

Catharina Lee

Kill ‘em with kindness: Can incompetent children make end-of-life decisions?

Submitted for the LLB (Honours) Degree

Faculty of Law

Victoria University of Wellington

2021

Contents

I	INTRODUCTION.....	5
A	What is Euthanasia and Assisted Suicide?.....	5
B	Euthanasia and Assisted Suicide in New Zealand	6
C	Euthanasia and Assisted Suicide for Children	6
II	INFORMED CONSENT TO MEDICAL TREATMENT	8
A	Informed Consent Requirements.....	8
B	The Gillick-competent Child	9
C	Actual Understanding Compared to Capacity to Understand	10
D	Right to Consent Compared to a Refusal to Consent.....	10
III	REFUSAL TO CONSENT TO MEDICAL TREATMENT CASES	11
A	Key Refusal to Consent to Medical Treatment Cases.....	12
1	Re R.....	12
2	Re W	12
3	Re E.....	12
4	Re M	13
B	The Common Thread	13
IV	EUTHANASIA AND ASSISTED SUICIDE FOR CHILDREN OVERSEAS	15
A	Child Euthanasia and Assisted Suicide in Belgium	15
1	Belgian Law on Euthanasia and Assisted Suicide for Children	16
2	The Concept of ‘Capacity for Discernment’	17
3	The Problematic Competency Test.....	18
B	Child Euthanasia and Assisted Suicide in the Netherlands.....	19
1	Dutch Law on Euthanasia and Assisted Suicide for Children	19
2	The Reality of Medical End-of-Life Decisions for Children in the Netherlands	20
3	Criticism by the Committee on the Rights of the Child	22

V	THE DIFFERENCE IN APPROACH IN LIFE AND DEATH SITUATIONS ...	22
A	Justifications for Child Euthanasia and Assisted Suicide	23
B	Why Should Children’s Lives Be Preserved?	24
C	What About Children’s Suffering?	25
D	What does this mean for Children’s Autonomy?	26
VI	WHAT DOES THIS MEAN FOR NEW ZEALAND?	27
A	New Zealand’s Law on Children’s Competency to Consent to Medical Treatment....	27
B	New Zealand’s End of Life Choice Act 2019	28
C	Should Child Euthanasia and Assisted Suicide be Legal in New Zealand?.....	28
VII	CONCLUSION.....	32
VIII	BIBLIOGRAPHY	35

Abstract

The English courts' have found unwaveringly in favour of preserving a child's life where the child has refused life-saving medical treatment. By contrast, Belgium and the Netherlands support a child's ability to consent to euthanasia and assisted suicide. This paper will compare the two different approaches to informed consent for children and their competency in making life and death decisions. It will analyse the underlying rationale and expose the problems with existing euthanasia and assisted suicide legislation for children. It will consider how the tension between upholding a child's right to autonomy and protecting their welfare ought to be balanced. It concludes by recommending against the provision of euthanasia and assisted suicide for children in New Zealand. It argues that children are incompetent to make end-of-life decisions, good competency assessments for euthanasia and assisted suicide are too difficult to craft, and the risk of undue influence and others deciding on children's behalf is too high. Moreover, extending New Zealand's euthanasia and assisted suicide legislation to children would be inconsistent with the value systems of non-Pākehā cultural groups within New Zealand, and would risk exacerbating existing health inequities for Māori and Pasifika.

Key words:

“Euthanasia”, “Assisted Suicide”, “Assisted Dying”, “Children's Informed Consent”, “New Zealand”.

I Introduction

There are few known cases where courts have deemed children competent to refuse lifesaving medical treatment. This reflects judicial attempts to act in the best interests of children and to save lives. These decisions have been criticised as not being in the child's best interests, failing to uphold the child's right to autonomy, especially if they appear able to make such a decision. This paper will consider whether euthanasia and assisted suicide is different from children refusing to consent to medical treatment, and why this might be the case. First, key English cases on a child's informed consent, where children refuse to consent to life-sustaining medical treatment, will be analysed; then compared to euthanasia and assisted suicide. Second, overseas regulations supporting children's informed consent to euthanasia and assisted suicide will be examined. Third, this paper will consider the tension between balancing a child's right to autonomy whilst protecting their best interests, and consequently the different approaches to children's consent to euthanasia and assisted suicide. Finally, this article will conclude by making recommendations on how New Zealand should proceed regarding whether children should be allowed to give their informed consent to euthanasia and assisted suicide.

A What is Euthanasia and Assisted Suicide?

Euthanasia and assisted suicide are distinct concepts. Euthanasia involves an attending health practitioner taking an action with the singular intention of causing a patient's death.¹ This usually takes the form of the injection of a lethal drug. Assisted suicide occurs when the patient is prescribed drugs, which they self-administer and take to die. Both these practices are distinct from the withdrawal and withholding of life-sustaining treatment.²

¹ "What is the Difference Between Euthanasia and Assisted Suicide?" Maxim Institute <<https://www.maxim.org.nz/>>.

² "When Death is Sought: Assisted Suicide in the Medical Context" (April 2011) New York State Task Force on Life and the Law <<https://www.ny.gov/>>.

B Euthanasia and Assisted Suicide in New Zealand

New Zealand will join Canada, Switzerland, the Netherlands, Belgium and various US and Australian states in having legalised euthanasia and assisted suicide for persons 18 years and over, when the End of Life Choice Act 2019 comes into effect in November 2021.³ This follows 65.1 per cent of New Zealand voters supporting the legislation at referendum in November 2020, surpassing the 50 per cent majority required to pass the law.⁴ Supporters of the legislation celebrate this as a positive shift towards making New Zealand a more compassionate and humane society by providing individuals with “choice, dignity, control, and autonomy over their own bodies”.⁵ They hope that legalising euthanasia and assisted suicide will prevent unnecessary suffering for individuals and their loved ones.⁶

C Euthanasia and Assisted Suicide for Children

It is likely that there will be future discussions on expanding New Zealand’s euthanasia and assisted suicide law to children, as seen in other jurisdictions. Most jurisdictions require eligible patients to experience ‘unbearable suffering’. In New Zealand, the person must additionally suffer from a terminal illness likely to end their life within 6 months.⁷

Euthanasia and assisted suicide are available for children of any age in Belgium. In the Netherlands, euthanasia and assisted suicide legislation has been recently expanded to include children aged between one and 12.⁸ Previously, it was only legal for children older than 12 and for infants up to a year old. In Canada, euthanasia and assisted suicide has only

³ End of Life Choice Act 2019, s2.

⁴ “Official Referendum Results Released” (6 November 2020) Elections NZ <<https://elections.nz/>>.

⁵ Hannah Martin “Referendum Results: End of Life Choice Act passes, legalising assisted dying” *Stuff* (online ed, New Zealand, 30 Oct 2020).

⁶ Above n 5.

⁷ End of Life Choice Act 2019, s5(1).

⁸ “Netherlands backs euthanasia for terminally ill children under-12” *BBC News* (online ed, 14 October 2020).

been legal for five years. However, the legislation is already being reviewed to consider whether ‘mature minors’ should have access to it.⁹

The most prevalent belief held by proponents of child euthanasia and assisted suicide legislation is that children who suffer unbearably should be allowed to have their suffering relieved by ending their life. They argue that euthanasia and assisted suicide provides for self-determination, parental determination, and “the beneficence of physicians to end unbearable suffering.”¹⁰ This makes it “gentler, easier and more humane for both the child and for the parents”, showing trust in children, parents and doctors to make the right decision.¹¹ Some argue that euthanasia and assisted suicide should be available for both competent and incompetent children.¹²

Opponents to child euthanasia and assisted suicide challenge the claim that euthanasia and assisted suicide is the only solution to unbearable suffering. They argue that good palliative care techniques such as terminal sedation are effective at relieving pain, and preferable to killing patients.¹³ Additionally, most people who choose to end their lives are not motivated by physical pain, but by existential suffering. The most common reasons given by people who choose to end their life are fears about the loss of autonomy or desire not to burden others.¹⁴ “Such concerns will generally not be relevant to small children.”¹⁵ Consequently, “it seems unlikely that simply extending the legal framework that is used in adults to younger and younger people will be either useful or necessary.”¹⁶

⁹ Ryan Patrick Jones “Here’s the latest on the review of Canada’s assisted dying law” *CBC News* (16 May 2021).

¹⁰ Marije Brouwer and others *Should Pediatric Euthanasia be Legalized?* (2018) 141 *Pediatrics*.

¹¹ Brouwer and others, above n 10.

¹² Brouwer and others, above n 10.

¹³ Brouwer and others, above n 10.

¹⁴ Oregon Health Authority Death “Oregon Death with Dignity Act 2019 Data Summary” (6 March 2020) *Oregon.gov* <oregon.gov>.

¹⁵ Brouwer and others, above n 10.

¹⁶ Brouwer and others, above n 10.

II Informed Consent to Medical Treatment

The framework used to protect children when making decisions is that of informed consent. This framework is used often in the context of medical treatment and sets the background to children's consent to euthanasia and assisted suicide.

A Informed Consent Requirements

Children are often presumed incompetent to consent to medical treatment because of their age. However, some countries assess children's competence to consent to medical treatment on a case-by-case basis. Assessing the validity of a child's informed consent requires consideration of the following factors.¹⁷

First, consent must be voluntary and without undue influence. Consider that children's levels of psychosocial maturity, even at 16 or 17 years old, do not come close to those of an adult.¹⁸ This renders children more susceptible to coercive influences, especially in the context of medical decisions heavily involving parents and physicians.

Second, consent must be informed. Information explaining the patient's state of health, available medical options, details of medical procedures and any risks, benefits, side effects, failure rates of proposed treatments or alternatives should be given.¹⁹ This must be done in a clear and simple way, without 'dumbing down' the relevant information.

Third, the child must be competent to consent to the medical treatment. This often requires an evaluation of aspects such as the child's cognitive ability to understand and to choose,

¹⁷ Ron Paterson "Legal and Ethical Dilemmas" in Ministry of Health *Consent in Child and Youth Health: Information for Practitioners* (Ministry of Health, Wellington, 1998) at 42.

¹⁸ Kristof Van Assche and others "Capacity for Discernment and Euthanasia on Minors in Belgium" (2018) 27 *Med L Rev* 242 at 253.

¹⁹ Ministry of Health *Consent in Child and Youth Health: Information for Practitioners* (Ministry of Health, Wellington, 1998) at 4.

whether the choice is based on rational reasons, the outcome, and the child's life experience.²⁰ These must be assessed in relation to the specific medical treatment.

B The Gillick-competent Child

It is useful to understand the law on children's informed consent to medical treatment in England, as it is likely a similar standard of informed consent is applicable to children in New Zealand.²¹

The leading English case about children being competent to give informed consent to medical treatment is *Gillick v West Norfolk and Wisbech AHA*.²² The issue considered was whether a doctor could lawfully provide contraceptive advice and prescriptions for a girl under 16 years of age. The majority in the House of Lords concluded that a child under 16 years of age can give effective consent. Speaking for the majority, Lord Scarman pronounced that:²³

A minor's capacity to make his or her own decision depends on the minor having sufficient understanding and intelligence to make the decision and is not to be determined by reference to any judicially fixed age limit.

This is the key principle from *Gillick*. It signifies a shift from the orthodox status-based approach where the child's age was the determining factor in assessing their competence, to the modern understanding-based approach which assesses children's competence to understand and decide on the medical procedure in question individually.

Additionally, Lord Scarman suggests that something more than mere cognitive understanding is necessary. This factor is integral in cases where children refuse to consent

²⁰ Vic Larcher, Anna Hutchinson "How should pediatricians assess Gillick competence?" (2010) 95 Arch Dis Child 307 at 307.

²¹ Health and Disability Commissioner (Code of Health and Disability Services Consumers' Rights) Regulations 1996, Sch 2, Right 7(2).

²² *Gillick v West Norfolk and Wisbech Area Health Authority* [1986] 1 AC 112 (UKHL) [*Gillick*].

²³ At 188, per Lord Scarman.

to lifesaving medical treatment and is similarly relevant when considering child euthanasia and assisted suicide. The patient should not only understand the nature of the advice being given but must have “sufficient maturity to understand what is involved.”²⁴ Moreover, the child’s ability to manage influences on their decision-making is important in assessing their maturity. Lord Scarman indicates that moral considerations and the child’s relationship with their parents are also of importance.²⁵

C Actual Understanding Compared to Capacity to Understand

In *Gillick*, Lord Fraser says that the minor must be “capable of understanding what is proposed, and of expressing his or her own wishes”.²⁶ There has been rigorous debate about whether *Gillick* stands for the proposition that informed consent requires actual understanding or capacity to understand. However, for our purposes we will assume that understanding requires both a capacity to understand and actual understanding of the proposed treatment. A higher degree of competence must be required when children wish to make a life and death decision.

D Right to Consent Compared to a Refusal to Consent

A child might be competent to consent to treatment, but not competent to refuse to consent to that same treatment. This is because the consequences of consenting to treatment can be different from the consequences of refusing treatment. An example of this is a child with tonsillitis who would be capable of consenting to taking penicillin to treat the condition but would not be capable of refusing to take penicillin, as they would not understand the full implications of rheumatic fever if they were to refuse treatment.²⁷ A child’s capacity to give informed consent to a proposed medical treatment must be distinguished from their capacity to refuse to consent.

²⁴ At 189, per Lord Scarman.

²⁵ At 189, per Lord Scarman.

²⁶ At 169, per Lord Fraser.

²⁷ Kathryn McLean “Children and Competence to Consent: *Gillick* Guiding Medical Treatment in New Zealand” (2000) VUWLR 551 at 557.

III Refusal to Consent to Medical Treatment Cases

English courts have staunchly rejected opportunities to allow children to refuse to consent to lifesaving medical treatment by finding children incompetent to make such decisions. This has been justified on the grounds that a child's decision to refuse to consent to lifesaving medical treatment cannot be in their best interests, as it does not preserve the health and life of the child.²⁸

For many critics, this view is inconsistent with the understanding-based approach to informed consent enshrined in *Gillick*. They argue that judges' assessments of children's competence have become a normative judgment based on what decision the child makes. This should not be the case, as the right to decide should not be confused with having to make the right decision.²⁹ They believe that once found competent, a child should be able to decide regardless of how unreasonable or undesirable their decision may appear to others.

However, most resist the idea of pursuing proposals for autonomy "to a point where children will be in danger of hanging themselves."³⁰ Informed consent for competent adults relies on the hope that individuals will behave rationally. Society is willing to allow a margin of error of competent adults making irrational, bad decisions. Yet, society is reluctant to support a child's right to decide when it will lead to serious emotional and physical consequences. There is a significant social distinction society makes between children and adults. Many believe it is necessary to find a means to override children's medical decisions when it would place them in a life-threatening situation.

²⁸ *Re R (A Minor) (Wardship: Consent to Treatment)* [1991] 3 WLR 592 (CA); *Re W (A Minor) (Consent to Medical Treatment)* [1993] 1 FLR 1; *Re E (A Minor) (Wardship: Medical Treatment)* [1992] 2 FCR 219 (CA); *Re M (Medical Treatment: Consent)* [1999] 2 FLR 1097.

²⁹ Carole Smith "Children's Rights: Judicial Ambivalence and Social Resistance" (1997) 11 IJLPF 103 at 106.

³⁰ Smith, above n 29, at 128.

A Key Refusal to Consent to Medical Treatment Cases

1 Re R

R was a suicidal, fifteen-year-old girl who was lucid and rational at times but was not *Gillick*-competent. R did not understand the nature of the proposed psychiatric treatment, the consequences of the treatment, and the anticipated consequences of a failure to treat. The Court of Appeal's finding demonstrates that evidence of psychological disorders and suicidal tendencies will likely be enough to render a child incompetent to refuse to consent to medical treatment. Courts will intervene to preserve the health and life of the child.

2 Re W

This case found that a child suffering from anorexia is incompetent to refuse medical treatment because of the nature of their illness. This affirms the finding in *Re R* that mental illnesses and psychological disorders can be interpreted as denying children the requisite competence to comprehend the true nature of their predicament, and thus to refuse medical treatment.³¹

3 Re E

The Court of Appeal decided that a 15-year-old Jehovah's Witness was incompetent to understand the full implications of his refusal to consent to a life-saving blood transfusion. This was despite the boy being of, "sufficient intelligence to be able to make decisions about his own wellbeing". Ward J said he could not judge the child's "considered wish to choose for oneself to die" to be consistent with his welfare:³²

He may have some concept of the fact that he will die, but as to the manner of his death and to the extent of his and his family's suffering I find he has not the ability to turn his mind to it nor will he do so.

³¹ Morag McDowell "Medical Treatment and Children: Assessing the Scope of a Child's Capacity to Consent or Refuse to Consent in New Zealand" (1997) 5 JLM 90.

³² *Re E*, above n 28, at 393.

The court prioritised the boy's "need for the chance to live a precious life" over his and his father's wish to refuse the blood transfusion.³³

4 *Re M*

This case dealt with a fifteen-year-old girl in urgent need of a heart transplant who was found incompetent to refuse to consent to the operation. Without this transplant, she was expected to die within a week. M said she understood the nature of the procedure and post-operative implications. She was depressed at the prospect of having to take a course of tablets daily, for the rest of her life, and said she would rather die than survive with another person's heart.

B The Common Thread

Re R and *Re W* illustrate how children will generally be rendered incompetent to refuse medical treatment when deemed to be suffering from psychiatric disorders or mental illness. This was despite evidence that both minors had "evidently considered the proposals for treating their respective conditions and...made an informed judgement" to refuse medical treatment.³⁴ Although a difference of opinion between a child and their physician does not in itself constitute evidence of incompetence, it is still important to consider, when assessing competence, whether the child's choice is based on rationale reasons and what the reasonable outcome of the child's decision might be.³⁵ These considerations are vital where children suffer from psychological disorders, which can seriously affect consideration of important factors in decision-making. If children suffering from psychological disorders were found competent to refuse medical treatment, it is likely they could cause serious harm to themselves.

Re E and *Re M* assess a child's competence to refuse to consent to medical treatment in the particular context of life and death situations. In both cases, the child was found to be incompetent because they did not fully understand the ramifications of their decision on

³³ *Re E*, above n 28, at 393.

³⁴ Smith, above n 29, at 117.

³⁵ Larcher and Hutchinson, above n 20, at 307.

themselves *and* their family. In *Re M*, Johnson J said that “events have overtaken [M] so swiftly that she has not been able to come to terms with her situation”.³⁶ Implicitly, both judges believed that the children’s refusal to medical treatment were irrational. The children were considered incompetent to refuse the treatment.

These decisions have been challenged as promoting untenable arguments. First, that both decisions assume that life-prolonging treatment is in the children’s best interests. Second, that it is not necessary to contemplate whether children have anticipated their response to dying and considered this when choosing to refuse treatment. The first point can be countered by the understanding that children cannot properly understand the consequences of a decision to die, and society’s responsibility to protect a child’s life fundamentally outweighs the child’s said right to autonomy. This is the starting point the English courts have proceeded from. Second, whether children understand the consequences of their refusal to medical treatment when assessing children’s competence is a necessary consideration. The hardship and suffering endured by the child *and* their family as a direct consequence of the child’s refusal to consent to medical treatment are integral considerations which the child must understand before deciding. Adults are more likely to appreciate these consequences of an end-of-life decision compared to children.

All four cases discussed reflect the judiciary’s efforts to restore the paternalistic veto of the court in life-threatening situations. This veto has been diminished by the competency test for children taken to its autonomy-oriented end. However, the *Gillick* competency test does not appear to have considered nor been intended to apply to situations where a child wishes to refuse medical treatment, causing serious harm to themselves or prematurely ending their life. Consequently, the English courts have prevented autonomy being the sole focus at the expense of a child’s life. Where life or death is in issue, a high degree of competence

³⁶ *Re M*, above n 28, at [12].

must be demonstrated. This bar is set intentionally high so that no child is likely to be deemed sufficiently competent.³⁷

IV Euthanasia and Assisted Suicide for Children Overseas

In contrast to the paternalistic approach of the English judiciary, countries which have legalised child euthanasia and assisted suicide allow children to end their life. This flows from the belief that it is not always in children's best interests to preserve their life.

This section will consider how child euthanasia and assisted suicide in Belgium and the Netherlands differ from the English approach. It will consider how the non-English rationale produces problems which are evident from their child euthanasia and assisted suicide legislation. First, the competency standards are often rudimentary and fundamentally deficient. Second, the legislation allows significant risks of non-autonomous decisions (involuntary euthanasia) occurring. Finally, evidence reveals that very few children at the end of life are competent to make end of life decisions.³⁸ Requests for euthanasia and assisted suicide rarely come from the child themselves, but more often come from parents,³⁹ or at the suggestion of physicians.⁴⁰

A Child Euthanasia and Assisted Suicide in Belgium

Since the 2014 amendment of Belgium's euthanasia and assisted suicide law to include all children, regardless of age, who have 'capacity for discernment', at least four children have chosen to end their life in this way. According to the 2018 report from Belgium's chief euthanasia regulatory body, the Federal Commission for Euthanasia Control and Evaluation, the three children euthanised in 2016 and 2017 were aged 9, 11 and 17 years

³⁷ Emily Jackson *Medical Law Text, Cases and Materials* (5th ed, Oxford Texts, 2019) at 266 in "Article 8 and Minors' Right to Refuse Medical Treatment" (20 January 2012) King's Student Law Review <<https://blogs.kcl.ac.uk/>>.

³⁸ Astrid M Vrakking and others "Medical End-of-Life Decisions for Children in the Netherlands" (2005) 159 *Arch Pediatric Adolesc Med* 802 at Table 4.

³⁹ Vrakking and others, above n 38, at 807.

⁴⁰ Vrakking and others, above n 38, at 805.

old.⁴¹ Their conditions were classified as either muscular dystrophy, brain tumours, or cystic fibrosis. In the 2019 report, the Commission received one declaration relating to the euthanasia of a minor patient.⁴² No comment was made as to what illness the child had.

The illnesses facing children who wish to end their life by euthanasia or assisted suicide encompass a broader range of scenarios than those seen in the refusal to consent to lifesaving medical treatment cases. The children in *Re E* and *Re M* would have died soon after refusing to consent to medical treatment. However, not all of the illnesses suffered by the Belgian children would have resulted in such immediate death. For example, the child in Belgium suffering from cystic fibrosis, an incurable and fatal congenital respiratory disease, could have received modern treatments to enable a high quality of life well into and often beyond their mid-30s.

1 Belgian Law on Euthanasia and Assisted Suicide for Children

Belgium's Euthanasia Law requires the physician performing euthanasia to ascertain that the patient is "conscious at the moment of making the request; the request is voluntary, well-considered and repeated, and is not the result of any external pressure."⁴³ Until 2014, only adults and emancipated minors could access euthanasia. The 2014 amendment to expand Belgium's Euthanasia Law to include all children, laid down five additional legal requirements. The amendment:⁴⁴

- (i) only allows euthanasia for those minors who have the capacity for discernment;

⁴¹ Arya Hodjat "Belgium Approved Euthanasia of 3 Minors, Report Finds" (25 July 2018) Voa News <<https://www.voanews.com/>>.

⁴² *Ninth Report to the Legislative Chamber 2018-2019*, Federal Commission for Euthanasia Control and Evaluation.

⁴³ Belgian Euthanasia Law art 3(1): 'The physician who performs euthanasia commits no criminal offence if he has ascertained that: the patient is [...] conscious at the moment of making the request; the request is voluntary, well-considered and repeated, and is not the result of any external pressure.'

⁴⁴ Van Assche and others, above n 18, at 248.

- (ii) requires that this capacity is not only ascertained by the attending physicians but also certified by an independent expert who has to be a child and adolescent psychiatrist or psychologist;
- (iii) stipulates that these minors can only receive euthanasia for physical suffering and
- (iv) only if they suffer from a condition that will result in death within the foreseeable future; and
- (v) does not give them the option to draft an advance directive requesting euthanasia should they in the future find themselves in a state of permanent unconsciousness.

Additionally, a child's decision to have euthanasia or assisted suicide in Belgium must be supported by the consent of their parents or legal guardian.

2 *The Concept of 'Capacity for Discernment'*

The concept of 'capacity for discernment' was first introduced into Belgian medical law in the 2014 amendment to the euthanasia and assisted suicide legislation.⁴⁵ It remains a concept of considerable uncertainty. It is not defined in the legislation and no criteria about what is required to assess a child's capacity is given.

When the constitutionality of the 2014 amendment to Belgium's euthanasia and assisted suicide law was brought before the Belgian Constitutional Court in 2015, the Court ruled that the concept of 'capacity for discernment' was sufficiently clear. The Court rejected the applicants' argument that the lack of definition and criteria to consider when assessing a minor's 'capacity for discernment' made it impossible to know what it meant and how it could be consistently applied.⁴⁶ They indicated that 'capacity for discernment' is analogous to the patient having the 'ability to express their wishes'.⁴⁷ In the context of euthanasia, it 'relates to the ability of the minor to understand the real implications of his euthanasia

⁴⁵ Van Assche and others, above n 18, at 249.

⁴⁶ Van Assche and others, above n 18, at 248.

⁴⁷ Van Assche and others, above n 18, at 249.

request and its consequences'.⁴⁸ Consequently, the amendment was not in breach of the principle of legal certainty and was not rejected.

The wording used by the Belgian Constitutional Court is similar to Lord Fraser's statement of the law regarding children's informed consent in *Gillick*, that the minor must be "capable of understanding what is proposed, and of expressing his or her own wishes".⁴⁹ In *Gillick*, the House of Lords largely left it to the discretion of medical practitioners to determine whether a child was of sufficient understanding and intelligence to comprehend the nature and implications of their decision. The Belgian Court appears to do the same here.

3 *The Problematic Competency Test*

Competency tests equivalent to the standard set in *Gillick* are not designed to be applied in the vastly different context of life and death situations like euthanasia and assisted suicide. A child's decision to consent to contraceptive advice and prescriptions from a doctor (the facts in *Gillick*) is incomparable to a child's decision to end their own life. The consequences of each decision are vastly different; likewise, the competency required of children is vastly different. Whilst children can be competent to consent to contraceptive advice and prescriptions, they are incompetent to refuse consent to lifesaving medical treatment.⁵⁰ Likewise, children are incompetent to choose to end their life by euthanasia or assisted suicide.

By allowing children of all ages to access euthanasia and assisted suicide, the Belgian law presumes that all children regardless of age could be competent. Doing so fails to consider the significant differences in children's cognitive abilities and psychosocial maturity as compared to adults. Children as young as nine years old are being treated as of the same maturity and competence as adults when this is simply not the case. Euthanasia and assisted

⁴⁸ Constitutional Court of Belgium (29 October 2015) 153/2015 (English translation) < <http://www.const-court.be/public/e/2015/2015-153e.pdf>>.

⁴⁹ *Gillick*, above n 22, at 169.

⁵⁰ "Article 8 and Minors' Right to Refuse Medical Treatment" (20 January 2012) King's Student Law Review <<https://blogs.kcl.ac.uk/>>.

suicide decisions involve complex medical, existential, and relational issues. Just as no child has been found competent to refuse lifesaving medical treatment because they do not fully understand the implications of death,⁵¹ no child is competent to end their life by euthanasia or assisted suicide. Society is fundamentally responsible for protecting children when their health and lives are in danger. Permitting the legalisation of child euthanasia and assisted suicide when children cannot properly understand the consequences of a decision to die is directly incompatible with this duty.

B Child Euthanasia and Assisted Suicide in the Netherlands

The Netherlands was the first country to legalise euthanasia and assisted suicide for children. Like Belgium, euthanasia and assisted suicide is permitted for infants and children of all ages.⁵²

1 Dutch Law on Euthanasia and Assisted Suicide for Children

The Dutch law requires that: the patient's request be voluntary and well-considered, their suffering be lasting and unbearable, the patient has been informed about their situation and prospects and has no other reasonable solution for the situation they are in, and that another physician who has seen the patient has been consulted and agreed to the patient's request.⁵³ 'Unbearable suffering' includes psychological suffering. The potential termination of a patient's life who primarily suffers psychologically applies to children.

Children between twelve to fifteen years old must additionally 'have a reasonable understanding of his interests', and the child's parents must agree with their request.⁵⁴ We can assume this criterion applies to the recent extension of the law to include children under the age of 12 years old. For children over sixteen, a euthanasia or assisted suicide request can be made without parents' permission.⁵⁵ Parents need only be informed of their request.

⁵¹ Above n 50.

⁵² Above n 8.

⁵³ Dutch Termination of Life on Request and Assisted Suicide (Review Procedures) Act 2001, Article 2(1).

⁵⁴ Dutch Termination of Life on Request and Assisted Suicide (Review Procedures) Act 2001, Article 2(4).

⁵⁵ Dutch Termination of Life on Request and Assisted Suicide (Review Procedures) Act 2001, Article 2(3).

Like the Belgian law, there is little information about what is required for physicians to assess whether a child has a ‘reasonable understanding of his interests’. However, in law, ‘reasonableness’ tends to be a relatively low threshold. This is lower than the high competency standard required for children to refuse to consent to life-saving medical treatment.

2 The Reality of Medical End-of-Life Decisions for Children in the Netherlands

The 2005 nationwide study on ‘Medical End-of-Life Decisions for Children in the Netherlands’ exposed considerable problems with children’s competence to make end-of-life decisions and concerns about the involvement and decision-making role of parents and physicians.⁵⁶

Like the findings of the English courts in the refusal to consent to lifesaving medical treatment cases, the study found that few children were considered fully or even partly competent to make end of life decisions.⁵⁷ Out of the 76 most recent end-of-life decisions in the study, only 9 children were considered fully competent, and 7 children were considered partly competent. Partly competent implies that the child could make simple choices and communicate these, or that the child was capable only of understanding simple information.⁵⁸ Of the 20 physician-assisted dying cases, only 4 children were considered competent, and 16 children were partly or completely incompetent.⁵⁹ This reveals that competence is not necessary for children to access euthanasia and assisted suicide in the Netherlands.

Requests for euthanasia or assisted suicide rarely came from the child themselves. This was still the case even when only the deaths of children who were old enough to ask for physician-assisted dying (above 12 years old) were taken into account.⁶⁰ Although parents

⁵⁶ Vrakking and others, above n 38.

⁵⁷ Above n 38, at Table 4.

⁵⁸ Above n 38, at 805.

⁵⁹ Above n 38, Table 4.

⁶⁰ Above n 38, at 807.

should be trusted to act in their child's best interests, a decision to terminate the life of a child being left in parents' hands is not something to be taken lightly. Nor was this an intended purpose of the legislation. Currently, parents can decide to end their incompetent child's life under the guise of this being the child's decision. This should not be permitted.

Children are occasionally involved in making their own end-of-life decision; however, it is more often the parents and physicians, not the child deciding. This is distinguishable from cases where the child themselves wished to refuse to consent to medical treatment, as in *Re R*, *Re W*, *Re E*, and *Re M*. The study observed:⁶¹

In most cases, pediatricians consider children unable to participate in the decision-making process because they are unconscious or because they are too young. Communication about end-of-life decision making for children typically involves caregivers, parents, and, if possible, the child.

Children's competence often comes secondary to what parents want, subject to the physician agreeing to the end-of-life decision. In some cases, the decision to euthanise the child was made without an explicit request from either the child or their parents, but at the suggestion of physicians.⁶² Such a precedent is concerning. An end-of-life situation is one of the most vulnerable stages of life. Parents and children can be easily influenced into making a decision they may later regret.

This study was limited to end-of-life decisions involving children suffering from terminal illnesses. However, it is important to recognise that the Dutch euthanasia and assisted suicide legislation includes children who suffer psychologically. Where a psychological illness causes a child to want euthanasia or assisted suicide, more complex factors come into play; the risk to the child's welfare and best interests becomes heightened. In *Re R* and *Re W*, the nature of the children's psychological illnesses made them incompetent to refuse medical treatment for this illness. Likewise, children suffering from psychological illnesses

⁶¹ Above n 38, at 808.

⁶² Above n 38, at 805.

should not be permitted to end their life. Euthanasia and assisted suicide are not treatments for psychological illnesses. It should not be contemplated for children.

3 Criticism by the Committee on the Rights of the Child

The 2015 Report of ‘Observations of The Netherlands’ by the Committee on the Rights of the Child criticised the euthanasia and assisted suicide legislation for children.⁶³ The Committee expressed their concerns about insufficient transparency and lack of supervision of the Dutch practice of child euthanasia and assisted suicide. In the Committee’s recommendations they showed concern about whether strong control of the practice was being ensured, whether the psychological status of children and parents were seriously taken into consideration when determining whether to grant the request, and whether reporting of cases were given the fullest possible overview.⁶⁴ They recommended that the Netherlands consider ‘abolishing the use of euthanasia towards patients under 18 years of age’.⁶⁵ The Committee’s recommendations reflect considerable concern that euthanasia and assisted suicide for children is potentially being used for untoward reasons, which might not be possible to detect due to the current procedures and legislation.

V The Difference in Approach in Life and Death Situations

A comparison of the two different approaches prohibiting children from refusing to consent to lifesaving medical treatment and permitting children to consent to euthanasia and assisted suicide reflect the tension between balancing children’s right to autonomy and ensuring a child’s welfare is protected. These differences appear to be justified by upholding either a child’s right to self-determinism or society’s duty to preserve the health and lives of children. However, on closer examination, there are further purposes and problems underlying each rationale.

⁶³ United Nations Committee on the Rights of the Child *Concluding observations on the further periodic report of the Netherlands* CRC/C/NDL/CO/4 (8 June 2015).

⁶⁴ Above n 63, at 6-7.

⁶⁵ Above n 63, at 6-7.

A Justifications for Child Euthanasia and Assisted Suicide

Broadly, the three main benefits of legalising euthanasia and assisted suicide are “(1) realising individual autonomy, (2) reducing needless pain and suffering, and (3) providing psychological reassurance to dying patients.”⁶⁶

Child euthanasia and assisted suicide legislation is often justified as promoting children’s autonomy and right to self-determinism. Autonomy refers to “governance over one’s actions.”⁶⁷ In the context of euthanasia and assisted suicide, individuals can determine whether they want to ask for and consent to end their life. This is considered a natural extension from allowing individuals to make health decisions, to then control the circumstances of their death.

Upholding children’s autonomy appears to be provided for by the child euthanasia and assisted suicide legislation in Belgium and the Netherlands, which have similar competency tests. The standard of competency is relatively low compared to the high level of competency required of children who refuse to consent to lifesaving medical treatment. From one perspective, the legislation of euthanasia and assisted suicide for children regardless of age, presumes that children may become competent at any time. This provides the opportunity for children to make an autonomous decision to end their life once they are considered competent. Alternatively, the legislation can be perceived as not considering competence to be an important consideration at all. At least, this is the practical effect that the Dutch legislation has. The study on medical end of life decisions in the Netherlands revealed that it is not uncommon for incompetent children to be euthanised. Consequently, it is unlikely that autonomy is the principal consideration behind child euthanasia and assisted suicide legislation.

⁶⁶ Ezekiel J Emanuel “What Is the Great Benefit of Legalizing Euthanasia or Physician-Assisted Suicide?” (1999) 109 *Ethics* 629.

⁶⁷ Lydia S Dugdale, Barron H Lerner and Daniel Callahan “Pros and Cons of Physician Aid in Dying” (2019) 92 *Yale J Biol Med* 747.

The notion that autonomy is an insufficient justification for legalising euthanasia and assisted suicide on its own is incorporated into most proposals for legalisation. In both the Netherlands and Belgium, patients must request euthanasia or assisted suicide, undergo an element of unbearable suffering, and another physician must certify the patient's request. Having more than the first requirement illustrates that autonomy is insufficient in itself; it must be accompanied by a further good.

The further good provided for individuals is to have a 'good death' or 'quality dying experience'. This is enhanced by the two other perceived benefits of legalising euthanasia and assisted suicide – alleviation of physical pain or existential suffering and the provision of psychological reassurance that this option remains. Autonomy of the child, and thus, assessing the child's competence to consent, are not the central consideration. Euthanasia and assisted suicide can simply be justified on the grounds of providing children and those who care for them with the option of ending their suffering.

This understanding explains the shift in argument from proponents of child euthanasia and assisted suicide legislation to include both competent and incompetent children of all ages. It also reveals why the practical reality of parents and physicians making end-of-life decisions, including euthanasia and assisted suicide, on children's' behalf, continues to occur. Under this rationale it does not matter that there are low competency thresholds for child euthanasia and assisted suicide legislation. It is only important that children can access it.

B Why Should Children's Lives Be Preserved?

By contrast, judges have refused to find children competent to refuse to consent to lifesaving medical treatment. Even when children have considered, evaluated, and appeared to make an informed judgement about the acceptability of a proposed treatment, the English courts have refused to allow children to decide to prematurely end their life. This comes from the basic premise that acting in the child's best interests always requires the preservation of their life. The justification for this is simple – the value of life is of such

importance that no one, not even the child themselves, should be allowed to take their own life.

Preserving life as a black and white rule forms the foundation of all societies. Euthanasia and assisted suicide are directly contrary to this. From this perspective, people do not have the prerogative to end their own or another's life, even with permission. This premise is further complicated by the evolving belief that it is better to be dead than to live with an impairment, ill health, disability, or 'suffering' of various kinds. 'Quality of life' is seen as the most important consideration, often more important than life itself. Notably, this was brought up by many submitters on New Zealand's End of Life Choice Bill when it was proceeding through Parliament. These submitters believe that quality of life is more important than its length, that individuals are autonomous, and it should be left to them to judge what amounts to a quality life and dignified death.⁶⁸

This view is problematic because assessing whether death is preferable to an individual's perceived lowered 'quality of life' is subjective. Some would argue that consequently, a decision to end one's life should be left to the individual; autonomy must prevail. However, a child's decision to end their life is not individualistic. Intentionally ending a person's life is an act that requires another person's participation. The child also exists within a family unit. Familial relationships and the impact of a child's life on others should not be so quickly dismissed.

C What About Children's Suffering?

Children are incompetent to decide to end their own life. A child's decision to do so is not individualistic; it should not be left solely to them. But what about the question of alleviating a child's suffering?

Supporters of euthanasia and assisted suicide legislation argue that it is compassionate to assist in patients' deaths. Those against the practice of euthanasia and assisted suicide

⁶⁸ End of Life Choice Bill 2018 (select committee report) at 9.

believe that treatment with care, love, and support is the only compassionate response.⁶⁹ However, the better question is whether ending a child's life as a response to their suffering outweighs the risks of permitting euthanasia and assisted suicide for children who are incompetent to decide.

The answer to this must be no. Society has a duty to protect the lives of children, both from themselves and from the malevolent or misguided intervention of others. Where citizen's lives are at serious risk society must intervene. It is not for parents or physicians to choose to end a child's life. It would be better to allow the natural course of events to play out, providing the child with the best medical care and family members with the necessary support, than to permit the intentional and artificial ending of children's lives.

D What does this mean for Children's Autonomy?

Deciding in favour of preserving a child's life when they wish to refuse lifesaving medical treatment or to consent to euthanasia and assisted suicide recognises that children's personal autonomy is not absolute nor determinative in life and death situations. Limits are placed on children's autonomy to engage in comparably less risky or dangerous activities like driving, drinking, and smoking. Where there is a risk that children will exercise their autonomy in a way that is harmful to themselves or others, society will intervene. This prevents children from making decisions they are not competent to make and that will cause them serious harm.

The English courts' reference to prioritising the welfare and best interests of the child parallels the principles of beneficence (giving benefit) and nonmaleficence (avoiding harm). These ethical principles prevail over autonomy. This is the best approach. The necessity of preserving children's lives is of even greater importance when considering the risks to children of having their life taken from them, without their understanding or consent, in the context of euthanasia and assisted suicide. This must be guarded against at all costs.

⁶⁹ End of Life Choice Bill 2018 (select committee report) at 9.

This does not mean that a child's views should be dismissed lightly,⁷⁰ nor does it mean that autonomy is no longer an important consideration. It is true that where life and death are at issue, it is of utmost importance that the child has a voice. Freedom of choice in adults is a fundamental human right. Judges must be very slow to interfere, especially as the child grows in age. However, in the context of end-of-life decisions autonomy is not the end goal, especially when children are incompetent to decide. The preservation of the child's health and life is key. Additionally, interference with an individual's liberty is justified when it prevents harm to others. As with any decision where the risk to the majority is disproportionate to the benefit to a minority, there are important restrictions on autonomy. In less serious medical decisions, minors' competence will be readily assessed, and room should be given to allow them to make decisions. However, allowing an incompetent child to consent to euthanasia or assisted suicide extends beyond what is safe or reasonable. Children ought to be protected from decisions they are not competent to make.

VI What does this mean for New Zealand?

A New Zealand's Law on Children's Competency to Consent to Medical Treatment

New Zealand's law on when children are presumed competent to consent or refuse to consent to medical decisions is unclear and inconsistent. Children over 16 years old have statutory capacity to consent or refuse to consent to medical, surgical, or dental treatment or procedures as if they were of full age.⁷¹ This is subject to the treatment being for the child's benefit.⁷² However, children under 16 years do not have this statutory capacity, except to give or refuse consent to an abortion.⁷³

⁷⁰ *Re S (A Minor) (Independent Representation)* [1993] 2 FLR 437 at 448.

⁷¹ Care of Children Act 2004, s36(1).

⁷² Care of Children Act 2004, s36(1)(b).

⁷³ P.D.G Skegg "Capacity to Consent to Treatment" in P.D.G. Skegg, R. Paterson et al. (ed) *Medical Law in New Zealand* (Thomson Brookers, Wellington, 2006) 188 in Michael Morrison "Children Consenting to Abortion in New Zealand: An Ethical and Legal Critique" (2015) 7 *Asian Bioethics Review* 26 at 28.

The lack of statutory capacity for children under 16 is inconsistent with the Code of Health and Disability Services Consumers' Rights 1996, which creates a presumption of competence for all consumers.⁷⁴ Although it is unclear whether parental consent is always necessary for medical treatment or procedures for children under 16 years, the Medical Council of New Zealand,⁷⁵ guidance for practitioners,⁷⁶ and academics suggest that it is likely that minors' common law capacity to consent to medical treatment, "has not been extinguished by New Zealand legislation, and that the consent of those under the age of 16 will sometimes be effective in law".⁷⁷

B New Zealand's End of Life Choice Act 2019

The End of Life Choice Act 2019 implements euthanasia and assisted suicide in New Zealand. To be eligible, a person must be aged 18 years or over, suffer from a terminal illness likely to end the person's life within 6 months, be in an advanced state of irreversible decline in physical capability, experience unbearable suffering that cannot be relieved in a manner that the person considers tolerable, and be competent to make an informed decision about assisted dying.⁷⁸ Persons are not eligible if they suffer only from a mental illness, disability, or are of advanced age. To be competent to make an informed decision about assisted dying, the person must be able to understand, retain, use, or weigh relevant information about the nature of assisted dying and communicate their decision.⁷⁹

C Should Child Euthanasia and Assisted Suicide be Legal in New Zealand?

It is reasonable to anticipate that the question of legalising child euthanasia and assisted suicide will arise in New Zealand's future, as it has in other countries. Mentions of

⁷⁴ Above n 21.

⁷⁵ "Informed Consent: Helping patients make informed decisions about their care" (September 2019) Medical Council of New Zealand <www.mcnz.org.nz>.

⁷⁶ Above n 21, at 4.

⁷⁷ P.D.G Skegg "Capacity to Consent to Treatment" in P.D.G. Skegg, R. Paterson et al. (ed) *Medical Law in New Zealand* (Thomson Brookers, Wellington, 2006) 188 in Amanda van Rooyen and others "What makes a child a 'competent' child?" (2015) 128 NZMJ 88 at 92.

⁷⁸ End of Life Choice Act 2019, s 5.

⁷⁹ End of Life Choice Act 2019, s 6.

extending the eligibility criteria to include those under 18 were made by submitters on the End of Life Choice Bill.⁸⁰ Additionally, the Section 7 report of the Attorney-General on the Bill found the age restriction discriminatory and unjustified under the Bill of Rights Act, as it was not connected to the objective of ensuring that only competent people are able to access euthanasia and assisted suicide.⁸¹

Fundamentally, upholding autonomy for a few is not the end goal of euthanasia and assisted suicide. The provision of a “good death” for all who need it is the primary end of legalising euthanasia and assisted suicide. This is unlikely to be limited to competent adults. In recognition of this, it is recommended that New Zealand’s euthanasia and assisted suicide law should remain as it currently is regarding children’s eligibility. It would be unwise to remove the 18-year-old age limit to allow children of any age to consent to euthanasia and assisted suicide for the following reasons.

Firstly, children under the age of 18 are not competent to consent to euthanasia and assisted suicide. Compared to adults, children are less able to act and think responsibly, restrain impulsiveness, and place a given decision in a larger temporal context.⁸² Adolescents generally do not possess the capacity to appreciate the long-term consequences of their choices until the age of 21.⁸³ Consequently, they are incompetent to consent to euthanasia and assisted suicide. Children suffering from psychological illnesses must also be protected from the choice to end their life as a medical ‘treatment’.

Secondly, even if children were competent to consent to euthanasia or assisted suicide, it would be extremely difficult to craft good competency assessments. There are already numerous difficulties in assessing children’s competence. No single standardised test to

⁸⁰ End of Life Choice Bill 2018 (select committee report) at 30.

⁸¹ End of Life Choice Bill 2018 (select committee report) at 30.

⁸² Irma M Hein and others “Why is it hard to make progress in assessing children’s decision-making competence?” (2015) 16 BMC Medical Ethics.

⁸³ Hein and others, above n 82, at 3.

determine competence exists.⁸⁴ Assessments of competence are often “difficult and contentious, since value judgements may be involved, even in circumstances where standardised test instruments are applied.”⁸⁵ Although there are tools to assess adults’ competence, assessing children’s competence requires different considerations, which are still lacking.⁸⁶ Incorporating varying levels of risk and complexities of decisions into competency tests are yet to be established.⁸⁷ This makes it very difficult for physicians to assess children’s competency in life and death situations.

Thirdly, legalising child euthanasia and assisted suicide would put many children at risk of being inadvertently and unknowingly coerced into ending their life. By virtue of their age, children are more naturally susceptible to others’ influence. Due to the need for approval and fear of rebuke from authority figures, children may be more obedient to parents and physicians. This will result in cases of involuntary euthanasia.

The high likelihood of children being involuntarily euthanised also places children’s “right to an open future” at peril. This right protects the child against having important life choices made for them by others before the child can decide for themselves.⁸⁸ The right is grounded in the same values as adult autonomy rights: self-determination and self-fulfilment. Feinberg says that such rights must be held in trust “out of respect for the sovereign independence of the emerging adult”.⁸⁹ Implicitly, parents and physicians should not be able to decide for children on matters such as ending a child’s life. This is important as children are vulnerable to being actively and unconsciously influenced by others to consent to euthanasia or assisted suicide. Children are not immune to recognising the burden they

⁸⁴ Larcher and Hutchinson, above n 20, at 308; Hein and others, above n 82, at 2; Amanda van Rooyen and others “What makes a child a ‘competent’ child?” (2015) 128 NZMJ 88 at 92.

⁸⁵ Larcher and Hutchinson, above n 20 at 307.

⁸⁶ Hein and others, above n 82, at 3.

⁸⁷ Hein and others, above n 82, at 4.

⁸⁸ Joseph Millum “The foundation of the child’s right to an open future” (2014) 45(4) J Soc Philos 522.

⁸⁹ Joel Feinberg “The Child’s Right to an Open Future” (1980) Aiken, William and LaFollette, Hugh eds. 124 in Joseph Millum “The foundation of the child’s right to an open future” (2014) 45(4) J Soc Philos 522.

put on their family in serious illness. They must be protected from subtle and overt pressure, intended and unintended, to end their life.

In the New Zealand context, it ought to be considered that euthanasia and assisted suicide is based on a Western philosophy prioritising autonomy, which is inconsistent with the value systems of non-Pākehā cultural groups within New Zealand. Non- Pākehā cultural groups tend to place a higher importance on life and the importance of family and community at the centre of decision-making. From a communal perspective, a child's decision to consent to euthanasia or assisted suicide is not simply a matter of individual autonomy. From the Māori worldview, the child's autonomy is constrained by their relationships with others in their whānau, hapū, and iwi.

Submitters on New Zealand's End of Life Choice Bill also believed that euthanasia and assisted suicide would, "breach the tapu (sacredness) of the person and have spiritual ramifications for all involved."⁹⁰ Arguably, it is a practice contrary to the Māori worldview where life and wairua (spirituality) are highly valued.⁹¹ This points against extending euthanasia and assisted suicide to children in New Zealand. Submitters also expressed concerns that legalising euthanasia and assisted suicide would perpetrate existing discrimination and prejudice in the health system.⁹² Māori and Pasifika are generally less able to pay for healthcare and access palliative care and are more likely to receive lower standards of care than other cultural groups.⁹³ This could cause them to be more likely to request euthanasia and assisted suicide than others.

It is also important to address concerns about the relationship between euthanasia and assisted suicide, and suicide. Some believe these concepts are distinct, that "where a person chooses to access assisted dying, the person does not truly want to die, but rather seeks to

⁹⁰ End of Life Choice Bill 2018 (select committee report) at 17.

⁹¹ End of Life Choice Bill 2018 (select committee report) at 17.

⁹² Carmen Parahi "Euthanasia referendum: Concern End of Life Choice Act created by middle class Pākehā to the detriment of Māori" (15 October 2020) Stuff <stuff.co.nz>.

⁹³ End of Life Choice Bill 2018 (select committee report) at 17.

escape unbearable or inevitable suffering.”⁹⁴ Others believe that allowing this practice will legitimise death as an acceptable response to suffering. One perspective is that “social sanctions promote a culture that transforms suicide into assisted suicide and euthanasia”.⁹⁵ There is evidence that drops in suicide rates in countries with legalised euthanasia and assisted suicide may well be due to the availability of the practice.⁹⁶ Another perspective emphasises the need for evidence that the “two acts are fundamentally different...that emphasising differences between them is not likely to do more harm than good.”⁹⁷

New Zealand has one of the highest youth suicide rates in the OECD.⁹⁸ There is significant concern that young people contemplating suicide might follow the rationale behind euthanasia and assisted suicide, and that this will have greater impacts on Māori and Pasifika who are currently disproportionately represented in New Zealand’s suicide statistics. More studies must be done to establish that euthanasia and assisted suicide will not worsen existing suicide rates in New Zealand before extending the practice to children is contemplated.

VII Conclusion

The incompetence of children to refuse life-saving medical treatment is analogous to the incompetence of children to consent to euthanasia and assisted suicide. In fact, the complexities and unique risks to children wishing to consent to euthanasia and assisted suicide call for a higher level of competency and protection than children refusing to consent to medical treatment.

⁹⁴ End of Life Choice Bill 2018 (select committee report) at 15.

⁹⁵ Herbert Hendin “Assisted Suicide, Euthanasia, and Suicide Prevention: The Implications of the Dutch Experience” (1995) 25 *Suicide and Life-Threatening Behaviour* 193.

⁹⁶ Hendin, above n 95, at 194.

⁹⁷ Phoebe Friesen “Medically Assisted Dying and Suicide: How Are They Different, and How Are They Similar?” (2020) 50 *Hastings Center Report* 32.

⁹⁸ “Suicide Statistics” (2021) Mental Health Foundation <mentalhealth.org.nz>.

Where children have refused to consent to life-saving medical treatment, courts have decided that to act in the child's best interests is to preserve their life. By contrast, euthanasia and assisted suicide legislation seeks to provide the means for patients to end their suffering by ending their life. As seen overseas, allowing children to end their life by euthanasia and assisted suicide comes with the significant risk that children will be unduly influenced and incompetent children euthanised. Although legalising child euthanasia and assisted suicide could relieve the suffering of a small number of children, this is significantly outweighed by the risks of allowing incompetent children to be euthanised. Permitting the practice under the cloak of competence, when parents and physicians will effectively be deciding for the child, goes against society's duty to protect children's lives.

Legalisation of child euthanasia and assisted suicide in New Zealand would not support New Zealand's commitment to the United Nations Convention on the Rights of the Child which requires the best interests of the child to be the primary consideration.⁹⁹ The risk to New Zealand children of being involuntarily euthanised is too great to consider permitting the practice in New Zealand. It would pose great risks to all New Zealand children, and expose vulnerable cultural groups, particularly Māori and Pasifika, to a disproportionate risk of being affected.

⁹⁹ United Nations Convention on the Rights of the Child, Article 3.

Word count

The text of this paper (excluding table of contents, footnotes, and bibliography) comprises approximately 8,044 words.

VIII Bibliography

A Cases

1 England

Re E (A Minor) (Wardship: Medical Treatment) [1992] 2 FCR 219 (CA).

Re M (Medical Treatment: Consent) [1999] 2 FLR 1097 (Fam).

Re R (A Minor) (Wardship: Consent to Treatment) [1991] 3 WLR 592 (CA).

Re S (A Minor) (Independent Representation) [1993] 2 FLR 437 (CA).

Re W (A Minor) (Consent to Medical Treatment) [1993] 1 FLR 1 (CA).

2 Belgium

Constitutional Court of Belgium (29 October 2015) 153/2015 (English translation)

<<http://www.const-court.be/public/e/2015/2015-153e.pdf>>.

B Legislation

1 New Zealand

End of Life Choice Act 2019.

Care of Children Act 2004.

2 Belgium

The Belgian Act on Euthanasia 2002.

3 Netherlands

Dutch Termination of Life on Request and Assisted Suicide (Review Procedures) Act 2001.

C Journal Articles

Amanda van Rooyen and others “What makes a child a ‘competent’ child?” (2015) 128 NZMJ 88.

Astrid M Vrakking and others “Medical End-of-Life Decisions for Children in the Netherlands” (2005) 159 Arch Pediatric Adolesc Med 802.

Carole Smith “Children’s Rights: Judicial Ambivalence and Social Resistance” (1997) 11 IJLPF 103.

Emily Jackson *Medical Law Text, Cases and Materials* (5th ed, Oxford Texts, 2019) at 266
Ezekiel J Emanuel “What Is the Great Benefit of Legalizing Euthanasia or Physician-Assisted Suicide?” (1999) 109 Ethics 629.

Herbert Hendin “Assisted Suicide, Euthanasia, and Suicide Prevention: The Implications of the Dutch Experience” (1995) 25 Suicide and Life-Threatening Behaviour 193.

Irma M Hein and others “Why is it hard to make progress in assessing children’s decision-making competence?” (2015) 16 BMC Medical Ethics.

Joel Feinberg “The Child’s Right to an Open Future” (1980) Aiken, William and LaFollette, Hugh eds. 124.

Joseph Millum “The foundation of the child’s right to an open future” (2014) 45(4) J Soc Philos 522.

Kathryn McLean “Children and Competence to Consent: Gillick Guiding Medical Treatment in New Zealand” (2000) VUWLR 551.

Kristof Van Assche and others “Capacity for Discernment and Euthanasia on Minors in Belgium” (2018) 27 Med L Rev 242.

Lydia S Dugdale, Barron H Lerner and Daniel Callahan “Pros and Cons of Physician Aid in Dying” (2019) 92 Yale J Biol Med 747.

Marije Brouwer and others *Should Pediatric Euthanasia be Legalized?* (2018) 141 Pediatrics.

Morag McDowell “Medical Treatment and Children: Assessing the Scope of a Child’s Capacity to Consent or Refuse to Consent in New Zealand” (1997) 5 JLM 90.

P.D.G. Skegg, R. Paterson et al. (ed) *Medical Law in New Zealand* (Thomson Brookers, Wellington, 2006) 188.

Phoebe Friesen “Medically Assisted Dying and Suicide: How Are They Different, and How Are They Similar?” (2020) 50 Hastings Center Report 32.

Michael Morrison “Children Consenting to Abortion in New Zealand: An Ethical and Legal Critique” (2015) 7 Asian Bioethics Review 26.

Vic Larcher, Anna Hutchinson “How should pediatricians assess Gillick competence?” (2010) 95 Arch Dis Child 307.

D Treaties

United Nations Convention on the Rights of the Child.

E Reports

End of Life Choice Bill 2018 (select committee report).

Ninth Report to the Legislative Chamber 2018-2019, Federal Commission for Euthanasia Control and Evaluation.

United Nations Committee on the Rights of the Child *Concluding observations on the further periodic report of the Netherlands* CRC/C/NDL/CO/4 (8 June 2015).

F Internet Materials

Article 8 and Minors' Right to Refuse Medical Treatment" (20 January 2012) King's Student Law Review <<https://blogs.kcl.ac.uk/>>.

Arya Hodjat "Belgium Approved Euthanasia of 3 Minors, Report Finds" (25 July 2018) Voa News <<https://www.voanews.com/>>.

Carmen Parahi "Euthanasia referendum: Concern End of Life Choice Act created by middle class Pākehā to the detriment of Māori" (15 October 2020) Stuff <stuff.co.nz>.

Hannah Martin "Referendum Results: End of Life Choice Act passes, legalising assisted dying" *Stuff* (online ed, New Zealand, 30 Oct 2020).

"Informed Consent: Helping patients make informed decisions about their care" (September 2019) Medical Council of New Zealand <www.mcnz.org.nz>.

"Netherlands backs euthanasia for terminally ill children under-12" *BBC News* (online ed, 14 October 2020).

"Official Referendum Results Released" (6 November 2020) Elections NZ <<https://elections.nz/>>.

Oregon Health Authority Death "Oregon Death with Dignity Act 2019 Data Summary" (6 March 2020) *Oregon.gov* <oregon.gov>.

Ryan Patrick Jones "Here's the latest on the review of Canada's assisted dying law" *CBC News* (16 May 2021).

"Suicide Statistics" (2021) Mental Health Foundation <mentalhealth.org.nz>.

"What is the Difference Between Euthanasia and Assisted Suicide?" Maxim Institute <<https://www.maxim.org.nz/>>.

“When Death is Sought: Assisted Suicide in the Medical Context” (April 2011) New York State Task Force on Life and the Law < <https://www.ny.gov/>>.

G Other Resources

Health and Disability Commissioner (Code of Health and Disability Services Consumers' Rights) Regulations 1996, Sch 2, Right 7(2).

Ministry of Health *Consent in Child and Youth Health: Information for Practitioners* (Ministry of Health, Wellington, 1998).