# Live and Let Die:

# The Legalisation of Euthanasia in New Zealand

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A dissertation submitted in partial fulfilment of the degree of Bachelor of Laws (with Honours)

University of Otago

October 2013

# Acknowledgements

To my supervisor, Stephen Smith, for his ideas and guidance, and for always maintaining his cheery disposition.

To my parents, for their help and support and for always believing in me.

Finally, to Alec for his love and encouragement.

## *Table of Contents*

# *I Introduction*

Decisions about how we die are significant and deeply personal issues of conscience.[1] Individuals should be able to make these decisions for themselves, to reflect their own convictions which they themselves have tried to live by, not the convictions of others.[2] Some people, who cannot be helped in any other way, may wish to hasten their deaths, believing that death will offer the only release from their suffering. Whether death should be able to be hastened through an act of euthanasia is a controversial issue. This dissertation will seek to examine this issue within the New Zealand legal framework.

My argument will begin in Part II by discussing the relevant law in New Zealand and examine how the Courts have interpreted this law in light of relevant cases. It will explain why there is a need for reform and document the legislative attempts to legalise euthanasia.

Part III will review the most frequently raised arguments both for and against euthanasia. These arguments will be analysed and a case will be presented for its legalisation.

Part IV will conduct a comparative analysis of the foreign jurisdictions which have legalised euthanasia or assisted suicide, or both. The common constituent elements of the legalisation regimes will be highlighted and used to inform the development of criteria for legalisation of euthanasia in New Zealand in Part V.

Finally, Part V will assess different options for reform in New Zealand and will ultimately propose that the most desirable option is to legalise euthanasia. I will then attempt to frame a suitable legislative proposal for its legalisation.

## *A Terminology*

There are a number of different types of euthanasia. It is essential for these to be outlined at the outset of this paper to ensure clarity in discussion.

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[1] Emily Jackson and John Keown *Debating Euthanasia* (Hart Publishing, Oxford, 2012) at 5.

[2] This was explained by six distinguished American philosophers in their joint submission to the US Supreme Court in 1997. Ronald Dworkin, Thomas Nagel, Robert Nozick, John Rawls, Thomas Scanlon and Judith Jarvis Thomson presented the "Philosophers' Brief" for the Respondents in *Washington et al v Glucksberg* 117 S Ct 2258 (1997) and *Vacco v Quill* 117 S Ct 2293 (1997) (cases heard at the same time) as cited in Emily Jackson and John Keown, *Debating Euthanasia*, above n 1, at 5-6.

## *1 Euthanasia*

*Euthanasia* was derived from the Greek words *eu* (good) and *thanatos* (death), but has acquired a much more specific modern usage.[3] The *Black's Law Dictionary* definition is *"*the act or practice of causing or hastening the death of a person who suffers from an incurable or terminal disease or condition, especially a painful one, for reasons of mercy".[4]

### (a) Voluntary, non-voluntary and involuntary euthanasia

In defining euthanasia, distinctions must be made between voluntary, non-voluntary and involuntary euthanasia. The distinctions are essential as they categorise the person's state of mind whose death may be brought about by euthanasia. *Voluntary euthanasia* is euthanasia that occurs after the person killed has requested to be killed.[5] *Non-voluntary euthanasia* occurs when the person killed is incapable of either making or refusing to make a request to be killed.[6] They may be considered incapable for reasons such as unconsciousness, immaturity, confusion, or mental retardation.[7] *Involuntary euthanasia* is euthanasia that occurs when the person is capable of requesting to be killed but has not done so.[8]

### (b) The distinction between active and passive euthanasia

The distinction between active and passive euthanasia is also essential as active euthanasia is currently illegal in New Zealand, whereas passive euthanasia is permissible in some circumstances. *Active euthanasia* is euthanasia performed by a facilitator (such as a healthcare practitioner) who not only provides the means of death, but also carries out the final death-causing act.[9] It is most commonly performed by a lethal injection of drugs. On the other hand, *passive euthanasia* is euthanasia committed through omitting to supply sustenance or treatment that, but for the decision and intent to terminate life, would have been supplied.[10] An example of passive euthanasia is the removal of life

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[3] Emily Jackson and John Keown , above n 1, at 1.

[4] Black's Law Dictionary (10th edition, 2014) at 672.

[5] Black's Law Dictionary, above n 4, at 673.

[6] Black's Law Dictionary, above n 4, at 672.

[7] PJ Downey "Euthanasia: Life Death and the Law" [1995] NZLJ 88 at 90.

[8] Black's Law Dictionary, above n 4, at 672.

[9] Black's Law Dictionary, above n 4, at 672.

[10] Black's Law Dictionary, above n 4, at 673.

support systems where the person has no prospect of recovery, making the continuation of treatment futile.

### *2 Physician-assisted suicide*

*Physician-assisted suicide* is distinguishable from active euthanasia in that the patient causes the final death-causing act, not the doctor. It is defined as a doctor's intentional act of providing a person with the medical means or the medical knowledge to commit suicide.[11] For example, a doctor may provide a patient with a prescription for a lethal dose of medication which is then administered by the patient.

### *3 Further discussion*

In order to limit the scope of this paper, discussion will be limited to physician-assisted suicide and active voluntary euthanasia. Any reference to euthanasia, unless stated otherwise, is intended to refer to active voluntary euthanasia.

[11] Black's Law Dictionary, above n 4, at 1662.

# *II The Current Legal Regime*

## *A Overview*

The object of this section is to examine the current legal regime in New Zealand. The law governing assisted suicide and euthanasia will be discussed and an analysis of relevant case law will be provided. It will explain why there is a need for reform and attention will also be given to legislative attempts to legalise euthanasia in New Zealand.

## *B The Law in New Zealand*

At common law, suicide was regarded as murder – a "felony of a man's self".[12] Suicide must have ceased to be a crime in New Zealand from 1893 at the latest, as this was when the Criminal Code Act 1893 (the Code) was enacted.[13] The Code imposed that criminal charges may be laid for criminal offences outlined under statute only. Suicide was not included as an offence; however, attempted suicide was an offence, punishable by two years' imprisonment.[14] The section relating to attempted suicide was later omitted from the Crimes Act 1961, effectively amounting to a repeal of attempted suicide as a criminal offence.[15] Aiding, abetting, counselling or procuring a person to commit suicide was also a crime under the Code,[16] punishable by life imprisonment. These modes of liability have remained offences under successive statutes and are currently governed by section 179 of the Crimes Act 1961:

> **Aiding and abetting suicide**
>
> Every one is liable to imprisonment for a term not exceeding 14 years; who
>
> (a) Incites, counsels, or procures any person to commit suicide, if that person commits or attempts to commit suicide in consequences thereof; or

[12] Francis Boyd Adams *Criminal Law and Practice in New Zealand* (2nd ed, Sweet & Maxwell, Wellington, 1971) at 325.
[13] Francis Boyd Adams *Criminal Law and Practice in New Zealand*, above n 12, at 325.
[14] Criminal Code Act 1893, s 193.
[15] P J Downey "Euthanasia: Life Death and the Law", above n 7, at 90.
[16] Criminal Code Act 1893, s 192.

(b) Aids or abets any person in the commission of suicide.

## *C Assisted Suicide in the New Zealand Courts*

A number of cases of mercy killing and euthanasia have been brought before the New Zealand courts. In such cases, defendants have been charged under one of four offences: aiding and abetting suicide,[17] manslaughter,[18] attempt to murder,[19] or murder,[20] depending on the facts of the case. After analysing these cases, I have developed a three type classification. Each case analysed falls within one of the types within the classification. The classification of the types of cases is as follows: in the first type, the defendant is found guilty of murder or attempt to murder. In the second type, the defendant is charged with murder, but is found guilty of manslaughter. Finally, in the third type, the defendant is found guilty of aiding and abetting suicide. The cases will be considered under these classifications. I will provide an example of a key case under each type and establish a sentencing range for cases within that type.

### *1 The three type classification*

(a) Type one: defendant is guilty of murder or attempted murder

A key case of this type is *R v Law*,[21] where the defendant, Mr Law, was found guilty of murder. What amounts to murder in a mercy killing type case can be gleaned from the following facts. Mr Law gave his wife, Mrs Law, a quantity of sleeping pills, then hit her head with a wooden mallet and placed a pillow over her face. Mrs Law died from asphyxiation, but the pathologist's report also noted that she had serious heart disease, which may have contributed to her death. Mrs Law had not recently expressed a wish to die, which led the Court to regard the defendant's conduct as being more serious. However, Mr Law explained that he and Mrs Law had "made a pact years ago" that if either of them got Alzheimer's disease, they would "do each other in".[22] Mr Law understood his wife to be saying that if either of them had Alzheimer's, the other person

[17] Crimes Act 1961, s 179.
[18] Crimes Act, s 171.
[19] Crimes Act, s 173.
[20] Crimes Act, s 167.
[21] *R v Law* [2002] 19 CRNZ 500.
[22] At [4].

would take that person's life.[23] The method by which this might occur had not been discussed in detail. Mr Law was sentenced to 15 months' imprisonment and was granted leave to apply for home detention.

The sentencing range for cases of this type ranges from 12 months' home detention[24] to 15 months' imprisonment,[25] with one exception. The case of *R v Crutchley*[26] falls outside the range, with a sentence imposed of six months' community detention and 150 hours of community work. Justice Keane considered this case to be "truly exceptional"[27] and distinguished it on the basis of Mr Crutchley's personal characteristics and the nature of the circumstances in which he acted. Mr Crutchley's actions were not premeditated, rather he acted in a state of panic as he saw his mother suffering before him.

(b) Type two: defendant is charged with murder, but is found guilty of manslaughter

*R v Stead*[28] is an example of a case falling within this type. The defendant, Mr Stead, was charged with the murder of his mother, but was found guilty of manslaughter. Mr Stead was implored by his mother to end her life following her failed attempt to commit suicide by ingesting an overdose of sleeping pills. Mr Stead made a series of persistent attempts to kill her by various means – injection with a syringe, carbon monoxide poisoning, smothering her with a pillow – and finally successfully killed her by stabbing. Mr Stead was sentenced to 12 months' supervision. This sentence established the lower bound in the sentencing range for cases of this type, with sentences ranging up to three years' imprisonment.[29]

(c) Type three: defendant is guilty of aiding and abetting suicide

*R v Ruscoe*[30] is an example of a case falling within this type. The defendant, Mr Ruscoe, was charged with aiding and abetting suicide of his tetraplegic friend, Mr Nesbit. Mr

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[23] At [5].

[24] See *R v Faithfull* (HC Auckland CRI 2007-044-007451, 14 March 2008).

[25] In *R v Law*, above n 21. For cases falling within this range, see: *R v Martin* (CA 199/04 14 February 2005) and *R v Davison* (HC Dunedin CRI-2010-012-4876, 24 November 2011).

[26] *R v Crutchley* HC Hamilton CRI 2007-069-83 9 July 2008.

[27] At [86].

[28] *R v Stead* (1991) 7 CRNZ 29.

[29] In *R v Simpson* HC Auckland, T010609, 12 October 2001. For cases falling within this range, see *R v Novis* HC Hamilton T42/87, 5 February 1988 and *R v Karnon* HC Auckland, S 14/99, 29 April 1999.

[30] *R v Ruscoe* (1992) 8 CRNZ 68.

Ruscoe placed approximately 50 sedative pills into Mr Nesbit's mouth (which he then voluntarily swallowed). When Mr Nesbit was asleep, a pillow was held over his head by Mr Ruscoe to ensure that death would result. Mr Nesbit had implored Mr Ruscoe to end his life and had agreed on the methods that would be used. He also sought and received reassurance that the pillow would be used to ensure that death would result. Mr Ruscoe was initially sentenced to nine months' imprisonment. On appeal, the court held that it was an appropriate case to "allow the promptings of humanity to prevail".[31] Taking into account the defendant's alcohol and psychological problems which had been triggered by the offence, including at one stage an inclination to commit suicide himself (for which he was temporarily institutionalised), the Court of Appeal held that the sentence should be substituted for a sentence of one year's supervision to help him rebuild his life.

Determining a sentencing pattern for cases of this type is much more difficult as there is a greater variation in sentence between cases. At the lowest end of the sentencing range, a discharge without conviction was granted in *R v Mott*[32] and was justified on the basis of the defendant's limited involvement. Mr Mott assisted his wife Rosie's death by obtaining a flow meter for a cylinder filled with nitrogen that she had purchased and taping it to the regulator on the cylinder. He discussed with Rosie how the equipment worked and stored it where she could access it when she desired. The pair ensured that Mr Mott was not present at the time of Rosie's death. The discharge without conviction was held to be further justifiable on the grounds that if Mr Mott had declined assistance, Rosie would nevertheless have succeeded in ending her life.

At the other end of the sentencing range, 18 months' supervision and 200 hours' community work was imposed on the defendant in *R v KJK,*[33] a sentence harsher than that imposed in *R v Ruscoe.*[34] The facts of this case however warrant this distinction as the defendant proposed the idea of entering into a mutual suicide pact with her depressed son, with the defendant aiding their attempt (which ultimately failed). The only remaining case of this type is *R v Davison,*[35] in which a sentence of five months' home detention was imposed. This sentence sits at the lower end of the range yet was justified on the basis that the defendant was not a New Zealand resident, so to impose a greater term was held to be unduly burdensome.

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[31] At 72.

[32] *R v Mott* [2012] NZHC 2366.

[33] *R v KJK* HC Christchurch CRI 2009-009-14397, 18 Feburary 2010.

[34] *R v Ruscoe*, above n 30.

[35] *R v Davison*, above n 25.

## *2 The judiciary's approach*

A number of common threads regarding the way in which cases of this kind have been approached by New Zealand courts have become apparent.

The Courts have uniformly emphasised that the sanctity of human life must be the starting principle in cases of this kind.[36] This principle is mandated on humanitarian grounds and is also enshrined in the New Zealand Bill of Rights Act 1990: "no one shall be deprived of life except on such grounds as established by law and are consistent with the principles of fundamental justice".[37] Whenever a life is ended, even for the most merciful motive, the Court has held that the sanctity of human life principle must dictate its response.[38]

The suggestion that there should be some relaxation of criminal liability in the case of mercy killing or euthanasia has not been accepted by the Courts.[39] To do so has been seen to risk undermining the rights of the weak, vulnerable and handicapped, who are entitled to the full protection of the law.[40] Thus, the Courts have expressed the need to impose sentences affirming the principle of the sanctity of life.[41] This may be achieved by imposing sentences which reflect the following purposes of sentencing: to hold the offender accountable for the harm done to the victim and the community,[42] to denounce the offender's conduct,[43] and to deter the offender – but more importantly others in the community – from committing the same or a similar offence.[44]

In *R v Ruscoe*, where the offence was aiding and abetting suicide (the least serious for cases of this kind), the Court held that imprisonment must be imposed unless there is a

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[36] See *R v Davison*, above n 25, at [26], See *R v Bell* HC Wanganui, S011886, 8 March 2002 at [22], *R v Stead*, above n 28 at 295, *R v Faithfull*, above n 24, at [8], *R v Crutchley*, above n 26, at [56], *R v Law*, above n 21, at [62] and *R v Martin*, above n 25, at [136].

[37] New Zealand Bill of Rights Act, s 9.

[38] *R v Albury-Thomson* (1988) 16 CRNZ 79, *R v Bell*, above n 36, at [38], *R v Crutchley*, above n 26, at [56].

[39] *R v Bell*, above n 36, at [22] and *R v Faithfull*, above n 24, at [8].

[40] See *R v Faithfull*, above n 24, at [8] and *R v Crutchley*, above n 26 at [56].

[41] *R v Crutchley*, above n 26, at [65].

[42] Sentencing Act 2002, s 7(1)(a).

[43] Sentencing Act, s 7(1)(e).

[44] Sentencing Act, s 7(1)(f).

"strong reason to the contrary"[45] that makes the case "very exceptional".[46] In a case of attempted murder or murder, there must therefore be even less room than in the case of assisting suicide for a short sentence of imprisonment. For a lesser sentence to be imposed, the circumstances would have to be "truly exceptional".[47] However, these principles do not seem to have been applied literally in subsequent cases. For cases of attempted murder or murder, imprisonment has not been applied outright in any case; leave to apply for home detention has always been granted. Moreover, in cases of aiding and abetting suicide, imprisonment has not yet been imposed.

The courts have also emphasised that each case must be considered on its own facts.[48] The circumstances of each case differ so greatly that there can be no invariable sentence and cases are also responsive to idiosyncratic indications for judicial mercy.[49] This is illustrated particularly in the third type of case – where the defendant is guilty of aiding and abetting suicide.

### *3 Need for reform*

A number of concerns become apparent from this review of New Zealand cases on assisted suicide. Firstly, it is unacceptable that in the face of clear breaches of the law, sentencing patterns bear no relation to the stated seriousness of the crimes committed.[50] In none of the cases analysed was the sentence imposed anywhere near the stated maximum that may be imposed for the offence. In fact, the imposition of such minor penalties for what the law considers culpable homicide undermines the law itself, and arguably demonstrates its unsuitability.[51]

Beyond this, we must also respond to the law as members of society. In all of these cases, the defendant's compliance with the request to help a loved one die was reluctantly

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[45] *R v Ruscoe*, above n 30, at 70.

[46] At 71-72.

[47] This was observed in *R v Crutchley*, above n 26, at [64].

[48] See *R v Mott*, above n 30, at [26], *R v Law*, above n 19, at [61], *R v Stead*, above n 26, at 295, *R v* Martin, above n 23, at [162].

[49] *R v Martin*, above n 25, at [162].

[50] M Webb "The Politics of 'Medicide' in New Zealand: a Cautious Proposal for Physician Aid-in-Dying" (1994) 5 Canterbury Law Review 1994 438 at 451.

[51] M Webb "The Politics of 'Medicide' in New Zealand: a Cautious Proposal for Physician Aid-in-Dying", above n 50, at 451.

performed in the absence of any perceived alternatives – essentially as acts of desperation.[52] This is illustrated through the foregoing case analysis. Consider the horrific details of Roger Stead's fumbled attempts to assist his mother's suicide, the heavy psychological cost suffered by Warren Ruscoe after assisting his best friend to die,[53] and the pain experienced by Evans Mott in knowing that he would not be able to be there in his wife's final moments due to fear of the legal repercussions. It is clear that forcing people to take matters into their own hands is far from ideal.[54] Providing a tightly controlled environment in which physicians could assist people to end their own suffering would surely be a more humane alternative.[55]

### *D Legislative Attempts in New Zealand to Legalise Euthanasia*

Three legislative attempts have been made to legalise euthanasia in New Zealand to date. These attempts all share two common features. Firstly, each has been a "Member's bill". Member's bills deal with matters of general public importance and may be introduced by a member who is not a Minister and who may be either in government or opposition.[56] Secondly, voting on such Bills has been by way of "conscience vote", where members are left to vote on the issue according to their consciences, free from party discipline.[57]

Michael Laws introduced his Death with Dignity Bill on 2 August 1995. The Bill had a unique feature in that it would not come into force unless a majority of voters at the next general election (in 1996) voted "yes" to the proposal: "Should the Death with Dignity Bill become law?"[58] The conscience of the nation would be expressed through a binding referendum.[59] To ensure that a person's request to die was voluntary, the Death with Dignity Bill proposed a five-step procedure which would have to be satisfied before a

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[52] M Webb "The Politics of 'Medicide' in New Zealand: a Cautious Proposal for Physician Aid-in-Dying", above n 50, at 451.

[53] M Webb "The Politics of 'Medicide' in New Zealand: a Cautious Proposal for Physician Aid-in-Dying", above n 50, at 451.

[54] M Webb "The Politics of 'Medicide' in New Zealand: a Cautious Proposal for Physician Aid-in-Dying", above n 50, at 451.

[55] M Webb "The Politics of 'Medicide' in New Zealand: a Cautious Proposal for Physician Aid-in-Dying", above n 50, at 451.

[56] David McGee, *Parliamentary Practice* (3rd ed, Dunmore Publishing, Wellington, 2005) at 307.

[57] At 96.

[58] Death with Dignity Bill 1995, cl 1(b)

[59] Rex Ahdar "Religious parliamentarians and euthanasia: a window into Church and State in New Zealand" 38 Journal of Church and State 569 at 574.

lethal mixture of drugs could be self-administered or administered by a physician orally or by injection.[60] The Death with Dignity Bill was defeated in Parliament 61 votes to 29.

Peter Brown introduced a second Death with Dignity Bill on 6 March 2003. Also involving voluntary euthanasia, the Bill set forth protective safeguards to ensure that any request to terminate life would be free, informed and non-coerced.[61] The Death with Dignity Bill was defeated narrowly at its first reading, with members voting 60 to 58 (with one abstention) not to send the bill to a select committee.

Most recently, in 2012, Labour MP Maryan Street placed the End of Life Choice Bill into the members' bill ballot. Its form broadly followed the format of the previous bills. In October 2013, the bill was withdrawn from the ballot "out of concern a debate about euthanasia could come up in election year and become a political football".[62] The Labour Party was also concerned the Bill could distract from its main policies and deter more conservative voters.[63] Although Street insisted that she would "put it back in the ballot like a shot" following the 2014 General Election,[64] as of this writing the sponsor has not been re-elected to the 51st New Zealand Parliament. The status of the End of Life Choice Bill is therefore currently uncertain. The possibility of it being picked up by another MP remains open.

[60] Rex Ahdar "Religious parliamentarians and euthanasia: a window into Church and State in New Zealand, above n 59, at 576.

[61] Rex J. Ahdar "Killing me softly: should euthanasia be legalised" (Family First New Zealand, Manukau City, 2014) at 7.

[62] Isaac Davison "Labour: euthanasia bill will return" *The New Zealand Herald* (online ed, Auckland, 16 October 2013).

[63] Isaac Davison "Labour: euthanasia bill will return", above n 62.

[64] Isaac Davison "Labour: euthanasia bill will return", above n 62.

# *III The Euthanasia Debate*

## *A Overview*

If one accepts that there is a need to amend the current prohibition against assisted suicide and that reform would most likely take shape by legalising euthanasia, it is necessary to review what is at stake in the "euthanasia debate". Arguments both for and against the legalisation of euthanasia are effectively endless; to address all of these arguments would be beyond the scope of this paper. The aim of this section is to address the arguments most frequently raised on either side of the debate. These arguments will then be analysed and a case presented for the legalisation of euthanasia.

## *B The Case for Legalisation of Euthanasia*

### *1 Self-determination or the principle of autonomy*

The main argument in support of the legalisation of euthanasia is based on the right of self-determination principle, or the principle of autonomy. According to this principle, each person has value and is worthy of respect, bears basic rights and freedoms and has the right to make his or her own life choices which determine his or her future.[65] Proponents argue that an individual should be able to choose how and when he or she will die, provided that this does not interfere with the rights of others.[66]

Proponents argue that the present legal prohibition on euthanasia is an unjustifiable infringement upon the liberty of those whom, with the choice, would choose to be killed.[67] Proponents of euthanasia therefore assert that it must be legalised to uphold an individual's interest in self-determination.

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[65] Margaret Otlowski *Voluntary Euthanasia and the Common Law* (Oxford University Press, New York, 1997) at 189.

[66] At 189.

[67] Margaret Otlowski *Voluntary Euthanasia and the Common Law*, above n 65, at 189. .

### *2 Alleviation of pain and suffering or the prevention of cruelty*

Another important argument supporting the case for legalisation of euthanasia is the need to alleviate pain and suffering and to prevent cruel treatment. Proponents argue that in circumstances where a person has no reasonable prospect of recovery, commonsense and compassion dictate that he or she should be allowed a merciful release from such suffering.[68] Analogies can be drawn to animals, which are commonly "put down" if they are experiencing pain and suffering. It is argued that if the practice is acceptable for animals, it should also be accepted for humans.

### *3 Promotion of human dignity*

Closely related to the foregoing arguments is the argument that legalisation of euthanasia will promote human dignity. Proponents argue that the notion of human dignity demands that individuals have control over significant life decisions, including the choice to die, and that this control should be acknowledged and respected by others.[69] The essence of this argument is encapsulated by Fletcher:[70] "to prolong life uselessly, while the personal qualities of freedom, knowledge, self-possession and control, and responsibility are sacrificed, is to attack the moral status of a person".

Evidence suggests that what people fear most towards the end of life is "loss of self".[71] Many terminally ill patients fear the future disintegration of their bodily and mental functions, or both,[72] and the resulting helplessness and dependence on others. An Oregon study of patients who have sought access to assisted suicide from 1998 to 2013 shows that the principal motivations for seeking death are loss of autonomy (cited by 91.4 percent of people), loss of dignity (80.9 percent), decreasing ability to participate in activities that made life enjoyable (88.9 percent), losing control of bodily functions (50.3 percent) and fear of becoming a burden on family, friends and caregivers (40 percent).[73]

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[68] Margaret Otlowski *Voluntary Euthanasia and the Common Law*, above n 65, at 203.

[69] Margaret Otlowski *Voluntary Euthanasia and the Common Law*, above n 65, at 204.

[70] Fletcher *Morals and Medicine* (Princeton, New Jersey, 1979) at 205-6.

[71] Emily Jackson and John Keown *Debating Euthanasia*, above n 1, at 9.

[72] Alister Browne "Assisted Suicide and Active Voluntary Euthanasia" 1989 2 Can. J.L. & Jurisprudence 35 at 38.

[73] Oregon Public Health Division, *Death with Dignity Act Report* (2013) <http://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Documents/year16.pdf>.

The legalisation of euthanasia would enable patients to prevent the indignity of a prolonged death by receiving assistance to end their lives through euthanasia at an earlier stage.

### *4 The distinction between active killing versus passive allowance of death*

The law draws a distinction between making a patient die and allowing them to die. The New Zealand position is outlined by Thomas J in *Auckland Area Health Board v A-G*:[74]

> Where "life" is being prolonged for no therapeutic or medical purpose, or, in other words, death is merely being deferred, the doctor is not under a duty to avert that death at all costs.

It is therefore acceptable for a doctor to let a patient die either by removing life support or by administering pain-relieving drugs where the foreseeable consequence is shortening life. However, administering the same pain-relieving drug with the intention to kill remains illegal.

Furthermore, a competent patient has the right to refuse medical treatment. The right is well established at common law,[75] and is reinforced in New Zealand by the Code of Patients' Rights[76] and in the Bill of Rights Act.[77] The meaning of this right is interpreted by Thomas J in *Auckland Area Health Board v A-G.*[78] The Bill of Rights provision that "everyone has the right to refuse to undergo medical treatment"[79] "enables a patient, properly informed, to require life systems to be discontinued".[80]

Proponents in favour of euthanasia argue that if the law recognises the patient's autonomy and self-determination as a justification for passive euthanasia, it is logically inconsistent to refuse to recognise the same interests as a justification for euthanasia.[81] It

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[74] *Auckland Area Health Board v A-G* (1992) 8 CRNZ 634 at 653.

[75] See PDG Skegg and Ron Paterson et al *Medical Law in New Zealand* (Brookers, Wellington, 2006) at 8.2.1.

[76] See Code of Health and Disability Services Consumers' Rights, rights 7(7) and 7(1).

[77] New Zealand Bill of Rights Act 1990, s 11.

[78] *Auckland Area Health Board v A-G*, above n 74.

[79] New Zealand Bill of Rights Act 1990, s 11.

[80] *Auckland Area Health Board v A-G* (1992), above n 74.

[81] Margaret Otlowski *Voluntary Euthanasia and the Common Law*, above n 65, at 191.

is argued that the law is inconsistent as both active killing and passive allowance of death involve the intentional termination of life.

### *5 Inconsistency with the law of suicide*

A further argument in favour of euthanasia is the perceived inconsistency in our law of suicide and euthanasia. Since it is not unlawful for a person to commit or attempt to commit suicide,[82] the law implicitly recognises an individual's right to take his or her own life.[83] It is argued therefore that if an individual has the right to take his or her own life, he or she should be able to seek assistance from others to achieve this end.[84]

Many object to this argument, arguing there is a distinction between suicide, an autonomous and self-regarding act, and assisted suicide or euthanasia, which requires third-party involvement.[85] It is argued that the involvement of a third party is the crucial difference, as it changes the conduct from being a purely private act to a form of public action with ramifications extending beyond the parties involved.[86] Furthermore, it has been suggested that if the argument in favour of euthanasia is based on self-determination, it would be inconsistent to ask a third party to assist.[87]

However, this objection ignores some of the practical realities relating to suicide. Some people who may wish to commit suicide may not be able to for two reasons: either they may not be physically able to secure the means or be physically able to commit suicide due to physical disability. An example of a person falling into the latter category in the New Zealand context is Mr Nesbit in *R v Ruscoe*.[88] Mr Nesbit had become tetraplegic after an accident. Wishing to end his own life, he enlisted the help of his friend Mr Ruscoe as his condition made him unable to administer the means to do so himself.

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[82] For a discussion of the law dealing with suicide and attempted suicide in New Zealand, see Part II, B of this paper.

[83] Margaret Otlowski *Voluntary Euthanasia and the Common Law*, above n 65, at 193.

[84] Margaret Otlowski *Voluntary Euthanasia and the Common Law*, above n 65, at 193.

[85] Margaret Otlowski *Voluntary Euthanasia and the Common Law*, above n 65, at 194.

[86] Margaret Otlowski *Voluntary Euthanasia and the Common Law*, above n 65, at 194.

[87] Margaret Otlowski *Voluntary Euthanasia and the Common Law*, above n 65, at 194.

[88] *R v Ruscoe*, above n 30.

### *6 What is morally right should be made legally permissible*

Another argument advanced by some proponents is that since euthanasia is acknowledged by many to be *morally* right, it should be made *legally* permissible.[89] This is supported by the argument that doctors are faced with conflicting demands when euthanasia is requested – on the one hand, there is the desire to act mercifully and relieve the patient's suffering and on the other, there is the concern to abide by the law and avoid violation of the criminal law.[90] Law should reflect prevailing morality and enable euthanasia.

### *7 Formalise already existing practices.*

A further argument in support of the legalisation of euthanasia is the need to formalise already existing practices. There are two separate aspects of this argument. Firstly, it is argued that since euthanasia already occurs in practice, we must institutionalise and regulate it by adopting appropriate safeguards to protect against its abuse. Secondly, it is argued that the practice should be legalised to overcome discrepancies between legal theory and practice.[91]

#### (a) The need to regulate and protect against abuse

Evidence is available to suggest that some doctors, including those in New Zealand, are already involved in the practice of euthanasia, despite its illegality. In a 2004 study of 1100 New Zealand physicians, physicians admitted to having hastened the death of 693 terminally ill patients over the previous 12-month period.[92] 428 of these cases involved a decision to withdraw or withhold treatment or increase pain relief with the probability that death would be hastened. 226 cases involved actions taken partly or explicitly to hasten death. In the remaining 39 cases, death was attributed to a drug that had been supplied or administered for that purpose, an action consistent with euthanasia. In 380 of these cases, there was no discussion with the patient before action was taken.[93] The main

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[89] See for example, G Williams "Euthanasia and Abortion" (1966) 38 UColo.LRev. 178 at 182, cited in Margaret Otlowski *Voluntary Euthanasia and the Common Law*, above n 65, at 206.

[90] Margaret Otlowski *Voluntary Euthanasia and the Common Law*, above n 65, at 206.

[91] Margaret Otlowski *Voluntary Euthanasia and the Common Law*, above n 65, at 207.

[92] Mitchell K and Owens G "End of life decision-making by New Zealand general practitioners: a national survey" (2004) Vol 117 No 1196 Journal of the New Zealand Medical Association at 2.

[93] At 4.

reason given for no discussion was that the patient was not competent. However, in 88 cases where the patient was competent, there was still no discussion with them.

The fact that the law is being violated is not a ground in itself for legalisation. However, because the practice is currently illegal, it is performed covertly,[94] without the regulation provided by legislative safeguards. It has also been noted that where doctors have become aware of a colleague's involvement in the practice, it is unlikely that they will report it.[95] Without safeguards, the risk that euthanasia is performed without the patient's request is heightened. This risk goes directly against the fundamental principle of euthanasia that is proposed – that it be voluntary. If legislation were implemented legalising euthanasia, these risks would be guarded against.

(b) Need to overcome discrepancies between legal theory and practice

Proponents have identified that even though there is evidence to suggest that some doctors are engaged in the practice of euthanasia, which is effectively murder per se, it is unlikely that a doctor would be prosecuted if they were discovered in practice, or if prosecuted, it is unlikely that they would be convicted.[96] From this premise, it is argued that the law in effect condones the practice of euthanasia. Proponents go on to assert that the disparity between legal theory and practice is unacceptable as it engenders disrespect for the law. Thus, euthanasia must be legalised to close the gap between legal theory and practice and ensure that doctors who perform euthanasia are not at risk of criminal prosecution.

### *8 Public support*

The level of public support further supports the legalisation of euthanasia. Opinion polls from around the world have usually been in favour of voluntary euthanasia.[97] Public support in New Zealand is also high. In a recent survey in New Zealand asking "should

[94] This conclusion is supported by survey findings showing doctors only rarely consult colleagues about patient requests for assistance in dying: see A Back "Physician-Assisted Suicide and Euthanasia in Washington State: Patient Requests and Physician Responses" (1996) 275 JAMA 919, 923, 924 cited in Margaret Otlowski *Voluntary Euthanasia and the Common Law*, above n 65.

[95] Margaret Otlowski *Voluntary Euthanasia and the Common Law*, above n 65, at 207.

[96] Margaret Otlowski *Voluntary Euthanasia and the Common Law*, above n 65, at 209.

[97] Joachim Cohen et al "Public acceptance of euthanasia in Europe: a survey in 47 countries" (2014) 59 Int J Public Health 143.

euthanasia be legalised in New Zealand", from 4281 respondents, 65.4 percent voted "yes", 24.6 percent voted "no" and 10.1 percent voted "I need to know more first".[98] New Zealand surveys in recent years have consistently indicated public support for the legalisation of euthanasia.[99] Although not a sufficient justification on its own for changing the law, public support is a relevant consideration as the law must be responsive to the people it serves.

### *9 Empirical evidence*

The legalisation of euthanasia and physician assisted suicide in overseas jurisdictions supports the case for its legalisation. Empirical evidence from these jurisdictions can support that the practice is operating effectively. Such evidence can serve to illustrate that the traditional catch cries against legalisation of euthanasia – fear of its abuse and the "slippery slope", which will be discussed in turn, have not been borne out in practice. The legislative regimes themselves,[100] and information about their practical operation, can also be used as guides for new implementing legislation.

### *10 Economics*

The legalisation of euthanasia would save government money spent on healthcare for the dying. Resources could be used more effectively, by reallocating it from those wanting to die to those wanting to live. Not surprisingly, this cold, utilitarian argument is seldom employed by proponents.[101] It is however the "elephant in the room" in this debate which is only likely to grow with increasing pressure on healthcare resources being attributable to an ageing population.[102]

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[98] Michelle Duff "Coronor urges MP to decide on euthanasia" (15 October 2013) Fairfax Media <http://www.stuff.co.nz/national/health/9282506/Coroner-urges-MPs-to-decide-on-euthanasia>.

[99] For a summary of some of the New Zealand surveys, see Rex J. Ahdar "Killing me softly: should euthanasia be legalised", above n 61.

[100] For an analysis of these regimes, refer to Part IV of this paper.

[101] Emily Jackson and John Keown *Debating Euthanasia* , above n 1, at 138.

[102] Emily Jackson and John Keown *Debating Euthanasia* , above n 1, at 138.

### *11 Evaluation*

A number of arguments have been put forward supporting the legalisation of euthanasia. It is submitted that these arguments, considered as a whole, create a *prima facie* case for its legalisation. This places an onus on the opponents of the legislation of euthanasia to present arguments to justify maintenance of the status quo; it is to these arguments that we now turn.

## *C The Case against Legalisation of Euthanasia*

Arguments advanced by opponents of the legalisation of euthanasia can be grouped into two different categories – doctrinal arguments and practical arguments. Doctrinal arguments are theoretical in nature, whereas practical arguments are concerned with the practical consequences of legalisation. According to the doctrinal approach, euthanasia is intrinsically wrong, regardless of the circumstances.[103] Due to its inherent wrongfulness, the act should remain subject to an unqualified prohibition.

### *1 Doctrinal arguments against euthanasia*

#### (a) Religious arguments against euthanasia

The focus of this analysis will be restricted to the arguments of the Christian tradition, which is the principal source of religious opposition to the practice of euthanasia. The practice of euthanasia has been consistently condemned by Christian groups, and of all denominations, the Roman Catholic Church has been most prominent in its opposition.

##### (i) Sanctity of human life

Central to the opposition to euthanasia is the principle of the sanctity of human life. This principle holds that human life is sacred, has intrinsic value, and therefore must be respected and preserved.[104] Life is seen as a gift from God, and supreme dominion over life belongs to God alone. Only God, the Creator of life, has the right to decide when a

[103] Margaret Otlowski *Voluntary Euthanasia and the Common Law*, above n 65, at 212.

[104] Margaret Otlowski *Voluntary Euthanasia and the Common Law*, above n 65, at 213.

life shall cease, and any direct killing without the authority of God is against the natural law.[105] Euthanasia rejects both "God's sovereignty and loving plan".[106]

(ii) Prohibition against intentional killing

In addition to this argument, killing is prohibited under the Ten Commandments, which remain a foundation for ethics for most Christians. The sixth commandment states, "thou shalt not kill", presumably prohibiting all intentional killing, irrespective of motive,[107] which therefore includes euthanasia.

(iii) The value of human suffering

Euthanasia does not align with the Christian belief in the value of human suffering. According to Christian teaching, physical suffering is not seen as an absolute evil, devoid of purpose. Rather, it is part of God's plan and allows an opportunity for the sufferer's redemption.[108] Those in contact with a suffering patient are also given the opportunity to practice Christian charity. This position was succinctly summarised by Rt. Hon Bill English, a practicing Catholic, in arguing against the Death with Dignity Bill 2003: "pain is part of life, and watching it is part of our humanity."[109]

(iv) Analysis of religious objections to euthanasia

Religious arguments will be convincing to those who accept the religious viewpoint. However, they cannot be said to be said to be universally relevant, particularly to the question of legalisation of euthanasia. Whilst the convictions of believers must be respected, it must be recognised that in a pluralistic and largely secular society, the freedom of non-believers must also be upheld.[110] A prohibition on euthanasia on the basis of religious beliefs should not be applied by law to those who do not share the same beliefs.

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[105] R Gula "Euthanasia: A Catholic Perspective" (1987) 68 Health Progress at 28-29 cited in Margaret Otlowski *Voluntary Euthanasia and the Common Law*, above n 65, at 213.

[106] "Vatican Declaration on Euthanasia" (1980) <http://www.vatican.va/roman_curia/congregations/cfaith/documents/rc_con_cfaith_doc_19800505_euthanasia_en.html>.

[107] Margaret Otlowski *Voluntary Euthanasia and the Common Law*, above n 65, at 212.

[108] Margaret Otlowski *Voluntary Euthanasia and the Common Law*, above n 65, at 215.

[109] Hansard (30 July 2003) 610 NZPD 7482.

[110] Margaret Otlowski *Voluntary Euthanasia and the Common Law*, above n 65, at 216.

(b) Acceptance of euthanasia would create a duty to kill

Another fundamental objection to euthanasia is that the creation of a *right* to seek euthanasia would impose on others a correlative *duty* to kill. This is based on the concept of rights which, in a strict sense, have generally been understood to entail correlative duties or obligations.[111]

A correlative duty to kill could be avoided by vesting in patients a *liberty* rather than a *right* to seek euthanasia and by *permitting* doctors to perform euthanasia at the request of the patient without creating any *duty* to do so.[112] Furthermore, legislation could explicitly state that no person would be required to perform euthanasia if another requested it.

*2 Practical arguments against euthanasia*

(a) Wedge or slippery slope argument

The most popular objection to the legalisation of euthanasia is the "slippery slope" or "thin edge of the wedge" argument. This argument states that legalising euthanasia today will lead to active non-voluntary euthanasia tomorrow, which will then lead to the termination of lives of those considered no longer valuable in society.[113] This argument often leads opponents to point out that euthanasia was legalised in Nazi Germany, thus implicitly arguing that allowing euthanasia will be the first step on a slippery slope from which further killings under less controlled circumstances will result, which could ultimately result in the commission of mass atrocities.

The "wedge" argument must be treated with caution as it could be used as a basis to oppose virtually any social policy.[114] The mere possibility that certain consequences may result is not a sufficient justification for refusing to allow euthanasia. Rather, it must be evident that the feared consequences are reasonably likely to occur.[115] Such evidence has not been provided as euthanasia has been legalised in a number of jurisdictions and remains legal after many years of its operation, and none of these jurisdictions has

[111] Margaret Otlowski *Voluntary Euthanasia and the Common Law*, above n 65, at 218.
[112] Margaret Otlowski *Voluntary Euthanasia and the Common Law*, above n 65, at 218.
[113] Alister Browne "Assisted Suicide and Active Voluntary Euthanasia", above n 72, at 46.
[114] Margaret Otlowski *Voluntary Euthanasia and the Common Law*, above n 65, at 221.
[115] Margaret Otlowski *Voluntary Euthanasia and the Common Law*, above n 65, at 220.

proceeded to expand the practice to non-voluntary situations. Moreover, it could be argued, by analogy, that the liberalisation of the law with regard to infanticide and suicide has not resulted in a diminution in respect for human life.[116]

The analogy drawn with Nazi Germany is implausible as there is no parity between the two cases. The Nazi programme of "euthanasia" was not voluntary; rather, people were killed without (or contrary to) their consent. The Nazi killings were also carried out in the interests of others, rather than in the interests of the victims. In the case of euthanasia, a person is killed at their own request and in their own interest.[117] Besides sharing the name "euthanasia", the two practices are not really alike, leaving no valid basis for this argument.

(b) Voluntariness and patient consent

Another common argument advanced by opponents to the legalisation of euthanasia is that we cannot be certain that we have the patient's voluntary and informed consent.[118] This is for two reasons. On the one hand, if the request is made by way of advance directive, it cannot be considered binding as it insufficiently informed. On the other hand, if the request is made when the individual is terminally ill, the pain and medication prevent him or her from making a fully rational decision. It is argued that in either case, a valid request cannot be made. A voluntary request is essential as without it, it would not be active *voluntary* euthanasia.

It is submitted that these concerns can be addressed through establishing appropriate safeguards to monitor the practice to reduce the possibility of doctors acting upon requests which are not completely voluntary. A patient would be required to satisfy a number of preconditions before his or her request could be considered voluntary. For example, there could be explicit requirements that he or she had capacity and that the request was voluntary, informed and durable.

Furthermore, we respect other healthcare decisions made by advance directive or by patients who are in pain or on medication and do not regard these decisions as being either not voluntary or made without informed consent. It seems nonsensical to suddenly alter the way we approach these decisions simply because of the nature of the stated wish.

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[116] Margaret Otlowski *Voluntary Euthanasia and the Common Law*, above n 65, at 222.

[117] Alister Browne "Assisted Suicide and Active Voluntary Euthanasia", above n 72, at 47.

[118] Alister Browne "Assisted Suicide and Active Voluntary Euthanasia", above n 72, at 46.

To do this seems to presuppose that no rational, fully informed person would ever request to die, which is not a sustainable argument.

(c) Potential for abuse

It is further argued by proponents that legislation legalising euthanasia would make it easier to commit criminal homicide. It is argued that a patient's request for euthanasia could be manipulated or that possibly, in collusion with doctors, the law could be taken advantage of to conceal a criminal homicide as euthanasia.

With appropriate safeguards in place, such as the requirement of ex ante reporting, it will be very difficult to pass off murder as euthanasia. As a result, it is unlikely that the incidence of undetected murder will increase with legalisation of euthanasia.

(d) Pressure to make a request

Opponents also argue that if euthanasia is legalised, people may feel obligated to request it. The terminally ill are often vulnerable and feel themselves to be (and often are) a burden to others. Many of the ill, however, although tired of the life they are living, do not truly wish to die.[119] Furthermore, the ill person's relatives or others whose care they are in, who would often prefer to be rid of the burden, may consciously or unconsciously exert pressures to request assistance in committing suicide or euthanasia.[120] It is argued that these pressures would be very difficult to both detect and avoid.

It is acknowledged that some such tragedies may occur, but this should not be taken as a reason in itself to prohibit euthanasia. The state allows police officers to carry guns, from which tragedies also result. However, these tragedies are accepted as part of the price paid for policies which are on the whole beneficial.[121] The same line should be taken with euthanasia.

Furthermore, any such tragedies may be guarded against through legislation. Statutory measures may be put in place to ensure that the request was voluntary. For example, some of the jurisdictions with legal euthanasia require that the request be made in

[119] Alister Browne "Assisted Suicide and Active Voluntary Euthanasia", above n 72, at 46.

[120] Alister Browne "Assisted Suicide and Active Voluntary Euthanasia", above n 72, at 46.

[121] Alister Browne "Assisted Suicide and Active Voluntary Euthanasia", above n 72, at 46.

writing,[122] repeated over a period of time,[123] and that the requester be referred to a counsellor or other practitioner to validate the reasons behind the request.[124]

It is therefore more appropriate and consistent with the principle of self-determination to use appropriate measures to guard against coercion and improper influence rather than to deny everyone the possibility of electing an earlier death.[125]

(e) Possibility of error

It is also argued that there is the possibility of errors in diagnosis or prognosis or the discovery of new treatments which will permit either survival or recovery.[126]

Whilst any of these outcomes is theoretically possible, they should be ruled out for all practical purposes. If it is beyond reasonable doubt that that the diagnosis and prognosis are correct and that a cure will not be discovered in time to help, this should be sufficient.[127] Guilt "beyond reasonable doubt" is the standard required for criminal prosecution and it is not possible to require more without making enforcement of the law impossible.[128] There is no clear reason why a more stringent standard should be required for euthanasia.

(f) Capacity for pain relief

Opponents also assert that palliative care has advanced to such a level that no one needs to feel overwhelming and uncontrollable pain. This has served to take the unpleasantness out of dying, so euthanasia is unnecessary.

These advances have not, however, removed pain altogether. As John Pollock, a 61-year-old Auckland GP facing death explained, "break through pain is common and its prevention requires constant medical attention which is not often available".[129] Pain can

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[122] See Part IV, C 2(b), citation 175.

[123] See Part IV, C 2(a), citation 172.

[124] See Part IV, C 2(b), citation 177.

[125] Margaret Otlowski *Voluntary Euthanasia and the Common Law*, above n 65, at 233.

[126] Alister Browne "Assisted Suicide and Active Voluntary Euthanasia", above n 72, at 45.

[127] Alister Browne "Assisted Suicide and Active Voluntary Euthanasia", above n 72, at 45.

[128] Alister Browne "Assisted Suicide and Active Voluntary Euthanasia", above n 72, at 45.

[129] John Pollock "Dying GPs plea for euthanasia" *The New Zealand Herald* (online ed, Auckland, 21 July 2010).

be relieved "to a large extent but at the cost of symptoms such as constipation, nausea and drowsiness, which may be partially controlled by other drugs with their side effects".[130] As a result, there is still a need, arguably reduced, for the legalisation of euthanasia.

(g) Effect on doctor/patient relationship

A further objection is that any change to the law permitting doctors to administer euthanasia would have serious implications for the relationship between doctor and patient. This argument is often supported with claims that doctors are opposed to euthanasia and do not want to be involved in its practice.

Opponents argue that the traditional role of doctors is that of a healer, trusted with the responsibility of saving and prolonging life. To allow doctors to administer euthanasia would undermine and compromise the objectives of the medical profession and destroy the trust and confidence essential to the success of the doctor-patient relationship.[131] Doctors would be viewed by their patients as killers, not healers. Furthermore, concerns have been raised regarding the possible psychological consequences to doctors if they participate in the practice of euthanasia.

The Hippocratic Oath is often cited by opponents as the textual basis for this claim. Most physicians take the oath, or an amended form, as a rite of passage upon graduation from medical school. Specifically, to support the claim that doctors should be regarded as healers and not killers, this passage of the oath is cited: "I will never give a deadly drug to anybody if asked for it, nor will I make a suggestion to its effect".[132] However, the Hippocratic Oath also requires a physician to relieve suffering: "whatever houses I may visit, I will come for the benefit of the sick".[133] The physician is therefore placed in a difficult position and regardless of whether they decide to participate in euthanasia or not, part of the oath is broken. Moreover, the oath also forbids a doctor to perform an abortion: "similarly I will not give to a woman an abortive remedy".[134] Both physicians and legislators managed to get past that principle. Participation in euthanasia would be voluntary for doctors, minimising the risk of any possible negative consequences to them.

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[130] John Pollock "Dying GPs plea for euthanasia", above n 129.

[131] Margaret Otlowski *Voluntary Euthanasia and the Common Law*, above n 65, at 242-243.

[132] V Barry "Moral Aspects of Health Care" 500 (1982) as cited in Carl "The Right to Voluntary Euthanasia" (1988-1989) 10 Whittier L. Rev. 489 at 532.

[133] V Barry "Moral Aspects of Health Care" 500 (1982), above n 132.

[134] V Barry "Moral Aspects of Health Care" 500 (1982), above n 132.

Furthermore, even when euthanasia is legalised, instances of it being performed will be relatively rare and it will not be something most doctors spend a significant amount of their time doing. For example, last year in Oregon, 122 people were given life-ending prescriptions and only 71 took the life ending medication and died. This accounted for 2.2 deaths per 1000 in the state.[135] There is no evidence to suggest that, if legalised, New Zealand statistics would reflect a significantly greater number of deaths through assisted means. It is therefore unlikely that the involvement of some doctors in a comparably rare procedure will make all patients view doctors as killers, not healers.

(h) Legalisation would discourage medical research and developments in palliative care

A further argument advanced against the legalisation of euthanasia is that it would discourage the search for new cures and treatments for the terminally ill. Opponents argue that the prohibition of euthanasia has encouraged such research.[136] If we permit euthanasia, we will be jeopardising future developments in these areas to the detriment of the majority of patients.

However, it cannot be assumed, as the euthanasia opponents seem to have done, that legalisation of euthanasia would necessarily have the effect of discouraging medical research and developments in palliative care.[137] In fact, evidence exists to confound this claim. Oregon, Washington and Vermont are considered United States leaders in palliative care,[138] despite each having legalised assistance to die. Furthermore, the European Association for Palliative Care has concluded that palliative care in European countries with legalised assistance to die is as well developed as it is elsewhere.[139]

As euthanasia is likely to be an option sought by only a small minority of people, justification would still remain for continuing research and encouraging developments to benefit the remaining majority. Those in the minority who might opt for euthanasia in

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[135] Oregon Public Health Division, *Death with Dignity Act Report* (2013), above n 73.

[136] Alister Browne "Assisted Suicide and Active Voluntary Euthanasia", above n 72, at 49.

[137] Margaret Otlowski *Voluntary Euthanasia and the Common Law*, above n 65, at 247-248.

[138] RS Morrison, DE Meier, R Augustin, P Souvanna "America's care of serious illness: a state-by-state report card on access to palliative care in our nation's hospitals joint publication by centre to advance palliative care and national palliative care research centre" (2011) 14 *J Palliative Med* 1094 at 1095.

[139] European Association for Palliative Care "Palliative care developments in countries with a euthanasia law" (2011) <http://www.commissiononassisteddying.co.uk/wp-content/uploads/2011/10/EAPC-Briefing-Paper-Palliative-Care-in-Countries-with-a-Euthanasia-Law.pdf>.

future still have a strong motivation to avoid having to resort to it as an option. Research and development will continue as society as a whole will still have the urge to continue to live longer. The opponents might be confusing a desire for euthanasia with an overarching desire to die; however, most people who request euthanasia do not want to die until they reach a certain state of ill health. The legalisation of euthanasia will not mean we will regard it as desirable or the "preferred option" at the end of life.

### *D Evaluation of the Case for and against Euthanasia*

Numerous points have been made both for and against the legalisation of euthanasia. Proponents have emphasised the importance of an individual's right to self-determination. It is argued that the risks and dangers associated with legalisation do not justify an absolute prohibition of euthanasia,[140] and that the risks and dangers can be minimised by safeguards contained in legislation.

On the other hand, opponents have argued that legislation, even under strict conditions, would create unacceptable risks, that the benefits would be far less than the dangers, and that these risks and dangers are too great to warrant a change in the existing law.[141]

After evaluating the arguments on both sides of the debate, I believe that the opponents' case is not strong enough to outweigh the prima facie case established by the proponents supporting the legislation of euthanasia. Opponents have the right to say: "This is not for me. I want to live until the bitter end" or if they are a doctor, "I want no part in helping patients to die", but they do not have the right to impose this preference on others.[142] Individuals' right to self-determination must be upheld and the potential risks and dangers posed by such legislation can be effectively eliminated by legislative controls.

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[140] Margaret Otlowski *Voluntary Euthanasia and the Common Law*, above n 65, at 248.

[141] Margaret Otlowski *Voluntary Euthanasia and the Common Law*, above n 65, at 248.

[142] Emily Jackson and John Keown *Debating Euthanasia*, above n 1, at 81.

# *IV Comparative Analysis of Foreign Jurisdictions*

## *A Overview*

A number of foreign jurisdictions have legalised a form of physician aid-in-dying, either euthanasia or physician-assisted suicide, or both. This section will state which jurisdictions have legalised either practice and explain how legalisation has been achieved. It will also discuss the common constituent elements that can be drawn from the legalisation regimes. The aim of this section is to use the existing regimes to inform the development of criteria for a legislative regime in New Zealand.

## *B Foreign Jurisdictions Legalising Euthanasia and/or Assisted Suicide*

Both voluntary euthanasia and physician-assisted suicide have been legalised in the Netherlands, Belgium and Luxembourg. Switzerland and the US states of Oregon, Washington, Montana and Vermont have legalised physician-assisted suicide only.

### *1 Netherlands*

The Netherlands was the first country to permit voluntary euthanasia and physician-assisted suicide. It was permitted in 1987, following the Supreme Court decision in the *Schoonheim* case.[143] The Termination of Life on Request and Assisted Suicide (Review Procedures) Act 2002 further formalised the process, codifying the criteria developed by further jurisprudence.

### *2 Belgium*

The law in Belgium permits euthanasia, but physician-assisted suicide is not regulated. Euthanasia was legalised by statute in 2002 and is defined as "intentionally terminating

[143] Ron LP Berghmans and Guy Widdershoven "Euthanasia in the Netherlands: Consultation and Review" 23 Kings Law Journal 109 at 110.

life by someone other than the person concerned, at the latter's request".[144] Assisted suicide is not an offence under Belgian law, nor is it permitted expressly in law.[145]

### *3 Luxembourg*

The law in Luxembourg permits euthanasia and physician-assisted suicide.[146] Parliament passed legislation in 2009 which stipulates that doctors who carry out euthanasia and assisted suicide will not face "penal sanctions" or civil lawsuits provided the legislative requirements are met.[147]

### *4 Switzerland*

Both physician-assisted and assisted suicide are legal in Switzerland, while euthanasia is illegal. Switzerland does not have an explicit statute which legalises the practice. Instead, the limitations of assisted suicide are outlined in the Swiss Penal Code. Article 115 considers assisting suicide a crime only if the motive is selfish, effectively condoning the practice for altruistic reasons. Article 114 prohibits euthanasia, although the crime has a lesser sentence than murder. A person who kills a person for compassionate motives on the basis of that person's genuine request will be fined or sentenced to a maximum sentence of three years' imprisonment.[148] This compares with murder which carries a mandatory minimum sentence of ten years' imprisonment.[149]

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[144] The Belgian Act on Euthanasia of May 28th 2002, s 2.

[145] Julia Nicol, Marlisa Tiedeman, Dominique Valiquet *Euthanasia and Assisted Suicide: International Experiences (Background Paper)* (Canadian Library of Parliament, 2011-67-E, October 2013) at Appendix A.

[146] Julia Nicol, Marlisa Tiedeman, Dominique Valiquet *Euthanasia and Assisted Suicide: International Experiences (Background Paper)*, above n 145, at Appendix A.

[147] Nicole Steck et al "Euthanasia and Assisted Suicide in Selected European Countries and US States: Systematic Literature Review" 51 Medical Law Journal 938 at 939.

[148] Swiss Penal Code, Article 114.

[149] Swiss Penal Code, Article 112.

### *5 Oregon*

The Oregon Death with Dignity Act was enacted in 1997, legalising physician assisted suicide but not euthanasia.[150] Terminally ill residents of Oregon with a prognosis of less than six months to live are able to obtain a prescription for medication for the purpose of committing suicide.[151] Certain conditions must be met before a prescription can be issued.

### *6 Washington*

The Washington State Death with Dignity Act, enacted in 2009, legalises physician-assisted suicide but not euthanasia.[152] The law is based on the law in Oregon, containing similar requirements.

### *7 Montana*

In 2009, the Montana State Supreme Court in *Baxter v Montana* established that terminally-ill patients may seek lethal medication in order to end their lives.[153] The Court held that although there is no constitutional right to physician assisted suicide in Montana, there is no legislation or case law to the contrary.[154] However, it avoided answering whether physician-assisted suicide is a right guaranteed under the Montana state constitution.[155] Since this right was not created through legislation, Montana's protection of physician-assisted suicide is more tenuous than protection offered by statute.[156]

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[150] Julia Nicol, Marlisa Tiedeman, Dominique Valiquet *Euthanasia and Assisted Suicide: International Experiences (Background Paper)*, above n 145, at 5.

[151] Julia Nicol, Marlisa Tiedeman, Dominique Valiquet *Euthanasia and Assisted Suicide: International Experiences (Background Paper)*, above n 145, at 4.

[152] Julia Nicol, Marlisa Tiedeman, Dominique Valiquet *Euthanasia and Assisted Suicide: International Experiences (Background Paper)*, above n 145, at 7.

[153] *Baxter v Montana* 224 P.3d 1211,1222 (Mont. 2009).

[154] *Baxter v Montana* 224 P.3d 1217,1222 (Mont. 2009).

[155] Stephen Hoffman "Euthanasia and Physician-Assisted Suicide: A Comparison of E.U. and U.S. Law" 63 Syracuse L. Rev. 282 2012-2013 at 395.

[156] Stephen Hoffman "Euthanasia and Physician-Assisted Suicide: A Comparison of E.U. and U.S. Law", above n 155, at 395.

### *8 Vermont*

An Act Relating to Patient Choice and Control at End of Life was enacted in Vermont in 2013, legalising physician-assisted suicide but not euthanasia.[157]

## *C Common Constituent Elements of the Regimes*

A number of common constituent elements can be drawn from the current voluntary euthanasia regimes. The constituent elements, and the similarities and differences in which each country deals with them, will be discussed in turn.

### *1 Condition of the person making the request to die*

#### (a) Terminally ill or incurably ill

The regimes diverge regarding the condition that the person requesting to die (the requester) must be in for their request to be valid. One class requires the requester to be terminally ill. This standard is recommended in Switzerland when the person assisting is a medical professional.[158] This standard is required in Luxembourg,[159] Oregon,[160] Washington,[161] and Vermont.[162] The other class applies a lighter standard, requiring that the requester be incurably ill and suffering unbearably, either physically or mentally. This standard applies in Switzerland (when the person assisting is not a medical professional), the Netherlands,[163] and Belgium.[164]

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[157] Julia Nicol, Marlisa Tiedeman, Dominique Valiquet *Euthanasia and Assisted Suicide: International Experiences (Background Paper)*, above n 145, at 8.

[158] Care of Patients in the End of Life: Medical-Ethical Guidelines of the SAMS, Swiss Academy of Medical Sciences (2004), at 6.

[159] Law on Euthanasia and Assisted Suicide of March 16th 2009, Art 4.3.

[160] The Oregon Death with Dignity Act, 127.820 § 3.02.

[161] Washington State Death with Dignity Act 2009, cl 1(1).

[162] An Act Relating to Patient Choice and Control at End of Life, § 5283(a).

[163] Termination of Life on Request and Assisted Suicide (Review Procedures) Act, s 2(b).

[164] The Belgian Act on Euthanasia of May 28th 2002, s 3(1).

(b) Age

For the request to be valid, the requester must be at least 18 years of age.[165] Two regimes take exception to this rule – Netherlands and Belgium. In the Netherlands, the request is valid if it is made by a person 12 years or older, with parental consent.[166] In Belgium, a request for euthanasia is valid by a person at any age, provided that person is terminally ill, in great pain and has parental consent if they are a minor.[167]

(c) Residency requirement

The regimes in Oregon, Vermont and Washington also require the requester to be a citizen of that state.[168] Presumably, this is to prevent "death tourism" being facilitated. The European regimes do not impose the same standard. In the Netherlands, despite no express provision in the legislation, the Ministry of Justice believes that it would not be possible for people to come from other countries to seek termination of life or assistance in suicide due the legislation's procedural requirements.[169] In Belgium, the requester must be a resident, but not necessarily a citizen.[170] No such requirement exists in the regimes of Luxembourg or Switzerland. "Death tourism" is particularly prevalent in Switzerland, due to the prevalence of Dignitas clinics which provide assistance in dying.

*2 Voluntary request*

Most of the regimes require the requester to have made the decision voluntarily, when they had capacity and were informed about their decision.[171]

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[165] For Luxembourg, see Law on Euthanasia and Assisted Suicide of March 16th 2009, Art 2.1. For Oregon and Washington, see the Oregon Death with Dignity Act and the Washington State Death with Dignity Act 2009 respectively which define an "adult" to be a person 18 years or over. For Vermont, see An Act Relating to Patient Choice and Control at End of Life, § 5283(4).

[166] Termination of Life on Request and Assisted Suicide (Review Procedures) Act, s 2(2)-2(4).

[167] "Belgium's parliament votes through child euthanasia" *BBC News*, (online ed, Europe, 13 February 2014).

[168] For Oregon, see the Oregon Death with Dignity Act s 127.800. For Washington, see Washington State Death with Dignity Act, 2009 cl 1(1). For Vermont, see An Act Relating to Patient Choice and Control at End of Life, § 5281.

[169] P Bellamy *Voluntary Euthanasia and New Zealand* (New Zealand Parliamentary Library, 2003) at 10.

[170] P Bellamy *Voluntary Euthanasia and New* Zealand, above n 169, at 9.

[171] For the Netherlands, see Termination of Life on Request and Assisted Suicide (Review Procedures) Act, s 2(a) and 2(2)-2(4). For Belgium, see The Belgian Act on Euthanasia of May 24th 2002, s 3(1). For

(a) Durability of request

The request must be established as durable under many of the regimes. To establish durability, the request must be repeated over a period of time.[172] The United States regimes in Oregon, Washington and Vermont specify that this time must be no less than 15 days after the initial request for the request to be considered valid.[173]

In Oregon and Washington, the physician must also recommend the requester to notify his or her next of kin of their request.[174] The requester will not, however, be denied of the life-ending medication on the sole basis that they are either unable or unwilling to notify their next of kin.

(b) Formalities

Most of the regimes require the request to be signed and in writing,[175] and for the attending physician to have consulted with at least one other independent physician who has also examined the requester.[176] The purpose of such consultation is to verify the validity of that person's request. Some regimes involve an additional requirement that the attending physician refer the requester to a counsellor or other mental health

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Luxembourg see Law on Euthanasia and Assisted Suicide of March 16th 2009, Art 2.1(1) and 2.1(2). For Switzerland, for physicians, see SAMS Guidelines, Art. 16. For Oregon see the Oregon Death with Dignity Act, 127.805 § 2.01. For Washington, see Washington State Death with Dignity Act 2009, cl 1 § 2. For Vermont, see An Act Relating to Patient Choice and Control at End of Life, § 5283.

[172] For Belgium, see the Belgian Act on Euthanasia of May 24th 2002, s 3(3) and for Luxembourg see Law on Euthanasia and Assisted Suicide of March 16th 2009, Art 7.

[173] For Oregon, see the Oregon Death with Dignity Act, 127.840 § 3.06. For Washington, see Washington State Death with Dignity Act 2009, cl 1 § 9. For Vermont, see An Act Relating to Patient Choice and Control at End of Life, § 5283(2).

[174] For Oregon see the Oregon Death with Dignity Act, 127.835 s 3.05 and for Washington, see Washington State Death with Dignity Act 2009, cl 1 § 8.

[175] For Belgium, see the Belgian Act on Euthanasia of May 24th 2002, s 4. For Luxembourg, see Law on Euthanasia and Assisted Suicide of March 16th 2009, Art 2.1(4). For Oregon, see the Oregon Death with Dignity Act, 127.805 § 2.02. For Washington, see Washington State Death with Dignity Act 2009, cl 1 § 2. For Vermont, see An Act Relating to Patient Choice and Control at End of Life, § 5283(5).

[176] For details see the following references: for the Netherlands see Termination of Life on Request and Assisted Suicide (Review Procedures) Act, s 2(e). For Belgium, see The Belgian Act on Euthanasia of May 24th 2002, s 2(3). For Luxembourg, see Law on Euthanasia and Assisted Suicide of March 16th 2009, Art 2.1(2). For Oregon, see the Oregon Death with Dignity Act, 127.815 § 3.01. For Washington, see Washington State Death with Dignity Act 2009, cl 1 § 1. For Vermont, see An Act Relating to Patient Choice and Control at End of Life, § 5283(7).

practitioner.[177] If the requester is suffering from a psychiatric or psychological disorder, including depression, there is a risk that judgment may be impaired. Their request will not be considered valid until it the counsellor or other mental health practitioner has certified that the person is not suffering from such a disorder which may impair judgment.

(c) Status of advance directives

An "advance directive" is defined by the New Zealand Medical Association as a written directive by which a person makes a choice about a future health care procedure that is intended to be effective only when he or she is not competent. A person is able to make a request for euthanasia under certain circumstances in the Netherlands, Belgium and Luxembourg. Seemingly this is because these regimes permit euthanasia, so if a person is not competent a physician can still administer the medication. This compares to the United States regimes which only legalise physician-assisted suicide. As this requires the person to administer their own medication to terminate their life, this is not possible if the person is not competent. For an advance directive to be accepted, the required elements for a voluntary request must have been established at the time the advance directive was created.[178]

### *3 Role of physicians*

Most euthanasia and physician-assisted suicide regimes require the person assisting to be a medical professional. The regime will either define "the physician" in the interpretation section,[179] with the provisions following referring to the acts of "the physician", or the

[177] See the Oregon Death with Dignity Act, 127.825 and Vermont's An Act Relating to Patient Choice and Control at End of Life, § 5283.

[178] For Netherlands, see Termination of Life on Request and Assisted Suicide (Review Procedures) Act, s 2.2. For Belgium, see The Belgian Act on Euthanasia of May 24th 2002, s 4(1) and for Luxembourg see Law on Euthanasia and Assisted Suicide of March 16th 2009, Art 4.

[179] For Netherlands, see Termination of Life on Request and Assisted Suicide (Review Procedures) Act, s 1(c). For Oregon see the Oregon Death with Dignity Act, 127.800 § 1.01. For Washington, see Washington State Death with Dignity Act 2009, cl 1 § 1. For Vermont, see An Act Relating to Patient Choice and Control at End of Life, § 5283.

regime will simply refer to "the physician" from the outset.[180] Switzerland's regime is exceptional – the person assisting need not be a medical professional.

The nature of the medical professional's assistance differs between the regimes. The assistance is more direct under the European regimes, with the attending physician performing the act inducing death, such as administering the lethal dose. It is important to note that these regimes all legalise euthanasia and in some cases physician-assisted suicide as well. Conversely, acknowledging that the regimes legalise assisted suicide only, the assistance under the United States regimes is more indirect. If a valid request is established, the physician will write a prescription for medication which, if filled and the medication is taken, will result in death.

### *4 Reporting requirements*

Physicians performing voluntary euthanasia or assisted suicide are typically required to register the act and submit the documentation to an overseeing body.[181] Such a body and its governance requirements are typically established through legislation. The body is required to review the completed documentation and ensure that the physician's conduct followed the correct procedure. If the majority of the committee (which will be defined in the legislation) believe that the correct procedure has not been followed, the physician will typically be referred to the public prosecutor.

Some of the regimes also require the overseeing body to present an annual statistical report based on the information that it has collected.[182] This may or may not be available to the public. Regardless, the report may be seen as a check on the practice to ensure that it is operating as desired and in accordance with the law.

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[180] For Belgium, see The Belgian Act on Euthanasia of May 24th 2002, s 3. For Luxembourg see Law on Euthanasia and Assisted Suicide of March 16th 2009, Art 2.1(1) and (2).

[181] For details, see the following references: for the Netherlands, see Termination of Life on Request and Assisted Suicide (Review Procedures) Act, Chapter 3. For Belgium, see The Belgian Act on Euthanasia of May 24th 2002, Chapter IV. For Luxembourg, see Law on Euthanasia and Assisted Suicide of March 16th 2009, Art 7 and 8. For Oregon, see the Oregon Death with Dignity Act, 127.815 § 3.11. For Washington, see Washington State Death with Dignity Act 2009, cl 1 § 15.

[182] See the Oregon Death with Dignity Act, 127.865 § 3.11.

# *V Options for Reform*

## *A Overview*

Having established that a case for the legalisation of euthanasia exists, discussion must turn to what method is most appropriate to achieve that aim. Three options exist which fall short of a legislative regime for euthanasia. These options will be discussed and weighed, before concluding that the preferable solution is to legalise euthanasia. A legislative proposal for legalising euthanasia will then be proposed.

## *B New Offence of "Homicide on Request"*

The least radical option for reform would be to introduce a new offence of "homicide on request", following the model adopted in a number of jurisdictions in continental Europe.[183] This would support the notion that killing, while always reprehensible, is less reprehensible when performed with the consent of the victim than when performed against his will.[184] An offence of "homicide on request" would have the advantage of attracting a lesser penalty than for murder or manslaughter, while symbolically retaining the sanction of criminal liability to distance the legislature from the appearance of having mandated a form of killing.[185] A person's motivation for killing would need to be determined in sentencing to distinguish homicide from "homicide on request". This proposal has its disadvantages however, the most significant being that physicians who assist a patient to commit suicide would still be criminally liable for their actions. As a result, physicians will likely be unwilling to provide assistance in the majority of cases, for fear of prosecution. This proposal therefore fails to address the underlying demand in the community for possibilities for assistance in dying.

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[183] For an analysis of these models see H Silving "Euthanasia: A Study in Comparative Criminal Law" (1954) 103 U Penn L. Rev 350 at 378-86. Admittedly, there are less radical alternatives still, such as simply reducing the liability for euthanasia from murder or manslaughter. It seems that New Zealand has defaulted to this position in many instances anyway: see Part II C (1)(b) of this paper. To formalise position would not effectuate a change in the current position.

[184] H Silving "Euthanasia: A Study in Comparative Criminal Law" (1954) 103 U Penn L. Rev 350 at 378.

[185] M Webb "The Politics of 'Medicide' in New Zealand: a Cautious Proposal for Physician Aid-in-Dying", above n 50, at 461.

### *C Introduce a Statutory Defence for Suicide Assistance*

To meet some of the aforementioned criticisms, scholars have advocated the creation of a new statutory defence for suicide assistance. The defence draws on the fact that suicide assistance may be a response to coercion and manipulation exerted by the principal against the assistant.[186] Where suicide assistance results from psychological pressure exerted by the suicidal individual, the imposition of harsh criminal penalties is manifestly inappropriate.[187] The reasoning behind the introduction of the statutory defence is aptly described by Catherine Shaffer:[188]

> The whole point of criminalizing suicide assistance is to protect the principal. If the principal has instigated or coerced the assistant's acts, the likelihood that punishing the assistant will protect suicidal individuals is small. Thus, if a person charged with assisting suicide can prove that [his or] her actions were a response to coercion or fear, a finding of criminal guilt may be appropriate as an expression of society's disapproval, but the penalty imposed should be lessened.

The defence would allow for the liability of some accessories of suicide to be mitigated, provided they acted with altruistic, not selfish, motives. This defence operates in Switzerland and provides that:[189]

> Any person who for commendable motives, and in particular out of compassion for the victim, causes the death of a person at that person's own genuine and insistent request is liable to a custodial sentence not exceeding three years or to a monetary penalty.

This compares with the offence of homicide which carries a maximum sentence of ten years' imprisonment.[190] Once again, this option does not fully remove the assistant's culpability, it merely reduces it. Furthermore, it does not remove the need for suicidal individuals to pressure those close to them to assist them in the act, leaving the possible risk of emotional trauma to the person who assists in the act.

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[186] M Webb "The Politics of 'Medicide' in New Zealand: a Cautious Proposal for Physician Aid-in-Dying", above n 50, at 461.

[187] C D Shaffer "Criminal Liability for Assisting Suicide" (1986) 86 Colum L Rev 348 at 357-358.

[188] C D Shaffer "Criminal Liability for Assisting Suicide", above n 187, at 357-358.

[189] Swiss Penal Code, Article 114.

[190] Swiss Penal Code, Article 112.

### *D Legalise Physician-Assisted Suicide*

The third main option for reform is to introduce legislation legalising physician-assisted suicide. This would allow physicians, within a tight legislative framework, to administer lethal doses of drugs to individuals upon request. This proposal has a number of advantages. Legalising physician-assisted suicide serves to stem some of the common concerns held by opponents to euthanasia. Aid in dying would be provided by physicians, removing concern that homicide of the terminally ill and severely disabled by friends and family may be disguised as suicide assistance, as these parties are not directly involved.[191] The proposal would also minimise the difficulty in ascertaining true voluntary consent. As the patient's death is precipitated by their own act, there is some assurance that they genuinely wanted to die.[192] If, after requesting assistance, a patient decides that he or she does not want to die, he or she can simply choose not to take the medication prescribed. It is argued that the situation is quite different when death is precipitated by a doctor. Some patients may feel embarrassed or intimidated to express uncertainty on the verge of being given a lethal injection, or would be concerned that the doctor may be hesitant to administer the lethal injection at a later time.[193] Furthermore, as the patient's actions precipitate their death, third party involvement is minimised.[194] This is advantageous as it avoids the risk of emotional trauma to the person who precipitates death.

Legalising physician aid-in-dying also addresses some more practical concerns. Firstly, patients wishing to commit suicide would have access to appropriate medical information and assistance in achieving their desired result.[195] This reduces risks associated with patient suicide, for example that the means chosen will be unreliable or inappropriately used. Another substantial advantage is that implementing the proposal would require only a minimal change to the structure of existing law.[196] New Zealand law already allows a plea of self defence as a defence against criminal homicide,[197] and this proposal would operate as an extension of the defence against criminal homicide.

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[191] Alister Browne "Assisted Suicide and Active Voluntary Euthanasia", above n 72, at 53.

[192] Margaret Otlowski *Voluntary Euthanasia and the Common Law*, above n 65, at 465.

[193] Margaret Otlowski *Voluntary Euthanasia and the Common Law*, above n 65, at 465.

[194] Margaret Otlowski *Voluntary Euthanasia and the Common Law*, above n 65, at 465.

[195] Margaret Otlowski *Voluntary Euthanasia and the Common Law*, above n 65, at 465.

[196] Alister Browne "Assisted Suicide and Active Voluntary Euthanasia", above n 72, at 53.

[197] Crimes Act 1961, s 48.

Physician-assisted suicide does not, however, represent a complete solution and is still fraught with some difficulty. As discussed earlier, a significant proportion of patients are not physically able to take the steps required to end their own lives. If physician-assisted suicide were legalised, able-bodied persons would have the right to commit suicide, but disabled people would not. Every person must have equal rights under the law, especially considering that the disabled's wish to die may be seen as the most understandable.[198] Moreover, if death is assisted by the physician, rather than being induced by them, it is possible that the medication prescribed will not cause a quick death and that further medical attention will be required to prevent a drawn out death.[199] Such intervention would not be able to be performed if only physician-assisted suicide were legal as this sort of assistance would be going beyond the legislation's scope.

If this option was adopted and the law was reformed to legalise assisted suicide, consideration would have to be given to the model used to secure such reform. In developing a legislative regime enabling physician-assisted suicide, particular consideration must be given to the structure of the legislation to ensure that irrational suicide was not encouraged by the regime.[200] Defining the scope of the regime would yield similar difficulties to defining a legislative regime enabling euthanasia. The requirements for this legislative regime will be discussed in turn. Discussion will be focused on the legalisation of euthanasia, but most of the issues raised apply equally to the legalisation of physician-assisted suicide.

### *E Legalisation of Euthanasia*

The final and most extensive option for reform is the legalisation of euthanasia. Framing a suitable legislative proposal for euthanasia is difficult, but this is not a justifiable reason to avoid addressing the issues at hand. A legislative proposal must be advocated to give legitimacy to my argument.

The requirements of a scheme legalising euthanasia will now be considered. Consideration will also be given to how such requirements have been implemented in the consultation draft of Maryan Street's End of Life Choice Bill (the Bill) as this is the most recent proposal for legalisation in New Zealand.

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[198] L Schiffer "Euthanasia and the Criminal Law" (1985) 42 UToronto Fac.L.Rev. 93 at 107.

[199] Margaret Otlowski *Voluntary Euthanasia and the Common Law*, above n 65, at 466.

[200] Margaret Otlowski *Voluntary Euthanasia and the Common Law*, above n 65, at 467.

## *1 Possible safeguards for the legalisation of euthanasia*

### (a) Condition of person making the request

#### (i) Terminally ill or incurably ill

One of the key decisions to be made in the legalisation of euthanasia is whether the practice should be restricted to the "terminally ill",[201] or whether the "incurably ill" should also be included within the scope of the legislation.[202] Either way, the meaning of the terms used must be defined in the statute to prevent ambiguity.

A number of justifications can be put forward for restricting euthanasia to the terminally ill. The primary justification for such a restriction is that the patient will die soon regardless of whether euthanasia is performed. With the incurably ill, it may be some time before they will die a natural death. It may therefore be argued that it is less harsh to kill a terminally ill person, as it is really only hastening their imminent death. This argument presupposes that a person being diagnosed as "terminally ill" will in fact die within the predicted time frame. This is not certain and many people end up living well beyond what was expected. This argument may effectively be turned on its head to assert that allowing the killing of the "terminally ill" may also be killing a person well before their natural death would have resulted.

A second justification for restricting euthanasia to the terminally ill is that by limiting the availability of euthanasia, the danger of the slippery slope will be reduced. The reasoning behind this position is neatly summarised by Amarasekara and Bagaric:[203]

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[201] The "terminally ill" standard is in place in Switzerland (when the person assisting is a medical professional), Luxembourg, Oregon, Washington and Vermont: see Part III C (1)(a) of this paper. This term is not defined in Street's End of Life Choice Bill 2012. "Terminal illness" is defined in clause 4 of New Zealand's Death with Dignity Bill 2003 as "an incurable and irreversible disease that has been medically confirmed and will, within reasonable medical judgement, result in the death of a patient".

[202] The "incurably ill" standard is in place in Switzerland (when the person assisting is not a medical professional), the Netherlands and Belgium: see Part III C (1)(a) of this paper. This term is not defined in the End of Life Choices Bill 2012. "Terminal illness" is defined in clause 4 of New Zealand's Death with Dignity Bill 2003 as "a medical condition which is generally accepted by the medical profession as seriously impairing the person's quality of life and unlikely to be capable of cure, either at the present time or in the reasonable future".

[203] K Amarasekara and M Bagaric "The Legalisation of Euthanasia in the Netherlands: Lessons to be Learnt" (2001) 27 Monash U.L. Rev 179 at 192.

> Once euthanasia is not confined to the terminally ill…there is the inherent risk that it may result in a diminution of the importance accorded to the right to life across the board and therefore lead to killing in other circumstances, or at least to a reduction in the endeavours taken to protect and save life.

Regardless of this, I support that any risk of a "slippery slope" eventuating in practice can be effectively eliminated through the imposition of adequate safeguards – in particular, requiring a high threshold for voluntariness. If these safeguards are imposed, the weak, vulnerable and handicapped will be adequately protected, regardless of whether euthanasia is confined to the "terminally ill" or extended to the "incurably ill" as well.

Thirdly, it has been argued that as the incurably ill are expected to live for a longer time than the terminally ill, there is a greater chance that a cure will be developed before their natural death. Thus, it may be advanced that since the incurably ill have a better chance of being "saved" from their current state of health, euthanasia should not be made available to them. I propose that such an argument is effectively countered by the proponents' argument that whilst finding a cure is possible, it should be ruled out for all practical purposes. If it is beyond reasonable doubt that a cure will not be discovered in time to help, this should be sufficient and a greater standard is not required.

On the other hand, the strongest justification for allowing those that are "incurably ill" to also be included within the scope of the legislation rests upon the two most fundamental arguments in support of legalising euthanasia: firstly, that each person, as an autonomous being, has the right to choose how and when he or she will die and secondly, that no one should be forced to endure pain and suffering as a result of an illness. The incurably ill have the right to the same degree of autonomy as the terminally ill and they too may be subjected to the same degree of pain and suffering from their illnesses. Based on these arguments, there is no justification to restrict the scope of euthanasia to the terminally ill. To do so would be unfair, especially considering that many patients with incurable illnesses will lack the physical capacity to commit suicide themselves.

Restricting euthanasia to the terminally ill in an attempt to minimise the risks involved with the practice is the easy way out of this debate. Any risks posed by extending the availability of euthanasia can be addressed by further safeguards. In my view, euthanasia must be extended to both the terminally ill and the incurably ill as any restriction in scope cannot be reconciled with the fundamental arguments behind euthanasia's legalisation. To reconcile the arguments addressed, a twofold test is proposed. Any patient requesting euthanasia must: (a) have a terminal or incurable physical or mental condition; and (b)

the suffering must be intolerable to that patient. Part (a) of the test will require an objective assessment, by a medical practitioner. Part (b) of the test will require a subjective assessment as it is up to the patient to decide what is intolerable by their own standards.

The Bill outlines a two-step test: a "qualifying person"[204] must be both mentally competent and suffer from either a "terminal disease or other condition that is likely to end his or her life within 12 months" or an "irreversible physical or mental condition that, in the person's view, renders his or her life unbearable".[205] This proposal would appear to be in line with my viewpoint, although it is difficult to assess if there is a direct nexus without any definition of "terminal illness" and "irreversible physical mental or condition" provided for in the Bill.

(ii) Age

Another important decision which must be made is whether euthanasia should be made available to minors,[206] as it is in the Netherlands[207] and Belgium.[208] The strongest justification for making it available to them rests once again on the fundamental arguments for legalising euthanasia. Minors too should have their own rights of autonomy and need not be subjected to pain and suffering from illness.

However, society deems the lives of children to be particularly valuable, so extending the law to them is likely to face harsh criticism. To counter these criticisms, strict limitations must be imposed. As Belgium is the only country which has fully removed any age restrictions for euthanasia, I propose that their legislation should be followed. The amendment to Belgium's law was heavily debated before being made into law in an aim to make it water tight. Whether it is operating in this way in practice may be assessed through analysis if required.

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[204] "Qualifying person" is defined in the End of Life Choice Bill 2012 to mean a person who is (a) either a New Zealand citizen or permanent resident; and (b) aged 18 years or over.

[205] End of Life Choice Bill 2012, cl 6.

[206] Meaning a person less than 18 years of age.

[207] Minor being a person 12 years or older, with parental consent: see Part 3 1(b) of this paper at citation 166.

[208] Minor being a person of any age, provided they are terminally ill, in great pain and have parental consent: see Part 3 1(b) of this paper at citation 167.

In Belgium, the standard for minors diverges from the "incurably ill" standard which exists for people of age. A minor requesting euthanasia must be terminally ill, close to death,[209] and deemed to be suffering beyond any medical help.[210] Suffering must be measured subjectively, as proposed in the earlier two part test. Further, the minor must be able to request euthanasia themselves and demonstrate that they fully understand their choice.[211] The request will then be assessed by a team of doctors, psychologists and others before a final decision is made subject to approval by the minors' parents.[212]

It is suggested that these limitations would balance the equal rights of minors against the criticisms of the extension of the practice. Furthermore, these limitations will ensure that cases occur only in exceptional circumstances. Doctors currently expect that most cases will involve adolescents and not children.[213]

My proposal diverts from the Bill, which restricts euthanasia to people 18 years or over.[214]

(iii) New Zealand residents

Euthanasia should be restricted to New Zealand residents to prevent the facilitation of "death tourism". Death tourism is prevalent in Switzerland where euthanasia is extended to non-residents. Whilst it is perfectly legal, people who disagree with euthanasia have major objections to it and have sought to limit the practice to Swiss residents only.[215] Such negative consequences would be prevented here if the practice was restricted to New Zealand residents only. A restriction to residents only exists in Oregon,[216] Washington,[217] and Vermont,[218] seemingly for the same reasons. This accords with the Bill, which restricts the scope of the practice to New Zealand residents.[219]

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[209] It is proposed that a further limitation would need to be placed on this standard, for example, with six months to live, as imposed in Oregon, Washington and Vermont.

[210] Charlotte McDonald-Gibson "Belgium Extends Euthanasia Law to Kids" *Time* (online ed, Brussels, 13 February 2014).

[211] Charlotte McDonald-Gibson "Belgium Extends Euthanasia Law to Kids", above n 210.

[212] Charlotte McDonald-Gibson "Belgium Extends Euthanasia Law to Kids", above n 210.

[213] Charlotte McDonald-Gibson "Belgium Extends Euthanasia Law to Kids", above n 210.

[214] End of Life Choice Bill 2012, cl 4.

[215] Olivier Guillod and Aline Schmidt "Assisted suicide under Swiss law" 2005 Eur. J. Health L. 25 at 31-32.

[216] The Oregon Death with Dignity Act, 127.800.

[217] Washington State Death with Dignity Act 2009, cl 1(1).

[218] An Act Relating to Patient Choice and Control at End of Life, § 5281.

### (b) Voluntary request

One of the main concerns advanced against legalising euthanasia is that we cannot be certain if a person's request is truly voluntary. Ascertaining the voluntariness of the patient's request is therefore of utmost importance in the decision to administer euthanasia.[220] Legislation permitting euthanasia must provide clear and convincing evidence that the patient genuinely wants assistance and the request has been made free from coercion and pressure from others.[221] I will propose that such evidence can be provided by implementing a number of preconditions which must be satisfied before a request can be considered as voluntary.

#### (i) Capacity

The patient must have decision-making capacity. Capacity is assessed regarding the particular question, and tests of competence vary according to gravity of the decision.[222] The decision to request euthanasia is clearly very serious, as the act precipitates death. Accordingly, it requires a very high standard of competence. Whether a patient requires psychiatric evaluation before making a request has caused some debate.[223] Some commentators have argued that there is a need for careful psychiatric scrutiny in all cases. I, however, tend to side with the opposing argument which advocates that this is too burdensome a requirement so it does not require codification in legislation. Rather, the determination of whether the patient has capacity should be left with the patient's doctor. This is a routine assessment that must be made in relation to other medical procedures. The doctor may however seek specialist help if they feel it is necessary, as already occurs in medical practice, or seek an opinion from an independent practitioner.

The Bill addresses these considerations by requiring the medical practitioner to certify that he or she has made appropriate enquiries and as a result of those enquiries the patient is assessed to be "mentally competent".[224] A person is presumed "mentally competent" unless evidence to the contrary is shown.[225] Mental competence is defined as having the

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[219] Cl. 4 states that to qualify, a person must be either a New Zealand citizen or permanent resident.

[220] Margaret Otlowski *Voluntary Euthanasia and the Common Law*, above n 65, at 478.

[221] Margaret Otlowski *Voluntary Euthanasia and the Common Law*, above n 65, at 478.

[222] R Sainsbury "End of Life Issues" in St George IM (ed) *Cole's medical practice in New Zealand, 12th edition* (Medical Council of New Zealand, Wellington, 2013) at 107.

[223] See Carl, "The Right to Voluntary Euthanasia", above n 132, at 544-546.

[224] End of Life Choice Bill 2012, cl 9(1)(d).

[225] End of Life Choice Bill, cl 5(2).

"ability to understand the nature and consequences of a request to end… [one's] life, in the knowledge that the request will be put into effect".[226] This test appears to assess capacity appropriately, specifically referencing it with the request to die. The Bill does not require a patient who has made a request to be referred for a psychiatric assessment or to an independent practitioner. It is suggested that reference could have been made to a referral at the medical practitioner's discretion, but I do not consider this to be essential.

(ii) Voluntary decision

A patient's doctor must also be satisfied that the patient's decision to request euthanasia is voluntary and free from coercion. This should require verification from an independent physician.

While not referring to a "voluntary" decision directly, the Bill refers to voluntariness indirectly in requiring both that the applicant genuinely wished to end his or her life,[227] and that there was no coercion placed on the applicant to make the request.[228] While this seems workable, the Bill's requirements for a voluntary request are weakened as the voluntariness does not require corroboration from an independent physician.

(iii) Informed decision

The patient's decision must also be informed. To make an informed choice, the patient must be given full information about his or her condition and prognosis, including any element of uncertainty in relation to this.[229] Full disclosure is "essential to the unfettered exercise of the right to self-determination".[230]

The Bill requires the medical practitioner to certify that the patient has been advised of all other medical options available, including palliative care.[231] This clause has been developed with the correct intention but falls short of the requirement I have proposed. To be fully informed, the patient also requires information about his or her condition and prognosis, as well as that of his or her medical options.

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[226] End of Life Choice Bill, cl 5(1).

[227] End of Life Choice Bill, cl 9(2)(b).

[228] End of Life Choice Bill, cl 9(2)(c).

[229] Margaret Otlowski *Voluntary Euthanasia and the Common Law*, above n 65, at 479.

[230] Margaret Otlowski *Voluntary Euthanasia and the Common Law*, above n 65, at 479.

[231] End of Life Choice Bill 2012, cl 9(3)(b).

(iv) Durability of request

Furthermore, the patient's request must be durable. A request can be considered durable if it is repeated over an extended period of time before it is acted upon. Durability can be confirmed by requiring the request to be repeated and requiring a minimum period of time to elapse between the first and second request.[232] This is to provide ample opportunity for the patient to reflect upon his or her decision and to provide some guarantee that the request is made earnestly and is enduring and not the product of an impulsive decision.[233] The patient must be given the choice to revoke his or her request in case he or she no longer wants to die and should be reminded of this choice to ensure that he or she does not feel bound by his or her request. The patient's doctor should recommend that the patient notify their family of his or her request for medication, but the patient should not be required to do so against his or her wishes.[234] A request will not become invalid if this requirement is not satisfied. This however excludes minors, whose requests are valid only with the approval of their parents or legal guardians.

The Bill requires a request to be durable as it requires the request to be confirmed no sooner than seven days after it was made.[235] This time frame is shorter than that of other jurisdictions, but this is immaterial. Enough time is provided for the request to be reflected upon and for the patient to ensure that they are certain. The Bill also requires the medical practitioner to encourage the patient to consult with his or her family or a close friend about the request and additionally, to seek counselling.[236] The medical practitioner must also advise the patient that he or she is not obligated to consult with anyone,[237] in line with my proposal.

(v) Formalities

Finally, certain formalities are required to evidence a patient's voluntary request. The patient's request, and confirmation of that request, should be in writing, and signed by

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[232] For example, two requests must be made, at least 15 days apart from each other under the regimes in Oregon, Washington and Vermont: refer to Part C 2(a) of this paper at citation 173.

[233] Margaret Otlowski *Voluntary Euthanasia and the Common Law*, above n 65, at 480.

[234] As is required in the Oregon Death with Dignity Act, 127.835 § 3.05

[235] End of Life Choice Bill 2012, cl 7(2)(c).

[236] End of Life Choice Bill 2012, cl 8(1).

[237] End of Life Choice Bill 2012, cl 8(2).

them.[238] If a patient is unable to unable to write a request or to confirm it in writing, he or she may instead mark the written request or confirmation with an X or indicate his or her written request by other means, and that request or confirmation be recorded in writing by another person. The request should also be witnessed by two independent witnesses, who are able to attest that the patient's decision is voluntary and informed. These formalities are considered to be important procedural safeguards. If a patient is required to make his or her request in writing, it is more likely to be the product of serious thought and reflection. A written request provides an increased assurance that it is truly voluntary and provides protection to both doctors and patients involved in its administration.[239] A further backstop could also be provided by requiring written documentation from the patient's doctor of their patient's medical condition, decision making capacity and the voluntariness of their request.

The Bill requires patients' requests to be both in writing and signed by them.[240] It also provides for the same alternative procedure if a person is unable to write a request or confirm it in writing. There is no requirement that the request be witnessed. A backstop is however required, as the patient's doctor is required to certify the validity of the patient's request and their capacity, voluntariness and medical condition.[241]

(vi) Status of advance directives

Attention must also be given to the status afforded to requests made by advance directives under legislation for euthanasia. As discussed earlier, whether a patient's advance request is truly voluntary has been questioned. Such a request would have to be made at a time the patient had capacity to express his or her own wishes and would come into effect if the patient no longer had this capacity.

The weight given to advance directives is controversial and there are a number of competing considerations which must be carefully weighed. Recognising advance directives as valid would have the advantage of maximising patient autonomy. It would enable patients to express their wishes in advance in the event that they suffered from a terminal or incurable condition and no longer have the decision-making capacity to

[238] As is required in Belgium, Luxembourg, Oregon, Washington and Vermont: refer to Part IV 2(b) of this paper, citation 173.

[239] Margaret Otlowski *Voluntary Euthanasia and the Common Law*, above n 65, at 480-481.

[240] End of Life Choice Bill 2012, cl 7(2).

[241] End of Life Choice Bill 2012, cl 9.

request euthanasia.[242] This would provide reassurance to many patients who may live in fear of suffering distress or indignity as a result of an illness. It would also serve to spare medical practitioners and relatives of the patient the burden of making difficult decisions on that person's behalf.

As has already been noted, concern has been expressed that requests expressed via advance directive are not as certain and reliable as requests expressed at the time euthanasia is sought. It has been argued that there is no guarantee that an advance request continues to accord with the wishes of the patient once he or she has lost decision-making capacity. Furthermore, patients may not be able to make informed decisions which are speculative of future circumstances. As a result, it is argued that advance directives entail an increased risk that decisions are made which do not in fact accord with the patient's wishes. As there is no practical means to reassess the voluntariness of the patient's decision, it is argued that there is a greater risk of mistake and abuse.

Advance directives for healthcare are, however, already widely accepted and used in New Zealand. A person is able to direct what action they would like to be taken if they sustain an unlimited number of specified conditions and become mentally incompetent to express their opinion about accepting or declining life-sustaining treatment. It follows that the same should apply to requests for euthanasia. Advance directives should be considered valid if a patient no longer has the mental capacity to express their opinion but has outlined that they would like euthanasia to be performed if they are terminally ill or are suffering from an incurable condition outlined by them or are suffering from specified symptoms as a result of that condition. It may be argued here that the extension of euthanasia goes too far, as legal advance directives for healthcare at present extend only to passive withdrawal of treatment, rather than active administration of treatment, as would be required for euthanasia. This argument can be countered, drawing upon the argument from proponents that there is no valid distinction between active killing and passive allowance of death.[243]

(i) Status of advance directives under the Bill

Advance directives are accepted as valid requests under the Bill, however they are extensively regulated.[244] A mentally competent person is able to make an advance

[242] Margaret Otlowski *Voluntary Euthanasia and the Common Law*, above n 65, at 482.

[243] Refer to Part III B (4) of this paper.

[244] End of Life Choice Bill 2012, cl 11-19.

directive that will come into effect when he or she becomes mentally incompetent. It will only be applicable if the person is in one of the same situations that would allow him or her, if he or she were mentally competent at the time, to make a request in person for medical assistance in ending his or her life.

(c) The role of physicians

An essential consideration is the physician's role in a regime for euthanasia. As discussed, physicians will be involved in ascertaining the eligibility of a patient. There is little dispute over this issue, the more controversial one is whether they should be involved in the administration of euthanasia.

I propose that the legislation should allow euthanasia to be performed by physicians only. The possibility of it being performed by nurses, family members or friends should be discounted. This should avoid any emotional trauma ensuing to the person who brings about death.[245] Justice Wild concurred with this view in *R v Lesley Jane Martin*, a case where a mercy killing was carried out by a nurse:[246]

> I do not think there can be any suggestion that, even if euthanasia were made legal, someone in your position would have been able to carry it out. I doubt that any new law would give a nurse that responsibility, much less a family caregiver.

Patient safety is another reason why euthanasia should be administered by a physician. Physicians have both the skills and resources to administer a quick and painless death and are also bound by strict codes of professional conduct and ethics so it can be assumed that they will act in the patient's best interests.

However, no person should be under the obligation to perform certain medical procedures. It is proposed that in New Zealand, the practice of euthanasia would operate like the conscience objection in the Contraception, Sterilisation and Abortion Act 1977.[247] Under this, medical professionals are not obligated to participate in procedures which may be considered objectionable on religious grounds – including performing an abortion or any operation for sterilisation purposes,[248] or to provide advice or assistance

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[245] Roger Crisp, "A Good Death: Who Best to Bring it?" (1987) 1 *Bioethics* ISSN0269-9702 74 at 75.

[246] *R v Lesley Jane Martin* unreported, HC Wanganui, CRI 2003-083-432, 30 April 2004, per Wild J.

[247] Contraception, Sterilisation and Abortion Act 1977, s 46.

[248] Contraception, Sterilisation and Abortion Act, s 46(1)(a).

relating to contraception.[249] This conscience objection should not extend so far as to allow a physician to give an outright "no" if asked by a patient to perform euthanasia. Physicians should be under a duty to refer the patient, as a minimum requirement, to another physician who may be willing to fulfil to their request.

(i) The Bill

The Bill does not provide a provision expressly stating the physician's role. This is, however, understandable as their role is implied in the legislation. The provisions of the Bill refer to acts being performed by a "medical practitioner", further defined as a person who is a registered practitioner of the Medical Council of New Zealand.[250] It can therefore be assumed that the Bill envisages the acts to be performed by physicians only. However, the Bill contains a further, somewhat curious, clause. The medical practitioner has the ability to delegate the role of administering death to another person, if the patient explicitly requests that other person participate and assist in their death, provided that person agrees to help.[251] This clause appears to be contrary to the underlying rationale for restricting the provision of euthanasia to physicians as it risks emotional trauma ensuing to the person assisting death and questionable patient safety.

(d) Reporting requirements

A further consideration is whether legislation should impose any formal reporting requirements on physicians who have performed euthanasia. It is asserted that physicians should be required to register the act and submit supporting documentation to a review body, also established by legislation, to prove that the due care requirements have been followed. This is consistent with ensuring that the practice is performed openly and is subject to public scrutiny. It would also provide a check that the practice was operating safely. Annual reports should be published by the overseeing body, which will be able to be used to monitor the frequency of euthanasia.

The Bill includes detailed reporting requirements. Firstly, it requires the Minister of Health to appoint a Registrar who is required to keep a register of advance directives and medically assisted deaths.[252] The Registrar is required to produce annual reports which

[249] Contraception, Sterilisation and Abortion Act, s 46(1)(b).

[250] End of Life Choice Bill 2012, cl 4.

[251] End of Life Choice Bill 2012, cl 23.

[252] End of Life Choice Bill 2012, cl 32 and 33.

include information in respect of the number of deaths carried out by the Act and any other relevant matters relating to the functioning of the Act.[253] A review body is also established,[254] to report to the House of Representatives on the functioning of the legislation.[255] Physicians are required to report to the Registrar after completing a medically assisted death and their report must contain details of the procedure.[256] The reporting requirements outlined in the Bill are lacking in one respect – they fail to include evidence that the due care requirements have been satisfied.

(e) Application to physician-assisted suicide

The preceding analysis has focused on a legislative framework for euthanasia. However, as discussed earlier, the legalisation of euthanasia would logically include the legalisation of physician-assisted suicide as well. The same criteria should apply for both practices. Although the physician is not active in bringing about the patient's death in physician-assisted suicide, the physician must still confirm the patient's eligibility and advise them as to how the medication is to be taken. The physician should also be present when the medication is taken, to ensure a painless death and should be ready and willing to administer further treatment if this does not result.

The Bill contains a further clause outlining various procedures that a patient may choose for a medically assisted death.[257] These procedures are available to a mentally competent person, to the extent that it is feasible. Both physician-assisted suicide and euthanasia are provided as available procedures under the Bill.

## *2 Conclusion*

The New Zealand Parliament should enact legislation legalising euthanasia. Such legislation must impose limitations on its practice, to ensure its purpose is being achieved and to safeguard against abuse. The foregoing analysis provides the elements I believe to be essential under such a regime.

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[253] End of Life Choice Bill 2012, cl 34.
[254] End of Life Choice Bill 2012, cl 35.
[255] End of Life Choice Bill 2012, cl 37.
[256] End of Life Choice Bill 2012, cl 24.
[257] End of Life Choice Bill 2012, cl 21.

New Zealand would hardly be pioneers in this field. Rather, we can benefit from the practical experience gained in other jurisdictions with regimes in place. The strengths of these regimes have been identified and can be drawn from to create what I believe to be an appropriate regime. The Bill is lacking certain necessary safeguards, so would require revision should it be reintroduced.

The regime I have proposed is fairly liberal. Although it requires a number of criteria to be met before euthanasia can occur (in the interests of safety), it makes euthanasia available to what is comparably a wide scope of people. It includes both the terminally ill and incurably ill as well as people of any age, subject to certain additional requirements. It is acknowledged that this scope may need to be limited to enable the legislation to be passed. Its scope may however be extended after the legislation has been in place for some time (as occurred in Belgium). Having said this, my belief still stands that the legislation should include such people, in the interests of autonomy.

## *VI Conclusion*

In conclusion, a statutory window should be opened to legalise euthanasia. The law already recognises that some people may choose to deliberately end their own lives,[258] and this recognition needs to extend further to acknowledge that some of these people will need assistance in their act. The law's response should be constructive rather than punitive.

Legalising euthanasia will not be the first step down some slippery slope towards moral and social atrophy.[259] It will not lead us to condone euthanasia for any reason whatsoever, nor does it commit society to accept non-voluntary euthanasia tomorrow and involuntary euthanasia the day after that. People should be given the right to choose to make their own decisions about how they die and euthanasia should be one of their options. Legalising euthanasia in limited circumstances under a legislative regime with strict controls will serve to strike a balance between the two extremes of the debate – the sanctity of life and the right to self-determination.

[258] Through the repeal of suicide as a criminal offence discussed in Part II B.

[259] M Webb "The Politics of 'Medicide' in New Zealand: a Cautious Proposal for Physician Aid-in-Dying", above n 50, at 465.

# *Bibliography*

## *A Cases*

### *1 New Zealand*

*Auckland Area Health Board v A-G* (1992) 8 CRNZ 634.

*R v Albury-Thomson* (1988) 16 CRNZ 79.

*R v Bell* HC Wanganui, S011886, 8 March 2002.

*R v Crutchley* HC Hamilton CRI 2007-069-83 9 July 2008.

*R v Davison* (HC Dunedin CRI-2010-012-4876, 24 November 2011).

*R v Faithfull* (HC Auckland CRI 2007-044-7451, 14 March 2008).

*R v Karnon* HC Auckland, S 14/99, 29 April 1999.

*R v KJK* HC Christchurch CRI 2009-009-14397, 18 Feburary 2010.

*R v Law* [2002] 19 CRNZ 500.

*R v Lesley Jane Martin* unreported, HC Wanganui, CRI 2003-083-432, 30 April 2004.

*R v Martin* (CA 199/04 14 February 2005).

*R v Mott* [2012] NZHC 2366.

*R v Novis* HC Hamilton T42/87, 5 February 1988.

*R v Ruscoe* (1992) 8 CRNZ 68.

*R v Simpson* HC Auckland, T010609, 12 October 2001.

*R v Stead* (1991) 7 CRNZ 291.

*2 United States*

*Baxter v Montana* 224 P.3d 1211,1222 (Mont. 2009).

***B Legislation***

*1 New Zealand*

Contraception, Sterilisation and Abortion Act 1977.

Crimes Act 1961.

Criminal Code Act 1893.

New Zealand Bill of Rights Act.

Sentencing Act 2002.

Death with Dignity Bill 1995.

End of Life Choice Bill 2012.

*2 Belgium*

The Belgian Act on Euthanasia of May 28th 2002.

*3 Luxembourg*

Law on Euthanasia and Assisted Suicide of March 16th 2009.

*4 Netherlands*

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

*5 United States*

An Act Relating to Patient Choice and Control at End of Life.

The Oregon Death with Dignity Act.

Washington State Death with Dignity Act 2009.

*6 Switzerland*

Swiss Penal Code.

***C Books and Chapters in Books***

Black's Law Dictionary (10th edition, 2014).

Francis Boyd Adams *Criminal Law and Practice in New Zealand* (2nd ed, Sweet & Maxwell, Wellington, 1971).

Fletcher *Morals and Medicine* (Princeton, New Jersey, 1979).

Emily Jackson and John Keown *Debating Euthanasia* (Hart Publishing, Oxford, 2012).

David McGee *Parliamentary Practice* (3rd ed, Dunmore Publishing, Wellington, 2005).
Margaret Otlowski *Voluntary Euthanasia and the Common Law* (Oxford University Press, New York, 1997).

R Sainsbury "End of Life Issues" in St George IM (ed) *Cole's medical practice in New Zealand, 12th edition* (Medical Council of New Zealand, Wellington, 2013).

PDG Skegg and Ron Paterson et al *Medical Law in New Zealand* (Brookers, Wellington, 2006)

### *D Journal Articles*

Rex Ahdar "Religious parliamentarians and euthanasia: a window into Church and State in New Zealand" 38 Journal of Church and State 569.

K Amarasekara and M Bagaric "The Legalisation of Euthanasia in the Netherlands: Lessons to be Learnt" (2001) 27 Monash U.L. Rev 179.

A Back "Physician-Assisted Suicide and Euthanasia in Washington State: Patient Requests and Physician Responses" (1996) 275 JAMA 919.

V Barry "Moral Aspects of Health Care" 500 (1982).

Ron LP Berghmans and Guy Widdershoven "Euthanasia in the Netherlands: Consultation and Review" 23 Kings Law Journal 109.

Alister Browne "Assisted Suicide and Active Voluntary Euthanasia" 1989 2 Can. J.L. & Jurisprudence 35.

Carl "The Right to Voluntary Euthanasia" (1988-1989) 10 Whittier L. Rev. 489.

Joachim Cohen et al "Public acceptance of euthanasia in Europe: a survey in 47 countries" (2014) 59 Int J Public Health 143.

Roger Crisp, "A Good Death: Who Best to Bring it?" (1987) 1 *Bioethics* ISSN0269-9702 74.

PJ Downey "Euthanasia: Life Death and the Law" [1995] NZLJ 88.

Olivier Guillod and Aline Schmidt "Assisted suicide under Swiss law" 2005 Eur. J. Health L. 25.

R Gula "Euthanasia: A Catholic Perspective" (1987) 68 Health Progress at 28-29.

Stephen Hoffman "Euthanasia and Physician-Assisted Suicide: A Comparison of E.U. and U.S. Law" 63 Syracuse L. Rev. 282 2012-2013.

Mitchell K and Owens G "End of life decision-making by New Zealand general practitioners: a national survey" (2004) Vol 117 No 1196 Journal of the New Zealand Medical Association.

RS Morrison, DE Meier, R Augustin, P Souvanna "America's care of serious illness: a state-by-state report card on access to palliative care in our nation's hospitals joint publication by centre to advance palliative care and national palliative care research centre" (2011) 14 *J Palliative Med* 1094.

L Schiffer "Euthanasia and the Criminal Law" (1985) 42 UToronto Fac.L.Rev. 93.

C D Shaffer "Criminal Liability for Assisting Suicide" (1986) 86 Colum L Rev 348.

H Silving "Euthanasia: A Study in Comparative Criminal Law" (1954) 103 U Penn L. Rev 350.

Nicole Steck et al "Euthanasia and Assisted Suicide in Selected European Countries and US States: Systematic Literature Review" 51 Medical Law Journal 938.

M Webb "The Politics of 'Medicide' in New Zealand: a Cautious Proposal for Physician Aid-in-Dying" (1994) 5 Canterbury Law Review 1994 438.

G Williams "Euthanasia and Abortion" (1966) 38 UColo.LRev. 178.

### *E Parliamentary and Government Materials*

#### *1 New Zealand*

Parliamentary Debates (Hansard) (30 July 2003) 610 NZPD 7482.

P Bellamy *Voluntary Euthanasia and New Zealand* (New Zealand Parliamentary Library, 2003).

*2 Canada*

Julia Nicol, Marlisa Tiedeman, Dominique Valiquet *Euthanasia and Assisted Suicide: International Experiences (Background Paper)* (Canadian Library of Parliament, 2011-67-E, October 2013) at Appendix A.

*3 United States*

Oregon Public Health Division, *Death with Dignity Act Report* (2013) <http://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Documents/year16.pdf>.

***F Reports***

Rex J. Ahdar "Killing me softly: should euthanasia be legalised" (Family First New Zealand, Manukau City, 2014).

***G Internet Materials***

Duncan Crawford "Belgium's parliament votes through child euthanasia" *BBC News*, (online ed, Europe, 13 February 2014).

Isaac Davison "Labour: euthanasia bill will return" *The New Zealand Herald* (online ed, Auckland, 16 October 2013).

Michelle Duff "Coronor urges MP to decide on euthanasia" (15 October 2013) Fairfax Media <http://www.stuff.co.nz/national/health/9282506/Coroner-urges-MPs-to-decide-on-euthanasia>.

European Association for Palliative Care "Palliative care developments in countries with a euthanasia law" (2011) <http://www.commissiononassisteddying.co.uk/wp-content/uploads/2011/10/EAPC-Briefing-Paper-Palliative-Care-in-Countries-with-a-Euthanasia-Law.pdf>.

Charlotte McDonald-Gibson "Belgium Extends Euthanasia Law to Kids" *Time* (online ed, Brussels, 13 February 2014).

John Pollock "Dying GPs plea for euthanasia" *The New Zealand Herald* (online ed, Auckland, 21 July 2010).

"Vatican Declaration on Euthanasia" (1980) <http://www.vatican.va/roman_curia/congregations/cfaith/documents/rc_con_cfaith_doc_19800505_euthanasia_en.html>.

### *H Other Resources*

Care of Patients in the End of Life: Medical-Ethical Guidelines of the SAMS, Swiss Academy of Medical Sciences, 1 at 6 (2004).

Code of Health and Disability Services Consumers' Rights.