

**“DIE ANOTHER DAY” –
SOME OBSERVATIONS ON THE LEGAL AND ETHICAL ISSUES RAISED
IN THE DEBATE ON VOLUNTARY EUTHANASIA**

Mr President, ladies and gentlemen, good evening. I am honoured to be able to serve this Society as your President over the next 12 months in what will be the Society’s 52nd year. Our Society held its first meeting in 1953. Our first president was Sir Alexander Johnston QC. I am told that meetings in those early years were held in less lavish surroundings than we enjoy today. I understand that meetings were held in a room known as “the Dungeon” beneath the old Supreme Court building, and that refreshments consisted of a cup of tea and Digestive biscuit. We have certainly made some improvements for the comfort of our members as the years have progressed.

I recall that following the introduction of accident compensation legislation many people predicted that this Society would become less relevant to members of our respective professions, and that interest in the Society’s proceedings would wane. These predictions have proved to be incorrect, and our membership numbers have continued to grow as the years have progressed.

This Society has prospered for many good reasons. One of the main reasons is the hard work and diligence of our leaders. I want to pay tribute to Alan Merry, who has led the Society with great distinction over the past 12 months. Alan has applied himself to the Society’s business with his unique combination of careful precision and quiet good humour. Not only did he take great care in the selection of our speakers last year, but he also found time to organise, and run, a conference on “Patient Safety and the Law” which was co-sponsored by our Society and the University of Auckland. It is a tribute to Alan’s dedication and indeed enthusiasm that the conference was a great success on a number of fronts and remarkably returned a modest profit to the Society.

Also, I want to mention Alan’s presidential address which, in my opinion, was of the highest calibre. I will always remember the video clip of the skier tackling what looked like an impossible slope as Alan ably persuaded us that when considering the question of negligence in a professional environment, it must be considered in the context of the circumstances relevant at the time. The argument was persuasive, and the synchronisation of Alan’s argument with the video clip was masterful.

I am sure I speak for all of us when I thank Alan for truly raising the bar in terms of his contribution to the Society over the past 12 months.

I also want to mention the hard work of our secretary, Mike Heron. Mike works away behind the scenes a lot of the time ensuring that the Society runs smoothly, and we on the committee are truly grateful for the way in which he goes about his work with a minimum of fuss. Several members have commented to me that Mike’s after dinner “thank you speeches” are eagerly anticipated, and on one or two occasions have, I am told, been the highlight of the evening. I don’t believe that this is a poor reflection on our speakers but rather, a testament to Mike’s skills as an orator.

This evening I would like to make some comment on the legal and ethical issues raised in the debate on voluntary euthanasia. It is a topical debate. It is impossible to have avoided media reports on the trial of Lesley Martin which is currently being conducted in the High

Court in Wanganui. Ms Martin is charged with the attempted murder of her terminally ill 60 year old mother. As the trial is still before the Court I will not be commenting on it in any detail. The trial has however, attracted significant media attention both in New Zealand and overseas. The trial has been used by those groups promoting legalised euthanasia to call for legislation of the type promoted by New Zealand First MP Peter Brown when he introduced the Death with Dignity Bill into Parliament on 6 March last year. The Bill's stated purpose was to:

“allow persons who are terminally and/or incurably ill the opportunity of requesting assistance for a medically qualified person to end their lives in a humane and dignified way and to provide for that to occur after medical confirmation, a psychiatric assessment, counselling, and personal reflection”.

Last year the Bill had its first reading in the House before it was rejected by a slim majority (60 votes against and 58 in favour). The Bill did not have the opportunity to be reviewed by a Select Committee and therefore, the opportunity for public submission and debate was lost. This is the second time in the last 10 years that such legislation has come before the House and been rejected. In 1995, MP Michael Laws introduced a Bill in almost the same terms which was rejected at the introductory stage.

There is no doubt that the concept of euthanasia ignites fierce debate. It is here that two of our deepest human values collide: the wish to prevent suffering, and the desire to protect human life.

Advocates for euthanasia legislation argue that the issues are very simple. They argue that each one of us should have the right to choose the time of our death and to make sure that it is peaceful. I don't agree that the issues are simple. The prospect of legalised euthanasia raises a significant number of spiritual, ethical and legal concerns.

This evening I want to look at the provisions of the Death with Dignity Bill, and examine some of the legal and ethical issues that voluntary euthanasia raises both for the medical profession and for society as a whole. I also want to look at some of the recent cases involving what have become known as “mercy killings” to determine whether legislation of the type proposed in the Death with Dignity Bill would help to avoid the tragic incidents which face the Courts in such cases.

First of all, I think it is important to identify the various categories of euthanasia which have been recognised. My observation from following the public debate on this topic is that there is a concerning level of misunderstanding of the issues. There is no doubt that the lack of clear definition and a blurring of the concepts of euthanasia and “mercy killings” has not assisted in achieving clarity of debate and a clear understanding of the issues in the minds of the New Zealand public. It is therefore helpful to start by identifying the recognised categories of euthanasia, and indicate their legal status in New Zealand.

There are six recognised categories¹:-

1. **Passive, voluntary euthanasia** – in which a conscious and rational patient refuses life prolonging treatment. Passive, voluntary euthanasia is legal in New Zealand. Section 11 of the New Zealand Bill of Rights Act provides that everyone has the right to refuse to undergo any medical treatment.
2. **Passive, speculative euthanasia** – where life prolonging treatment for a comatose patient, or a patient otherwise unable to give informed consent, is discontinued.

¹ Set out in the Parliamentary Library background note dated 22 September 2003: *Voluntary Euthanasia and New Zealand* at page 2.

There have been a number of reported cases involving this category of euthanasia and they are clearly testing for the Courts.

An example is *Auckland Area Health Board v Attorney General*², where the Court was asked to determine whether doctors' actions in withdrawing artificial ventilator support from a "Mr L" would make them guilty of culpable homicide. Mr L was described as having a living, but impaired brain that was entirely disengaged from his body. He could move neither muscle nor limb, and was unable to communicate by even elementary means. There was no prospect of recovery and in those circumstances the Court held that withdrawing the ventilator support would not constitute culpable homicide for the purposes of the Crimes Act 1961.

It is clear from the reported cases in this area that whilst passive, speculative euthanasia has not been legislated for in this country it is, in appropriate circumstances, practised.

3. **Active, voluntary euthanasia** – where a conscious and rational patient requests, and is given, assistance to die. The assistance is usually given by a medical professional by way of the administration of lethal drugs. Active, voluntary euthanasia is not legal in New Zealand today and it is this category of euthanasia which the Death with Dignity Bill was seeking to legalise.
4. **Active, speculative euthanasia** – whereby lethal medication is administered to a patient who is comatose or a patient otherwise unable to give his or her informed consent. Section 167 of the Crimes Act provides that such action constitutes murder.
5. **Passive, involuntary euthanasia** – involuntary euthanasia is always, by definition, against the patient's express consent. It involves the cessation of life prolonging treatment to a conscious and rational person against his or her will. Section 151 of the Crimes Act which imposes a duty to provide the necessities of life deems such action, or inaction, to be illegal.
6. **Involuntary, active euthanasia** - involves lethal medication being administered to a conscious and rational patient against his or her will. This is clearly murder as defined in section 167 of the Crimes Act.

That therefore is a brief summary of the recognised categories of euthanasia and their legal status in New Zealand. It was against this background that the Death with Dignity Bill was introduced into Parliament in March last year. The main aim of the Bill was to make active, voluntary euthanasia permissible in New Zealand in certain limited circumstances.

The Bill set out certain criteria for eligibility and prescribed a process whereby a patient could request a medical practitioner's assistance to end his or her life. The request by the patient was required to be in writing. To be eligible to seek such assistance the patient had to satisfy certain criteria and in particular:-

- (a) be over the age of 18 years;
- (b) be terminally and/or incurably ill and experiencing pain and suffering or distress to an extent unacceptable to the patient; and
- (c) the patient must be mentally competent to make such a request.

² [1993] 1 NZLR 238.

The Bill also prescribed a procedure whereby the patient could make an “advance directive”. The patient would complete a written advance directive in the early stages of his or her illness at a time when they were mentally competent to do so and in anticipation of reaching a stage in their illness where they were incapable of giving such instruction. The patient’s wishes to terminate his or her life would then be carried out in accordance with the advance directive.

The process anticipated by the Bill involved the patient seeing four separate medical professionals before the procedure could be carried out.

The medical practitioner who receives and accepts the written request (known as “the attending medical practitioner”) has primary responsibility for the process. He or she is responsible for:-

- making an initial determination as to whether the patient has a terminal and/or incurable illness;
- determining whether the request has been made voluntarily and properly;
- informing the patient of the medical practitioner’s diagnosis and prognosis, and of the potential risks associated with the medication prescribed if the patient’s wishes are to be carried out; and
- advising the patient of the feasible alternatives available including comfort care, hospice care, and available pain control.

The attending medical practitioner must then refer the patient to a second medical practitioner known as the “consulting medical practitioner”. That practitioner must independently examine the patient, consult the patient’s records, and confirm the diagnosis and prognosis of the attending medical practitioner. The second medical practitioner must also verify that the patient’s request is voluntary, and inform the patient of alternative means of care.

If the consulting medical practitioner disagrees with the views of the attending medical practitioner as to diagnosis or prognosis then the patient must be advised within 24 hours, and the process is discontinued.

The patient must also be referred to a psychiatrist for assessment. The psychiatrist must complete a written report addressing the question of whether the patient is suffering from any mental disorder or clinical depression that may cause impaired judgment. If the psychiatrist is of the view that the patient is suffering from impaired judgment, then the process cannot continue.

The patient must also be referred to a registered trained counsellor who must discuss the decision with the patient, and counsel the patient as to the implications of that decision.

Once all of the steps prescribed have been completed, the patient is informed that the request may be carried out. The Bill prescribed a 48 hour “reflection period” during which the request cannot be carried out, and during which the patient can rescind the request at any time.

ARGUMENTS FOR AND AGAINST EUTHANASIA

The proposed legislation set out a number of safeguards designed to protect both the patient and the process from abuse. However, it also presents a number of legal and ethical issues

both for the patient and for medical practitioners involved in the process. I want to briefly summarise the arguments both for and against voluntary euthanasia, and make some comment on the strengths and weaknesses of those arguments.

Arguments for voluntary euthanasia

1. **Euthanasia in one form or another is already being practised by doctors in this country** – The argument here is that a process prescribed by legislation would ensure both a consistency of approach, and would make sure that any such procedures were open to professional scrutiny rather than carried out in an environment where no controls are in place. The evidence to support the contention that euthanasia is practised by doctors in New Zealand is, in my opinion, relatively thin, although it cannot be totally ignored. A reported 1998 survey³ showed that of 125 Waikato Hospital doctors surveyed, 17 admitted helping a patient to die. Another survey completed last year⁴ revealed that of 2,600 GPs surveyed, 39 of them admitted that in the preceding 12 months they had prescribed, supplied or administered drugs for the explicit purpose of hastening the end of a patient's life or enabling the patient to end their own life.

There needs to be some caution in this area because there is a clear distinction to be drawn between active euthanasia which is illegal in this country, and the ability of a doctor to lawfully administer pain killing drugs despite the fact that he or she knows that an incidental effect of that application will be to abbreviate the patient's life.

2. **It is the patient's life and the patient should be able to dictate when and how they die** - The difficulty with this argument is that by doing so the patient is in effect insisting upon a treatment that is unlikely to be consistent with the best standards of medical or health care practice. This is obviously a difficult issue for the medical practitioner being asked to assist. This argument also ignores the fact that whilst it is the patient's life, there are potentially other victims if the patient's life is ended prematurely. Our Courts have recognised these other victims in the line of mercy killing cases which I refer to later.
3. **A majority of New Zealanders have indicated that they support the concept of voluntary euthanasia** - A number of polls have been reported in the past ten years which support this view. A 1995 One Network News Colmar Brunton poll found that 62% of those polled were in favour of the legalisation of voluntary euthanasia.⁵ In December 2000 a New Zealand Herald DigiPoll survey of some 756 people indicated that 61% supported the legalisation of voluntary euthanasia.⁶ Again, caution needs to be exercised here, given the relatively small number of people involved in the reported surveys.
4. **It is inhumane to allow a patient to endure intolerable pain and suffering in circumstances where death is inevitable in any event** - In my view this is probably the most compelling argument advanced by proponents of euthanasia legislation. My research suggests that there is no clear consensus amongst medical professionals, nor a clear understanding in the public domain, as to whether adequate hospice care is available to the vast majority of New Zealanders who need it, and whether palliative care has reached the stage where intolerable pain and suffering can be avoided, and

³ *Landmark NZ Study brings euthanasia back into spotlight*, Sunday News, 29 March 1998, p4.

⁴ *Dozens of MPs help patients die study finds* New Zealand Herald, 2 March 2003.

⁵ *MPs throw out euthanasia bill* The Dominion, 17 August 1995, p1.

⁶ *Voluntary euthanasia gaining support – poll* Evening Post, 28 December 2000.

if so, whether such care is readily available to all patients. I want to return to this point later.

Arguments against voluntary euthanasia

Those arguing against the legalisation of voluntary euthanasia say:-

1. **Such legislation would undermine the sanctity of human life which is a fundamental human value** - Legislation such as the New Zealand Bill of Rights Act 1990 upholds this principle. Also relevant here are the provisions of the Sentencing Act 2002 which introduced a new sentencing regime for murder. In particular, the Sentencing Act enables the Courts (whilst retaining a strong presumption in favour of life imprisonment for murder), to be able to take into account mitigating factors in imposing a lesser sentence. Those who argue against euthanasia legislation say that the provisions of the Sentencing Act enable the Court to preserve and uphold the fundamental value of human life, whilst acknowledging that there are a small number of cases where those who assist in the suicide of another, or are involved in “mercy killings”, may be entitled to have mitigating factors taken into account, and a lesser sentence imposed, without necessarily condoning the actions of the guilty party.
2. **Such legislation would change the nature of the doctor and patient relationship** - The Declaration of Professional Dedication, sworn by all medical professionals, is fundamental to the trust and confidence in which the medical profession is held. If voluntary euthanasia was legalised, this trust will be, at the very least, compromised. With the ever present option of voluntary euthanasia the elderly and ill could potentially begin to fear the doctor who they historically relied upon as a care-giver. There is no doubt that the elderly and the seriously ill are already in a vulnerable position, and the introduction of such legislation has the potential to significantly increase their vulnerability.
3. **The patient already has the right to refuse treatment which is futile or intrusive** - Both the New Zealand Bill of Rights Act and the Health and Disability Services Commissioners Act are relevant here. Patients have the right to make an informed choice and give informed consent regarding their health care options. A choice includes a decision to receive or refuse services, or to withdraw consent to those services.
4. **The law in New Zealand already allows treatment to relieve suffering even if in doing so it hastens death** - As I indicated earlier, cases such as *Auckland Area Health Board v The Attorney-General* make it clear that the provision of additional pain relief to a patient is lawful if the doctor’s purpose is to relieve pain, even though a known incidental effect will be to shorten the patient’s life, provided that the doctor acts in the patient’s best interests and in accordance with responsible medical opinion.
5. **Such legislation would lead to patient abuse and killings without patient consent** - The concern here is that the elderly or weak may be coerced or may feel obliged to elect voluntary euthanasia as an option rather than potentially feeling that they are a financial or emotional burden on their families. In circumstances where a patient has given an advanced directive, there is the concern that the patient’s life could be ended well before the patient would have intended. These concerns have also been expressed in Belgium and The Netherlands where this type of legislation has been in place for approximately 18 months, and there is some evidence to suggest that patient abuse has occurred.

6. **Finally those arguing against legalised voluntary euthanasia argue that medical science has reached the stage where palliative care is effective to avoid pain and suffering for most patients, and that good hospice care is available to the majority of New Zealanders** - These assertions are challenged by euthanasia advocates. I believe that the accuracy of these assertions needs to be thoroughly tested. The question of the effectiveness of palliative care and the availability of good hospice care are probably the most compelling arguments either for or against the introduction of euthanasia legislation.

My observation is that there appears to be a range of views amongst medical professionals as to the effectiveness of palliative care in controlling pain. Some argue that up to 85% of patients can be relieved from pain and suffering, whilst others are more optimistic and suggest that up to 98% of cases can be satisfactorily dealt with.

The availability of good hospice care is also a matter which requires further investigation. Both Hospice New Zealand and the New Zealand Medical Association have been reported as conceding that access to hospice care by many New Zealanders is still an issue, with many dying patients around New Zealand receiving substandard treatment. Those bodies, quite rightly in my view, argue that the answer is not to introduce legislation enabling the early termination of life, but rather to invest in resources to make sure that adequate care is effective and available.

I should also note here that from the newspaper reports on the Lesley Martin trial referred to earlier, the question of whether Mrs Martin was afforded appropriate palliative and hospice care have become important issues in the defence case.

CASE LAW IN NEW ZEALAND

That therefore, is a summary of the arguments for and against legalised voluntary euthanasia. Those who argue for such legislation predict that if it was introduced, there would be a significant reduction in the number of cases involving mercy killings because family and friends would not be put in the position of being asked, or feeling compelled, to take what amounts to criminal actions to bring about the death of another for compassionate reasons. Having read these cases and considered the scope of the proposed legislation, I am in some doubt as to whether this prediction would prove to be correct.

In the past 20 years or so our Courts have been faced with difficult situations where the accused have committed murder or manslaughter in circumstances where their actions were motivated by merciful reasons. The Courts have on appropriate occasions recognised mitigating factors, and sentencing Judges have gone to great lengths to justify more lenient sentences in those circumstances. On each occasion the Courts have been careful to stress the value that society places on human life and the sanctity which human life deserves, but at the same time have felt able to show compassion without necessarily condoning what amounts to criminal actions in tragic circumstances.

The question therefore, is whether the introduction of voluntary euthanasia legislation, of the type proposed by the Death with Dignity Bill, would result in many of these tragic circumstances being avoided. There are many reported cases of this type. I will deal briefly with two cases that came before the courts (and a third case that did not) with that question in mind.

In the case of *R v Ruscoe*⁷ Ruscoe pleaded guilty to aiding and abetting a suicide. The victim (Nesbit) was a 30 year old man who as a result of a building site accident, had been rendered a tetraplegic. The evidence before the Court was that Nesbit suffered from

⁷ (1992) 8 CRNZ 68, Court of Appeal.

extreme pain, muscular spasms, hypothermia at times, and severe breathing problems. He often spoke of suicide. Ruscoe was a long standing friend of Nesbit's, and the Court found that he was asked by Nesbit to assist in his suicide.

The Court found on the facts that Ruscoe put pills in Nesbit's mouth and provided water with which Nesbit voluntarily swallowed the pills. Once Nesbit was asleep, Ruscoe put a pillow over Nesbit's head and he died of suffocation.

From the information available in the judgment it would appear that Nesbit would have qualified in terms of the criteria for making a request for assistance to voluntarily terminate his life under the proposed legislation, assuming that he was found to be mentally competent to make such a request. Assistance would therefore have been available to Nesbit to end his life with the help of a medical professional.

Ruscoe would not of course have been entitled to assist in the way that he did, but Nesbit's wishes may well have been able to be carried out without putting Ruscoe in the difficult position in which he found himself.

The case of *R v Law*⁸ is representative of a number of the reported cases involving older people suffering incurable illnesses. Mr Law, aged 77 years, pleaded guilty to murdering his wife of 50 years. Mr Law's wife had been diagnosed as suffering from dementia, the likely cause of which was Alzheimer's disease. Her condition had continued to deteriorate and she required constant care. She had expressed a wish to die rather than to continue to deteriorate as a result of her illness.

Mr Law killed his wife by giving her a quantity of sleeping pills and subsequently suffocating her using a pillow.

Whilst Mrs Law may have been suffering from an incurable illness, the fact that she was suffering from dementia means that her impaired mental state would have prevented her from seeking assistance under voluntary euthanasia legislation. She would have needed to have completed an advanced directive in order to obtain medical assistance to end her life.

Finally, I mention the case of Ralph Vincent whose terminally ill wife took her own life in September 2002.⁹ Mrs Vincent stockpiled various drugs which she took one evening whilst alone in her bedroom. She was found the following morning with a plastic bag over her head and a note beside her instructing anyone who found her not to attempt to revive her. Police investigated the case and decided that there was insufficient evidence to charge Mr Vincent with any part in his wife's death. Mr Vincent makes the point in various published articles, that had such legislation been in place he could have been with his wife at the time that her life ended, as opposed to having to distance himself from her final acts for fear of potential prosecution.

I have concluded from reading the various reported cases, of which I have only been able to share a sample with you tonight, that voluntary euthanasia legislation may potentially assist in only a very small number of cases. Because of the specific criteria which must be satisfied in order to request assistance under such legislation, only a very small number of patients would qualify.

⁸ (2002) 19 CRNZ 500, High Court, Hamilton.

⁹ Reported in: *They kissed and she went to bed to die* The New Zealand Herald, May 2003.

CONCLUSION

In weighing up the arguments for and against legalised voluntary euthanasia, the most compelling argument which I have identified in support of such legislation is the concern to avoid intolerable pain and human suffering in circumstances where the condition of the patient is such that death is inevitable.

Having said this, the arguments against the introduction of euthanasia legislation are, in my view, summarised in a most compelling way by the authors of a study completed by the Otago University Bioethics Centre when they said:¹⁰

“In New Zealand we have a number of measures available to us in death and dying. These include the right of patients to decline life-saving treatment, the provision of good palliative care, the permission for doctors to achieve symptom relief even at the cost of risking life, and specific guidelines about futile treatment. These measures reduce to a very small number the cases in which active euthanasia would seem to be the only alternative to a cruel death. The issue before us is whether this very limited need justifies the massive change we would make to the ethos of care in dying in New Zealand.”

I believe it is unfortunate that when rejecting the Death with Dignity Bill in its first reading, Parliament denied the New Zealand public the ability to have the matter publicly debated through the select committee process.

The only viable alternative would appear to be the establishment of a Royal Commission of Inquiry to investigate and report on the arguments for and against euthanasia legislation. The approach of establishing a Royal Commission has a worthwhile precedent. In the mid-1970s the subject of abortion similarly vexed and divided our society. A Royal Commission provided much of the ground work for, and the thinking behind, the 1977 Contraception, Sterilisation and Abortion Act. By furnishing a structure for reasoned fact based discussion and suggesting a variety of safeguards, the Commission's report was able to take some of the sting out of the issue.¹¹

Perhaps a similar approach is warranted in this case. A Royal Commission could look, for example, at how such legislation operates in Belgium and the Netherlands, and examine whether the safeguards in place in those jurisdictions are proving to be adequate. A Commission could also carefully examine the question of whether good quality palliative care is effective in controlling pain, and whether good quality hospice care is readily available to those in need in New Zealand.

These are important questions, and they, and other contentious issues raised in the debate, could benefit from independent and objective assessment.

There is no doubt that the introduction of voluntary euthanasia legislation has significant adverse consequences for the relationship between doctor and patient.

Having looked at the arguments both for and against euthanasia legislation, I want to conclude by endorsing the view which has been repeatedly expressed by medical professionals when they say that the issues for patients including loss of dignity, pain, suffering and being a financial or emotional burden, all have remedies that do not involve the somewhat extreme and final step of killing the patient.

¹⁰ Cited in Baird T “Euthanasia – Ethical issues” August 2003, Vol.3 No.4, NZFP, 247 at 249.

¹¹ See discussion in Editorial, “Commission the answer on euthanasia” *The New Zealand Herald* 1 August 2003.

Thank you.

Mark Sandelin
30 March 2004