

Very unsafe safeguards

Don Mathieson QC

In their article *“There is no ‘slippery slope’ to the End of Life Choice Act, say senior legal professionals”* of 15 September 2020, Catherine Marks and Colin Gavaghan have expressed the opinion that the safeguards in the End of Life Choice Act are “safe enough”. On the contrary they are likely to prove very unsafe. Marks and Gavaghan also tell readers that there has been no “slippery slope”. That is contrary to the clear international evidence and very misleading. Only those readers who have not kept up with what has happened in Belgium and Canada, to give but two examples, will be convinced by their general assertion which they make without benefit of facts. In Belgium, euthanasia for deformed children is now permissible. In Canada, since the law was changed in 2016, there has been pressure on members of the Canadian Paediatric Society by parents to euthanise disabled or dying children and infants.

The most significant gap in these lawyers’ pro-EOLC Act arguments is their failure to consider those societal facets of the issue before us which are very dangerous to several sectors of the population. Euthanasia has always been a multi-faceted issue but has commonly been wrongly reduced by proponents to considerations of pain and suffering, and viewed exclusively through an individualist and self-centred lens.

Their key words are “pain”, “choice” and “dignity”. Their first reason for law reform is that “without law change some people will continue to suffer terribly at the end of their life”. They do not even bother to distinguish between physical, psychological and existential suffering. The latter includes a sense of impending loss of “control”. Nor do they allude to the fact that modern science enables everyone to die without physical pain in all but a tiny percentage of cases. Nor do they provide any description of the excellent quality (though less than complete availability) of New Zealand’s palliative care facilities and services.

They argue that “extensive evidence” shows that “people take their lives prematurely when assisted dying is not available”. This implies that people generally don’t when it *is* available - presumably because they are content to stay their hand in the meantime secure in the knowledge that if things turn out badly they can get assisted to die at a later stage. No evidence can be advanced for this assertion for the simple reason that we have never hitherto allowed doctors to kill patients in this country. So this supposed reasoning can never have been actually in any distressed person’s mind.

Let us look a little more closely than Marks and Gavaghan do at the “safeguards” in the EOLC Act. We need to ask whether they will work in practice. At first sight they appear to be numerous and impressive. In reality, however, they are weak and will provide only very limited protection against elder abuse or mistake.

Take as an example the good-looking supposed safeguard that a health professional must not, in the course of providing any health service to a person, initiate any discussion that in substance, is about assisted dying. Nothing in the Act would prevent a doctor suggesting to a person’s relative that their dad “ought to be considering assisted dying” –with the expectation that this will be acted on and lead

to a (technically) non-initiated discussion. Nothing would prevent the attachment of “have you considered” posters to the wall of a doctor’s reception area. And suppose that a doctor disregards the Act, but not wilfully, and does initiate a discussion about assisted dying. No criminal liability can ensue. What about holding that practitioner to account in disciplinary proceedings? it is most unlikely that this would ever occur. Suspicion may abound but the best witness will probably be dead, there will have been no tape recording of the discussion, and the doctor, anxious to avoid damage to his or her practice, will hardly be likely to accept that initiation occurred. No disciplinary process will be launched without evidence for the prosecution.

The “safeguards” in the Act consist of duties and restrictions imposed on those who process assisted dying applications. They are illusory if they can never or hardly ever be enforced in legal proceedings. The question whether the duties and restrictions are legally enforceable has been conveniently ignored by the Act’s proponents.

Elder abuse is rampant in our country. Financial abuse is a substantial segment of it. Persuading an elderly parent who has lost her mental sharpness to apply for assisted dying with the motive of gaining an inheritance more rapidly is the ultimate form of elder abuse. Doctors must “do their best to ensure that the person expresses their wish free from pressure from any other person”. They are obliged to confer with other health practitioners “who are in regular contact with the person” but often none will exist. They must confer with approved members of the person’s family.

Such conferences will be most unlikely to reveal the content of family discussions, or the existence of a pattern of subtle persuasion. The doctor will typically not have been present when any such persuasion was applied. A doctor only has to “do their best”. The doctor will be able to discharge that obligation conscientiously while still being largely in the dark about what has been said or done.

There are two kinds of slope where slippage will be virtually inevitable. The first is legislative. The second is interpretive. The pressure will almost inevitably grow for the legislative eligibility criteria to be broadened. It will be alleged that to do otherwise would be wrongful discrimination. Dementia sufferers, at least those with a severe form, will be sought to be brought within the net. So will those experiencing severe clinical depression. No jurisdiction which has authorized euthanasia has ever later resolved to turn the clock back: movement is always in the direction of expanded categories and/or relaxation of any statutory restrictions.

On a recent TV programme David Seymour pooh-poohed talk about the future: that was illegitimate according to him. We are only voting on the wording of the EOLC Act as it has finally emerged from Parliament. That is obviously true, and indeed needs emphasizing. But not contemplating very likely developments is about as sensible as evaluating our country’s economic situation at the moment we vote in the General Election and ruling out any discussion of what the job market and other aspects of the economy will look like in 2021.

A significant example of interpretive slippage is the fourth requirement for eligibility. An applicant has to be one who “experiences unbearable suffering that cannot be relieved in a manner that the person considers tolerable.” Two significant interpretations are quickly likely to be adopted. First, although we are being bombarded with the word “pain”, that is not the word in the Act-which speaks of “suffering”. Many people who have no physical pain will be held to be nevertheless “suffering’. Their suffering will be psychological or existential. Letitia Seales’s concerns fell within either or both of those categories. So therefore they are “eligible”. Secondly, imagine a case where the person could have the suffering relieved, and it is objectively utterly unreasonable not to give available treatment a go. It will almost certainly be decided by pro-euthanasia medical practitioners (and by the courts) that since

there is nothing in the Act about reasonableness that cannot be relevant. It would then follow that if the person simply maintains that the available, and possibly inexpensive, treatment is “not tolerable to me” that is decisive. Medical common sense can be disregarded because it is irrelevant.

The EOLC Act needs to be assessed with the help of our knowledge as to what is likely to happen in practice. Marks and Gavaghan give no indication that they consider this important. Mr Seymour builds an argument on the numerous steps that have to be gone through between the first inquiry and the lethal injection. Those steps, trumpeted as “safeguards”, reinforce my last point. The EOLC Act propounds an elitist programme. It will be accessible fairly readily by intelligent and well-educated middle-class people who will be able to weigh the significance and seriousness of seeking an assisted suicide very well. Dying with a supportive family after a glass of wine. But what is the end of life like for vulnerable and physically frail elderly, especially the many who are isolated from their family, confused about their medical condition and open to any advice, however bad? Maggie Barry MP has rightly emphasised that “the corrosive effects of loneliness and the feeling of worthlessness and being a burden can become overwhelming”. (Sunday Star Times 27 September)

A vulnerable person may have apparently given a fully informed and unpressured consent? Who will be able to be sure? Especially in the absence of what might have acted as a real safeguard, the mandatory obtaining of psychiatric advice in close proximity to the appointed day.

Each of the vaunted safeguards against the subjection of many in our community to premature and wrongful death is illusory. As we slip down the slope the prospect of many involuntary and some non-voluntary deaths will become a reality.

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