Act 1990 "states the fundamental principle of the sanctity of human Life" (*Shortland v Northland Health Ltd* [1998] 1 NZLR 433 at 444):

VE addresses situations where you cannot end your existence yourself; you need the assistance of someone else to end your life.

It's my life and what right do you have to tell me what I can do with it? The state does not own my body, I do!

Being free to act does not mean the state must provide the means for everyone to realise their desires or implement their choices.

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 NZ courts have been steadfast in their defence of the sanctity of life principle. For example, Venning J in *R v Faithfull* (High Court Auckland, 8 March 2008, at [8]) noted:

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.

Keane J echoed this: "I must begin from the principle that human life is sacred and that those in the last extremity, either because they are very unwell, or because of their advanced age, or both, and when they are very vulnerable, are entitled to the full protection of the law": *R v Crutchley*, High Court Hamilton, 9 July 2008, at [56].

Nonetheless, as the Court of Appeal in *Shortland* add, the final clause in s8 above 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 treatments which offer no real benefit or which they find too burdensome. But, on other occasions, as John Keown (2012: 91) 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."

Whose choice?

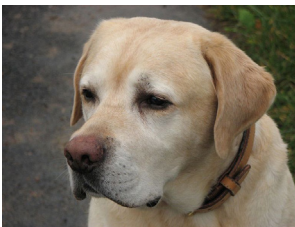
Just whose autonomy will be exercised here? Who will really get to choose? Healthy citizens who seek euthanasia...

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** (Finnis 2011b: 258, italics in original, bold added).

The irony is that what starts out as an autonomous choice ends up resting in the hands of other people (George et al 2005: 684). "If assisted suicide was acceptable professional practice, physicians would make a judgment as to who was a good candidate for it. Physician neutrality and patient autonomy, independent of their physician's advice are largely myths": Judge John Noonan in *Compassion in Dying v State of Washington*, 49 F 3d 586 at 592 (9th Cir 1995).

2. Compassion

"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 mortality or passage of life (Pilcher 2010:101). They do not rationalise (or least we cannot ascertain whether this be so) their suffering as

Human life is inviolate even if the person in question has consented to its violation.

We put to sleep dogs and cats when they are suffering, why not our tortured, cancer-ridden mother?

Human life is sacred and those in the last extremity are entitled to the full protection of the law.

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 (Pilcher, *ibid*). The analogy 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” or “destroyed” (the softer “put to sleep” phrase is hardly apt now) but those which are abandoned, unwanted or simply a nuisance. Pilcher (2010: 102) continues

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.

3. Legal Hypocrisy 1: The “Double Effect” Doctrine

“The administration of pain-relieving drugs where the foreseeable consequence is shortening of life is OK, yet administering the same drugs with the intention to kill is not. This is hypocritical.”

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 command would be killed on that very day. Obviously, however, he did not intend that any of them should be killed (Lord Goff, quoted in Keown 2012:107-108).

“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” (Finnis 2011b: 256). 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.

The law of murder has consistently recognised there is an important difference between intending death versus merely foreseeing death. Intention could be stretched to include foreseen likely effects, but such an extended meaning has been steadfastly rejected from the criminal law. As the US Supreme Court in *Vacco v Quill*, 521 US 793, 802-3 (1997) clarified:

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.

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” (Keown 2012: 110).

4. Legal Hypocrisy 2: Active Killing versus Passive Letting Die

“The law is also hypocritical in allowing a doctor to turn off a life-support machine at the patient's request (or at the behest of the next-of kin) but not allowing the doctor to administer a lethal injection at the same patient's request.”

There is a clear legal distinction between the withdrawal of medical treatment and actively administering a lethal drug, between letting die and killing. The courts have

Is not the more compassionate and caring approach to alleviate pain and suffering?

The administration of pain-relieving drugs where the foreseeable consequence is shortening of life is OK, yet administering the same drugs with the intention to kill is not. This is hypocritical.

The law of murder has consistently recognised there is an important difference between intending death versus merely foreseeing death.

“recognized the distinction between ‘letting a patient die’ and ‘making that patient die’” (US Supreme Court in *Vacco v Quill* (1997) 521 US 793, 807).

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. Bland, aged 17 at the time of the tragedy, had suffered irreparable brain damage and spent the last three years in a deep coma. His family, together with the attending medical staff, supported discontinuation of all life-sustaining treatment including ventilation, nutrition and hydration by artificial means. The Court declared the hospital could do so. Lord Goff stated:

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, 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 (*Bland*: 865)(bold added).

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

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 (*Bland*: 865).

The US Supreme Court in *Vacco v Quill* (at 799-800) similarly endorsed the distinction:

Unlike the Court of Appeals, we think the distinction between assisting suicide and withdrawing life sustaining treatment, a distinction widely recognized and endorsed in the medical profession and in our legal traditions, is *both important and logical*; it is *certainly rational*...

The distinction comports with fundamental legal principles of *causation* and *intent*. First [on causation], when a patient refuses life sustaining medical treatment, he dies from an underlying fatal disease or pathology; but if a patient ingests lethal medication prescribed by a physician, he is killed by that medication...

Furthermore, [on intent] a physician who withdraws, or honors a patient’s refusal to begin, life sustaining medical treatment, purposefully intends, or may so intend, only to respect his patient’s wishes and “to cease doing useless and futile or degrading things to the patient when [the patient] no longer stands to benefit from them”(italics added).

In a comprehensive recent examination of the topic, the High Court of Ireland (*Fleming v Ireland* [2013] IEHC 2 at [93]) concluded there “is an enormous and defining difference” between withdrawal of medical treatment and physician-assisted suicide:

The courts have “recognised the distinction between ‘letting a patient die’ and ‘making that patient die’”.

The law is also hypocritical in allowing a doctor to turn off a life-support machine at the patient’s request (or at the behest of the next-of kin) but not allowing the doctor to administer a lethal injection at the same patient’s request.

Once euthanasia is recognised as lawful in these circumstances, it is difficult to see any logical basis for excluding it in others.

The state cannot constitutionally *compel* the competent adult to accept medical treatment since this would be wholly at variance with the obligation to protect the person. . . . It is, however, a fallacy to suppose that physician assisted suicide can be equated with this, precisely because it involves *active participation* by another in the intentional killing of that other, even if this is genuinely and freely consensual.

The primary intention of the doctor is to respect the patient's wishes to not receive medical treatment.

The Irish court drew support from the decisions of the Canadian Supreme Court (*Rodriguez v Canada* [1993] 3 SCR 519) and the European Court of Human Rights (*Pretty v United Kingdom* (2002) 35 EHRR 1; *Haas v Switzerland* (2011) 53 EHRR 33) where those highest-level appellate tribunals upheld the ban on assisted suicide.

The NZ position on the withdrawal of futile treatment is the same as the UK. In *Auckland Area Health Board v Attorney General*, Justice Thomas was asked by the hospital if it could, with the support of his parents, withdraw ventilation from a patient, 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: "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" (at 253).

The primary intention of the doctor is to respect the patient's wishes to not receive medical treatment. The law has always prohibited the forced imposition of medical treatment. To treat someone without her consent is both a tort and the crime of battery (*Bland* at 857; *Gluckberg* at 725). A doctor who helps a patient commit suicide, however, "must necessarily and indubitably intend primarily that the patient be made dead" (*Vacco* at 802).

Most people in the country want it; it's a democracy and therefore let us introduce it.

Not all judges or scholars are convinced by the distinction. For some, it is little more than "a meaningless exercise in semantic gymnastics" (Michigan Supreme Court in *People v Kevorkian*, 527 NW 714, 728 (1994)). Lord Brown-Wilkinson in *Bland* (at 885) 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.

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" (*Compassion in Dying* at 594). 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 explains: "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" (*Compassion in Dying* at 594). It is because others are implicated that the possibility of abuse arises. The second person may harbour motives or have agendas that do not advance the recipient's welfare: quite the reverse.

With euthanasia there is the introduction of "an external agency of death": Lord Hoffman in *Bland* 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).

5. Public Support

"Most people in the country want it, it's a democracy and therefore let us introduce it."

It is because others are implicated that the possibility of abuse arises.

Opinion polls around the globe have usually been in favour of VE (see eg Cohen et al: 2013). The most recent survey in NZ asked whether euthanasia ought to be legalised. (This was, like many such media surveys, an online poll with self-selected responses

and not a scientific poll with randomised selection of respondents). Of the 4276 respondents, 2797 said "yes" (65.4%), 1050 "no" (24.6%) and 429 "I need to know more first" (10%).

The Table below summarises some of the NZ surveys:

YEAR	POLLING ORGANISATION	FOR	RESULTS	SOURCE
2013	Fairfax NZ News		Online response (self-selected) from 4276 readers to the question: "Should euthanasia be legalised in NZ?" Yes, 65.4%, No, 24.6%; I need to know more first, 10%.	http://www.stuff.co.nz/national/health/9282506/Coroner-urges-MPs-to-decide-on-euthanasia
2013	Curia Market Research	Family First NZ	Random telephone survey, 1000 respondents. "If someone really wants to die, doctors should be allowed to help them kill themselves?" Agree, 57%; Disagree, 31%; Unsure/refuse to answer, 11%. If the Government spent more on quality palliative care for people with terminal illnesses, almost no one would die in prolonged pain or suffering. Agree, 52%; Disagree, 32% Unsure/ Refuse, 16% (Margin of Error 3.2%)	http://www.familyfirst.org.nz/wp-content/uploads/2014/03/Euthanasia-Palliative-care-2013.pdf
2013	Key Research	Herald on Sunday	Do you think doctors should be allowed by law to end an incurable patient's life, if the patient requests it? Yes 60.5%, No 18.2%, Depends on situation 16.2%, Unsure 5.1%	http://www.nzherald.co.nz/nz/news/article.cfm?c_id=1&objectid=10857496
2012	Sunday Star-Times		More than 85 % of more than 1000 respondents to an online, self-selected, readers' survey supported voluntary euthanasia.	http://www.stuff.co.nz/national/health/6824636/Strong-public-support-for-euthanasia
2012	Horizon Research Ltd	Voluntary Euthanasia Society of New Zealand Inc.	From an online poll of 2969 self-selected adults, 62.9% support entitling all mentally competent adults to receive medical assistance in ending their life if they are suffering from a terminal illness or an irreversible physical or mental medical condition that in their view renders their life unbearable. 12.3% oppose this; 15.8% are neutral; 9% are not sure.	http://www.stuff.co.nz/national/politics/7678617/Support-grows-for-euthanasia ; http://www.horizonpoll.co.nz/page/254/62-9-support
2010	Research NZ		500 people aged over 15 years polled (randomly) by telephone on whether assisted suicide should be permitted. 47% supported it, 44% opposed it and 8% did not know. Among Maori and Pacific Islanders, 37 % supported assisted suicide; 57% opposed it, and 11% did not know. (Margin of error 4.9%)	http://www.stuff.co.nz/national/health/4048840/Public-divided-over-euthanasia http://www.researchnz.com/pdf/Media%20Releases/RNZ%20Media%20Release%20-%202010-08-19%20Assisted%20suicide.pdf
2010	NZ Herald		82 % of "more than 6000" nzherald.co.nz poll respondents in an online self-selected survey said euthanasia should be legalised	http://www.nzherald.co.nz/nz/news/article.cfm?c_id=1&objectid=10660398
2009	Massey University, School of Communication, Journalism and Marketing		To the questions sent by mail: "Suppose a person has a painful incurable disease. Do you think that doctors should be allowed by law to end the patient's life if the patient requests it?" Yes, 69%; No, 19%; Don't Know, 12% "Suppose a person has an incurable disease, but with medication is not in pain. Do you think that doctors should be allowed by law to end the patient's life if the person requests it?" Yes, 45%; No, 39%; Don't Know, 16% "Suppose a person is not in pain and does not have an incurable disease but is permanently and completely dependent on others for all their physical needs. Do you think that doctors should be allowed by law to end the patient's life if the person requests it?" Yes, 44%; No, 39%; Don't Know, 18%.	http://www.massey.ac.nz/massey/about-massey/news/article.cfm?marticle=euthanasia-support-dependent-on-circumstances-29-03-2010 http://www.nzherald.co.nz/nz/news/article.cfm?c_id=1&objectid=10634249
2008	Colmar Brunton	Voluntary Euthanasia Society of New Zealand	Over 2,000 New Zealanders aged 15 years and over were asked: "In some countries, though not all, if you have an illness that results in your being unable to have an acceptable quality of life, you are legally allowed to get help from a doctor to help you to die. If you had an illness or condition which resulted in your having a quality of life that was totally unacceptable to you, would you like to have the legal right to choose a medically assisted death?" 71 % said Yes; 20%, No; 9% Don't Know 9%	http://web.archive.org/web/20100107110416/http://www.ves.org.nz/polls.php http://www.odt.co.nz/news/national/25502/most-support-voluntary-euthanasia-survey

2008	Massey University	International Social Survey Programme	From a randomly selected survey of 1027 adults, 70% support assisted suicide for someone with a painful incurable disease provided a doctor gives the assistance. Support drops to 50% for suicide assisted by someone else, and opposition increases from just over 15% to just under 35%. (Margin of error 3%)	<i>Religion in New Zealand: international social survey programme.</i> Palmerston North: Massey University, Department of Communication, Journalism and Marketing (March 2009) p 4
2002	Massey University, Marketing Department	International Social Survey Programme	Random mail survey of 1000 New Zealanders. The questions asked were: "Suppose a person has a painful incurable disease. Do you think that doctors should be allowed by law to end the patient's life if the patient requests it?" Yes, 73%; No, 17%; Don't Know, 10%. Still thinking of that person with a painful incurable disease, "Do you think that someone else, like a close relative, should be allowed by law to help end the patient's life, if the patient requests it?" Yes, 49%; No, 38%; Don't Know, 13% (Margin of error 3.1%)	http://www.massey.ac.nz/~wwpubafs/2003/press_releases/30_01_03a.html
2000	NZ Herald Digi poll		61% support the legalisation of euthanasia, 27% opposed legalising mercy killing. NOTE: this self-selected poll does not include the word "voluntary".	http://web.archive.org/web/20100107110416/http://www.ves.org.nz/polls.php

Public opinion polls have to be treated with caution (Keown 2012: 113-4). First, the way the question is worded can be crucial. Were the respondents asked about the turning off of machines linked up to persons in an irreversible coma? This is withdrawal of futile and burdensome treatment, not euthanasia. Were the respondents presented with the alternative of well-resourced and accessible or free hospice care alongside VE or PAS in the questionnaire? Support typically drops for VE and PAS when state-funded palliative care is on the table. One Quebec study concluded that:

the use of the argument that public opinion is in favour of euthanasia to support changing laws must be critically examined. 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 (Marcoux et al 2007: 238).

Nonetheless, when VE and withdrawal of treatment were differentiated by separate carefully-worded questions, the support for euthanasia was still high (69.6% in favour of euthanasia compared to 85.8% supporting treatment withdrawal). To their credit, the wording in several (but not all) of the NZ surveys above 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. If most citizens thought Kim Dotcom should be extradited – or, for that matter, knighted – that is not how such matters should be determined.

It is not unfair to note that there is a degree of "media priming" at work in the euthanasia controversy (Johnstone 2014) as there is in many other controversies (smacking, 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 were a matter of great importance and a policy priority (Johnstone 2014). It is not, and there is no urgency for Parliament to resolve the debate once and for all by legislative action.

6. Empirical Evidence

"Voluntary euthanasia and physician-assisted suicide have been operating in places like the Netherlands for a while now. Experience shows it works well there. The tired catch-cries of 'abuse' and 'slippery slopes' are scaremongering."

First, an important cautionary note is in order. Citation of the relevant empirical literature and research findings is fraught with danger. This study you are reading

Were the respondents presented with the alternative of well-resourced and accessible or free hospice care?

is no different! Downie et al (2012) in a scathing critique of another scholar's work – they castigated a much-cited paper by Pereira (2011) as one that “should not be given any credence in the public policy debate” given that his conclusions “are not supported by the evidence” – make the following salutary comments:

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 (Downie et al: 134, 137)(bold and italics added).

A very small number of jurisdictions have decriminalised both VE and PAS: the Netherlands, Belgium and Luxembourg, while Switzerland and the US states of Oregon, Washington, Montana and Vermont have legalised PAS only. The constituent elements to VE regimes either operating or proposed (such as Maryan Street's End of Life Choice Bill, “Street bill”) will usually include the following:

- **The Request:** Typically, this must be express (or explicit) and in writing. Requests will usually be limited to adults. Clause 7(2) of the Street bill, for example, requires that any request must be in writing, signed and confirmed in writing within 7 days of it being signed. Applicants under the Street bill must be 18 years or over (cl 4).
- **The condition of the requester:** The person seeking to end his or her life will usually be required to be suffering from a terminal disease. The Street bill goes further by allowing non-terminally-ill persons to seek their own death. They must be enduring an irreversible physical or mental affliction that makes their life “unbearable.” Whether suffering from a terminal disease or not, he or she must be of sound mind and not subject to coercion. The bill states:
 6. (1) A qualifying person may receive medical assistance to end his or her life if he or she –
 - a. is mentally competent; and
 - b. suffers from either of the following conditions:
 - (i) a terminal disease or other medical condition that is likely to end his or her life within 12 months;
 - (ii) an irreversible physical or mental condition that, in the person's view, renders his or her life unbearable.

The certifying medical practitioner must be satisfied that the applicant “genuinely wishes” to end his or her life and “there was no coercion placed on the applicant to make a request” (cl 9(2)). The applicant must have been told of the medical alternatives available, “including palliative care”, by the medical practitioner (cl 9(3)). The patient may, of course, change his or her mind and cancel or delay the fateful event (cl 21 (2)).

- **The nature of the person assisting suicide or administering the lethal procedure:** VE and assisted suicide will usually require the person assisting to be a medical professional. The Street bill (cl 3) stipulates for the involvement of a registered medical practitioner. The very process is described throughout the bill as “*medically assisted death*”. It is possible under some regimes for others, such as nurses or friends or family members, to be directly involved. The Street bill (cl 23) enables the attending medical practitioner to delegate the termination to another person explicitly selected by the patient. Persons requested to participate in the end of life process may decline to do so (cl 27(1)). In the case of a medical practitioner he or she must refer the person to another doctor (cl 27(20)).
- **Prior (ex ante) vetting:** VE will commonly require the persons to be seen by a

It is possible under some regimes for others, such as nurses or friends or family members, to be directly involved.

Voluntary euthanasia and physician-assisted suicide have been operating in places like the Netherlands for a while now. Experience shows it works well there. The tired catch-cries of ‘abuse’ and ‘slippery slopes’ are scaremongering.

counsellor or mental health practitioner. The request to end one's life may need to be checked by a second doctor as well. The Street bill requires the certification of a second medical practitioner – who need not know the patient – before the terminating procedure can take place (cls 9-10). The bill also provides that the attending doctor must “encourage” the patient to seek professional counselling and to consult with his or her family or a close friend (cl 8).

- **Reporting (*ex post facto* monitoring):** The relevant medical professionals conducting VE will typically be required to report to some overseeing entity and the latter will be charged with the duty to review completed VE procedures. The Street bill requires doctors to report to the Registrar of End of Life Directives and Medically Assisted Deaths within 14 days after completion of the procedure (cl 24). That registrar must report annually (cl 34) to a statutory body, the End of Life Choice Review Body, who, in turn, must report to Parliament (cl 37).

The Netherlands

VE has been permitted in the Netherlands since a Supreme Court decision in 1987. It was the first country to do so (see Berghmans & Widdershoven 2012). 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, in 1990, a mere 18 percent of euthanasia terminations were reported, in 1995, 41 percent, whereas by 2005, the figure had increased to 80 percent (van der Heide et al 2007: 1964; Berghmans & Widdershoven 2012: 112).

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 (Keown 2012: 124-128).

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 PAS (Keown 2012: 120). 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 thankfully halved (to 560 patients) (*Fleming v Ireland* [96]; Keown 2012: 120) but this still represents a considerable number of persons whose life was ended without their express consent.

Belgium

Here, almost 1.0 percent (66) of all deaths (6,927) that took place in Flanders (the Dutch-speaking part) between June and November 2007 were without explicit request, and 2.0 percent (142 deaths) were with the patient's explicit request (Chambaere et al 2010). There were 208 physician-assisted deaths (3.0 percent of all deaths) which underscores the low take-up rate for VE and PAS generally in those nations that have decriminalised it. Returning to instances of PAS without an explicit request (32 percent of the total number of assisted deaths), 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” (Chambaere et al 2010: 898).



The figure of 1.0 percent had at least dropped from the 3.2 percent of deaths without a patient's explicit consent in 1998 (Chambaere 2010: 900; Bilsen et al 2009). The reporting of euthanasia by physicians in Flanders, Belgium is low – approximately half (52.8%) of all estimated cases of euthanasia in 2007 were reported to the Federal Control and Evaluation Committee (Smets et al 2010: 819).

VE has been permitted in the Netherlands since a Supreme Court decision in 1987.

One extremely important question is the prevalence of VE conducted without an explicit request by the patient.

The reporting of euthanasia by physicians in Flanders, Belgium is low.

Luxembourg

The country's parliament passed a bill legalising euthanasia in March 2009 (Steck et al 2013: 939; Watson 2009).

Switzerland

Since 1982, right-to-die organisations assist suicides (Steck et al 2013: 939). Cases of PAS undertaken without the patient's explicit request accounted for almost 1 percent of all deaths (*Fleming v Ireland* at [99]). Recent research by the University of Bern found that about 16 percent of those helped by right-to-die organisations such as Dignitas had no underlying illness. (Steck et al 2014: 8)



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Oregon

PAS in Oregon was legalised in 1997 when the Death with Dignity Act came into force. The utilisation has been low: from 1998 to 2010 only 525 patients have used the law, although the numbers have been growing annually (Keown 2012: 132). The legislation requires that patients be terminally ill (defined as 6 months or less to live).



One study states that no one received physician assistance in dying who was not determined by two physicians to be terminally ill (Battin et al 2007: 594). 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 PAS has not been met" (Finlay and George 2011: 173).

The Oregon Health Department annual reports caution that its figures do not include patients and physicians who might act outside the Act (ibid). The legal regime is characterised by confidentiality. As Keown (2012: 132) 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."

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. Helpfully, 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. It seems that the vast majority (92.5 percent) of patients have not been referred for psychological examination (Keown 2012: 135). Ganzini et al (2008) studied 58 Oregonian patients suffering from a terminal illness who requested assistance in dying. Of these, 18 were given clearance to do so by the assessing physicians. Of the 18, three (i.e. one in six) had treatable but undiagnosed clinical depression at the time of their assessment. The authors concluded that "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."

PAS (but not VE) is also now legal in the states of Washington (Death with Dignity Act 2009), Montana (following the 2009 Montana Supreme Court decision, *Baxter v Montana*, 2009 MT 449) and Vermont (An Act Relating to Patient Choice and Control of the End of Life 2013).

The current practice of the Death with Dignity Act in Oregon may not adequately protect all mentally ill patients.

7. Economics

"Euthanasia could result in valuable savings in public healthcare and geriatric services expenditure."

A large amount of the public purse is spent on healthcare for the dying, demented and elderly. Fewer of society's scarce resources might be consumed if a civilized euthanasia regime were to be introduced. This harsh argument from economics is seldom if ever heard issuing from the lips of advocates for VE, but, as Keown (2012: 138) suggests, it is arguably "the elephant in the room" in the debate.

The cold, fiscal reality is that "End of life care is expensive and having citizens opt for an earlier death is associated with substantial government savings" (Mishara and Wiesstubb 2013: 434).

Another smaller-sized "elephant" is the increasing demand for human organs suitable for transplants (Graham and Prichard 2013: 20). Macabre and distasteful as this thought might be, organ donation euthanasia facilitates the efficient supply of these commodities (see Wilkinson and Savulescu 2012).

It is arguably "the elephant in the room" in the debate.

Euthanasia could result in valuable savings in public healthcare and geriatric services expenditure.

IV. The Case Against Euthanasia

In large measure the arguments against VE have been covered in the previous section where the objections to and criticisms of the arguments in favour of VE were canvassed. There are, nonetheless, some additional points to be considered.

1. Abuses 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 PAS is susceptible to normal human error or even deliberate, malicious exploitation. As a *NZ Herald* editorial pithily put it, “devising a robust euthanasia regime, complete with adequate safeguards, seems hardly feasible” (*NZ Herald* 2004).

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, racial and ethnic minorities, the handicapped and disabled, women, 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 PAS in the Netherlands and PAS 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 (Battin et al 2007: 597).

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 etc, factors that transcend socio-economic groups (Finlay and George 2011).

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 (2013) contends:

The proposal that euthanasia and/or physician assisted suicide (PAS) should be legalised targets older people. They form the bulk of the audience at public meetings on the subject. Older people are the main supporters of activists such as Dr. Philip Nitschke and Leslie Martin. It is their membership that holds organisations such as the Voluntary Euthanasia Society together... It is ironic then to discover that it is *older people (and those with disabilities, of whom older people form a large percentage) who actually have the most to fear from legalising these practices....*

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

“Devising a robust euthanasia regime, complete with adequate safeguards, seems hardly feasible.”

NZ Herald Editorial

Real vulnerability depends upon emotional fragility, communicative difficulties, having unrelieved symptoms of a distressing medical condition etc.

It is ironic then to discover that it is older people who actually have the most to fear from legalising these practices.

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. What we see is probably only the surface of a deeper underlying problem because many older people are reluctant to complain about their care-givers' behaviour, especially if the family is involved, for fear of repercussions. Hence subtle and not so subtle pressure on older people to request euthanasia where it is available as an option for medical "care" is not always because the family has the best interests of their ageing relative at heart (italics and bold mine).

Every District Health Board in the country has an Elder Abuse team.

Slippery slopes

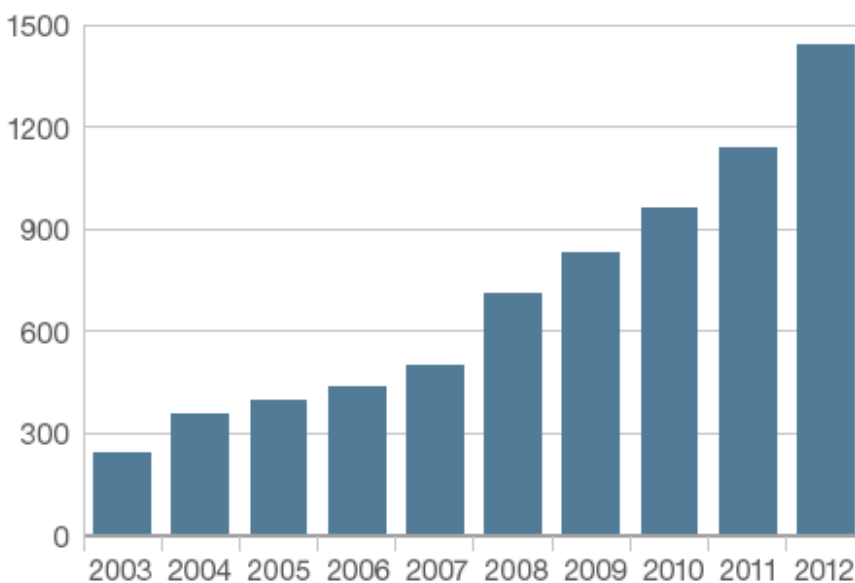


Many critics emphasise the unwitting extension of VE over time—the so-called "slippery slope" phenomenon. Will it eventually become a mechanism to terminate the lives of those who do *not* consent to it as well those who do, that is, will it degenerate into involuntary euthanasia? Will it be available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

Slippery slope arguments come, as Emily Jackson (2012: 53) points out, in three forms. 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 (see *Bland* at 865; George et al 2005: 684). For instance, if one allows adults suffering from incurable terminal diseases then what prevents those with curable diseases from demanding this "treatment"? (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 PAS demonstrates that abuse in fact occurs. The *psychological* slippery slope is the notion that once we become accustomed to the idea of VE and PAS 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.

Once we become accustomed to the idea of VE and PAS it becomes easier for society to take further steps.

Adult euthanasia cases in Belgium



Source: European Institute of Bioethics

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 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 (see Stoyles and Costreie 2013: 689). 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 some 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 (Pilcher 2010: 34). Our society may decriminalise prostitution and lift most of the legal sanctions against it. But this does not bestow on us a human right to sell our bodies, to hire lap dancers or watch pornography.

Yet to decriminalise VE or PAS might all too quickly follow this path. Decriminalisation could be seen as a societal endorsement of it, one worthy of the mantle and protection accorded to 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* (at 733) commented that if assisted suicide were to be recognised and protected as a matter of constitutional right, it would be difficult to resist the argument that “every man and woman in the United States must enjoy it.” If some citizens are currently deprived of enjoying this newly minted right, then “equality” and non-discrimination demands they be granted it too. Why should adults alone have this right? Why should those who are competent to request it alone have this option?



It is plausible to believe that as society becomes used to the deliberate termination of lives or “therapeutic killing” (George et al 2005: 684) it might become willing to extend the process to new categories and situations. (But here one might say the societal mindset has already been shaped and de-sensitised to active killing. For while capital punishment was abolished long ago – in 1961 for murder, and in 1989 for treason – abortion continues to be allowed.) Euthanasia’s popularity, so to speak, may also rise. In the Netherlands, the prevalence of medical euthanasia has more than doubled in the decade to 2012 (Waterfield 2013).

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 PAS 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 (van der Heide et al 2007: 1960) 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.” Furthermore, the practice of “continuous deep sedation” was used in conjunction with possible hastening of death in 7.1% of all deaths in 2005, an increase from 5.6% in 2001. A later study in *The Lancet* (Onwuteaka-Philipsen et al (2012: 912)) 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).” The authors suggest that “one reason for this decrease might be the increased attention for palliative care over the last decade” (ibid 913). Comforting as that decrease is, it still means that 0.2% of all deaths were unlawful. I noted earlier that some 1.0 percent of all deaths that took place in Flanders between June and November 2007 were without an explicit patient request (Chambaere et al 2010; Bilsen et al 2009).

In the Netherlands, the prevalence of medical euthanasia has more than doubled in the decade to 2012.

There are studies that show that abuses have occurred despite the safeguards.

Why would doctors who currently ignore the law prohibiting euthanasia be any more willing to comply with new legal guidelines.

On the other hand, there are also studies that show abuses and slippery slopes have not eventuated: see e.g., Battin 2007; Verhagen 2013.

One argument by supporters of VE or PAS 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 PAS. Decriminalisation would bring these unlawful practices “out into the open” (Keown 2012: 114).

However, there is little empirical data to back up this contention (Mishara & Weistubb 2013: 429). UK research indicates that deaths from PAS, VE and non-voluntary euthanasia in that country are “extremely low” (Seale 2006: 6) and that PAS and euthanasia without an explicit patient request “are rare or non-existent” (Seale 2009: 201). Yet, in New Zealand there is one study that, disturbingly, found the prevalence of euthanasia was higher. A national survey by Mitchell and Owens (2003) published in the *British Medical Journal* received responses from 1255 NZ general practitioners of which 1100 (88%) reported attending a death in the past year and 693 (63%) had made a medical decision that could hasten death in the last 12 months. Furthermore:

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. A further 132 (19%) had withdrawn or withheld treatment explicitly to hasten death, 63 (48%) without discussion with the patient. 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 (ibid 202-203).

This is but one study, but it is certainly concerning that 39 doctors admitted to engaging in euthanasia or assisted suicide.

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 PAS? (Keown 2012: 117).

“Bracket creep”



Over time, the eligibility criteria for VE and PAS may be widened. In the Netherlands the age of consent for VE has been lowered to allow children aged 12 years or older to consent to being euthanized provided their parents also consent (Graham and Prichard: 22). In 2013 Belgium’s Senate voted to amend the euthanasia law to abolish age

restrictions on those can avail themselves of euthanasia (Higgins 2013). The Belgian House of Representatives, by 86 votes to 44 (with 12 abstentions), followed suit in February this year (Waterfield 2014b). The law will apply to those under 18 (the minimum age) but they will have to satisfy certain conditions such as parental consent and psychiatric assessment (NZ Herald 2014). A letter from 160 Belgian paediatricians that the amendment was rushed and unnecessary (BBC 2014) fell

In 2013 Belgium’s Senate voted to amend the euthanasia law to abolish age restrictions.

“Application for children with terminal illness was a bridge too far in my view at this time. That might be something that may happen in the future, but not now.”

*Labour MP
Maryan Street*

upon deaf ears. Mind you, opinion polls show that the extension of euthanasia to children enjoys the support of three-quarters of Belgians (Waterfield 2014a). To return to NZ, interestingly, Labour MP Maryan Street has commented: "Application for children with terminal illness was a bridge too far in my view at this time. That might be something that may happen in the future, but not now" (Fleming 2013).

The practice of neonatal euthanasia began when the Dutch legalised euthanasia. According to nationwide surveys, in about 1% 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 (Verhage 2013: 293). After the introduction of the Groningen Protocol in 2005 (see Verhagen and Sauer 2005), 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 realised. The numbers of neonatal euthanasia cases have *decreased* in the 5 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 (Verhagen 2013).

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 (Ingelbrecht et al 2010: 905).

2. Coercion Revisited: Self-Imposed Pressure

Coercion is undoubtedly a subtle concept (see Graham and Prichard 2013: 14). The stark contrast between requested versus unrequested euthanasia is simplistic. As Richard Doerflinger (1998: 17) explains: "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."

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

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**. . . (Finnis 2011b: 262, bold added).



Debates on VE and PAS usually focus on egotistic 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 (Mishara and Weisstub 2013: 432). The feeling by the terminally ill that one does not want to be a burden to others and thus "the decent thing to do" (as Finnis puts it) 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 and friends". In most of the years between 1998 to 2012 (10 years out of 15) more than one in three patients perceived themselves as being a burden to their nearest and dearest (Graham and Prichard 2013: 15).

If VE or PAS were permitted "many might resort to it to spare their families the substantial financial burden of end-of-life healthcare costs". So wrote the US Supreme Court (*Glucksberg* at 732). But this point is just as valid in New Zealand and not just the hyper-expensive American healthcare system. Elderly and ailing

There are many steps on the road from dispassionate, autonomous choice to subtle coercion.

"My being killed is what my relatives expect of me and is in any case the decent thing to do."

"More than one in three patients perceived themselves as being a burden to their nearest and dearest."

Oregon Public Health

patients are all too aware that their increasingly expensive rest home and geriatric care is steadily dissipating the inheritance that awaits their children. Sadly, the more unscrupulous and callous offspring would not be slow in pointing this out either.

Shift in the burden of proof

Next, the very climate in which one exercises choice changes when VE is introduced. The dying are now, so to speak, put on back foot. A subtle change in the burden of proof takes place, as Doerflinger (1998: 17, original italics, bold mine) notes:

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 or even selfish**.

The terminally ill and disabled (and depressed) are forced to defend their “selfish” decision to live and to spurn the option of an easy death. Keown (2012: 121) recounts the disturbing statement by the lead authors of the Dutch national surveys that it has 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.

In other words, a law passed that allowed persons to “opt in” for VE or PAS has quickly led to a situation where the practice has become so normalised that it is now up to people who do not want it to actively “opt out”.

Rational suicide?



The design of a VE or PAS regime is heavily premised on the clear-minded, rational person undertaking a cool, rational choice. But how “rational” a decision can one make when one is suffering from a painful terminal disease? Mishara and Weistubb (2013: 431) observe:

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 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 (bold added).

Quite so. They continue:

This results in the paradoxical situation where proponents of legalising euthanasia and assisted suicide **insist upon the right to make a “rational” choice under circumstances where rational decision making is much less**

Elderly and ailing patients are all too aware that their increasingly expensive rest home and geriatric care is steadily dissipating the inheritance that awaits their children.

How “rational” a decision can one make when one is suffering from a painful terminal disease?

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 (bold added).

One may question, as Professor of palliative medicine, Baroness Finlay of Llandaff cautions, the rather rosy, idealised world which advocates of VE or PAS tacitly assume:

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* (Foreword to Pilcher (2010) 13) (italics added).

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 (Heath 2012).

Depression

Depression is a concern in requests for euthanasia/PAS because it is potentially reversible and may affect the patients’ competency, particularly in the relative weighting they give to positive and negative aspects of their situation and possible future outcomes. Depressed patients can be viewed as a vulnerable population in this context as their request for death may be part of their illness, with the correct response being treatment rather than assistance in dying (Levene and Parker 2011: 205).



Many who request PAS revoke that request if their depression and pain are satisfactorily treated (Mishara and Weistubb 2013: 433). Most VE and PAS 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 PAS despite the presence of treatable but undiagnosed depression at the time of their psychiatric assessment. More recently, however, a study by Levene and Parker (2011: 210) 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.

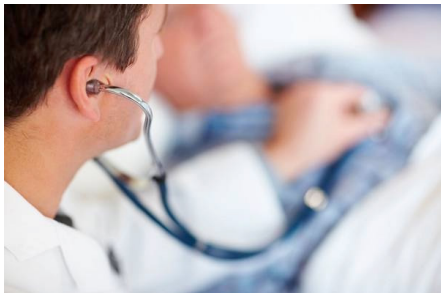
The authors even pose the question (ibid 209) whether the presence of depression ought to be a disqualifying factor given that depression does not necessarily make patients incompetent to make medical decisions. The Street bill stipulates that the applicant must be “mentally competent”, but that begs the question whether depression renders one incompetent. It also begs the question of how such depression will be identified. Even very mild depression—of the kind that would not render a person legally incompetent—can have a marked effect on one’s

Depressed patients can be viewed as a vulnerable population in this context as their request for death may be part of their illness.

Many who request PAS revoke that request if their depression and pain are satisfactorily treated.

predisposition to live or die. (I am indebted to Dr John Kleinsman for this point). Add to that the fact that virtually all patients who are facing death or battling an irreversible debilitating disease are depressed at some point. Under the current law, most move through this to another level. If VE or PAS is allowed, many patients who would have otherwise traversed this difficult dark phase, and found meaning in continued living, may not get that chance and will die prematurely.

3. Medical Profession Opposition



The majority of the medical profession, both in New Zealand and in many overseas countries, is firmly opposed to VE and PAS. There are exceptions. Some countries, as we have seen, have allowed it. And some groups (e.g., Doctors for Voluntary Euthanasia Choice in Australia (Willoughby 2013)) and some physicians—Drs Jack Kevorkian and Philip Nitschke being the

most (in)famous—support VE and PAS. But they are in the minority. Thus, in New Zealand:

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* (NZMA, italics and bold added).

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" (AMA 2007: para 10.5). Likewise, the Canadian Medical Association states: "The CMA does not support euthanasia or assisted suicide. It urges its members to uphold the principles of palliative care" (CMA 2007). And, lastly, the American Medical Association (1996) concurs:

it is understandable, though tragic, that some patients in extreme duress—such as those suffering from a terminal, painful, debilitating illness—may come to decide that death is preferable to life. However, permitting physicians to engage in euthanasia would **ultimately cause more harm than good**. Euthanasia is **fundamentally incompatible with the physician's role as healer**, would be difficult or impossible to control, and would **pose serious societal risks** (bold added).

Why is there this stern opposition? The principal reason is that the role of the physician would be fundamentally altered, as would the nature of the patient-doctor relationship. The Tasmanian AMA's submission on that state's proposed VE bill comments:

The NZMA is opposed to both the concept and practice of euthanasia and doctor assisted suicide.

"Euthanasia is fundamentally incompatible with the physician's role as healer."

American Medical Association

You [the Tasmanian Government's Consultation paper on Voluntary Assisted Dying] claim that trust in the doctor-patient relationship will not be undermined should doctors participate in assisted dying but you only provide one citation to support this claim (page 22). We believe that to *fundamentally change the role of doctor as one who supports life to one who takes life* will have profound, unpredictable effects on the perception and practice of medicine (AMA Tasmania, italics added).

Finnis (2011b: 261) 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.” In this new VE era, doctors’ self-understanding would be quite different. So-called “therapeutic killing” (is there an uglier term?) would now be a tool in their medical kitbag. VE would become “a routine management option” (Finnis 2011b: 260):

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. . . (Finnis 2011b: 260, italics mine).

Where does this place the unfortunate ailing patients? How do they perceive their doctor? How do they view their nearest and dearest? Finnis (ibid) forebodes there might be:

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.

To fundamentally change the role of doctor as one who supports life to one who takes life will have profound, unpredictable effects on the perception and practice of medicine.

Fears of dying tend to dissipate when terminally-ill patients receive good hospice or palliative care.

4. Palliative Care Sufficient



Living Every Moment

New Zealand has a well-developed network of hospices and palliative medicine is widely practised. Given this, there is really no pressing need for euthanasia. Nearly all pain is treatable. Granted, *nearly* all is not all, and thus in the tiny number of instances where it cannot be nullified, the case for euthanasia remains. So the current situation (banning VE or PAS) “inevitably leads to optimal management being denied to some patients” (Willoughby 2013).

Interestingly, 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 (Kastenbaum 2006; Mishara and Weisstub 2013: 433).

There is a concern that if VE and PAS were to be legalised the provision of palliative care might be reduced. Chambaere et al (2011: 19) 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 PAS have been introduced—10 years—and that “trends for complex social issues such as this one may only become apparent after a longer period.”

There is a concern that if VE and PAS were to be legalised the provision of palliative care might be reduced.

V. 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 PAS initially appear convincing. We should respect people's personal autonomy and free choice, euthanasia is a compassionate response to unbearable suffering, it has worked well in those nations that have implemented it, and so on.

But on closer analysis the arguments for VE are less persuasive. There is a genuine concern that any VE law – even one carefully drafted with requisite safeguards – is vulnerable to abuse.

Ms Maryan Street's End of Life Choice Bill is a well-intentioned attempt to design an operationally safe euthanasia regime, but it has its weaknesses. These are not so much inherent problems in the Act (fuzzy definitions, unwieldy procedures etc) but the very environment in which any law would have to function. Any VE law would face the ineradicable reality of self-imposed pressure. 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.



Voluntary euthanasia has the allure of being an enlightened and compassionate response to the plight of the suffering. But its practical operation is fraught with risks and there are slippery slopes that are indeed slippery. But perhaps the most ominous change is one that cannot be proved.

There will 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 a manner hitherto unknown.

The era of therapeutic killing will have arrived.

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 terminally ill will be put in the invidious position of having to justify why they should not avail themselves of this state-approved option.

The era of therapeutic killing will have arrived.

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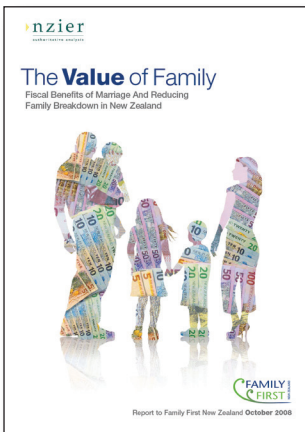
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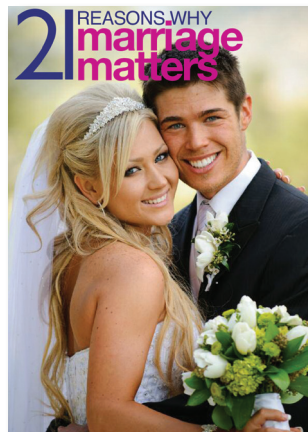
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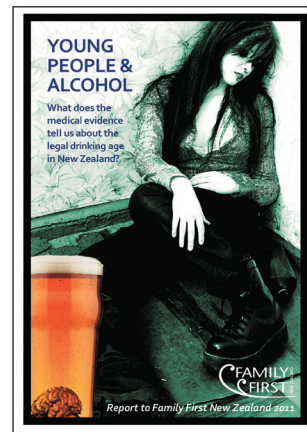
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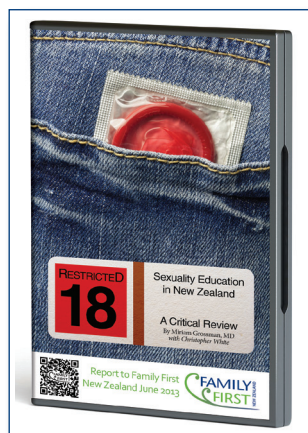
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