Comment

Editor: Dan Meagher

END-OF-LIFE CHOICE IN NEW ZEALAND’S PARLIAMENT AND COURTS

The issue variously termed “euthanasia”, “assisted suicide” or “aid in dying”\(^1\) repeatedly has been raised in New Zealand. There have been three legislative attempts to permit it. Each of them shared three common features. First, they took the form of a Members’ Bill, rather than government legislation. While Members’ Bills enable Parliament to consider matters of substantive policy that the current government does not regard as a legislative priority, they come with certain inherent limitations. The MP who authors the Bill has no access either to the public service’s policy resources or to legislative drafting assistance provided by parliamentary counsel. Without this help to craft careful and coherent legislative proposals, the quality of Members’ Bills is often wanting.

The second common feature of the three Bills is that their fate was decided by way of a “conscience vote”, where individual MPs were permitted to decide whether to support or oppose the measure free from the otherwise very strict party discipline that prevails in New Zealand’s parliamentary environment. Consequently, individual MPs faced potentially intense personal lobbying and scrutiny when voting on the matter. The third commonality is that a MP representing an opposition party proposed each measure. While the fact that the issue was approached on a conscience basis loosened the ties of party loyalty somewhat, its championing by a member of the minority side of the House of Representatives made negotiating the necessary support for its passage more difficult.

These commonalities may help to explain why none of these three attempts to introduce aid in dying into New Zealand law progressed beyond the first stage of parliamentary scrutiny. The first proposal for change – the Death with Dignity Bill 1995 (NZ) – was introduced in the wake of the passage of the Rights of the Terminally Ill Act 1995 (NT) and closely mirrored that legislation’s content. However, the Bill was defeated by 61 votes to 29 at its first reading. It was substantially reintroduced in 2003, only to once again be voted down at first reading by a narrow 60 votes to 58 (with one abstention).

In both cases, parliamentary opponents of the legislation pointed to perceived flaws in the Bill’s design and application as being so fatal that it did not warrant proceeding to the Select Committee stage to allow for public submissions. One such perceived flaw – inadequate safeguards for patients who requested aid in dying by way of an advance directive – led the Attorney-General to issue a notice under s 7 of the New Zealand Bill of Rights Act 1990 (NZ) (NZBORA) that it unjustifiably limited that legislation’s guarantee to the right to life.\(^2\) And a postscript to the Parliamentary Library’s summary of the proposed legislation noted that:

The Bill needs to be thoroughly checked and proofread, as there are numerous mistakes, inconsistencies, and lacunae or gaps. For example, are the terms “physician” and “medical practitioner” interchangeable? If so, one expression should be used instead of two. There are many grammatical and drafting errors.\(^3\)

The last legislative vehicle for aid in dying was launched in 2012, when the End of Life Choice Bill (NZ) was placed into the Members’ Bill ballot.\(^4\) However, its author subsequently withdrew it from potential parliamentary consideration in October 2013 “out of concern a debate about euthanasia could

\(^1\) One of the marks of disagreement in this field is that those on opposing sides cannot even agree on a common terminology for the matters at stake. I will use the term “aid in dying” to refer to a fatal dose of medication provided by a doctor at the request of a terminally ill, competent individual who is suffering intolerably for the purpose of ending his or her life at a time of his or her own choosing. If that marks me out as a proponent of legal change in this area, that is because I am.


\(^4\) Due to the fact that there are far more Members’ Bills authored than there are places on Parliament’s order paper, the introduction of such Bills into Parliament is decided by drawing numbered balls from a cloth bag.
come up in election year and become a political football”.  

The opposition Labour Party, of whom the Bill’s author was a member, had been widely associated in the public eye with previous (successful) Members’ Bills on social matters, such as criminalising the use of force against children for disciplinary purposes, legalising prostitution and permitting same-sex marriage. Labour’s leadership was concerned that linking the Party to yet another controversial matter of social policy would not only deflect attention from the “jobs and growth” campaign platform it wished to focus upon, but could alienate socially conservative voters in the Pacifica and Maori community. Following the 2014 election, the Bill was reintroduced into the ballot, only to once again be withdrawn at the Party leader’s “request” as: “That stuff on euthanasia, it isn’t the time for us to be talking about that.”

Current prospects for legislative reform are considered at the end of this comment. As at December 2014, however, there was no realistic prospect of Parliament taking action to change the law in the short-to-medium term. Consequently, the courts became the only realistic venue for anyone seeking to have a right to receive aid in dying recognised in New Zealand law. Below, this comment examines how the issue has been dealt with in this venue.

**THE HIGH COURT’S RULING IN SEALES V ATTORNEY-GENERAL**

In late 2014, as her inevitable death from brain cancer approached, a 42-year-old lawyer named Lecretia Seales wanted the option of receiving aid in dying from her (unnamed) general practitioner, who in turn was willing to provide that aid. Ms Seales’ own actions would not breach the law; it has not been an offence in New Zealand for anyone to attempt to end her or his own life since 1961. However, should a doctor aid Ms Seales to do so, she or he ran the risk of arrest and prosecution for breaching the Crimes Act 1961 (NZ).

A doctor who directly administers a lethal dose of medication at a patient’s request for the purpose of ending his or her life might be prosecuted for “culpable homicide” – in the form of murder or manslaughter – under s 160. Providing a lethal dose of medication in the knowledge a patient may self-administer it to end his or her life sometime in the future might lead to a prosecution for aiding or abetting suicide under s 179. In order to provide Ms Seales’ doctor with legal certainty, therefore, Ms Seales sought declarations in the High Court regarding the current law’s application to her situation. The primary remedy sought was for the Court to rule that a doctor who provides aid in dying at the request of a terminally ill, competent individual falls outside of the above provisions of the Crimes Act, thereby permitting Ms Seales to receive the treatment she desired.

Alternatively, if the Court could not interpret the legislative provisions in this way, Ms Seales wanted it to find that the law’s effect in preventing her from gaining access to aid in dying is inconsistent with the NZBORA. While this remedy would not enable Ms Seales to access aid in dying – s 4 of the NZBORA explicitly prohibits a court from invalidating or refusing to apply a statute because of any inconsistency with the rights it guarantees – it would provide a strong message to Parliament that the law in this area is seriously deficient. The theoretical availability of such “declarations of inconsistency” recently had been affirmed by the High Court;  

Collin J’s judgment in Seales v Attorney-General therefore provides us with a somewhat definitive statement of the present law on aid in dying, as well as important findings about that law’s justifiability.  

**The reach of the Crimes Act**

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6 Davison, n 5.
9 Commissioner of Police v Afakasi [2015] NZHC 123. It should be noted that Ms Seales passed away from her illness the day before Collins J’s judgment was released publicly.
In regards the first issue – whether the Crimes Act’s prohibitions cover the actions of a doctor who administers aid in dying directly to a patient, or who gives it to a patient to self-administer at a later date – Collins J answered in the affirmative.

His Honour found that a doctor who directly administers a fatal drug to Ms Seales with the intention of terminating her life breaches the Crimes Act, s 160 by killing another person through an “unlawful act”.10 Somewhat strangely, the exact nature of that unlawful act was not specified; Collins J suggested that the doctor “probably” would commit an assault on Ms Seales, or “in all likelihood” would administer a poison with the intent to cause grievous bodily harm.11 Nevertheless, his Honour was satisfied that, under s 160, a doctor’s direct administration of aid in dying would amount to murder or manslaughter.

By the same token, Collins J also ruled that the s 179 prohibition on aiding or abetting suicide covers providing a patient with the means to self-administer aid in dying. His Honour found that the legislative provision’s intent was to preserve “the sanctity of human life”, not simply to protect the vulnerable in society.12 As such, Ms Seales’ decision to take a fatal drug with the intention of ending her own life would constitute a “suicide” under the Crimes Act as her death would be intentional, voluntary and caused by the drug taken.13 A doctor who provided her with a fatal drug knowing she was contemplating using it to end her own life would thus fall foul of s 179 of the Crimes Act.14

Collins J’s interpretation of the Crimes Act provisions is an orthodox, albeit conservative, one. It certainly was not the only way the legislation might have been read.15 Nevertheless, his Honour’s judgment is dispositive of the question whether any form of aid in dying currently is permitted under New Zealand law. It is not.

**Consistency with the NZBORA**

Having found that the Crimes Act could not be interpreted in a manner that permitted aid in dying, Collins J then turned to examine whether this outcome is consistent with the rights and freedoms contained in the NZBORA. Two rights were at issue: Ms Seales’ s 8 right not to be deprived of life; and her s 9 right not to be subjected to cruel, degrading or disproportionately severe treatment.

Regarding s 8, a unanimous Canadian Supreme Court recently held that a total prohibition on aid in dying breached the equivalent guarantee in the Canadian Charter of Rights and Freedoms 1982 (Can) (which is, in turn, the model for the NZBORA).16 The Canadian Court found that the prohibition’s effect was to cause some terminally ill people to end their lives sooner than they otherwise would choose to and it was not necessary to impose this outcome on competent, consenting, terminally ill individuals in order to protect generally the lives of vulnerable members of society.

Although this precedent is not binding in New Zealand, the links between the NZBORA and the Canadian Charter imbue it with very strong persuasive authority. Unsurprisingly, therefore, Collins J accepted that a prohibition on aid in dying has the same potential consequence in New Zealand regarding individuals ending their lives prematurely.17 However, his Honour then found that this consequence was not inconsistent with the NZBORA itself as, in distinction to Canada, the deprivation of life was “on such grounds as ... are consistent with the principles of fundamental justice”.18

With respect, this conclusion is hard to sustain. Collins J based his contrasting treatment of the right on an alleged difference in intent behind Canada and New Zealand’s criminal law prohibition on

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10 Seales v Attorney-General [2015] NZHC 1239, [112].
12 Seales v Attorney-General [2015] NZHC 1239, [132].
13 Seales v Attorney-General [2015] NZHC 1239, [144].
14 Seales v Attorney-General [2015] NZHC 1239, [145].
17 Seales v Attorney-General [2015] NZHC 1239, [166].
18 Seales v Attorney-General [2015] NZHC 1239, [186], [191].
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assisting suicide. Canada’s legislature was concerned only to protect the lives of vulnerable individuals, while New Zealand’s wanted to protect the lives of all persons. Therefore, his Honour concluded, it is not inconsistent with the principles of fundamental justice for New Zealand’s prohibition to apply more broadly and capture individuals in Ms Seales’ position.

With respect, this reasoning is wrong. His Honour’s basis for distinguishing between the Canadian and New Zealand parliamentary intent is somewhat flimsy. Nothing in the legislative history or background legal practices of the two nations justify a finding that the legislatures in each nation had different things in mind when they decriminalised attempted suicide. Furthermore, the analysis of whether the effect of the law in question is consistent with the principles of fundamental justice is hopelessly short-circuited by accepting a broad, generic legislative purpose such as “protecting the sanctity of life”. At no point, therefore, does Collins J confront the important question; why should the State have in place a law that causes competent, rational, terminally ill individuals to take their own lives at a point earlier than they otherwise would? What justification can the State have for producing such an outcome?

Consequently, Collins J was mistaken to conclude that the Crimes Act prohibition on aid in dying is consistent with the NZBORA, s 8 right not to be deprived of life. That error may not have changed his Honour’s conclusion as to how the Crimes Act can be interpreted. But his Honour should have considered whether to issue a declaration that the current law is inconsistent with the rights and freedoms guaranteed in the NZBORA.

In regards to Ms Seales’ s 9 right, Collins J’s reasoning is more robust. In line with overseas authority, his Honour found that the prohibition on receiving aid in dying did not subject Ms Seales to “treatment” at all. Consequently, while the effect of the prohibition may be cruel, degrading and disproportionately severe, this did not trigger the relevant right under the NZBORA.

BACK TO PARLIAMENT

The practical effect of Collins J’s judgment is that, for the moment, a doctor cannot lawfully provide aid in dying even to a competent, terminally ill patient who wishes to receive it. His Honour also was very clear as to the appropriate forum for any change to that law: “the fact that Parliament has not been willing to address the issues raised by Ms Seales’ proceeding does not provide me with a licence to depart from the constitutional role of Judges in New Zealand.” However, there are hints in Collins J’s judgment that he believes Parliament ought to address this matter:

By focusing upon the law it may appear that I am indifferent to Ms Seales’ plight. Nothing could be further from the truth. I fully acknowledge that the consequences of the law against assisting suicide as it currently stands are extremely distressing for Ms Seales and that she is suffering because that law does not accommodate her right to dignity and personal autonomy.

While New Zealand’s current law cannot provide Ms Seales with access to aid in dying and this outcome is deemed consistent with the comparatively narrow range of rights protected by the NZBORA, Collins J’s judgment does not mean that this law is desirable. To the contrary, preventing those in Ms Seales’ position from gaining access to aid in dying denies individuals very important individual rights. It forces them to die in undignified ways and so denies them recognition of their status as rational, competent individuals able to choose in their own best interests.

20 See Carter v Canada (Attorney-General) [2015] SCC 5, [77]-[78].
21 In particular, Rodriguez v British Columbia (Attorney-General) [1993] 3 SCR 519; R (Pretty) v Department of Public Prosecutions [2002] 1 AC 800.
22 Seales v Attorney-General [2015] NZHC 1239, [205]-[207].
23 Seales v Attorney-General [2015] NZHC 1239, [211].
Whether this state of affairs will change is a moot point. Following the judgment in Seales v Attorney-General, the House of Representatives’ Health Select Committee has agreed to hold an inquiry into the issues it has raised. That inquiry may result in a recommendation that Parliament legislate to permit some form of aid in dying. The general public certainly appears to desire such a move, with 75% of respondents in a recent opinion poll giving an affirmative answer to the question: “[d]o you think a person who is terminally or incurably ill should be able to request the assistance of a medical practitioner to end their life?” However, unless and until a reform Bill is brought before the House for passage into law, individuals in Ms Seales’ situation will continue to be denied a choice as to how to end, rather than live, their lives.  

Andrew Geddis  
Professor, Faculty of Law, University of Otago


26 In October 2015, the Act Party MP David Seymour introduced the “End of Life Choice Bill” into the members ballot; <http://www.parliament.nz/en-nz/plb/legislation/proposed-bills/51HOH_MEMBILL191_1/end-of-life-choice-bill>. It has not yet been drawn for debate in the House.