

THE POLITICS OF 'MEDICIDE' IN NEW ZEALAND: A CAUTIOUS PROPOSAL FOR PHYSICIAN AID-IN-DYING

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Albert Camus raised a number of eyebrows when he once claimed that judging whether life is or is not worth living amounts to answering the fundamental question of philosophy. If identifying suicide as the only truly serious philosophical problem was provocative, it pales next to the storm of controversy that has lately engulfed retired Michigan pathologist Jack Kevorkian. Dubbed "Dr Death" by the ever-imaginative American press, Kevorkian has gained infamy as the inventor of a rudimentary suicide machine which has thus far helped 20 people in the United States to end their lives. Kevorkian's case has become something of a *cause célèbre* thanks to a frenzied media who seem unsure whether to lionise or vilify the central protagonist. Where television talk show appearances have made Kevorkian's exploits the subject of knee-jerk popular debate, his brand of physician-assisted suicide has excited lawyers, bioethicists, and policy makers into more considered analysis. Administering lethal doses of drugs to patients on request has been identified by many scholars as the next major social movement, and has even been hailed as 'the most important new civil-rights issue likely to come along'.¹

Enlisting help to bring about one's death, it would seem, is now very much political. Building on this realisation, this article seeks to place the issue of physician-assisted suicide within both a legal and public policy framework.² The first section traces the history of suicide assistance, and recasts the modern debate it has sparked in terms of two significant currents within society. An overview of the present law covering physician aid-in-dying is provided in the second part of the paper. The third section rehearses various policy arguments for and against medically-administered euthanasia. It also surveys international developments in this area and examines a number of proposals for reform. The discussion concludes by answering a question that is suggested throughout: whether physician aid-in-dying should be regarded as suicide or murder; a legally permissible act of self-determination or an attenuated form of homicide.

BACKGROUND TO THE DEBATE

When any is taken with a torturing and lingering pain, so that there is no hope either of cure or ease they should no longer nourish such a rooted distemper, but choose to die since they cannot live but in such misery.

Sir Thomas More, *Utopia*.

1 A Caplan, quoted in: 'At Crossroads, US Ponders Ethics of Helping Others Die', *New York Times*, 28 October 1991, at A15.

2 As this statement implies, the focus for this article is assisted suicide within a medical ambience, not the equally controversial area of mercy killings. Likewise, I am not concerned here with proposals formally to mandate passive euthanasia, a procedure which is already widely practiced in the clinical setting without attracting criminal prosecution. Nor will I examine the contentious issue of when patients are incompetent and must be represented by a third party, a situation in which questions of surrogate or proxy decision-making come to the fore. These complex topics have all been dealt with at length elsewhere.

Suicide³ and euthanasia have a long and value-laden history. We have probably all heard stories of the past in which suicide has been the noble act of a religious martyr or the heroic self-sacrifice by a captured soldier. At the same time, we will be equally familiar with some of the bloody episodes in world history where genocidal campaigns have been disguised as well-meaning efforts to give certain groups of people a "good death". These contradictory associations form part of the backdrop to the contemporary debate on physician aid-in-dying. In the following section, this debate will be located within a more specific historical and socio-cultural context.

Historical overview

Terminally ill and elderly people often elected the time and manner of their death throughout history. The social acceptability of this practice was usually motivated by powerful cultural norms. The ancient Celts, for instance, believed that an individual who died of disease or senility went to hell, but one who faced such a death and committed suicide was rewarded with a place in heaven.⁴ Suicide by agent was also not uncommon. In some archaic societies it was traditional for the family to assist in killing one of their ailing members, while one medical historian living in classical Greece records many cases in which doctors gave poison (usually hemlock) to their dying patients.⁵ Indeed, it is possible to distinguish at least eight recurring types of non-compulsory suicide that were sanctioned during the Graeco-Roman period. While this typology includes some rationales for suicide that we would find difficult to accept today, one with enduring relevance to contemporary times is the desire to escape victimisation by a painful illness or infirmity; conditions often linked to the onset of old age. Coupled with the desire to distribute food resources most efficiently, for example, this led the citizens of Ceos to commit suicide once they had reached the age of 60.⁶

The philosophical debate over suicide and euthanasia likewise has strong roots, and the history of western thought is rich in discussions on these topics. Plato, Aristotle, Pythagoras and the Stoics in the ancient Greek world; the medieval Jewish and Christian casuists; and early-modern writers such as Michel de Montaigne, John Donne, David Hume and Immanuel Kant; have all grappled with the issues raised by these practices in a lengthy and sophisticated way.⁷

- 3 It is wise to clarify here just what we mean by "suicide". The first thing to note is that, from a philological viewpoint, suicide is an inherently fluid concept which is constantly in a state of flux: D Daube, 'The Linguistics of Suicide' (1972) 1 Phil & Pub Affairs 387. Furthermore, it is routinely confused by obtuse ramblings about the professional, ethical, philosophical, jurisprudential, and legal distinctions between killing and letting die. (It is beyond the scope of this short paper to consider the often gymnastic reasoning of arguments used in this largely semantic conflict.) As a form of behaviour, however, suicide has a recognisable praxis which few would dispute: the deceased voluntarily takes steps either to actively terminate his or her own life or, by omission, let himself or herself be killed. M Windt, 'The Concept of Suicide', in M Battin and D Mayo (eds.), *Suicide: The Philosophical Issues* (New York, 1980), 39–41. See also *Brophy v New England Sinai Hosp Inc* 497 NE 2d 626 (1986), at 644, per O'Connor J ('the termination of one's own life by act or omission with the specific intention to do so').
- 4 R Gillon, 'Suicide and Voluntary Euthanasia: Historical Perspectives', in A B Downing (ed), *Euthanasia and the Right to Death* (London, 1969), 182. Gillon also lists anthropological evidence which suggests that voluntary euthanasia was approved of in various Nordic, Siberian, Eskimo, Polynesian, and African communities: *ibid.* 182–3.
- 5 N Elliott, *The Gods of Life* (New York, 1974), 117–8.
- 6 Strabo, *The Geography*, 10.5.6.
- 7 This area is covered in admirable detail by P Carrick, *Medical Ethics in Antiquity* (Dordrecht, 1985), esp Chs 3 and 7; and by the authors in B A Brody (ed), *Suicide and Euthanasia: historical and contemporary themes* (Dordrecht, 1989).

Speaking generally, the representation of suicide as a mode of dying rather than as an act of killing first appears in Greek culture of the fourth and fifth centuries BC. The concept of “rational” suicide also has its genesis here. We find the following passage in Seneca’s *Ad Lucilium Epistulae Morales*:

[M]ere living is not a good, but living well. Accordingly, the wise man will live as long as he ought, not as long as he can. He will mark in what place, with whom, and how he is to conduct his existence, and not the quantity of his life It is not a question of dying earlier or later, but of dying well or ill. And dying well means escape from the danger of living ill.⁸

Roman scribes articulated similar views on achieving a “good death”. Pliny the Younger believed that the right to die when one pleased was ‘God’s best gift to men among the sufferings of life’, and considered the carefully reasoned choice to commit suicide to be ‘worthy of the highest applause’.⁹ This belief has also been espoused by a number of later writers. Most notably, Donne penned the first great modern defence of suicide in his famous work *Biathanatos*, although a short essay by Hume can be seen to present a more fully-developed and perceptive set of arguments for its moral permissibility.¹⁰

Equally, though, there has been concerted resistance to any form of suicide throughout history, particularly by the church, and this resistance has been carried into the present law on assisted suicide. Building on the thoughts of St Augustine in the early fifth century, the views of St Thomas Aquinas are perhaps the most well-known of the religious and philosophical objections to suicide. Writing in that mighty tome the *Summa Theologica*, Aquinas argued that Scripture condemned any form of suicide through the sixth commandment not to kill, a premise from which he went on to claim that self-killing violates the law of Nature, the law of the community, and the law of God.¹¹ These simplistic theological arguments informed later thinking on the subject. In English writing after Donne, for instance, suicide was variously condemned as murder, criminal behaviour, contrary to religion and Scripture, against Nature, against human nature, and against virtue and morality.¹²

Many of these strands were picked up by ecclesiastical law to justify imposing a variety of sanctions against those who committed suicide, including terrible indignities performed on the corpses themselves. Harking back to the anti-suicide laws of ancient Rome, the Council of Nîmes made this condemnation of suicide part of the Canon Law in 1182, with broader acceptance soon to follow. Legal historians concur that while it may have been a crime as early as the tenth century, 1485 is the latest date under English law from when suicide was equated with murder as a criminal offence.¹³

8 Seneca, *Ad Lucilium Epistula Morales*, XCIII.ii. One of Seneca’s favourite metaphors was of life as a banquet at which only the greedy guest overstays his visit.

9 Pliny, *Epistles*, I.xxii. ‘[C]almly and deliberately to weigh the motives of life or death’, Pliny continues, ‘and to be determined in our choice as reason counsels, is the mark of an uncommon and great mind’.

10 This essay, entitled ‘On Suicide’, is reprinted in D Hume, *Essays: Moral, Political and Literary* (Oxford, 1963), 585–96.

11 Aquinas, *Summa Theologica*, II–II, Q.64, A5. Earlier, Augustine had spoken of suicide as cowardly in escaping the ills of life, a weak act rising from a person’s ‘softness of spirit’ (*mollities animi*), and believed that it deprived the person who committed suicide of the opportunity for repentance.

12 S E Sprott, *The English Debate on Suicide* (La Salle, 1961), 41ff.

13 See E Stengel, *Suicide and Attempted Suicide* (Harmondsworth, 1964), 60.

The modern movement for reform

Historical trends, this time in biomedicine, also provide the context for assisted suicide emerging on the contemporary social policy agenda. To a large extent its topicality derives from the fact that the twentieth century has witnessed some dramatic shifts in cultural attitudes towards death and dying. As the celebrated French historian Philippe Aries has noted, the first of these important shifts concerns the institutionalisation of the dying process itself.¹⁴ Whereas once most deaths occurred at home in the presence of one's family, death has gradually become displaced to the point where up to 80% of all deaths now take place in institutional settings such as hospitals or nursing homes. These settings are usually experienced as alienating and impersonal by the dying individual. The second important historical change involves the causes of mortality in our era. While medical advances in eradicating infectious and communicable diseases has led to a marked increase in average life-expectancy, it has also resulted in quick-acting "killer diseases" being replaced by chronic and degenerative diseases as the major causes of death; diseases that are debilitating over an extended period of time.¹⁵

Not only is the dying process apt to be more painful and protracted than it once was but advances in medical technology now enable clinicians to prolong the dying process even further through the use of life-support machines. Ironically, these shifts have both occurred at a time when a greater emphasis is being placed on patient autonomy and the right to self-determination. It is the discrepancy between this ideology of personal control and the modern experience of loss of control during the dying process that can be seen as the main driving force behind the call for allowing physician assisted suicide.¹⁶

Beyond a recognition of these cultural catalysts, the proposal for reform which this paper examines is grounded on two essential facts. First, doctors are already performing what amounts to voluntary euthanasia with seeming impunity. Although they are understandably reticent in admitting publicly that they have actively helped patients in their care to end their lives, overseas studies indicate that a significant number of doctors are already engaged in taking such steps. In a recent Australian survey of 869 doctors from the state of Victoria, for example, 107 admitted to having initiated procedures to terminate the life of one of their patients.¹⁷ Medically-assisted euthanasia is most visible in the United States, where there have been a number of high-profile cases in which doctors have administered lethal drugs to their terminally ill patients.¹⁸ The most notorious of these to date

14 P Aries, *Western Attitudes Towards Death: From the Middle Ages to the Present*, trns P M Ranum (Baltimore, 1974), 85–103.

15 According to Statistics Department figures from 1988, the major causes of death in New Zealand are now all chronic illnesses. The three leading causes of mortality for people that year were: ischaemic heart disease (7,252), malignant neoplasm (6,481), and cerebrovascular disease (2,693). See Department of Statistics, *New Zealand Yearbook 1992* (Wellington, 1992), 137.

16 This point is well-made by C Campbell, "'Aid-in-dying' and the taking of human life" (1992) 18 *J Med Ethics* 128.

17 H Kuhse and P Singer, 'Doctors' practices and attitudes regarding voluntary euthanasia' (1988) 148 *Med J Aust* 623. The sampling techniques used in this study were later subject to criticism: see (1988) 149 *Med J Aust* 276–82.

18 One of the earliest instances was brought to light in an anonymous letter: 'It's Over, Debbie' (1988) 259 *J Am Med Assoc* 272. This described the author's injection of a lethal dose of morphine into a patient with terminal ovarian cancer, after she had repeatedly asked the doctor to advance her death.

involve Dr Kevorkian, a self-styled angel of mercy whose methodology has done much to polarise public opinion on physician-assisted suicide.

There are other, less obvious, ways in which doctors have been involved in helping some patients deliberately end their lives. As Ian Kennedy has adverted, it is 'a fine line between aiding suicide and making available, for example, certain drugs to relieve pain which, if more than a certain dosage is taken, will cause death'.¹⁹ In early March 1991, Dr Timothy Quill provoked a storm of controversy when he recounted in the *New England Journal of Medicine* how he prescribed a potentially lethal dose of barbiturates for one of his cancer patients, knowing that she intended to use them to end her life. Even more controversially, when the woman's family notified the physician that she had committed suicide, Dr Quill proceeded to list acute leukemia as the cause of death so as to save the family from the stigma of suicide.²⁰

The second grounding for this study is the fact that there is a tangible demand within the community for physician aid-in-dying as well as powerful reasons why we should wish to substitute it for some of those means which are currently being employed to commit suicide. With respect to the potential demand, one need look no further than the sobering estimate that there is one suicide in the United States every 19 minutes.²¹ Obviously not all of these deaths will be related to factors which might add weight to calls to legalise voluntary euthanasia. It is therefore important to clarify the causes of suicide which signal a need within society for more humane forms of aid-in-dying to be permitted.

As a preliminary remark, it should be noted that the aetiology of suicide has long perplexed social scientists. During the 1840s, for example, some commentators sought to explain increasing numbers of suicides by blaming such fantastic causes as atmospheric moisture and excessive masturbation.²² Former US President Dwight Eisenhower, a man not noted for his intellectual rigour, even went so far as to assert that the high Swedish suicide rate was a vivid example of the perils of uncontrolled social welfare. The factors advanced today as relevant are considerably more prosaic.²³ One common theme is the sense of despair that is contingent on a person's affliction with a terminal illness. Echoing international patterns, research in New Zealand indicates that almost one quarter (24.4%) of all people who commit suicide have one or more serious physical illnesses.²⁴ Overseas evidence suggests that the emergence of the acquired immunodeficiency syndrome (AIDS) since 1981 has also contributed to an increase in suicide attempts.²⁵

19 I M Kennedy, 'The Law Relating to the Treatment of the Terminally Ill', in *Treat Me Right: Essays in Medical Law and Ethics* (Oxford, 1988), 326. The same point is made by McEachern CJBC in the tragic case of *Rodriguez v A-G of British Columbia* (1993) 79 CCC (3d) 1, at 11: 'there is only a conceptual line that lacks practical reality between physician assisted suicide and palliative care'.

20 T E Quill, 'A Case of Individualised Decision Making' (1991) 324 *New Eng J Med* 691.

21 G P Smith, 'All's Well That Ends Well: Towards a Policy of Assisted Rational Suicide or Merely Enlightened Self-Determination?' (1989) 22 *UC Davis L Rev* 275, at 278.

22 D Maguire, *Death by Choice* (New York, 1975), 216. With regard to the second factor listed here, the two major cures designed to stem suicidal urges were cold showers and laxatives!

23 Refer to W H Trethowan, 'Suicide and Attempted Suicide' [1979] 2 *Brit Med J* 319.

24 N Antoniadis, *Suicide Risk and Prevention: A New Zealand Case Study of Coroner Files* (Wellington, 1988), 20. Physical illness at the time of death is also considered to be an important predictor of suicide by E Robins, *The Final Months: A Study of the Lives of 134 Persons who Committed Suicide* (New York, 1981).

25 See P M Marzuck et al., 'Increased Risk of Suicide in Persons with AIDS' (1988) 259 *J Am Med Assoc* 1333. As Dutch intern Jan Borleffs notes, euthanasia is now looked upon in many hospitals as the ultimate treatment doctors can give their dying AIDS patients, and their 'last responsibility to them'. Quoted in 'New law offers Dutch a way out', *The Evening Post*, 10 February 1993, at 30.

In addition, a number of studies have underlined the link between suicide and losses in physical capacity and independence in later life; losses due primarily to chronic sickness or debilitating surgery.²⁶ The feeling of impotence and helplessness that flows from this physical incapacity is the core depression of the elderly, and constitutes a major reason for suicide within this cohort. In a study of New Zealand Coroners' files by Nicholas Antoniadis, of the 85 individuals in the 60+ age group that committed suicide during 1981, over 51% (44) suffered from a low quality of life because of chronic or terminal sickness.²⁷ Antoniadis provides the following case-study:

A 62 year old married man had been a hospital patient for two years He had a long standing hypertensive condition and had cancer of his thigh. An operation and radiotherapy did not arrest the malignancy and amputation was recommended. Continuous pain and the prospect of mutilating surgery proved too much for him. He took his life with a gunshot to the head. He left a suicide note stating that he could not stand the pain any longer, he could hardly walk and that his life was unbearable.

Not only is there an obvious demand for aid-in-dying within certain groups in society — a demand which one might expect to increase with the spread of AIDS and the so-called “greying” of the population — but the gruesome way in which people are often forced to commit suicide tends towards some liberalisation of the current ban against doctors providing patients with the means to effect their own death. The prospect of having to rely on one of the traditional methods of committing suicide (gunshot, slashed wrists, ingestion of poison, etc) must be frightening for a person who has come to the rational decision to kill himself or herself, and is an added burden which he or she need not have to endure.

The significance of the debate

Accepting for the moment that there is a need to reappraise the law governing assisted suicide, it is important at the outset to clarify just what is at stake in the movement for reform. Undoubtedly the critical issue in this debate is just where responsibility lies for managing death. Does control rest with the State, the medical profession, or with individuals themselves? A number of scholars have launched stinging attacks against the monopoly over death-related issues which is exercised by government in western societies.²⁸ Others have doubted the received wisdom of leaving the power to make life-and-death decisions in the hands of the medical profession, a group whose members, it is said, are ill-equipped to deal with such difficult politico-legal and moral questions.²⁹ Increasingly the call has gone out for greater personal autonomy in making such important decisions, a move which follows the logic that if a person is in control of his or her own life then that person must surely be in control of his or her own death.³⁰

This sentiment has been consistently expressed in public opinion polls. To take just one example, 81% of those questioned in a 1991 *New York*

26 For example, M Miller, 'Geriatric Suicide: The Arizona Study' (1978) 18 *The Gerontologist* 488.

27 N Antoniadis, op cit n 24 at 49. The case-study which follows in the text is derived from the same source: *ibid*.

28 For example, see H T Engelhardt, Jr, 'Death By Free Choice: Modern Variations on an Antique Theme', in B A Brody (ed), op cit n7, esp 255-62.

29 S McLean and G Maher (eds), *Medicine, Morals and the Law* (Aldershot, 1983), esp 57.

30 This is only a recent feature of western cultures. The development towards this attitude in the twentieth century has been charted by P Aries, op cit n14, Ch 1. See also A Toynebee, *Man's Concern With Death* (London, 1968), 122 et seq.

Times survey believed that a doctor should be allowed to fulfil a patient's wishes, even if that meant allowing the person to die, with another 64% of respondents affirming that doctors should be permitted directly to inject or administer lethal drugs on request.³¹ Similar trends are evident in this country, with a 72% approval rating being recorded for active voluntary euthanasia in a 1991 Morgan Gallup poll.³² As a New Zealand administrative tribunal also recently observed, 'the existence of voluntary euthanasia groups within the community is evidence that many people support the right to choose death where there is no longer any quality of life left'.³³

It is against this backdrop of a mounting dissatisfaction with barriers to personal control of end-of-life decisions, a demand for a more accountable and responsive medical establishment, and a climate of public opinion favouring the liberalisation of aid-in-dying possibilities, that the current debate over physician-assisted suicide crystallises. Armed with this understanding, the law's response to this practice may be examined in a critical and revealing light.

THE CURRENT LEGAL REGIME

End-of-life decisions are particularly difficult to adjudicate precisely because the issues arise in a legal twilight zone — boundaries that are not clear in the first place often become even more obscure as time passes — and end in darkness when the patient dies.

William Winslade, *End-of-Life Medicine, Law, and Ethics*.

As one would expect, the law relating to assisted suicide is a product of the general law on suicide. This legacy is, however, one of limited reach. Although it had long been considered immoral and subject to severe penalty under ecclesiastical law, suicide was not formally recognised as a criminal act at common law until 1854.³⁴ The reasons for this delay are not readily apparent. Certainly, the criminalisation of suicide does not appear to have been part of any deliberate attempt to rationalise penal policy in this area. According to Glanville Williams, the English courts may have been simply motivated to enrich the treasury's coffers, given that the standard punishment for self-murder at the time was confiscation of the deceased's land and chattels.³⁵ As Blackstone explains in his *Commentaries on the Laws of England*, suicide was viewed during this period as not only a serious offence against God and nature, but also against the king himself as he was being deprived of a subject. The difficulty of punishing the dead was cited as the reason for inflicting on suicides the double punishment of forfeiting their personal property and dishonouring their corpse.³⁶

31 'Euthanasia Favored in Poll', *New York Times*, 4 November 1991, at A16. This figure of over two-thirds support is consistently attained in most surveys. A recent Californian poll, for instance, indicated that 70% of respondents felt that assisted suicide of seriously ill patients who wish to die should be legalised: 'Doctors Debate Helping the Terminally Ill Die', *New York Times*, 24 May 1993, at A1, A25.

32 Cited in M Otlowski, *Active Voluntary Euthanasia — A Timely Reappraisal* (Tasmania, 1992), 34.

33 *Re "Final Exit"* [1993] NZAR 122, at 129. This decision by the Indecent Publications Tribunal classified Derek Humphry's book *Final Exit* (New York, 1991), the controversial and best-selling guide to self-deliverance, as not indecent.

34 *R v Doody* (1854) 6 Cox Crim Cas 463. See, later, *R v Burgess* (1862) 169 Eng Rep 1387; and *R v Man* (1914) 2 KB 107. The standard early history is given by W Larremore, 'Suicide and the Law' (1903-4) 17 *Harvard L Rev* 331.

35 G Williams, *The Sanctity of Life and the Criminal Law* (London, 1958), Chapter 7.

36 W Blackstone, *Commentaries on the Laws of England*, Vol 4 (London, 1825), 188-90. See also the King's Bench decision of *Hales v Petit* (1565) 75 Eng Rep 387, at 400.

While the punishments of forfeiture and escheat were abolished in the mid-1870s,³⁷ suicide remained a criminal act in England well into the twentieth century. Attempted suicide, too, was a misdemeanour offence punishable by a fine or imprisonment. Interestingly, the number of prosecutions for this latter offence were far from negligible. During 1946-55, for example, some 45,000 cases of attempted suicide were brought to the attention of the British and Welsh police, of which almost 6,000 were brought to trial; 94% of defendants were found guilty, and 308 were sent to prison without the option of a fine.³⁸ Partly in response to charges that the law was being implemented capriciously, both suicide and attempted suicide were legalised in the United Kingdom under the Suicide Act 1961. Aiding or abetting a suicide remains, however, a punishable offence.³⁹

The scope of criminal liability in New Zealand

While the offences of suicide and attempted suicide were removed from New Zealand's statute books considerably earlier in 1893, as in England it is still a crime under New Zealand law to assist in the commission of a suicide. Section 179 of the Crimes Act 1961 provides as follows:

179. 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 consequence thereof; or
- (b) Aids or abets any person in the commission of suicide.

Section 310 of the Crimes Act outlawing conspiracy to commit an offence may also have some relevance. The offence of conspiracy generally consists of an 'agreement of two or more persons to effect any unlawful purpose, whether as their ultimate aim, or only as a means to it, and the crime is complete if there is such an agreement, even though nothing is done in pursuance of it'.⁴⁰ It seems likely that a doctor who agrees to assist a patient to commit suicide, either directly or indirectly, would fall within this definition. Under s 66 of the Crimes Act a person could also be guilty until his or her death as a party to an offence being committed by those aiding his or her suicide. All of these provisions are retained in the proposed Crimes Bill before Parliament.

As well as the prohibition contained in s 179, the other legal impediment to physician-mediated suicide is the fact no one can consent to his or her own death at the hands of another. The relevant provision of the Crimes Act states:

63. Consent to death No one has the right to consent to the infliction of death upon himself; and, if any person is killed, the fact that he gave any such consent shall not affect the criminal responsibility of any person who is party to the killing.

This principle seems problematic. If one does not presuppose a particular ideological or religious viewpoint, it is difficult to see how a general philosophical argument could demonstrate that killing another competent person in accordance with his or her prior, non-coerced request is in fact a *malum in se*. That is to say, it is hard to see how suicide in this context

37 See J F Stephens, *A History of the Criminal Law of England* (London, 1883), 105.

38 E Stengel, *op cit* n13, 61.

39 Suicide Act 1961 (UK) s 2. For examples of the judicial application of this particular section, see *R v Reed* [1982] Crim LR 819; and *R v Hough* (1984) 6 Cr App R 406.

40 *Crofter Handwoven Harris Tweed Co Ltd v Veitch* [1942] 1 All ER 142, at 146, per Viscount Simon LC.

could ever be called intrinsically evil. As a matter of logic, if it is legally acceptable for a person to bring an end to his or her own life, it should not be illegal if that person chooses to seek his or her end at the hands of another. Despite these intellectual difficulties, it is a well established rule of the common law that consent to any overtly self-destructive action will not legally validate that action.⁴¹

Finally, it is appropriate to consider the legal position of doctors who hasten the death of a person already suffering from a terminal disorder. Section 164 of the Crimes Act makes this position clear:

164. Acceleration of death Every one who by any act or omission causes the death of another person kills that person, although the effect of the bodily injury caused to that person was merely to hasten his death while labouring under some disorder or disease arising from some other cause.

For this provision to be invoked, the test that must be satisfied is that the accused's action amounted to more than a *de minimis* contribution to the victim's death.⁴² It need not have been the substantial cause of death. Although there are no reported cases in which section 164 has formed the basis of a prosecution in this country, presumably it could be used to charge a doctor with culpable homicide who accelerated the death of a terminally ill patient by administering a lethal quantity of medication.⁴³

The position in practice, however, is not so clear cut. It has already been noted that the distinction is often illusory between legitimately providing terminally ill patients with pain-relieving drugs and knowing that a lethal overdose of those drugs will be taken by patients in order to end their lives. Although the medical profession seems to accept the administration of life-shortening palliative care as both acceptable and commonplace, it is arguable under section 164 whether this practice is actually lawful. The question then becomes: when does prescribing a judicious mix of analgesic and anxiolytic medications to alleviate suffering become, in the law's eyes, an injudicious act of aiding and abetting a suicide?

The critical element is clearly the intent with which the doctor acts. While the physician's motive is immaterial, his or her intention is all important. As Lord Mustill has said of this situation in a recent judgment:

The fact that the doctor's motives are kindly will for some, although not for all, transform the moral quality of his act, but this makes no difference in law. It is intent to kill or cause grievous bodily harm which constitutes the *mens rea* of murder, and the reason why the intent was formed makes no difference at all.⁴⁴

This proposition was also expressed in *R v Cox*.⁴⁵ In that case, Ognall J noted that there is an 'absolute prohibition on a doctor *purposefully* taking life as opposed to saving it'. No matter if that course is prompted by the humanitarian desire to end suffering, he directed, 'what can never be lawful is the use of drugs with the primary purpose of hastening the moment of death'. 'So to act', as Lord Goff has observed, 'is to cross the Rubicon that

41 Eg *R v Brown* [1993] 2 WLR 556. This is a judgment whose voyeuristic appeal seems likely to secure it a fond place in the hearts of law students for many years to come.

42 *R v Hennigan* [1971] 3 All ER 133.

43 This reading accords with that of D B Collins, *Medical Law in New Zealand* (Wellington, 1992), 192, ¶7.4.2. Section 164 merely codifies the common law position that hastening death by improper medical treatment may constitute the crime of murder or manslaughter: *R v Burdett* (1916) 86 LJKB 871. See also *R v Dyson* [1908] 2 KB 454.

44 *Airedale NHS Trust v Bland* [1993] 1 All ER 821, at 890.

45 Unreported. Noted [1993] 1 Med L Rev 232. This case is discussed more fully below, at p 449.

runs between on the one hand the care of the living patient and on the other euthanasia'.⁴⁶

Putting to one side the problem of establishing causation, then, a strict interpretation of the existing criminal law indicates that doctors will be guilty of homicide if they administer a potentially lethal quantity of pain-relieving drugs to a patient with the intention that they be used to commit suicide. Provided the requisite *mens rea* and *actus reus* can be established, the physician's motive, and the fact that the patient consented to the administration of the drugs, are irrelevant.

The position at common law

Given the existence of such clear heads of liability, one might expect to find a significant body of case-law applying them. A quick scan of the major law reports soon reveals this confidence to be misplaced. Instead, the defining characteristic of those cases involving doctors which fall under the rubric of assisted suicide is their combined rarity and leniency of treatment.⁴⁷ Of the meagre fare that is available, the leading authority is usually taken to be the 1957 English case of *R v Adams*.⁴⁸ Turning on the administration of large doses of morphine and heroin to an elderly patient, this case is routinely held up for its approach to whether doctors are justified in adopting a course of treatment which effectively shortens a patient's life. In an oft-quoted direction to the jury, Devlin J said:

If the first purpose of medicine, the restoration of health, can no longer be achieved, there is still much for a doctor to do, and he is entitled to do all that is proper and necessary to relieve pain and suffering, even if the measures he takes may incidentally shorten life.

According to Devlin J, this conclusion flows from interpreting the cause of death in a 'common sense' way. To his mind, no sensible person would look at the acceleration of a patient's death brought about by a doctor administering medical treatment and say that the doctor had actually *caused* the death of the patient.⁴⁹

Such an approach involves a barely disguised manipulation of the principles of causation. The basis for Devlin J's suggestion that pain-killing drugs can *never* be the operating cause of death is, as a matter of factual causation, obviously a tortuous fiction. The doctor's actions undeniably precipitated the patient's death in that case. One supposes, therefore, that while the former is the cause in fact, it is somehow not the cause in law.⁵⁰ It is difficult to understand how this could possibly be right. As Lord Mustill has bluntly remarked, such an interpretation seems to require 'not manipulation of the law so much as its application in an entirely new and illogical way'.⁵¹ In sum, while its intention may be applauded, the direction in

46 *Airedale NHS Trust v Bland* [1993] 1 All ER 821, at 867.

47 There are, of course, powerful policy reasons why this should be so. As Margaret Otowski opines, 'if strict criminal law principles were to be invoked, doctors would be encouraged to practice defensive medicine, and this would result in tighter, less sensitive, rationing of pain relief'. M Otowski, *op cit* n32, 20.

48 Unreported. Noted [1957] Crim L Rev 365. The judge in this case, Devlin J, subsequently wrote a rather laboured book about this particular trial. See P Devlin, *Easing the Passing* (London, 1985).

49 This exercise in legal sophistry has frustrated even normally reserved commentators. See, for instance, J C Smith and B Hogan, *Criminal Law*, 7th ed. (London, 1992), 332.

50 This is the preferred solution of P D G Skegg, *Law, Ethics and Medicine* (Oxford, 1984), 135-6. One other inventive approach has been to argue that what fell to be determined in *Adams* was not causal responsibility, but rather if the casual connection was outside the *de minimis* range: see *Smithers v R* (1977) 75 DLR (3d) 321, at 329. This interpretation, also, seems overly strained.

51 *Airedale NHS Trust v Bland* [1993] 1 All ER 821, at 892.

Adams constitutes shaky ground on which to build a general proposition of law.

A coherent justification for the rule in *Adams* may yet be made out. This involves placing reliance on a doctor's obligations when caring for a terminally ill patient. As detailed by Ognall J in *Cox*, the parameters of this duty are that:

if a doctor genuinely believes that a certain course is beneficial to his patient, either therapeutically or analgesically, even though he recognises that course carries with it a risk to life, he is fully entitled, nonetheless, to pursue it. If sadly ... the patient dies, nobody could possibly suggest that ... the doctor was guilty of murder or attempted murder.

At first blush this seems to be an application of the doctrine of "double effect". Briefly stated, this philosophical device holds that a person whose act is intended to achieve a primarily positive result (pain relief) does not intend any foreseeable secondary consequences of that act which are negative (hastening death). However, this type of distinction has never been part of the criminal law,⁵² and it cannot be thought to have been introduced specifically to deal with physician aid-in-dying.

Rather than relying on intellectual sleight-of-hand, the stronger defence of the rule in *Adams* is one grounded on the responsibility of a doctor to do all that is medically possible to alleviate a patient's suffering. On this account, where the patient's pain is of a such an intensity that it is no longer susceptible to relief by standard medication, it would actually be a breach of the doctor's duty were he or she *not* to adopt the only available course of pain-relief treatment, even though it imported a risk (or indeed certainty) that the patient's life would be shortened. The acceptability of the doctor's action here stems from its congruence with dutiful medical practice.⁵³

Thus far we have established that the application of painkilling drugs which have the incidental effect of abbreviating a patient's life may be countenanced by an appeal to duty. Instincts of compassion and mercy alone will not be enough to justify a doctor providing potentially deadly drugs on request. Having said this, of course, even in clinical situations which fall short of this standard it will always be open to physicians to argue that a certain patient was given a lethal quantity of pills merely to ease his or her pain or sleeping disorders, and to invite the court to believe them.⁵⁴ Judging from the paucity of case-law involving health professionals in this context, it would seem that such a strategy is highly effective where it is required. Take, for instance, proceedings instituted in England under section 2 of the Suicide Act 1961. In an empirical study of the period from 1961-70, it was found that only 12 of an initial 80 cases reported to the Director of Public Prosecutions were actually brought to trial, none of which involved a doctor as the defendant.⁵⁵ Research in other jurisdictions supports this trend. In her comprehensive review of such cases in Australia during the last 30 years, Margaret Otlowski concludes that almost all genuine instances of assisted suicide were treated with exceptional leni-

⁵² *R v Moloney* [1985] AC 905; *R v Hancock* [1986] AC 455; *R v Nedrick* [1986] 3 All ER 1.

⁵³ 'Such a decision may properly be made as part of the care of the living patient, in his best interests; and, on this basis, the treatment will be lawful. Moreover, where the doctor's treatment of his patient is lawful, the patient's death will be regarded in law as exclusively caused by the injury or disease to which his condition is attributable': *Airedale NHS Trust v Bland* [1993] 1 All ER 821, at 868, per Lord Goff.

⁵⁴ I M Kennedy, 'The Legal Effect of Requests by the Terminally Ill and Aged not to Receive Further Treatment from Doctors', in *Treat Me Right*: op cit n 19, 342.

⁵⁵ P Jones, 'Criminal Law and Suicides' (1973) 13 Med Sci & Law 110.

ency, either through the exercise of prosecutorial discretion, outright acquittals, findings of guilt on lesser charges, light sentencing by the court, favourable parole determination, or even the use of executive clemency.⁵⁶ The only one of these cases involving a doctor was eventually discharged at trial on the basis of insufficient evidence.⁵⁷

In the few isolated prosecutions of doctors for euthanasia, it has not always been insufficient evidence which has led to an acquittal. Two remarkable American decisions illustrate the propensity of juries to acquit in these cases directly against the weight of evidence. In *People v Montemarang*⁵⁸ a New York doctor was charged with the murder of a 59 year old patient who suffered from terminal cancer of the throat. Despite evidence that the doctor had indeed given the patient a fatal dose of potassium chloride, an action which he testified was taken so as to end the man's suffering, the jury in the case summarily acquitted him. There was even less room for doubt in *People v Sander*,⁵⁹ where a physician was prosecuted for murdering a cancer-patient by injecting lethal amounts of air into her vein. That his intent was to bring about the patient's death was spelt out in his entry on the hospital records at the time: '[p]atient was given 10cc of air intravenously repeated four times. Expired within ten minutes after this started.' At trial, the doctor made no attempt to deny his actions, claiming only that it could not be proven he had actually caused the patient's death. In the face of strong forensic evidence to the contrary, the jury subsequently acquitted him of murder, apparently accepting that his acts were not a proximate cause of the patient's death.

In recent years there have been a scattered number of prosecutions for murder brought against doctors in the United Kingdom. In the 1986 case of *R v Carr*,⁶⁰ a doctor was accused of attempted murder for injecting a massive dose of phenobarbitone into a patient who was diagnosed with terminal lung cancer. He, too, was acquitted of the charge despite compelling evidence of guilt. The senior house officer at the centre of *R v Lodwig*⁶¹ was similarly charged with the murder of a terminally ill cancer patient. In the days before his death, the patient concerned was no longer lucid, was convulsed with fits, and was racked by agonising pain. Implored by the patient's family to relieve his suffering, Dr Lodwig infused a mixture of potassium chloride and lignocaine, a few minutes after which the patient died peacefully. Although he declared his intention had been 'to kill the pain and not the patient', the results of an initial pathology report indicated that the cause of death had been acute potassium poisoning. Yet again, however, a *prima facie* case of homicide was not pursued. Although committed for trial, when the matter came before the court the prosecution offered no evidence against the doctor, leading the judge to direct that a verdict of not guilty be entered.

The most fully-reasoned authority on hand is *R v Cox*,⁶² a case decided in September 1992. The defendant was a consultant rheumatologist. He

56 M Otowski, 'Mercy Killing Cases in the Australian Criminal Justice System' (1993) 17 Crim L J 10. This trend is drawn in even sharper terms in the United States. In her review of American state responses to suicide assistance, Catherine Shaffer established that from 1930 to 1985 not one court decision on a prosecution for assisting a suicide appears in an official case reporter, despite the numerous newspaper references to such acts having taken place. C D Shaffer, 'Criminal Liability for Assisting Suicide' (1986) 86 Colum L Rev 348, at 358.

57 *R v Lim*. Unreported. Western Australia Court of Petty Session, No.56036 (1988).

58 Unreported. Nassau County Court, No 37717 (1959).

59 Unreported. Noted (1950) 48 Mich L Rev 1197.

60 Unreported. Noted *The Sunday Times*, 30 November 1986, 1.

61 Unreported. Noted *The Times*, 16 March 1990, 3; also (1990)140 New L J 587.

was charged with attempted murder after administering a potentially lethal dose of potassium chloride to one of his patients of 13 years who was suffering intractable and incurable pain. The patient died within minutes of the injection being administered. The Court was told that, in the days immediately prior to her death, she had repeatedly asked her medical attendants to end her life. Found guilty by the jury, Ognall J employed his discretionary power to impose only a 12 month suspended sentence on Dr Cox. (Neither did strong sanction come from his peers: at a later disciplinary hearing the General Medical Council declined to suspend Dr Cox, preferring instead to censure him.)

To summarise, prosecutors, judges, and juries have generally shown sympathy towards those practitioners who have helped suffering patients to die. They have been reluctant to impose the full rigours of the law despite the fact that, on the evidence before them, serious provisions of the criminal code have been violated. The reasons for this degree of leniency need not distract us. However, this trend is significant to the extent that one must begin to question whether the present law against physician aid-in-dying should be brought into line with the actual behaviour of law enforcement agencies. If, as appears to be the case, those doctors who do assist a patient to die typically escape criminal liability, what then is the efficacy of retaining on the statute-books the offence which purports to bars the practice? Put another way, what wisdom is there to a law prohibiting physician-assisted suicide which is consistently overridden in the interests of humanity? These are questions to which I will soon return.

Assisted suicide in the New Zealand courts

The New Zealand jurisprudence in this area is even more limited. To date, there have been no cases of medically-assisted suicide brought before our courts. Section 179 of the Crimes Act has, however, been the subject of three criminal prosecutions in this country; although in each case the suicide assistance may more appropriately have been called a mercy killing. In the first of these cases, *R v Novis*,⁶³ the defendant was charged with murder for shooting his pain-ridden father, an elderly man who was terminally ill with cancer, following earnest pleas for him to do so. Found not guilty of murder by the jury, Mr Novis was convicted of manslaughter and sentenced to 12 months' supervision.

The second case involving section 179, *R v Stead*,⁶⁴ is somewhat more bizarre. Here the defendant was accused of murdering his mother after she had failed in her own attempt to commit suicide by ingesting an overdose of sleeping pills. Again, the deceased implored the assistant to end to her life. In carrying out his mother's wish to die, however, the evidence presented at the hearing revealed a disturbing comedy of errors by the defendant. After failing to kill the elderly woman with a injection of sedatives using a syringe, carbon monoxide poisoning via a hose attached to the exhaust pipe of a car, and smothering her with an eiderdown pillow, the exasperated son only succeeded in his mission by repeatedly stabbing her with a kitchen knife. After reviewing the abnormal facts of the case, the jury cleared the defendant of murder but found him guilty of manslaughter. The court at first instance sentenced him to 3 years' imprisonment, which was later confirmed on appeal.

62 Unreported, noted [1993] 1 Med L Rev 232.

63 Unreported. HC (Hamilton Reg.), T42/87, 5 February 1988, per Anderson J.

64 (1992) 7 CRNZ 291.

The third and leading authority in this area is *R v Ruscoe*.⁶⁵ The background facts of this case are reasonably well-known. As it is material to the suicide itself, the defendant placed some 50 sedative pills in the mouth of his tetraplegic friend (which he then voluntarily swallowed), after which a pillow was held over the sleeping man's head to ensure that death would result. The deceased had fully agreed on the methods to be used in ending his life, and had even sought the defendant's assurance that the pillow would be used immediately prior to his falling asleep for the last time. At trial the defendant was convicted of aiding and abetting the commission of a suicide, and initially sentenced to 9 months' imprisonment. On appeal, the court thought it appropriate to 'allow the promptings of humanity to prevail'. Having regard to Mr Ruscoe's alcohol and psychological problems which were triggered by the offence, including at one stage a wish to commit suicide himself (for which he was temporarily institutionalised), the Court of Appeal held that a non-custodial sentence of one year's supervision was more conducive to helping him rebuild his life.

What can we extract from this brief review of the New Zealand cases on assisted suicide? First, from the perspective of either an academic or practising lawyer it is unacceptable that in the face of clear breaches of the law sentencing patterns bear no relation to the stated seriousness of the crime. The imposition of almost no penalty for what the law considers to be culpable homicide debases the coinage, and arguably demonstrates the unsuitability of the law itself. Beyond this complaint, we may also respond to these tragedies as concerned members of society. In all these cases, the defendants' compliance with the request to help a loved one die was reluctantly performed in the absence of any perceived alternatives. They were essentially acts of desparation.⁶⁶ Considering the bloody manner in which Peter Novis took his father's life, the horrific details of Roger Stead's fumbling attempts to carry out his mother's suicide, and the heavy psychological cost suffered by Warren Ruscoe after assisting his best friend to die, it is clear that forcing people to take matters into their own hands in this way is far from ideal. Providing a tightly controlled environment in which physicians could assist people to end their own suffering would surely be a more humane alternative.

A POLICY APPROACH TO REFORM

In a certain state it is indecent to live longer. To go on vegetating in cowardly dependence on physicians and machinations, after the meaning of life, the right to life, has been lost, that ought to prompt a profound contempt in society [One should instead] die proudly when it is no longer possible to live proudly.

Frederick Nietzsche, *Twilight of the Idols*

To this point we have established that, despite a need for firmer guidelines, New Zealand's sole regulation in the area of physician aid-in-dying comes from a few restrictive sections of the Crimes Act. These provisions make it a criminal offence for anyone to assist another person to die. This was seen to entail a number of problematic distinctions and, in any event,

⁶⁵ Unreported. CA 445/91, 20 March 1992; per Cooke P, Hardie Boys and Gault JJ. The short quotation which follows in the text is taken from p 7 of the transcript.

⁶⁶ Margaret Otlowski offers a similar summation in her review of Australian mercy killing cases. 'If medically administered euthanasia or assisted suicide were an option for terminal or incurable patients', she observes, 'the defendants in these cases would probably not have felt compelled to take the matter into their own hands'. M Otlowski, op cit n 56, at 39.

does not appear to be strictly enforced. While some of the reasons why this might not be appropriate have already been introduced, it remains to assess systematically the merits and demerits of reforming this area of the law. The question that will be posed in this part of the paper is whether New Zealand should narrow the gap between the current law and actual practice regarding assisted suicide, and if so, how best to achieve that end.⁶⁷

Objections to physician-assisted suicide

The criminalisation of assisted suicide has been justified by appeals to various state interests, moral imperatives, and practical considerations.⁶⁸ For our purposes, these objections may be split into three main areas of concern. The first relates to the harm such legalisation might do to the doctor/patient relationship. A number of commentators have suggested that the trust which defines the relationship between physician and patient may be adversely affected if doctors are seen to be involved in active euthanasia.⁶⁹ The underlying fear is that the benign image of doctors as healers in society will be contaminated with the contradictory role of “bringers of death”, evoking images of a Grim Reaper who has exchanged his black cape and sickle for a white coat and syringe. Others have speculated on the erosion of the medical profession’s own confidence and authority that may stem from such a move.⁷⁰ In their manual on *Practical Medical Ethics*, Alastair Campbell and his associates offer the following advice:

we are toying with a potentially tragic cocktail when we mix a soupçon of the intent to kill into the attitudes of those who care for the dying. It is too tempting to put an end to difficult problems in clinical practice. Therefore, terminal care doctors, even more than other doctors, must guard their sensitive and caring intuitions.⁷¹

Elsewhere, it has been argued that it is inappropriate to serve the *motive* of relieving distress and affording a patient a good death by endorsing the *intent* to kill as part of the medical ethos. According to this argument, ‘such an intent runs counter to the proper humility and restraint that should govern

67 It is impractical within the compass of this short article to examine *all* the reasons that have been put forward either defending or attacking the criminalisation of physician-assisted suicide. A more comprehensive treatment may be found in A S and J Berger (eds), *To Die or Not to Die? Cross-Disciplinary, Cultural, and Legal Perspectives on the Right to Choose Death* (New York, 1990); and C D Forsythe and V G Rosenblum, ‘The Right to Assisted Suicide: Protection of Autonomy or an Open Door to Social Killing’ (1990) 6 Issues L Med 3.

68 These arguments have been fully canvassed elsewhere. The most concise account is given by A Browne, ‘Assisted Suicide and Active Voluntary Euthanasia’ (1989) 2 Can J of L and Jurisp 35, at 40–9. The *locus classicus* of the main objections is still Y Kasimar’s ‘Some Non-religious Views against Proposed “Mercy Killing” Legislation’ (1958) 42 Minn L Rev 969.

69 Alexander Capron has given one of the clearest voices to this sentiment. ‘I never want to have to wonder whether the physician coming into my hospital room is wearing the white coat (or the green scrubs) of a healer’, he writes, ‘concerned only to relieve my pain and restore me to health, or the black hood of the executioner. Trust between patient and physician is simply too important and too fragile to be subjected to this unnecessary strain’. A M Capron, ‘Legal and Ethical Problems in Decisions for Death’ (1986) 14 Med Health Care 141. The same conclusion is reached by J K Mason and R A McCall Smith, *Law and Medical Ethics* , 3rd ed. (London, 1991), 322.

70 For example, N Tonti-Filippini, ‘The Doctor–Patient Relation: Legislative and Professional Change’, in H Caton (ed), *Trends in Biomedical Regulation* (Sydney, 1990), 3–20.

71 A Campbell et al., *Practical Medical Ethics* (Auckland, 1992), 117. In their 1988 report on euthanasia, the British Medical Association also isolated this danger as a compelling reason why physician-assisted suicide should not be mandated, arguing instead that ‘the pressure for active euthanasia can often be met adequately and more creatively by suitable and sympathetic terminal care’. In their view, ‘where humane care and a positive affirmation of the value of each person (no matter what their condition) is the prevailing clinical attitude (hospices are a good example) euthanasia requests are rare’. BMA, *Euthanasia* (London, 1988), 24. For completeness, I note that the Canadian Medical Association, American Medical Association, and World Medical Association have apparently all condemned physician-assisted suicide. See *Rodriguez v A–G of British Columbia* (1993) 79 CCC (3d) 1, at 35, per Hollinrake JA.

medical intervention where there is no clear right answer, and the patient's needs may be expressed obliquely'.⁷²

While understandable, these fears seem to be rather overstated. There is naturally merit in retaining the ancient prohibition against killing; a duty which is affirmed in the Hippocratic Oath. However, modern doctrine demands that above all else physicians act in the best interests of their patients; a criterion which can only realistically be defined by the autonomous patient himself or herself (where he or she is competent to do so). Stated reductively, while the doctor/patient relationship is not a direct analogy of master and servant, health providers must recognise that at the end of the day their profession is a service industry. As a patient contemplates the control he or she could possibly exert over his or her mode and circumstances of death — one of the most momentous decisions a person could ever make — the patient is surely entitled to rely on the support of his or her physician if he or she chooses to call upon it. It might then be thought that a doctor who was asked to facilitate the termination of a patient's life should, providing it sat comfortably with both sound medical judgment and his or her own value system, give effect to that request if it was in the patient's best interests. To do *otherwise* could more accurately be called a betrayal of the doctor/patient relationship.

At any event, only the incurably nostalgic could interpret the proposal to mandate such a form of assisted suicide as a mortal danger to the traditional virtues of the doctor/patient relationship. The dynamics of this relationship have already changed significantly. As two American researchers have recently pointed out, '[p]hysicians who remember when a patient could be admonished for noncompliance are now confronted with patients who tell them in advance what services and treatments they are prepared to accept or reject'.⁷³ Viewed against this re-negotiation of authority in what was once an unquestioned hierarchical relationship, it could be argued that objections against medically-assisted suicide which invoke its preservation actually betray a latent professional fear of losing more *power*, not trust.

Either way, criticism of physician aid-in-dying is certainly not uniform within the medical community. Worldwide developments within the profession have contributed to the impetus for reform in this area, with a growing body of literature advocating some liberalisation of the current prohibition against physician-aided euthanasia.⁷⁴ Peter Roberts, head of Wellington Hospital's Intensive Care Unit, is one of an increasing number of New Zealand doctors who have responded pragmatically that '[d]oing a good job can sometimes mean giving people a creative death'.⁷⁵

The second major argument levied against decriminalisation is that mandating even a limited form of physician assisted-suicide will begin a dangerous slide towards the day when persons who are considered socially worthless are compulsorily euthanised à la Nazi Germany.⁷⁶ By accepting

72 G R Gillett, 'Intent in Law and Medicine' [1991] NZLJ 115, at 121.

73 R Wood and R Mero, 'Washington State's "Death with Dignity" Initiative', in R H Blank and A L Bonnicksen (eds), *Emerging Issues in Biomedical Policy: Volume II* (New York, 1993), 102.

74 An early example is the illustrious heart-surgeon Christiaan Barnard: *Good Life, Good Death* (London, 1980). More recently, see S Wanzer et al, 'The Physician's Responsibility Towards Hopelessly Ill Patients: A Second Look' (1989) 320 *New Eng J Med* 844; Institute of Medical Ethics Working Party on the Ethics of Prolonging Life and Assisting Death, 'Assisted Death' (1990) 336 *The Lancet* 610; and R Syme, 'A patient's right to a good death' (1991) 154 *Med J of Aust* 203.

75 Quoted in 'Choosing Death', *Christchurch Press*, 19 September 1992.

76 For a detailed examination of the development of euthanasia in Germany from 1920-45, see Leo

that a person's life can be of such a lesser quality as not to be worth living, wider judgments about the "social worth" of individuals are bound to follow, so the argument runs, and thereafter the belief that society has no obligation to care for those adjudged to be burdens on the community. Starting with a subtle change in societal attitudes towards those with terminal illnesses, sensitivity to the needs of the elderly and disabled is predicted to diminish by gradual increments.⁷⁷

This is the familiar "thin end of the wedge" or "slippery slope" argument beloved by the paranoid of the world over. In the narrowly-drawn context of assisted suicide, however, it is an objection that need not delay us. As a noted South African medical ethicist points out, the crucial element is the voluntary nature of the decision to seek an early end to life. To adopt his words,

Philosophers are not inclined to take slippery slope arguments very seriously in the absence of overwhelming evidence that the slope is indeed slippery, and as long as there is a conceptual barrier to keep one from sliding down it. The conceptual barrier in this instance is the patient's consent. As long as a patient must request euthanasia before he or she receive it ... there is little danger of social abuse.⁷⁸

This construction seems entirely sensible. The ultimate responsibility for the decision to die resides in the autonomous hands of the person seeking to end his or her life,⁷⁹ not the second party called upon to facilitate that decision. This rebuttal may be called the Pontius Pilate defence. If the moral reasoning of this defence provides a rather dubious precedent, it neatly illustrates the fundamental brake on any slippage that will always be present in the situation envisaged by this article. Provided that the individual's moral autonomy is preserved as the threshold condition for an assisted death, there is simply no gradient to the allegedly slippery slope.

On a purely empirical basis there is also no reason to suggest that legalising aid-in-dying will lead to an increase in the number of suicides or murders. Such is the lesson of Texas, a state in which there has historically been a legal vacuum regarding the criminality of suicide, and where up until 1973 aiding and abetting suicide was permissible.⁸⁰ Likewise, the experience of the Netherlands suggests that the decriminalisation of physician-assisted suicide does not inevitably lead to non-consensual euthanasia, nor does it spell disaster for the fabric of society.⁸¹ With respect,

Alexander's disturbing article, 'Medical Science under Dictatorship' (1949) 241 *New Eng J Med* 39. In 1985, the last year of his life, Dr Alexander saw disturbing parallels between Germany during the Nazi era and America in the 1980s. Refer to C E Koop and E R Grant, 'The Small Beginnings of Euthanasia: Examining the Erosion in Legal Prohibitions Against Mercy Killing' (1986) 2 *J Law, Ethics & Pub Pol* 585, at 590.

77 Y Kasimar, 'Some Non-Religious Views Against Proposed Mercy-Killing Legislation' (1958) 42 *Minn L Rev* 969. A modern adherent of this school of thought is N Hentoff, 'The Church, the Law, and the Advancing Armies of Death' (1990) 33 *The Catholic Lawyer* 1.

78 C Elliott, 'Dying rites: the ethics of euthanasia', *New Scientist*, 20 June 1992, at 27.

79 Incredibly, this in itself has occasioned complaint. Richard McCormick has criticised physician-assisted suicide because of its 'absolutisation of autonomy'. He contends that the supreme value placed on personal autonomy in this context leads to a rejection of dependence on others, and a concomitant rejection of the compassion they might offer. R A McCormick, 'Physician assisted suicide: flight from compassion' (1991) 108 *Christian Century* 1132. I must confess great difficulty in grasping where the argument is in this objection. Retaining one's autonomy does not necessarily equate with anti-social tendencies, merely that the locus of decision-making power rests finally with the individual. Besides which, complaining about having too much autonomy is rather like complaining that one has too much liberty or freedom. Both statements are equally absurd.

80 H T Englehardt, Jr, and M Malloy, 'Suicide and Assisting Suicide: A Critique of Legal Sanctions' (1982) 36 *Southwestern L J* 1003.

81 See below, p 461.

then, it is easy to disagree with law reform agencies which predict that: '[t]o allow euthanasia to be legalised, directly or indirectly, would be to open the door to abuses, and hence indirectly weaken respect for human life'.⁸² Any comparison here with Nazi Germany and the spectre of eugenics is also unhelpful; an *in terrorem* argument which serves only to interfere with our ability to assess the respective pros and cons of the proposal in a dispassionate way.

Ultimately, it is always possible to argue that "social goods" such as the desire to prevent unnecessary suffering or the innate liberty of both doctor and patient, together outweigh any harmful effects to the social order which might be caused by freeing assisted suicide from criminal sanctions.⁸³ Yet even after dismissing slippery slope arguments on this basis, governments are obviously still reticent in allowing competent individuals to dispose of their own lives. This reluctance is often explained on paternalistic grounds. Philosophers such as Gerald Dworkin have argued that the state has an implicit contract to intervene paternalistically in order to protect people's best interests and to prevent them from inflicting self-harm.⁸⁴ (However, the authority for such intervention vanishes when it is clear that competent individuals are choosing to commit suicide on the basis of all the information relevant to their decision. As the phraseology suggests, such is the case for all those who opt for "rational" suicide.) Underpinning this justification is the state's interest in preserving the life of its members; an interest grounded on the protection of the sanctity of life.

This is the third main argument which is commonly levied against the legalisation of physician-assisted suicide. The sanctity of life is certainly a notion which has powerful associations in our culture. As Thomas J observed in a recent judgment,

Life, and the concept of life, represents a deep-rooted value immanent in our society. Its preservation is a fundamental humanitarian precept providing an ideal which not only is of inherent merit in commanding respect for the worth and dignity of the individual but also exemplifies all the finer virtues which are the mark of a civilised order. Consequently, the protection of life is, and will remain, a primary function of the criminal law.⁸⁵

The importance of this principle is further recognised in article 6 of the International Covenant on Civil and Political Rights, and in section 8 of the New Zealand Bill of Rights Act 1990.

Although the sanctity of life is not an absolute concept, some critics have argued it would be irreparably devalued if doctors were allowed to assist their patients to commit suicide. Pointing to the dangers inherent in measuring life qualitatively, these critics read far-reaching implications into the State supporting certain individuals in their decision to seek euthanasia from a physician. By allowing a terminally ill, elderly, or physically disabled person to seek an early passing, the legal system is essentially saying to these groups within the community: 'Your fear is

⁸² LRCC, *Euthanasia, Aiding Suicide and the Cessation of Treatment* (Ottawa, 1983), 18.

⁸³ In a well-known response to the arch conservative Yale Kasimar, this was the conclusion reached by Professor Williams. See G Williams, "'Mercy Killing' Legislation — A Rejoinder' (1958) 43 Minn L Rev 1. Professor Kasimar's views on euthanasia, which he has expounded over a thirty year period, are conveniently assembled in a recent review article: 'When is There a Constitutional "Right to Die?" When is There No Constitutional "Right to Live?"' (1991) 25 Georgia L Rev 1203.

⁸⁴ G Dworkin, 'Paternalism', in R Wasserstrom (ed), *Morality and the Law* (Belmont, 1971), 107–26.

⁸⁵ *Auckland Health Board v A-G* [1993] 1 NZLR 235, at 244. According to Blackstone, the protection of life is the first regard of English law: *Commentaries on the Laws of England* 130.

valid. You are useless to society, and your desire not to be a burden on others is sufficient to justify your death'.⁸⁶

There is undoubtedly some strength to this argument. Were the practice of physician-assisted suicide to be decriminalised, a real danger would exist of pressure being placed on some individuals — especially the elderly and mentally impaired — to terminate their lives.⁸⁷ That danger should be acknowledged in any statutory exception to the current law against voluntary euthanasia, with provision being made for safeguards to be built into the eligibility criteria that would protect the vulnerable against coercion.⁸⁸ It is, however, more difficult to accept that simply decriminalising doctor-assisted suicide will brutalise society by equating social disability with social death. As was mentioned earlier vis-à-vis the perception of the medical profession, it is unclear what implicit cultural messages may be transmitted from the act of removing criminal sanctions from overt physician aid-in-dying. While a valid concern, then, it might equally be argued that our priority here should be to rethink social attitudes towards death generally so that a new sensitivity evolves towards the deeply-felt need for *quality* of life. In this respect, we might be drawn to accept the logic of the following statement:

Life cannot be reasonably regarded as an unconditioned good, but rather as something which is valuable only if one has the possibility of wanted experience. Thus if a person who can no longer have any experiences at all, or any wanted experiences, or if continuing to live requires unwanted experiences which overbalance the wanted experiences, then that person has a good reason to die.⁸⁹

In other words, we need to invert the privileged opposition between life and death. For some this will mean rejecting the paternalism which denies people the chance to make their own decisions on what is perhaps the most personal of all subjects: when and how they will die. An argument along these qualitative lines appears more intuitively correct, to this writer at least, than those premised on absolute valuations of human life for its own sake.

Arguments in favour of physician aid-in-dying

Against these three main objections can be marshalled an impressive battery of counter-arguments which favour the cautious legalisation of physician-assisted suicide. The usual starting point is the manifest inconsistency of the law's approach to suicide and assisted suicide, in which the somewhat unique situation obtains that participation in a non-criminal act is itself regarded as criminal. If it is not illegal for me to deliberately end my life, one naturally asks, how can it be wrong for me to solicit the help of another person to carry out the same act? If the end-state to be achieved (suicide) is not considered to be a criminal act, why then should sanctions attach to the means (medical assistance) that might sometimes have to be

⁸⁶ J Zima, 'Assisted Suicide: Society's Response to a Plea for Relief or a Simple Solution to the Cries of the Needy?' (1992) 23 Rutgers L J 387, at 397. Later in her Note, Zima proposes that existing criminal prohibitions against voluntary euthanasia be strengthened so as to combat this threat.

⁸⁷ See G Gelfand, 'Euthanasia and the Terminally Ill' (1984) 63 Nebraska L Rev 741, at 762-3.

⁸⁸ And, as Alexander Smith remarks, it is not altogether a bad thing if the law is somewhat slow to endorse the right to self-determination in dying: 'Legal rigidity in this area may seem conservative and unsympathetic, but to the vulnerable, the frightened, the unproductive and demanding elderly, it may be a very important and highly-prized lifeline'. A M Smith, 'Ending Life', in C Dyer (ed), *Doctors, Patients and the Law* (Oxford, 1992), 118.

⁸⁹ A Browne, 'Assisted Suicide and Active Voluntary Euthanasia' (1989) 2 Can J of L and Jurisp 35, 54.

used in order to reach that end? As a matter of logic, no penalty should accrue in the latter situation when the second party is only really acting as a servant.

As a result of this perceived inconsistency, a number of commentators have asserted that there is a *prima facie* case for legalising physician-mediated suicide. Alister Browne gives a useful gloss on their reasoning:

If a person has a good reason to die, and does not have the means to commit suicide, he should, *prima facie*, be allowed to request and receive those means from those willing to provide them, and if he is too weak to swallow a pill or inject himself, to authorise others to deliver the fatal dose. Thus the right to suicide under certain conditions entails the *prima facie* right to assisted suicide and active voluntary euthanasia.⁹⁰

Not only is the law's present stance inconsistent from a practical point of view, champions of assisted suicide say, but it clashes with some of our most basic philosophical ideals. It is perhaps not the place here to digress into a throughgoing philosophical defence of aid-in-dying. In parenthesis, though, it might be helpful to unpack a few of the concepts which undergird such a defence. The most obvious of these in western political thought is the idea of personal autonomy. Refined by various medieval scholars and theologians, the idea of the autonomous moral agent found its classic exposition in the metaphysics of Immanuel Kant. In the twentieth century, the notion of autonomy (infused with all its powerful connotations) has been especially prominent in the discourse on biomedical ethics. Max Charlesworth, one of many, argues that a liberal pluralist society cannot abdicate its central commitment to the value of personal autonomy in the area of aid-in-dying.⁹¹ As autonomous moral agents, he reasons, people have the right to decide in certain circumstances that their quality of life is so diminished that continued existence is pointless and should therefore be ended. Where such decisions are made and physicians are called upon to give effect to them, he concludes, they ought not to be punished for their role as ancillaries when they are guilty of no more than respecting their patient's autonomy.

Elsewhere in the law, of course, the principle of individual autonomy is already accorded extensive protection. For example, the provision of non-emergency treatment by a doctor without a patient's consent is likely to constitute a criminal battery.⁹² More saliently, it is settled law that a sane adult has the right to refuse medical treatment⁹³ even if he or she realises that it will result in his or her death.⁹⁴ The concept of self-determination

90 Ibid, 39–40. This argument is also developed by Shari O'Brien, 'Facilitating Euthanatic, Rational Suicide: Help Me Go Gentle into that Good Night' (1987) 31 St Louis U L J 655, at 670–1.

91 M Charlesworth, *Bioethics in a Liberal Society* (Hong Kong, 1993), Ch 3.

92 *Reibl v Hughes* [1980] 2 SCR 880, at 890–1, per Laskin CJ; *In re F (Mental Patient: Sterilisation)* [1990] 2 AC 1, at 71, per Lord Goff of Chieveley. See, generally, P D G Skegg, 'Medical Procedures and the Crime of Battery' [1974] Crim L Rev 699.

93 *Beatty v Cullingworth* [1896] BMJ 1546; *R v Johnston* (1903) 9 ALR 11, etc. In *Malette v Shulman* (1990) 67 DLR (4th) 321, a doctor who gave a blood transfusion to an unconscious Jehovah's Witness carrying a card which unequivocally prohibited such an action, was found guilty of battery and subsequently ordered to pay the patient \$20,000 in damages. In that case the Court held that a competent patient's right to refuse treatment is an unqualified one, that is to say, it is not premised on an understanding of the risks of refusal. Even where the risks are foreseen, it is not material that the decision to refuse treatment is irrational: *Sidaway v Board of Governors of the BRHN Hospital* [1985] AC 871. An example is the American case of *Lane v Candura* 376 NE 2d 1232 (1978), where the Massachusetts Court of Appeals found that a competent patient could refuse to submit to a leg amputation even where it was not the "rational" thing to do.

94 This position seems somewhat anomalous when one considers that it might foreseeably contravene the rule against consenting to one's own death (s 63), and also that under section 41 of the Crimes Act any person is justified in using such force as is reasonably necessary to prevent the

animates this right to refuse life-saving medical treatment, a concept given eloquent expression by Cardozo J in *Schloendorff v Society of New York Hospital*.⁹⁵ '[e]very human being of adult years and sound mind has a right to determine what shall be done with his own body'. New Zealand's leading case on medical negligence echoes this reasoning.⁹⁶ The concept of self-determination can also be seen to inform the right to decline medical treatment which is provided for by section 11 of the New Zealand Bill of Rights Act 1990.

Reasoning from such authorities, it might be contended that if one takes the right of the individual to control his or her own body to its logical conclusion, a person should be able to determine the manner and timing of his or her own death insofar as this does not impinge on the rights of others. The assumption here is that the right of the competent individual to self-determination trumps the State's interest in the preservation of life. In the context of terminally ill patients, this conclusion is made even more compelling if one factors in the natural human interest in being free from agonising pain which frustrates all efforts at relief.

Co-extensive with this argument is the line taken by some critics that the law has no place in seeking to prevent assisted suicide at all. Invoking John Stuart Mill's formula that the criminal law should only restrain individual freedom so as to protect society and its members from harm, these champions of voluntary euthanasia point to the fact that it cannot be said to violate anybody's rights. In this respect, physician-assisted suicide is yet another example of that jurisprudential chestnut, the "victimless crime". Philippa Foot puts the case for this view:

It does not seem that one would infringe someone's right to life in killing him with his permission and in fact at his request. Why should someone not be able to waive his right to life, or rather, as would be more likely to happen, to cancel some of the duties of non-interference that this right entails? [R]eligion apart, there seems to be no case to be made out for an infringement of rights if a man who wishes to die is allowed to die or even be killed.⁹⁷

Moreover, it is difficult to see how acceding to the request of a suffering individual for a quick and painless death could in any way endanger society as a whole. Its conditional decriminalisation in the medical setting would not somehow equate with moral endorsement, any more than the same is true where homosexuality between consenting adults is decriminalised. The message implicit in such a move would be no more than to say that the

consequences of a suicide (which is what this refusal may effectively be). Thus a doctor who administered treatment to a patient to prevent her from committing suicide would presumably be absolved from criminal liability, even though the physician's conduct might technically constitute an assault or battery: D B Collins, op cit n 43, 200, ¶ 7.7.2. See also P D G Skegg, op cit n 50, 110-11; and *R v Duffy* [1967] 1 QB 63.

⁹⁵ 105 NE 92, at 93 (1914). The question whether the right to prevent suicide prevails over the right to self-determination is the subject of conflicting authority in the United States. While there is an implicit assumption that it does prevail in *Re Caulk* 480 A 2d 93 (1984), dicta by Compton AJ in *Bowvia v Superior Court* 225 Cal Rptr 297 (1986) suggests otherwise, asserting that the right to die is an integral part of our right to control our own destinies and thus outweighs the state's interest in preventing suicide. In *Cruzan v Director, Missouri Department of Health* 110 S Ct 2841 (1990) a majority of the United States Supreme Court (made up of four dissenting and one concurring judge) held that the state's interest in preserving the sanctity of life does not necessarily outweigh the right to self-determination enjoyed by competent patients.

⁹⁶ *Smith v Auckland Hospital Board* [1965] NZLR 191, at 219, per Gresson J ('An individual patient must ... always retain the right to decline operative investigation or treatment however unreasonable or foolish this may appear in the eyes of his medical advisers'). See, generally, R Paterson, 'The Right of Patients to Refuse Treatment', *NZ Doctor*, 19 August 1991, 33.

⁹⁷ P Foot, 'Euthanasia', in E McMullin (ed), *Death and Decision* (Washington, 1978), 102-3.

decision to seek aid-in-dying falls squarely within the realm of personal morality.

Another variant on the theme of autonomy is the position within American jurisprudence that '[t]he decision to live or die is a personal choice grounded in the constitutional right to privacy'.⁹⁸ According to this argument, private decision-making in matters which are essentially personal is a fundamental and protected right, a right which lacks any substance if those who aid a person to die in accordance with their wishes are themselves subject to criminal sanction. As the court in *Superintendent of B S School v Saikewicz*⁹⁹ stated, '[t]he constitutional right to privacy ... is an expression of individual free choice and self-determination as fundamental constituents of life. The value of life as so perceived is lessened ... by the failure to allow a competent human being the right of choice [to die]'. On the basis of such authorities, at least one commentator has urged that:

in cases involving a competent terminal patient, the right to privacy doctrine demands that the patient not be precluded from seeking and securing the assistance of others in committing self-euthanasia. (Denial of such assistance would violate the patient's right to privacy in the choice of, and time and manner of, one of life's fundamentally private events, death.) Only patients with access to the necessary information and assistance can make a meaningful choice.¹⁰⁰

Arguably the strongest critique that may be levied against the current law on aid-in-dying, though, rests on another perceived inconsistency — this time the widespread incidence of passive euthanasia. According to a recent admission by the American Hospital Association, up to 70% of the daily death toll in the United States is medically-assisted, 'somehow timed or negotiated, with all concerned parties privately concurring on withdrawal of some death-delaying technology or not even starting it in the first place'.¹⁰¹ Such cases of passive euthanasia are not uncommon in New Zealand.¹⁰² A number of writers have pointed out that the distinction drawn at law between passive euthanasia (withdrawing or not initiating life-sustaining medical treatment) and active euthanasia (administering a lethal dose of drugs) is one based on policy considerations not logic, for there is

98 K S Berk, 'Mercy Killing and the Slayer Rule: Should the Legislatures Change Something?' (1992) 67 Tulane L Rev 485, at 500. See also *Bowvia v Superior Court* 225 Cal Rptr 297 (1986), at 306 ('a desire to terminate one's life is probably the ultimate exercise of one's right to privacy').

99 370 NE 2d 417 at 426 (1977). Likewise, in the recent Canadian authority of *Nancy B v Hotel-Dieu de Quebec* (1992) 86 DLR (4th) 385, at 391, it was held that keeping a patient suffering from Guillain-Barre Syndrome on an artificial respirator without her consent amounted to an unacceptable interference with her right to personal privacy, and a devaluation of her human dignity.

100 S Wolhandler, 'Voluntary Active Euthanasia for the Terminally Ill and the Constitutional Right to Privacy' (1984) 69 Cornell L Rev 363, at 379. (Footnote integrated into text.) Wolhandler furnishes a raft of other authorities in support of his contention, at 369-76.

101 Quoted in 'Euthanasia: set to rival the abortion debate', *Christchurch Press*, 13 April 1992, at 23. The most common means of passive euthanasia involves "Do Not Resuscitate" (DNR) orders, or "no codes", which are routinely used in hospitals to designate those patients who are not to be given life-saving treatment, most commonly following cardiopulmonary collapse. These usually unwritten protocols are discussed by S E Bedell et al, 'Do-not-resuscitate orders for Critically Ill Patients in the Hospital' (1986) 256 J Am Med Assoc 189; S Younger, 'DNR Orders: No Longer Secret, But Still a Problem' (1987) 17 Hastings Center Rep 24; and R M Keating, 'Exclusion from Resuscitation' (1989) 82 J of the Royal Soc Med 402.

102 According to Dr Roberts, staff under his control at Wellington Hospital face decisions about withdrawing life support from a patient about once a month. Reported in 'Choosing Death' *Christchurch Press*, 19 September 1992. There is also recent judicial authority on this point. In the High Court decision of *Auckland Health Board v A-G* [1993] 1 NZLR 235, Thomas J held that if a doctor, acting bona fide, withdraws the ventilatory support system of a patient because, in accordance with recognised and approved medical opinion, it serves no therapeutic or medical benefit, he or she does not act unlawfully.

no *practical* difference between these methods of facilitating an early death. At the most basic level, each entails a physician helping to terminate a patient's life in accordance with the patient's own wishes, whether express or imputed. The inconsistency in the law's treatment of these practices has led many to question the validity of singling out active euthanasia for criminal sanction. As one commentator has put it,

It is legally inconsistent to honour a terminal patient's request that life support equipment be removed, but to deny a similarly situated patient's request for an immediate and painless end merely because a second party's active assistance is needed to implement the latter request. Prohibiting a second party from helping a patient commit self-euthanasia by imposing legal sanctions on that party is effectively equivalent to denying the patient the right to make that decision in the first place.¹⁰³

Alternatives to the status quo

If one accepts, as this writer does, that there is a well-reasoned case for amending the current prohibition against assisted suicide, it remains to consider which of the available alternatives is best implemented in its place. Comparative law on assisted suicide unearths a full spectrum of substitute regimes. Following the model of a number of continental jurisdictions, perhaps the least radical option would be introducing the new offence of 'homicide on request'.¹⁰⁴ This would have the advantage of presumably attracting a lesser penalty than for murder or manslaughter, yet (symbolically) retaining the sanction of criminal liability so as to distance the legislature from the appearance of having mandated a form of killing. The disadvantages of this proposal are equally obvious. Mostly significantly, physicians who assist a patient to commit suicide would still be subject to punishment for their actions. In addition, the proposal fails to address the underlying demand within the community for aid-in-dying possibilities.

To meet such criticisms, some legal scholars have advocated the creation of a new statutory defence for suicide assistance, a proposal which has resonances of the traditional defence of necessity. This proposal draws on the fact that suicide assistance may well be a response to coercion and manipulation exerted by the "victim" against the assistant.¹⁰⁵ Where complicity in suicide results from psychological pressure exerted by the suicidal individual, the imposition of harsh criminal penalties is a manifestly inappropriate legal response. As Catherine Shaffer has pointed out,

the whole point of criminalising 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 a suicide can

¹⁰³ S Wolhander, op cit n 100, 369. See also Note, 'Physician-Assisted Suicide and the Right to Die with Assistance' (1992) 105 Harvard L Rev 2021, at 2040 ('In each case, the patient's interest in self-determination gives the patient a right to die, whether by refusing treatment, having treatment withdrawn, or accepting the assistance of a physician').

¹⁰⁴ The position under Swiss and German law is given an excellent discussion by 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. David Lanham, for instance, has advocated simply reducing the benchmark liability for euthanasia from murder to manslaughter. D Lanham, 'Euthanasia, pain killing, murder and manslaughter', Paper presented at the Australasian Law Teachers Association Conference, 30 September-3 October 1993. It seems to this writer, however, that this is effectively the default position in New Zealand law anyway, judging from the discretionary sentencing in *Novis*, *Stead* and *Ruscoe*. To formalise this position would not therefore amount to a genuine change of what has already identified as an unsatisfactory state of affairs.

¹⁰⁵ There is a dearth of literature on the psychodynamics of suicide assistance, with what research that has been published being widely scattered among secondary sources. Perhaps the best primary coverage is to be found in J Birtchnell, 'Psychotherapeutic Considerations in the Management of the Suicidal Patient' (1983) 37 Am J of Psychotherapy 24.

prove that 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.¹⁰⁶

Such an exception to the present law would allow the liability of some accessories to suicide to be mitigated, provided they acted with altruistic, not selfish, motives.¹⁰⁷ It does not, however, remove their culpability *per se*.¹⁰⁸

While this option appears sound in principle, a more fitting solution would be removing the need for suicidal individuals to pressure those close to them to help end their lives at all. This could be achieved by allowing for doctors to administer lethal doses of drugs to them on request. Such a situation would have the important benefit of providing a check on those who seek to commit suicide, enabling troubled individuals to be identified and counselled, where otherwise they would presumably have convinced another person to end their life through fiat. It also addresses the fear that homicide of the terminally ill and severely disabled by friends and family for *ignoble* motives might be disguised as well-meaning assistance to suicide.

The third main option for reform is actually legalising physician aid-in-dying within a series of tight controls. An important working model of such a system is already to be found in the Netherlands. Although active voluntary euthanasia remains unlawful under article 293 of the Dutch Penal Code (carrying a maximum 12 year jail sentence), doctors will not be prosecuted for their involvement in the practice provided it is performed in accordance with strict guidelines sanctioned by the Dutch courts. More specifically, the following criteria must be satisfied:

- (i) there must be physical or mental suffering which the sufferer finds unbearable;
- (ii) the patient must make an explicit and repeated request which leaves no room for any doubt concerning his or her wish to die;
- (iii) the patient must not only be competent, but his or her decision must be well-informed, free from coercion, and enduring;
- (iv) there must be no acceptable alternative for the patient to improve his or her position; and
- (v) the physician must exercise care in making and carrying out the decisions, and may only act after consultation with another independent medical practitioner.¹⁰⁹

This form of active euthanasia and assisted suicide has been performed openly since around 1970. A government report published in 1991 estimates that it accounts for some 2,700 deaths each year in Holland, a figure which represents 2.1% of all mortality. Although there was evidence of

¹⁰⁶ C D Shaffer, *op cit* n 56, 358.

¹⁰⁷ Thus, article 115 of the Swiss Penal Code provides: 'Whoever, from selfish motives, induces another to commit suicide or assists him therein shall be punished, if the suicide was successful or attempted, by confinement in a penitentiary for not more than five years or by imprisonment'. Article 64 allows for a discretionary power, whereby '[t]he judge may mitigate the punishment ... where the actor was induced to commit the act by honourable motives ...'.

¹⁰⁸ An exception here is the position under Uruguayan law, which allows for total exculpation. Article 37 of the Penal Code of Uruguay provides: 'The judges are authorised to forego punishment of a person whose previous life has been honourable where he commits a homicide motivated by compassion, induced by repeated requests of the victim'.

¹⁰⁹ Refer to H J J Leenen, 'Euthanasia, assistance to suicide and the law: developments in the Netherlands' (1987) 8 *Health Policy* 197; and H Ritger et al, 'Euthanasia Across the North Sea' [1988] 297 *Brit Med J* 1593.

lethal overdoses being administered involuntarily to some unconscious patients with only a few hours or days to live, the report concluded that such technical abuses were extremely rare and that four times as many requests for euthanasia were turned down as were accepted.¹¹⁰ Not all observers of the Dutch system have been enthusiastic supporters, however. The absence of a legislative structure of regulation has led some critics to charge that attempts to protect vulnerable patients have been half-hearted and ineffectual. On this basis, Carlos Gomez has suggested that 'the Dutch experience might better serve as a cautionary tale than as a paradigm worthy of emulation',¹¹¹ arguing instead that the Netherlands requires an enforceable code that gives greater access to public scrutiny and control. Reacting to such charges, the Dutch parliament enacted a law in February 1993 which formally guarantees doctors immunity from prosecution if they stringently follow a 28 point checklist which shows: that the patient is terminally ill; suffers from unbearable pain; and has repeatedly asked to die. This statute took effect in early 1994.¹¹²

Of these various overseas models, the Dutch response appears the most enlightened. It effectively combines a respect for patient autonomy with a commitment to safeguarding the vulnerable. Its careful mix of self-determination within a controlled medical ambience could well be applied to the New Zealand setting. In this country it could be overlaid on the existing infrastructure of hospice care and the evolving palliative ethos, where it would provide simply a mechanism of last resort rather than, as is the case in the Netherlands itself, a potential barrier to finding other ways to control terminal physical pain.¹¹³ Its introduction would not pre-determine treatment decisions, merely provide people with a further choice. And choice, rather like autonomy, is not something that one can have too much of.

What are the chances of reform?

Some brief comments should be made finally about the likelihood of physician-assisted suicide being decriminalised in this country. While a survey of the position in the Netherlands indicates that it is practical to legislate for the "right to die" with medical assistance, a greater insight into the feasibility of New Zealand adopting such legislation may be gained from the US, where two controversial attempts have recently been made to create exceptions to state legislation which prohibits assisted suicide.

110 This report was unavailable to the writer at the time this article went to print. Details of its contents were abstracted from P Van der Maas et al, 'Euthanasia, assistance to suicide and the law: developments in the Netherlands' (1991) 338 *The Lancet* 669. Cf T Harper, 'Where Euthanasia is a Way of Death' (1987) 64 *Med Economics* 23 (estimating between 6,000 and 10,000 deaths per year are attributable to this procedure).

111 C P Gomez, *Regulating Death: Euthanasia and the Case of the Netherlands* (New York, 1991), xvii.

112 'New law offers Dutch a way out', *The Evening Post*, 10 February 1993, at 30. This law was approved by the Dutch Senate, 37 votes to 34, in November 1993, and was introduced into law in January 1994. Cf the conditions imposed by the draft declaration in McEachern CJBC's minority judgment in *Rodriguez v A-G of British Columbia* (1993) 79 CCC (3d) 1, at 24-25.

113 Given the permissibility of euthanasia in the Netherlands, there is seen to be little incentive to extend palliative care, which consequently remains poorly developed. J H Segers, 'Elderly persons on the subject of euthanasia' (1988) *Issues L Med* 407, at 409. As David Orentlicher has written, it would indeed be both ironic and tragic if the emphasis on physician-assisted suicide were to dissipate efforts to humanely care for terminally-ill patients within existing settings. D Orentlicher, 'Physician Participation in Assisted Suicide' (1989) 262 *J Am Med Assoc* 1844. Others have expressed a similar concern that providing for medically-assisted euthanasia might interfere with research towards more effective modes of pain relief. For example, see A Jonsen, 'Reflection on Washington State's Initiative 119', in R H Blank and A L Bonnicksen, (eds), op cit n 73, 100 ('If pain can be ended by the death of the patient, why persist in the careful titration of medicine and emotional support that relieves pain and, at the same time, supports life?').

The issue of physician aid-in-dying first became overtly politicised in America during mid 1991 with the troubled passage of Initiative 119 in Washington state.¹¹⁴ Labelled the Death With Dignity Act, this Initiative sought to offer complete criminal, civil, and administrative immunity to physicians who assisted in a competent patient's death, provided that he or she had clearly expressed the wish for aid-in-dying, and that two independent physicians agreed in writing the patient's condition was terminal. While enjoying a high level of public support at first, efforts to discredit the Initiative by Roman Catholic groups in particular — who launched a series of damning television commercials which claimed the Initiative lacked *any* safeguards to prevent the wholesale euthanasia of weaker groups — and negative publicity surrounding the actions of Dr Kevorkian immediately before the ballot, conspired to defeat the proposal on election day by a vote of 54% to 46%.

A similar story was played out in California during the presidential elections in November 1992, where voters rejected an equivalent proposal (Proposition 161) by an identical margin. Again, surveys taken in the months preceding the ballot showed 75% of respondents favoured the basic concept of physician aid-in-dying. Despite this, the ranks of those voting against its legalisation were swelled in the run-up to the election following a scare tactic advertising campaign which focussed on the supposedly inadequate safeguards contained in the initiative.¹¹⁵

What lessons do these political defeats have for any attempt to decriminalise physician-assisted suicide in New Zealand? A cynic might reply that it underscores the fact that any far-reaching policy decisions must not be left to anything as democratic (read fallible) as "the will of the people". Even on a more balanced perspective, the probability that any of the main New Zealand political parties would adopt such a divisive issue as part of their electoral platform approaches zero. As a result, it may be that any reform in this extremely sensitive area will need to be instituted through a conscience vote in Parliament, rather than "relying" on a mandate by partisan election, or the vagaries of a one-off referendum. In a related point, the remarkably similar rejections in Washington and California signal the power of (religious) lobby groups to play upon the public fear of mistakes and abuses in implementing physician aid-in-dying. Assuaging these fears would need to be a priority in any attempt to change the law in this area.

Beyond these pragmatic considerations, it remains to be seen whether the public support for physician-assisted suicide will gather sufficient momentum to force a change in New Zealand law. Regardless of whether any change is imminent, the legal, ethical, and policy issues it raises deserve a much greater level of scrutiny than they have received to date. This review should be a priority given the growing international trend towards social and judicial acceptance of some form of physician-assisted suicide.¹¹⁶ A systematic examination of aid-in-dying possibilities by the New Zealand Law Commission would be consistent with the reform efforts that have been undertaken in all the other major common law jurisdictions.¹¹⁷ New Zealand is already becoming out of step with overseas developments in the

114 See R Wood and R Mero, 'Washington State's "Death with Dignity" Initiative' in R H Blank and A L Bonnicksen (eds) *op cit* n 73, 100.

115 A Capron, 'Even in Defeat, Proposition 161 Sounds a Warning', 23 *Hast Center Rep* 32.

116 In addition to earlier references cited on the level of support and recognition this practice has garnered, see the discussion of this point in A A Koury, 'Physician-assisted suicide for the terminally ill: The ultimate cure?' (1991) 33 *Ariz Law Rev* 677.

117 These are conveniently summarised by M Otlowski, *op cit* n 32, 37–43.

area of advance directives, by thus far failing to make provision for “living wills” and durable powers of attorney which apply in the biomedical decision-making context.¹¹⁸

It is instructive to note that the House of Lords, spurred into action by the disturbing case of *Airedale NHS Trust v Bland*, established in February 1993 a new committee chaired by Lord Walton of Detchant to examine the whole area of euthanasia and the withdrawal of life-sustaining treatment.¹¹⁹ It is disappointing that the same initiative was not taken in New Zealand after the similarly troublesome cases of *Ruscoe* and *Auckland Health Board v A-G* during 1992. One sincerely hopes that papers such as this will contribute to a critical dialogue in this country which leads to a review of death-related issues.

CONCLUSION

Perhaps we ought to make suicide respectable again. Whenever anyone kills himself there's a whole legal rigmarole to go through — investigations, inquests and so on — and it all seems designed to find someone or something to blame. Can you ever recall a coroner saying something like: “We've heard all the evidence of how John Smith was facing literally insuperable odds and he made a courageous decision. I record a verdict of a noble death”?

Brian Clark, *Whose Life Is It Anyway?*

The weight of argument is against the *de facto* toleration of assisted suicide in favour of legislation which specifically empowers doctors, within exacting guidelines, to facilitate the death of patients who elect to commit suicide. A narrow statutory window on physician aid-in-dying should therefore be opened which closely follows the Dutch model.¹²⁰ Such an amendment would express the belief that, free from legal constraint, men and women will occasionally come to the rational decision to deliberately end their lives, and that some of them will require assistance to bring that end to pass. In short, it would recognise that the wish to commit suicide

118 A pioneering legislative model is not far from hand. Victoria's far-reaching Medical Treatment Act 1988 (as amended) resonates to the principle of patient autonomy in enshrining the unqualified right to refuse treatment, either directly or through an agent, and creating the offence of medical trespass. For commentary, see D Lanham, ‘The Right to Choose to Die with Dignity’ (1990) 14 Crim L J 401; and D Lanham and S Woodford, ‘Refusal by Agents of Life-Sustaining Medical Treatment’ (1992) 18 Melb U L Rev 659.

For a meticulous review of state laws in America dealing with advance directives, see B D Colen, *The Essential Guide to a Living Will* (New York, 1991). An interesting empirical study of their use has recently been completed by L L Emanuel et al, ‘Advance Directives for Medical Care: A Case for Greater Use’ (1989) 324 New Eng J Med 889. Note also the passing in December of 1991 the federal Patient Self-Determination Act, a statute which requires newly admitted hospital patients to be informed of their rights to make an advance directive stating their treatment preferences in the event they become incompetent.

119 ‘More House of Lords Activity’ (1993) B6 Bull Med Ethics 5, at 5–6. The need for action was placed in its most forceful terms by Lord Mustill: ‘The whole matter cries out for exploration in depth by Parliament and then for the establishment by legislation not only of a new set of ethically and intellectually consistent rules, distinct from the general criminal law, but also of a sound procedural framework within which the rules can be applied to individual cases’. *Airedale NHS Trust v Bland* [1993] 1 All ER 821, at 889.

120 It hardly needs to be said that completely to decriminalise aiding, abetting, or counselling suicide would be dangerously unwise. The criminal law should jealously guard its ability to punish those who act in a reprehensible way to encourage or facilitate another person to commit suicide. Two examples spring to mind: the person who, for financial reasons, takes advantage of another's depressed state to encourage him to end his life; and the malicious individual who, knowing of another person's suicidal tendencies, provides him with a sufficient quantity of drugs to kill himself. As will have been obvious for some time, the proposal contained in this article is directed solely at allowing willing physicians to ease the passing of those patients who request such assistance. This limited exception would leave extant the broader protection offered by s 179 of the Crimes Act.

is not an unthinking aberration. It follows that the call for physician aid-in-dying should be greeted with societal understanding not repulsion; and the law's response should be constructive, not retributive.

To a large extent, this proposal for reform is reflected in the evolving popular support for voluntary euthanasia, a fact which tells us a number of things about the currents in society. At one level, it signifies that death has become an irreversibly public condition. Even more far-reaching is the indication it gives of the growing level of public activism aimed at asserting more control over biomedical decisions. Much of the furore over Dr Kevorkian's suicide machine stems from the fact that, in this age of medical populism, it is not unusual for individuals to go outside the conventional health-care system in order to find effective relief from pain. Quite simply, there would be no suicide machine were there not a need and demand for it amongst people dissatisfied with what they are presently being offered (and in some cases subjected to) by mainstream medicine.

The fact that so many people have drawn upon Dr Kevorkian's assistance signals that, for those with terminal illnesses in particular, the dying process in contemporary society is regarded as worse than death itself. It thus seems likely that a small number of individuals will continue to take matters into their own hands so as to end their suffering, and that retaining the current prohibition against medical aid-in-dying will merely result in the concealment of assisted suicides, not their prevention. Viewed in this light, criminalisation is an inappropriate response to the sad reality that some people will always seek the help of others to end what they feel is an existence not worth continuing with.

Legalising physician-mediated euthanasia as a narrow exception to the existing law does not necessarily portend the first step down some slippery slope towards moral and social atrophy. It does not lead us inexorably to condone euthanasia for all manner of frivolous reasons, nor does it commit society to ultimately accepting *involuntary* euthanasia in the future. That is not to assert that people will always choose wisely to end their lives, but nor does it demand that elderly or terminally ill patients (in particular) choose assisted suicide rather than extended palliative treatment and/or hospice care. The key here is the voluntary aspect of the procedure: it must be voluntary so as to guard against possible coercion of marginalised and vulnerable groups within the community, yet this inevitably leaves open the possibility that some people will err in their decision to end their lives prematurely. If we as a society are serious about letting competent individuals take control of their own lives, though, this is a danger that we must be prepared to accept.

In *The Paradoxes of Legal Science*, Benjamin Cardozo observed that, in the law, 'our course of advance ... is neither a straight line nor a curve. It is a series of dots and dashes. Progress comes *per saltum*, by successive compromises between extremes'.¹²¹ To legalise the strictly-controlled option of physician aid-in-dying would be just such a middle-way between the "absolutes" of the sanctity of life and the right to self-determination. In the submission of this writer, it would also be an important and overdue progression for the criminal law of New Zealand.

121 B N Cardozo, *The Paradoxes of Legal Science* (Westport, 1928), 26.

