L671

LEWES, A. Euthanasia.

ALISON LEWES

EUTHANASIA

A CHALLENGE TO THE LEGISLATIVE PROCESS

LLB(HONS) RESEARCH PAPER
LAWS 489

LAW FACULTY
VICTORIA UNIVERSITY OF WELLINGTON

1997

e
AS741
VUW
A66
L671
1997

VICTORIA
UNIVERSITY OF
WELLINGTON
*Te Whare Wananga
o te Upoko o te Ika a Maui*

LIBRARY

TABLE OF CONTENTS

I	**INTRODUCTION**	3
II	**MEANING OF KEY TERMS**	4
A	ACTIVE AND PASSIVE EUTHANASIA	4
	1 The act/omission dichotomy	4
B	THE SPECTRUM OF VOLUNTARINESS	5
III	**BACKGROUND TO THE DEBATE**	6
A	HISTORICAL OVERVIEW	6
B	THE CLIMATE FOR CHANGE	7
IV	**THE LEGAL POSITION IN NEW ZEALAND**	8
A	STATUTORY LAW	8
B	APPLICATION OF THE LAW	9
C	THE COMMON LAW APPROACH	10
V	**THE MEDICAL APPROACH TO AID-IN-DYING**	11
A	GOOD MEDICAL PRACTICE	12
B	THE DOCTRINE OF DOUBLE EFFECT	12
VI	**LEGISLATIVE PROBLEMS**	13
A	OBJECTIONS TO EUTHANASIA	13
	1 Practical objections	13
	2 Slippery slopes	15
	3 Doctors as killers	15
B	ARGUMENTS IN FAVOUR OF EUTHANASIA	16
	1 Logic and consistency	16
	2 Equality and human rights	17
	3 Personal autonomy	17
	4 Limits to state intervention	18
VII	**LEGISLATIVE SOLUTIONS**	18
A	OREGON	19
B	THE NETHERLANDS	19
C	THE NORTHERN TERRITORY	20
D	FURTHER INTERNATIONAL REFORMS	21
	1 Compassion in Dying v *State of Washington*	21
	2 Death with dignity in South Australia	22
VIII	**THE PROSPECTS OF REFORM IN NEW ZEALAND**	23
IX	**CONCLUSION**	24
X	**BIBLIOGRAPHY**	26

I INTRODUCTION

From time to time in the course of ordinary social progression, issues arise which call into question the very nature of the relationship between law and society. It is well understood that one of the main purposes of the law, if not its fundamental function, is the protection of human life. The importance of this protection cannot overemphasised; it forms the basis of the human rights and fundamental freedoms which all people enjoy and regulates the conduct between members of society and the State. As such, the preservation of life is a vital state interest.

While the concept of the sanctity of life is central to all modern legal systems and is entrenched in jurisprudence, recent judicial decisions have shown that the preservation of life itself is not absolute. In some situations, particularly when people are in pain or distress, or are near the end of life, their personal interest in ending their suffering may be greater than the State's interest in their continued life. New Zealand courts have held that while life represents a deep-rooted value in society, the sanctity of life is qualified in some situations and regard must also be had to the values of human dignity and personal privacy.[1] This finding can be seen to represent a softening of some attitudes in the judiciary and the legislature towards the desperation some people may face at the end of life. Sympathy and compassion among certain judges and politicians have created a global climate of change where the concepts of autonomy and self-determination, in death as in life, are paving the way to an international acceptance of euthanasia.

The issue of euthanasia presents a unique challenge to the legislative process. It requires society and its leaders to confront an issue which many say has overtaken sex as the main taboo topic of western society; death.[2] The increasingly liberal nature of modern society, recent advances in medical technology and a rapidly aging population have forced the once hidden issue of euthanasia into the limelight of current debate. Euthanasia is an issue which, if it continues to be ignored, has the potential to break from its currently secret confines and rush rampant across the established status quo, leaving significant harm in its wake. The challenge for the

---

[1]*Auckland Area Health Board* v *Attorney General* [1993] 1 NZLR 235, 245. A man who suffered from Guillain-Barre syndrome was left completely paralysed with his brain effectively cut off from his body in a state that was described as "living dead." He survived by means of artificial ventilation. The court directed that he be allowed to die; that such a decision was in his best interests and afforded with good medical practice. This was a landmark case in New Zealand. It will be explored in more detail subsequently. See also *Re G* [1997] 2 NZLR 201.

[2]R Gott and R Linden *No Easy Way Out : The Euthanasia Debate* (Australian Issues Series, CIS Publishers, Victoria, 1993), 4. The authors submit that most people are "in denial" about the reality of death and therefore choose to ignore it. A further problem is that death is not an event with which most people have a lot of contact; remoteness in this way allows for social inaction. It is arguable that this situation is changing, in relation to New Zealand's high rates of youth suicides and road deaths.

LAW LIBRARY
VICTORIA UNIVERSITY OF WELLINGTON

legislature is to develop laws which will effectively respond to the tide of change and give positive guidance to future generations.

Euthanasia, by whatever name it is given, is happening now and it needs to be regulated. Modern technology and resulting medical practice have moved ahead faster than society's ability to construct a legal and ethical code sufficient to deal with them. At present the law is at odds with common practice, in relation to both our own country and other jurisdictions. Current practices in the management of dying, outside the law, are now sufficiently well established that we ignore them at our peril. The need for control is evident and that must come through the proper channels of the legislative process. It is submitted that anything else is an abdication of responsibility by the leaders of our country.

II MEANING OF KEY TERMS

Much of the controversy surrounding euthanasia stems from the rhetoric which is used to define the discussion. Depending on the agenda of the proponent, euthanasia has various descriptions which range from the merciful extinction of life, to mercy killing, to hastening death, to murder.[3]

The Oxford Dictionary defines euthanasia as "the bringing about of a gentle, easy death in the case of incurable and painful disease." Other sources describe "the act or practice of putting to death persons suffering from incurable and distressing disease as an act of mercy."[4] Regardless of an actual definition, several elements become apparent; the person is suffering from some sort of disease and compassion motivates their assisted death. Distinctions are made about the way in which death is brought about.

A ACTIVE AND PASSIVE EUTHANASIA

Active euthanasia is best described as the doing of a positive act which causes the death of the patient. This could be by such means as the administering of a lethal injection to the patient. Passive euthanasia is best defined as the omission to do an act which would continue the life of the patient. This encompasses the withdrawal of life support systems which have been keeping the patient alive and the withholding of treatment which would also prolong life.

1 The act/omission dichotomy

The significance of the two forms of euthanasia is that they are distinguished by their culpability. The positive act of causing death is

[3] P Key "Euthanasia: Law and Morality" (1989) 2 AULR 224, 231.

[4] *Black's Medical Dictionary* (37ed, A&C Black, London, 1992).

illegal, while the omission to act to save a patient's life is legal, where the doctor is acting with lawful excuse. Although it is argued that the end result is the same, as is arguably the doctor's intention, it is most significant how that end is brought about. Euthanasia by active means is illegal, while it is accepted medical practice to withdraw life support from patients who are intended to die. The neglect to provide life-saving treatment to some patients in order to cause euthanasia is also accepted medical practice.[5]

B THE SPECTRUM OF VOLUNTARINESS

Proponents argue that the above distinction is more apparent than real and that the correct way to distinguish between acceptable and unacceptable forms of euthanasia is on the grounds of consent.[6] Voluntary euthanasia on this analysis, whether by active or passive means, has an ethical claim to being legitimate because it is based on an individual's free will. At present, voluntary passive euthanasia is enshrined in the express right of a patient to refuse any medical treatment while voluntary active euthanasia remains illegal.[7]

Non-voluntary euthanasia describes situations where a patient may be incompetent or otherwise unable to give their express consent to euthanasia. In these situations the hastening of a gentle, easy death may be seen as being in the patient's best interests or the court will use substituted judgment to allow the death to occur because it is deemed to be what the patient would have wanted.[8] Non-voluntary passive euthanasia has widespread legal support in the form of the withdrawal of life support systems which allow a patient to die. This can also include the withdrawal of nutrition and hydration.

Involuntary euthanasia is culpable homicide. It describes the situation where a patient may want to cling to life but it is decided that they should be assisted to die regardless. This can occur where a patient's quality of

[5]D Cole *Medical Practice In New Zealand: A Guide to Doctors Entering Practice* (Medical Council of New Zealand, Wellington, 1995) 49. Doctors entering practice are reminded that although euthanasia, the act of deliberately ending the patient's life is illegal, they can still make a decision not to intervene to treat new problems as they arise. They can also use the doctrine of double effect in pain relief, discussed further on p13.

[6]See Voluntary Euthanasia Society promotional material, per Frank Dungey, Island Bay, Wellington. This group states that euthanasia without the consent of the person concerned is not worthy of the name. It further rejects the concept of "mercy killing" as euthanasia should be administered only in carefully defined circumstances by medical practitioners.

[7]The New Zealand Bill of Rights Act 1990, s11.

[8]See *Re G* [1997] 2 NZLR 201, 212. This case concerned an elderly man who had been totally immobilised in hospital with severe brain damage and no prospect of recovery since a road accident eighteen months earlier. Evidence was given that he would have preferred to die rather than continue to live. The court agreed that this was "an entirely reasonable inference from his character and general philosophy of, and approach to, life" and that accordingly he should be allowed to die.

life is deemed by the doctor, or another concerned party to be worse than it is actually regarded by the patient. This may lead to the mercy killing of an ailing person by another who believes they are doing the best thing to relieve the patient's suffering. The term 'euthanasia' is not appropriate in this instance because the patient has not consented to their fate.

Although voluntariness is not a key ingredient for the definition of euthanasia, it must be present in order for euthanasia to be an ethically acceptable act.

III BACKGROUND TO THE DEBATE

The background to the euthanasia debate is relevant because many of the issues which legislators face in this area find their origin in times very different to our own. An example is the Hippocratic Oath. This is an ethical declaration doctors make when entering practice which is said to prevent them from practicing active euthanasia.

A HISTORICAL OVERVIEW

The Hippocratic Oath dictates the personal virtues a doctor must have as well as the professional ethics of compassion, knowledge and dedication to the welfare of the patient. The Oath (in translation) states:[9]

> I will follow that system of regimen which, according to my ability and judgment I consider for the benefit of my patients, and abstain from whatever is deleterious and mischievous. I will give no deadly medicine to anyone if asked, nor suggest any such counsel.

The significance of this statement is that the approach of the medical profession is based around a series of ethical guidelines which were probably written in the 5th century BC and which could not even be said to have been the prevalent view of the time. The issue of euthanasia obviously existed at that time, but even then there were different ideas of how to approach it. The Platonists, the Stoics and the Cynics all believed that suicide was permissible for the diseased while other schools of philosophy actually thought it was honourable to die in such a situation.[10]

It is important to understand that many of the current guidelines on euthanasia came out of times and situations which are very different to the world we find ourselves in today. For example, the Hippocratic Oath goes on to state "and in like manner I will not give to a woman a pessary to

---

[9]See D Mendelson "The Northern Territory's Euthanasia Legislation in Historical Perspective" (1995) 3 JLM 136, 138. The Hippocratic oath was incorporated into current medical practice by the World Medical Association (WMA) in the form an International Code of Ethics known as the Declaration of Geneva 1947.

[10] See above n9. Plato quotes Socrates as saying that great suffering in illness justified suicide and that even Aesclepius, the god of healing, would not wish to prolong such suffering.

produce abortion" although of course this is common practice today.[11] Similarly, the prohibition against suicide in western society originates from early European history where taking one's own life was seen as an offence against God and nature, and later against the King, who was being deprived of one of his subjects (and thus their labour and taxes).[12]

B THE CLIMATE FOR CHANGE

It is interesting to note that the church continues its prohibition against suicide even while society is becoming increasingly secular.[13] Further changes to the nature of society have created a climate for change and a need for the legislature to respond. Throughout the long history of euthanasia efforts have been made to address the issue in a number of jurisdictions worldwide.[14] Momentum for this change has come from several sources; the institutionalisation of the dying process, the changing causes of death, huge advances in medical technology over time and the newly empowered role of the patient in the current health system.

It has been stated that "(d)eath is no longer the natural event it once was."[15] Certainly, the manner in which it occurs has undergone some dramatic changes. Modern medicine has effectively eradicated the swift-acting killer diseases which caused most of the deaths earlier this century. The predominant causes of death which remain are chronic diseases which are degenerative and debilitating and occur over an extended period of time.[16] The vast majority of deaths take place in an institutional setting such as a hospital or rest home and technology has further developed means of prolonging the whole process of dying.[17]

The combination of these factors have served to alienate the patient from the control they are normally able to exercise over their own life and death

---

[11]See above n9.

[12]T Cipriani "Give me Liberty and Give Me Death" (1995) 3 JLM 177,181. The history of suicide is long and complex. At one point people who committed suicide were buried at the crossroads of a highway with either a stone over their face or a stake through their heart because it was thought that otherwise they would rise again as vampires and ghosts.

[13]See K Healey (ed) *Life and Death Matters* (Issues for the Nineties, The Spinney Press, Sydney, 1994) 6. Declaration of the Vatican on Euthanasia 1980. The Catholic Church condemns euthanasia which it defines by intention and the manner of acting. Doctors must not end the life of the dying patient, for to do so violates divine law.

[14]In Britain alone there have been at least three attempts to legislate in as many years; the Voluntary Euthanasia Bill 1969, the Incurable Patients Bill 1976 and the Suicide (Amendment) Bill 1985.

[15]See above n13, 2.

[16]M Webb "The Politics of 'Medicide' in New Zealand: A Cautious Approach for Physician Aid-in-Dying" (1994) 3 CLR 438, 441. This trend has been noted by the Department of Statistics.

[17]See above n16. It is estimated that less than 20% of all deaths now occur outside hospitals and other institutions.

decisions. This led to recognition that patients needed to be empowered in their relationship with health care systems.[18] One way of achieving this was through emphasising patient rights such as the right to be fully informed of all matters affecting them, and the right to make their own decisions on healthcare.[19] This new emphasis on patient autonomy, self-determination and other rights came at a time when other members of society were arguing for the liberalisation of society in different ways. The climate of change which has followed suggests that euthanasia or assisted suicide could become the next major social movement, and may even characterise our approach to the new century.

IV THE LEGAL POSITION IN NEW ZEALAND

The legal position in New Zealand has been created by statutory law and modified over time by common law developments. The separation of powers in our democratic process dictates that Parliament makes the law and the courts then apply the law; as will be seen, this is not always the case.

A STATUTORY LAW

Criminal liability for euthanasia is established by Part VIII of the Crimes Act 1961 which details crimes against the person. "The killing of a human being by another, directly or indirectly, by any means whatsoever" is homicide, as defined by s158. Culpable homicide is then defined as being either manslaughter, or if the intention of the offender is to cause death or bodily harm known to be likely to cause death, murder.

The s167(a) definition of murder, as being if the offender means to cause the death of the person killed, is a clear prohibition of active euthanasia.[20] This is the case regardless of the motives behind the act.
Furthermore, s63 provides that:

> **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.

---

[18]G Gillett "Ethical Aspects of the Northern Territory Euthanasia Legislation" (1995) 3 JLM 145, 150.

[19]The Declaration of Lisbon 1981 is a WMA directive on patient rights. The Health and Disability Commissioner of New Zealand also produced a Code of Health Consumers Rights in 1995 which is significant for patients.

[20]Passive euthanasia is not similarly prohibited. Section 160(1)(b) provides that the killing of a person by omission will only be culpable if it was an "omission without lawful excuse to perform or observe any legal duty." The withdrawal of life support and the withholding of treatment from patients in accordance with "good medical practice" is regarded as lawful excuse.

Culpable homicide is therefore not ameliorated by the fact that a person might have requested that they be put out of their suffering and that such an act was done only at their request. No one has the right to consent to the infliction of their death. It is further established that even if a person was seriously ill to begin with and their death was merely been hastened on its way, that death will still be deemed to have been caused by the intervention of the third party. The acceleration of death is prohibited. Section 164 of the Crimes Act 1962 provides:

> **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.

In addition to these prohibitions on hastening death, the law also includes the offence of assisting in the commission of a suicide. It is significant that although suicide and attempted suicide were decriminalised in 1893, it has remained an offence to aid or abet these acts.
Section 179 of the Crimes Act 1961 provides that:

> **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.

The clear message of the law, therefore, is that euthanasia is strictly prohibited. Any attempt to intentionally bring about the death of another person, whether for compassionate reasons or any other, will be dealt with strongly. The provision of serious penalties such as imprisonment of up to 14 years for aiding and abetting suicide supports this censure. However, the reality is that the full force of the law against euthanasia is really brought to bear on people who practise compassionate killing.

B APPLICATION OF THE LAW

Proceedings based upon Part VIII of the Crimes Act 1961 in relation to euthanasia are extremely rare. Although it is acknowledged that such situations occur fairly frequently, they are hidden from public scrutiny for a number of reasons.[21] These have been identified as including four main factors.[22]

---

[21]There have been a number of studies into the prevalence of euthanasia in society, most of which have been based around surveys of medical practitioners. One such survey found that half the doctors questioned had been asked by patients to hasten their death. Of those, 19-27% admitted to having taken active steps to bring about the death of a terminally ill patient. This study was empirically sound. See M Van Der Weyden (ed) "Medicine and the Community - the Euthanasia Debate" (1995) Med J of Aust 162, 165.

[22]See above n3, 230.

Firstly, there are inherent problems in proving a charge of murder against a physician, not the least of which is causation, whereby the act of the doctor can be demonstrably proved as being sufficiently causally connected to the resulting death. Secondly, even if this is established, the nature of the criminal justice system is that different filtering processes will determine whether the decision to prosecute will be made. Thirdly, juries are commonly reluctant to convict doctors and other people when they have been motivated by compassionate means. Finally, any person who is convicted after all of these considerations is likely to be treated with clemency by the sentencing judge.

It therefore becomes apparent that prosecution is rare and leniency throughout the criminal process is common in these situations. The Court of Appeal acknowledged this approach when they stated in the case of *R* v *Ruscoe* that they would "allow the promptings of humanity to prevail," even when the defendant had plainly breached very serious laws.[23]

C THE COMMON LAW APPROACH

The common law approach to this issue is at odds with express statutory provisions which provide extensive criminal culpability for actions which hasten death. To date there have been no cases of physician-assisted suicide which have reached the New Zealand courts, in contrast to other jurisdictions.[24] There have been several prosecutions for section 179 aiding and abetting suicide.

In one case, *R* v *Novis*, the defendant shot and killed his father who was terminally ill with cancer and in terrible pain.[25] The father had pleaded with his son to shoot him. A jury found Novis not guilty of murder. He was convicted of manslaughter and sentenced to 12 months' supervision.

R v *Stead* was based on similar facts; a compassionate son carried out his mother's earnest wish to die.[26] The difficulty in this situation was that the mother was not actually terminally ill but rather seriously disturbed. She had attempted to take her own life but failed. Her son attempted to kill her by injecting her with sedatives, poisoning her with carbon monoxide, smothering her with a pillow and only succeeded by repeatedly stabbing her with a kitchen knife. The defendant was cleared of murder but found guilty of manslaughter and sentenced to 3 years' imprisonment.

---

[23](1992) 8 CRNZ 68, 71.

[24]For two examples of physician-assisted suicide see *R* v *Adams* (*Bodkin)* [1957] Crim LR 365 and *R* v *Cox* Unreported, 18 September 1992. Similar actions are most commonly absolved of culpability on the ground of double effect.

[25]Unreported, 5 February 1988, High Court, Hamilton, T42/87.

[26]*R* v *Stead* (1991) 7 CRNZ 291. This was described as "a disturbing comedy of errors."

Finally, *R* v *Ruscoe* needs little introduction. The facts of this case were quite unique. Ruscoe agreed to help a tetraplegic friend end his life. They agreed on the method and Ruscoe placed some 50 sedative pills in his friend's mouth which he then voluntarily swallowed. Ruscoe then held a pillow over his friend's face to ensure he would die, this assurance having been sought by the friend. Ruscoe was convicted at trial of aiding and abetting the commission of suicide and sentenced to 9 months' imprisonment. On appeal this was reduced to one year's supervision, regard having been had to Mr Ruscoe's alcohol and psychological problems.

This is a very cursory examination of New Zealand case law. As previously stated, proceedings on the issue of euthanasia and assisted suicide are rare, and it is significant that the cases which do find their way through the criminal justice system go largely unreported. However, even from these brief cases we can see that there are clear breaches of the criminal law where lenient sentencing significantly devalues the stated seriousness of the crime. Having said that, the sympathetic judicial response is entirely in keeping with the tragic circumstances in which these awful events occur. It has been summarised that:[27]

> 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 desperation. .... 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.

V THE MEDICAL APPROACH TO AID-IN-DYING

The medical approach to the issue of aid-in-dying contrasts significantly with that of the legal approach. The World Medical Authority has expressly stated that the patient has a right to die with dignity.[28] This recognition sits somewhat uneasily with the statement that:[29]

> Euthanasia, that is the act of deliberately ending the life of the patient even at the patient's own request, is unethical. This does not prevent the doctor from respecting the desire of the patient to allow the natural process of death to follow its course in the terminal phase of sickness.

Doctors are advised to "(a)lways bear in mind the obligation of preserving life, but allow death to occur with dignity and comfort when death of the body appears to be inevitable.[30] The practice of medicine has three broad

---

[27]See above n16, 451.

[28]WMA Declaration of Lisbon 1981.

[29]WMA Declaration on Euthanasia 1987.

[30] See above n5. NZMA Code at 22.

purposes; the preservation of life, the curing of disease and the relief of suffering. When the first two purposes are no longer sustainable the doctor is still under an obligation to ensure the well-being of the patient through the relief of pain. Pain and symptom control are the priority for dying persons. As the edges blur between legitimate pain relief and illegitimate euthanasia, protection is afforded to the medical practitioner in the form of two different concepts; that of "good medical practice" and the doctrine of "double effect."

A GOOD MEDICAL PRACTICE

The observance of "good medical practice" ameliorates the criminal culpability of doctors in situations of passive euthanasia. The Crimes Act 1961 details the obligations of doctors. These include s151, the duty to provide the necessaries of life, s155, the duty of persons doing dangerous acts and s157, the duty to avoid omissions dangerous to life. The omission to perform any of these duties leads to criminal responsibility unless the perpetrator has lawful excuse for their actions. In relation to decisions taken in the management of dying, doctors have a "lawful excuse" to withdraw life support systems and withhold treatment when these acts comply with "good medical practice."[31]

Good medical practice describes situations where the doctor's decision to withdraw or withhold treatment is bona fide and in the best interests of the patient, the decision is one which would "command general approval within the medical profession," the patient's family agree with the decision and give their consent, and the doctor's decision is approved by a recognised ethical body.[32] The acceptance by the medical profession of the practice of passive euthanasia has led some commentators to describe it as a "de facto recognition of the right to die."[33]

B THE DOCTRINE OF DOUBLE EFFECT

The concept of lawful excuse through good medical practice does not extend to include active euthanasia. The hastening of death by doctors through a positive act is traditionally protected by the doctrine of double effect. This doctrine developed from the affirmation of Devlin LJ in *R* v *Adams* that a physician "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."[34]

---

[31]See above n1. The criteria can also be found in the earlier New Jersey case of *In the Matter of Karen Quinlan* 355 A 2d 647 (1976) (NJ:SC).

[32]See above n1, 251. Doctors have a lawful excuse to withdraw treatment when the medical assistance they offer no longer serves any therapeutic purpose for the patient.

[33]See above n9, 182.

[34][1957] Crim LR 365, 375.

The doctrine of double effect derives from the doctor's obligation to relieve patient suffering. As long as the intent of the action is to alleviate suffering it is not relevant that a consequential effect of the act may be to shorten life. Double effect is often practised through the gradual dose escalation of certain medication which becomes lethal in high concentrations. The primary result of such action must be the relief of otherwise unbearable pain, regardless of the fact that death may be a foreseeable secondary result. Some commentators have described this as a "rhetoric-reality gap" whereby practitioners are able to hide behind the false application of the doctrine of double effect even though the main intention and certain outcome is to hasten the patient's death.[35] Such inconsistency and secrecy has long characterised the euthanasia debate.

VI LEGISLATIVE PROBLEMS

Law makers face a number of problems in the legislation of this issue. Their task requires the examination of the arguments for and against euthanasia. A balance must be struck between the interests of the individual and those of society. The legislation as it pertains to the sanctity of human life must be very finely drafted to address the practical concerns people have about the issue. Tight regulation is required, but again this must be sufficiently flexible to cope with the changing nature of society.

A OBJECTIONS TO EUTHANASIA

Objections to euthanasia are commonly based on three grounds; state interests, moral imperatives and practical considerations. Each of these overlap and combine, with the main objection to euthanasia being that the overall cost to society of the legislated provision of euthanasia outweighs any arguments which may be made in favour of individual needs and rights.

1 Practical objections

These are commonly based on the possibility of mistake, the fear of abuse and the procedural problems inherent in the management of dying.[36] It is argued that mistakes are always a possibility in the diagnosis of terminal illness and that euthanasia will remove the chance that such mistakes could be found and rectified. Legislation would need to address this concern through the requirement that all possible candidates seek a second medical

---

[35] R Hunt "Palliative Care - The Rhetoric-Reality Gap" in H Kuhse (ed) *Willing to Listen, Wanting to Die* (Penguin, Melbourne, 1994).

[36] There are numerous objections which are raised against euthanasia. It is interesting to note that in the modern debate less emphasis is placed on theological or vitalist arguments which hold that human life is an absolute value in itself and as such every effort should be made to prolong it. Opponents of euthanasia in previous times also stressed the redemptive nature of suffering as positive aspect of prolonging death; however, this sits uneasily with modern attitudes towards pain relief and symptom control. See above n3, 232.

opinion on their prognosis and alternative options such as palliative care and counseling have been fully explored.

A further concern is the difficulty in ensuring that the consent of the patient is free and full. In practical terms, the patients who seek euthanasia are likely to have been weakened by the course of their disease, and while are still "competent" in the strictest sense of the term, should not morally be allowed to end their life. Legislation must provide adequate safeguards to ensure the validity of the consent is tested throughout the path to euthanasia, so that it is a genuine and enduring desire to hasten the end of life. Provisions would need to be included to allow the patient to withdraw their consent at any time up to and including the act of euthanasia.

An additional objection is that there is no actual need for euthanasia in modern society. It is argued that pharmaceutical innovations and the recent prioritisation of pain relief and symptom control have removed the need for euthanasia. This is certainly the case in the majority of situations; however, it has been accepted that pain relief to an extent acceptable to the patient is not always possible. In some situations the level of medication required to relieve pain renders the patient unconscious or leaves them in surviving in "an artificial twilight existence."[37] Since it has been contended that consciousness is what makes life valuable, it is apparent that the need for euthanasia may continue to exist in some situations.[38] It is further acknowledged that in a very small number of cases, the nature of the disease is such that it is not possible to relieve a patient's pain at all. This type of situation has been described by one palliative care specialist where:[39]

> Pain, particularly that due to infiltration by cancer of extremely sensitive nerve-rich areas such as the brain, head and neck, pelvis and spine, is commonly episodic and excruciating, aggravated by movement, and may be likened to a dental drill on an unanaesthetised tooth nerve. As such it is not capable of adequate control by palliative medicine. Five to ten percent of cancer pain may be of this type and can only be 'palliated' by producing a prolonged unconsciousness, coma or 'pharmacological oblivion'.

Another palliative care specialist has further asserted that:[40]

> If we can all acknowledge that there are "hard cases," where dying persons cannot obtain acceptable relief of suffering, regardless of our own views on active euthanasia, this would be a constructive step in obtaining community consensus about how to proceed.

---

[37]See above n3, 239. The condition is described by Glanville Williams as including nausea, giddiness, extreme restlessness and long hours of consciousness of a hopeless condition.

[38]See above n2, 28.

[39]S Chapman and S Leeder (eds) *The Last Right? Australians Take Sides on the Right to Die* (Mandarin, Victoria, 1995) 129.

[40]M Ashby "Hard Cases, Causation and Care of the Dying" (1995) 3 JLM 152.

2 *Slippery slopes*

Fear of the flow-on effects of legislating for euthanasia is a significant objection. The argument is this; once we have legalised voluntary euthanasia, even within strictly controlled circumstances, what is to stop the gradual spread of the procedure to include non-voluntary or involuntary euthanasia which would then endanger the most vulnerable groups in society? This fear arises out of the use of the term 'euthanasia' to describe the programme of social and ethnic cleansing pursued by Nazi Germany in the Second World War.[41] It must be noted in response to this that the Nazis never practised voluntary euthanasia, so there was no slide down a slippery slope; the agenda was mass murder by whatever title.

The concerns of the overall cost to society are certainly valid and in order to minimise the threat to society the law must be drafted in the strongest possible terms of voluntariness. It cannot be denied that such a law could have the effect of cheapening life to the extent that some vulnerable people would choose euthanasia if the option were available so as to avoid becoming a burden to others. However it has been suggested that "(t)he will to live is probably the strongest living force of all" and this is unlikely to be extinguished in one go.[42] Since its decriminalisation last century, suicide is an option which is available to people who want to end their lives and who have the practical means to bring this about themselves. The mere fact that an act such as euthanasia has been decriminalised should not drastically change people's individually held beliefs about the appropriateness of such an action.[43]

3 *Doctors as killers*

A final concern is that the practice of euthanasia will cause significant harm to the doctor/patient relationship because doctors will now be seen as killers instead of healers. This would result in a loss of trust and confidence in the profession and would significantly undermine their positive role in society. Conversely, it has been argued that what doctors fear most from this move is not a loss of trust but the loss of power and control they currently exercise over the management of dying.[44]

---

[41] See above n16, 453.

[42] See above n39, 128.

[43] See above n43. The issue is said to be one of peace of mind. Just because most people insure against fires does not mean that they expect to have a fire, but the knowledge that they are protected in such an event is reassuring to them. Similarly, studies have shown that while up to 80% of the general public support the issue of euthanasia, only 6% of patients at an in-patient hospice and palliative care unit in Adelaide actually expressed a wish for assistance to die at the time of being asked the question. Perhaps this demonstrates that in most cases, where you have fought to stay alive in terrible circumstances, you intend to keep fighting to hold on to life until the very end. See above n40, 155.

[44] See above n16, 453.

The doctor/patient relationship is traditionally complex yet has changed in subtle ways in recent years. Where once the patient simply did what they were told and took their medicine, there is now the expectation that they should actively participate in their treatment decisions.[45] There is increased emphasis on patient rights and a new language of empowerment where patients are regarded as "health consumers."[46] It has been further stated that there should be a genuine partnership between patients and health care professionals in the management of all health issues.[47] The presence of such a partnership would go a long way towards ensuring that confidence is maintained in the medical profession; patients would also no doubt have strong faith in a medical practitioner who would always act in their best interests, in whatever way that might be.

B ARGUMENTS IN FAVOUR OF EUTHANASIA

On the other side of the debate are arguments which favour the legislation of euthanasia. These arise out of the current situation where euthanasia is said to be already practised in several forms. The need is to address this situation and tidy it up so that the law is consistent with acceptable common practice. Arguments supporting euthanasia are largely based around the inconsistencies in current laws, the individual's right to self-determination, equality and other human rights as well as the limits which should be prescribed to state control over one's personal affairs.

1 Logic and consistency

The acts of suicide and attempted suicide are legal in this country, as they are in most jurisdictions around the world, yet it is illegal to aid or abet the commission of suicide. An inconsistency is created in the law whereby it is criminally culpable to facilitate an act which is itself legal. Participation in a non-criminal act is itself regarded as criminal in this instance.

It is illogical that while the end to be achieved (suicide) is not considered a criminal act, yet generally, the means to that end (assistance) is prohibited. This presents no problem for most people contemplating the hastening of their death; however, some less able bodied people are seriously prejudiced by the sanction against assistance.

The further inconsistencies regarding the prohibition of euthanasia have been explored earlier in this essay and need only be revisited briefly. These

---

[45]See above n5, 9. Patients are traditionally "non-complaining, dependent and vulnerable - the very origin of the name implies long suffering and calm subservience." The issue of patient rights therefore emerged slowly.

[46]See above n45. See also the 1995 Code of Health Consumers Rights. It is acknowledged that economic reasons as much as empowerment are behind this linguistic shift.

[47]See above n 18, 151.

are the application of the doctrine of double effect, the defence of good medical practice and the statutory right of the patient to refuse treatment, even where this may hasten death.[48] The fact remains that in express legal terms euthanasia is illegal.

2 *Equality and human rights*

It is arguably an issue of equal rights that persons who are able can simply choose to end their life, while the disabled or incapacitated are denied the assistance which would allow them to achieve the same end.
Section 21 of the Human Rights Act 1993 prohibits discrimination on the grounds of:

> (h) Disability, which means
> (i) Physical disability or impairment:
> (ii) Physical illness:
> (iii) Psychiatric illness:
> (iv) Intellectual or psychological disability or impairment:
> (v) Any other loss or abnormality of psychological, physiological, or anatomical structure or function:
> (vi) Reliance on a guide dog, wheelchair, or other remedial means:
> (vii) The presence in the body of organisms capable of causing illness.

It would not be a common application of the Human Rights Act to allowing disabled people that same right to choose death that able people enjoy. However, this rights-based approach was presented to the courts prior to the provision of this Act. Defence counsel acting for Mr Ruscoe, who assisted in his disabled friend's suicide, submitted:[49]

> Mr Ruscoe was doing no more than act, in effect, as the arms of Mr Greg Nesbit who wanted to die (and he had expressed that wish not only to Mr Ruscoe but also to a number of others). Mr Nesbit himself could not use his arms. Someone had to act as his arms for him.

3 *Personal autonomy*

Personal autonomy is the right to self-determination and the freedom of will. This encompasses the right to make the vital decisions which affect the most significant aspects of our life. The right to self-determination is the means by which a patient can refuse medical treatment in order to hasten death, through either the withdrawal of life support or the withholding of therapeutic measures. It is argued that since this right incorporates the most important decisions made regarding life, it should also extend to include vital decisions about death. Autonomous human beings should have the right to decide when their quality of life is such that

---

[48] See above n7.

[49] N Hampton QC "Correspondence" (1995) NZLJ 166. It has already been noted that in effect Ruscoe received no punishment for his crime.

they do not want to go on living, and should be then able to act accordingly.[50]

This argument finds some support among the judiciary. Cory J's approach in the case of *Rodriguez* v *AG of British Columbia* was to argue that the right to die derives from the right to life. She stated:[51]

> The life of an individual must include dying. Dying is the final act in the drama of life. If, as I believe, dying is an integral part of living, then as a part of life it is entitled to the constitutional protection provided by s7. It follows that the right to die with dignity should be as well protected as is any other aspect of the right to life.

Although personal autonomy is not an absolute, it overcomes state interests in the preservation of life when the patient has a terminal illness or is in considerable distress. It is at these moments that the right to self-determination is most needed.

4 Limits to state intervention

Proponents of euthanasia characterise it as both an issue of personal autonomy and a victimless crime. The state is said to overstep its mandate to govern when it interferes with the private concerns of competent adults. In an oft-quoted passage, J S Mill asserts:[52]

> The only purpose for which power can be rightfully exercised over any member of a civilised community, against his will, is to prevent harm to others ... over himself, over his own body and mind, the individual is sovereign ... The only freedom which deserves the name, is that of pursuing our own good in our own good way, so long as we do not attempt to deprive others of theirs, or impede their efforts to obtain it.

Cardozo J went on to state that "every human being of adult years has a right to determine what shall be done with his own body."[53] The clash between private and state interests in relation to the preservation of life call into question the very mandate a government is given in the democratic process. The operation of the law is to protect and enhance the life of citizens; not to oppress them without cause.

VII LEGISLATIVE SOLUTIONS

That there is a clear need for the regulation of current practices in the management of dying is apparent; the real issue is how best to proceed

[50] See above n16, 457. Max Charlesworth is one of the main proponents of this view.

[51] 107 DLR 4th 342 (1993).

[52] JS Mill *On Liberty* (1859) (Appleton-Century-Crofts, New York, 1975) 9.

[53] *Schloendorff* v *Society of New York Hospital* 211 NY 125, 105 NE 92 (NY 1914).

with the reform of the law in this area. In many jurisdictions worldwide the development of common law on euthanasia has been completely at odds with the express black letter of statutory law. Where this is acknowledged as being unacceptable, various efforts have been made to tidy up the law so as to codify common practice. This movement is discernible in a number of American states, England and Australia, each with varying degrees of success. Elsewhere groups have been charged with the task of reviewing the law and current practice and reporting back to the government on the desirability of reform.[54]

In 1991 Washington came close to passing an initiative which would have legalised physician-assisted suicide. The legislation made good progress but narrowly failed at the last moment. This was said to be due to a perception that there were inadequate safeguards controlling the practice. This was emphasised in a huge advertising campaign by the Catholic Church aimed at convincing the public of the undesirability of the legislation.[55] The problems of the lack of safeguards were rectified the following year when a Death with Dignity Act was proposed for California, although again the Act failed to pass.

A OREGON

Legislation permitting physician-assisted suicide did however pass on 8 November 1994 in the State of Oregon. Entitled the Death with Dignity Act, the legislation is unique in that it specifically forbids the taking of a patient's life by lethal injection, mercy killing or active euthanasia. Instead, doctors are permitted to supply patients with a medical prescription of lethal drugs, following a cooling off period of at least 15 days.

The legislation did not last long in practice. One month after its introduction a federal judge issued a preliminary injunction blocking the new law from taking effect. The following year the law was struck down by the US District Court as being unconstitutional. It was said to violate the Equal Protection Clause of the 14th Amendment.[56]

B THE NETHERLANDS

The approach to euthanasia in the Netherlands has not been so straightforward. Active euthanasia has been openly practised since the early 1970s. By 1987 the Royal Dutch Medical Association had issued

---

[54]One such review procedure was performed by the Canadian Law Commission in the wake of *Rodriguez* [1993]. The Commission rejected euthanasia and focused its findings on the state interest in the sanctity of life.

[55]See above n12, 187. The Catholic Church spent US$1.9million on their television and radio campaign.

[56]See above n12, 188. There have been indications that the State of Oregon is likely to appeal against this decision and is prepared to take the issue to the Supreme Court.

guidelines on what constituted acceptable medical practise in this area. A non-prosecution stance in the common law emerged in accordance with the medical guidelines on common practice. In 1993 the common practice of euthanasia was formally approved by the Dutch Parliament. Regulation was provided by means of a 28-point checklist which formally guarantees doctors immunity from prosecution if they strictly follow each requirement. Doctors are required to show that the patient is terminally ill, suffers from unbearable pain and has repeatedly asked to die.

The Dutch response to this difficult issue has been hailed by many for its enlightened response to patient autonomy while still showing a commitment to the protection of the vulnerable.[57] However, a government report found that doctors did not seem to be adhering to the guidelines, and in addition the practice of euthanasia was becoming alarmingly widespread.[58]

C THE NORTHERN TERRITORY

Recent approaches to the issue of euthanasia have been more overt than ever before. The Northern Territory successfully passed a law in 1995 which expressly legalised the practice of active voluntary euthanasia. Entitled the Rights of the Terminally Ill Act 1995, the law gave immunity to medical practitioners who, in accordance with the statute, comply with their patient's request to end their life. This may be either by aiding their suicide or directly and intentionally killing them.

The legislation required 25 steps to be completed by both doctor and patient before the act of euthanasia could be performed.[59] These steps were seen as safeguards to the counter the possibilities of mistake or abuse and were designed to ensure that the patient's wish to die was genuinely voluntary, fully informed and enduring. Alternative options such as palliative care and counseling needed to have been explored and the patient would make a declaration to this effect, stating "I am satisfied that there is

---

[57] See above n16, 467.

[58] See above n12, 190. The report is known as the Remmelink Report, and was undertaken in 1991 before the 28-point checklist was formally passed into law. It is perhaps too early to tell whether this problem has been rectified through legislation. The finding of the report could be cited as an authority for the proposition that guidelines on euthanasia need the full weight of the law behind them in order to effectively regulate medical practice.

[59] M Perron Voluntary Euthanasia Society public seminar on the Rights of the Terminally Ill Act 1995, Wellington, 26 May 1997. It is significant to note that the successful passage of the Act was based on many social factors which were unique to this situation. The Bill was developed by Marshell Perron and introduced to Parliament while he was the Chief Minster, although he resigned before the issue was debated publicly so that his position would not influence the casting of conscience votes. Even so, Perron's long and distinguished political career must have given mana to the issue so that it was not as easily dismissed as it was in New Zealand the same year. Finally, the Northern Territory Parliament comprises 25 members, making political accord somewhat easier to obtain than it is in larger legislatures.

no medical treatment reasonably available that is acceptable to me in my circumstances."[60]

The Act made significant and widespread impact on the rest of Australia. The issue of euthanasia became the subject of intense public debate and was explored on many different levels of social commentary. The Commonwealth Parliament of Australia was moved to overturn the Act. It was held that the power of the Legislative Assembly of the Northern Territory did not extend to:[61]

> the making of laws which permit or have the effect of permitting (whether subject to conditions or not) the form of intentional killing of another called euthanasia (which includes mercy killing) or the assisting of a person to terminate his or her life.

The euthanasia debate has taken on huge political significance in Australia. The decision of the Commonwealth Parliament to quash the law lead to a renewed push for statehood by many Northern Territory citizens.[62] It is incredible to think that one issue could have such a far-reaching effect.

D FURTHER INTERNATIONAL REFORMS

There have been at least two additional developments to the international climate of euthanasia reform in recent months. The first is significant because it consists of the judicial recognition of a right to die by the United States Court of Appeals.[63]

1 Compassion in Dying v *State of Washington*

A group of physicians and their terminally ill patients had challenged the constitutionality of a Washington statute that prohibited any person assisting another to commit suicide, in relation to physician-assisted suicide of the terminally ill.

The plaintiffs alleged that they had a constitutionally protected liberty interest under the 14th Amendment to commit physician-assisted-suicide without undue governmental interference. They further argued that the statute should be declared unconstitutional because it did not afford equal protection to all patients by allowing medical assistance for the withdrawal of life-support systems but prohibited physician-assisted-suicide for terminally ill patients. The court in the first instance agreed. It likened

---

[60]The Rights of the Terminally Ill Act 1995, schedule detailing the "(r)equest for assistance to end my life in a humane and dignified manner."

[61]The Euthanasia Laws Act 1996, s50A.

[62]See "Anti-euthanasia vote brings bitterness" *The Dominion*, Wellington, New Zealand, 25 March 1997.

[63]*Compassion in Dying* v *State of Washington* (No 94-35534) F (9th Cir 1996), 49 F 3d 586 (9th Cir 1995), 850 F Supp 1454 (1994).

euthanasia to abortion and held that such decisions were included among the liberties protected by the Fourteenth Amendment. At the heart of liberty was the right to define one's own concept of existence.[64]

The court stated that it did not believe a distinction of constitutional significance could be drawn between refusing life-sustaining treatment and physician-assisted suicide by an uncoerced, mentally competent, terminally ill adult. It concluded therefore, that there was a constitutional right to physician-assisted suicide. This finding was subsequently overturned on the appeal of the State of Washington. Among the established grounds of appeal were that the District Court had reached its decision without consideration of Washington's interests which were said to "individually and convergently outweigh any alleged liberty of suicide."[65]

The District Court's decision to strike down the legislation which prohibited physician-assisted-suicide was finally upheld by the United States Court of Appeals on 6 March 1996. The overall outcome was a recognition that the patient had a right to control the manner and time of his or her own death. This was based on an extension of the constitutionally guaranteed right to refuse life-sustaining treatment found by the Supreme Court of the United States in *Cruzan* v *Director, Missouri Department of Health*. [66]

The Court of Appeals further found that there was no useful distinction to be made between active and passive actions which hasten one's death. "[W]e see little, if any, difference for constitutional or ethical purposes between providing medication with a double effect and providing medication with a single effect, as long as one of the known effects in each case is to hasten the end of each patient's life." Actions in hastening death were permissible as long as they were based on voluntariness.

The impact of these findings on the practice of euthanasia both nationally and internationally cannot be understated. This is the first instance where the right to die has been expressly articulated, and explored in a manner that provides comprehensive guidelines for other decision-makers to follow. It is possible that this decision will represent a major turning point in the global struggle to come to terms with euthanasia.

2 *Death with dignity in South Australia*

A second major development has come through traditional legislative channels. It is a new Private Members Bill which is set to formally legalise both active and passive euthanasia in South Australia. The Bill has passed

---

[64]See *Planned Parenthood* v *Casey* 112 SC 2791 (1992). "[T]his court finds the reasoning in *Casey* highly instructive and almost prescriptive."

[65]See above n63, (1995) 591.

[66]497 US 261 (1990).

its first reading and is currently being processed in the Upper House before it may be put before the Lower House.

The new Bill is regarded as a model to follow, by the New Zealand Voluntary Euthanasia society, in that it is clear, succinct and drafted in plain English.[67] It covers the situations of terminal illness and serious diminution of quality of life. The legislation encourages the self-administration of lethal substances, but where this is not possible, a doctor is allowed to perform the active steps to hasten the end of life. The Society has provided copies of the legislators to New Zealand MPs who have indicated a willingness to support the issue, with a view to similar legislation being introduced in this country.

VIII THE PROSPECTS OF REFORM IN NEW ZEALAND

The South Australia Bill is seen as being far superior to the legislation which Michael Laws and Cam Campion introduced to Parliament by way of a Private Member's Bill in 1995. The attempt to legalise euthanasia in this country failed spectacularly. The reasons for the failure can be blamed more on the controversial nature of the issue of euthanasia than on the Death with Dignity Bill itself.

The Bill was rejected on its first vote, a conscience vote, by a majority of 61 to 29.[68] This effectively nipped the legalisation of euthanasia in the bud, and further exploration of the issue was avoided. It also arguably silenced public debate which could have been fostered had the issue been referred to a select committee. Many MPs thought it would be a good idea to pass the Bill on to the select committee stage so that it could be the subject of debate and public submissions, but this did not happen[69].

The Bill had also provided for a binding referendum to be held so that the public could have their say on the issue. Although the Bill did not get to this stage of the legislative process, the operation of binding referenda could have a significant effect on the future prospects of the reform of social issues. Where the requisite majority of voters have been in favour of an issue and this has been proved by referendum, the Bill concerned passes directly into law. This mechanism was developed for the new political climate under MMP.

The rejection of the euthanasia debate by Parliament was at odds with public opinion on the issue at the time. Laws had held a referendum in Hawkes Bay to gauge public opinion before he introduced the Bill to

---

[67]Correspondence with J Jones, Society President.

[68]NZPD, vol 528, 8725, 16 August 1995.

[69]See above n68, 8702.

LAW LIBRARY
VICTORIA UNIVERSITY OF WELLINGTON

Parliament. Of the 57% of adult constituents who voted, 79% supported euthanasia.[70] This result was consistent with that of a nationwide poll conducted by Morgan Gallup in September 1994.[71] This calls into question the nature of democracy and the role of Parliament. Surely the very purpose of representative democracy is that where the fully informed will of the people may be ascertained, it should be effected, as long as the resulting law is in the best interest of society. It seems that Parliament's distaste for the issue of euthanasia lead to an abdication of responsibility in this case.[72]

IX CONCLUSION

However difficult and distressing the issue of euthanasia may be, it will not simply go away because it is ignored. It is a practice which occurs now in many forms. The practice occurs illegally in our society and as such is unregulated. The potential for abuse is high in a system where the rules are secret to all but a few.

Euthanasia presents a unique challenge to the legislative process because it requires issues to be confronted which find their origin in times very unlike our own. It also requires a fine balancing between the interests of the State and those of individuals. Lastly, legislation which requires a set of strict rules and safeguards to be set up for a process as unpredictable and uncontrollable as the act of dying itself is almost impossible to prepare. Drafting for this issue presents its own set of dilemmas. However, since the tide of change calling for law reform has now begun, and is being swept along by sporadic judicial mutterings, it is imperative that legislators act now to ensure we have adequate safeguards to control common practice in vital areas. This is the function of the law.

The time has come for society to address the taboo of dying and all the issues which accompany it, and guidelines need to be provided for the regulation of society in the form of the codification of acceptable common practice. These guidelines must come in clear, express and authoritative terms. The guidelines must come from legislation, not from the self-regulation of medical practice and nor from the compassionate offerings of the judiciary.

It will be a mark of the strength of our society and of our legislative process if we rise to the challenge posed by euthanasia and work together

---

[70] The actual question was "should euthanasia be permitted for a person who is terminally ill and has given prior consent?"

[71] "Most Support Euthanasia in Hopeless Cases" *Time*, Auckland, New Zealand, 14 November 1994. A Colmar Brunton poll conducted soon after the Bill was introduced found support for the Bill to be at about 62%.

[72] See G Wehrle "The Death with Dignity Bill: The Ethics of the Bill and the Parliamentary Process by which it was defeated" (1996) VUW Honours Seminar, 13.

to create laws for a practice which has been disguised by rhetoric and convenience for too long. On the subject of euthanasia Lord Browne-Wilkinson was moved to state:[73]

> [I]t seems to me imperative that the moral, social and legal issues raised by this case should be considered by Parliament. The Judges' function in this area of the law should be to apply the principles which society, through the democratic process, adopts, not to impose their standards on society. If Parliament fails to act, then Judge-made law will of necessity through a gradual and uncertain process provide a legal answer to each new question as it arises. But in my judgment it is not the best way to proceed.

---

[73] *Airedale NHS Trust* v *Bland* [1993] 1 All ER 821, 879.

X BIBLIOGRAPHY

Statutes

Crimes Act 1961 (NZ)
Death with Dignity Bill 1995 (NZ)
Human Rights Act 1993 (NZ)
New Zealand Bill of Rights Act 1990 (NZ)

Medical Care for the Dying Bill 1995 (WA)
Medical Treatment Act 1988 (Vic)
Natural Death Act 1983 (SA)
Natural Death Act 1988 (NT)
The Rights of the Terminally Ill Act 1995 (NT)
Euthanasia Laws Act 1997 (Commonwealth Parliament of Australia)

Cases

Airedale NHS Trust v *Bland* [1993] 1 All ER 821.

Auckland Area Health Board v *Attorney General* [1993] 1 NZLR 235.

Compassion in Dying v *State of Washington* 49 F 3d 586 (9th Cir 1995).

Cruzan v *Director, Missouri Department of Health* 497 US 261 (1990).

F v *West Berkshire Health Authority* [1989] 2 All ER 545 (HL).

Frenchay Healthcare NHS Trust v *S* [1994] 2 All ER 403.

Griswold v *Connecticut* 381 (US) 479 (1965).

In the Matter of Karen Quinlan 355 A 2d 647 (1976) (NJ:SC).

Nancy B v *Hotel-Dieu de Quebec* (1992) 86 DLR (4th) 385.

Planned Parenthood v *Casey* 112 SC 2791 (1992).

R v *Adams (Bodkin)* [1957] Crim LR 365.

R v *Cox* Unreported, 18 September 1992.

R v *Novis* Unreported, 5 February 1988, High Court, Hamilton, T42/87.

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

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

Re C (adult: refusal of medical treatment) [1994] 1 All ER 819.

Re "Final Exit" [1993] NZAR 122.

Re G [1997] 2 NZLR 201.

Rodriguez v *AG of British Columbia* 107 DLR 4th 342 (1993).

Roe v *Wade* 410 US 113 (1973).

Schloendorff v *Society of New York Hospital* 211 NY 125, 105 NE 92 (NY 1914).

Journal Articles

M Ashby "Hard Cases, Causation and Care of the Dying" (1995) 3 JLM 152.

T Cipriani "Give me Liberty and Give Me Death" (1995) 3 JLM 177.

"Euthanasia - an international debate" NZMA Newsletter August 1994.

G Gillett "Ethical Aspects of the Northern Territory Euthanasia Legislation" (1995) 3 JLM 145.

L Gormally "Why the Select Committee on Medical Ethics of the House of Lords Unanimously Rejected the Legislation of Euthanasia" (Seminar Proceedings at St Vincent's Hospital, Sydney, 10 November 1995).

LR Henneveld "The long overdue debate: medical decisions near the end of life" (1994) 107 NZMJ 157.

I Illich "Death Undefeated" (1995) 311 BMJ 1652.

P Key "Euthanasia: Law and Morality" (1989) 2 AULR 224.

SF Kreiner "Does Pro-Choice Mean Pro-Kevorkian? An Essay on *Roe*, *Casey*, and the Right to Die" (1995) 44 AULR 803.

SAM McLean "Letting die or assisting death: how should the law respond to the patient in persistent vegetative state?" (1994) 11 Law in Context 3.

D Mendelson "The Northern Territory's Euthanasia Legislation in Historical Perspective" (1995) 3 JLM 136.

PE Mullen "Euthanasia: An Impoverished Construction of Life and Death" (1995) 3 JLM 121.

"Medical Consent: Indiana Supreme Court holds that Family may Terminate Treatment for a Never-Competant Patient in Persistent Vegetative State" (1992) 105 HLR 1426.

"The Dilemma of the Person in a Persistent Vegetative State: A Plea to the Legislature for Help" (1989) 54 MLR 645.

M Webb "The Politics of 'Medicide" in New Zealand: A Cautious Approach for Pysician Aid-in-Dying" (1994) 3 CLR 438.

G Wehrle "The Death with Dignity Bill: The Ethics of the Bill and the Parliamentary Process by which it was defeated" (1996) VUW Honours Seminar.

"Withdrawal of Nutrition and Hydration from Incompetent Patints in Missouri" (1989) 54 MLR 713.

Texts

Bioethics Research Centre *Proceedings of the International Seminar on Bioethics* (University of Otago, Dunedin, 1993).

AV Campbell (ed) *Persistent Vegetative State and the Withdrawal of Food and Fluids* (Bioethics Research Centre Report, Dunedin, 1993).

A Campbell, M Charlesworth, G Gillett and G Jones *Medical Ethics* (2ed, Oxford University Press, Auckland, 1997).

S Chapman and S Leeder (eds) *The Last Right? Australians Take Sides on the Right to Die* (Mandarin, Victoria, 1995).

D Cole *Medical Practice and Professional Conduct in New Zealand* (2ed, Roydhouse Publishing, Caterton, 1988).

D Cole *Medical Practice In New Zealand: A Guide to Doctors Entering Practice* (Medical Council of New Zealand, Wellington, 1995).

R Gott and R Linden *No Easy Way Out : The Euthanasia Debate* (Australian Issues Series, CIS Publishers, Victoria, 1993).

Hastings Centre *Guidelines on the Termination of life-Sustaining Treatment* (Briarcliffe Manor, New York, 1987).

K Healey (ed) *Life and Death Matters* (Issues for the Nineties, The Spinney Press, Sydney, 1994).
House of Lords *Report of the Select Committee on Medical Ethics* (HMSO, London, 1994).

B Jennett "The persistent vegetative state: medical, ethical and legal issues" in A Grubb (ed) *Choices and Decisions in Health Care* (John Wiley & Sons, Chichester, 1993).

J Keown (ed) *Euthanasia Examined : Ethical, Clinical and Legal Perspectives* (Press Syndicate of the University of Cambridge,UK, 1995).

D Lanham *Taming Death by Law* (Longman Professional, Melbourne, 1993).

JK Mason and A McCall-Smith *Law and Medical Ethics* (2ed, Butterworths, London, 1987).

Northern Territory Legislative Assembly "Report of the Inquiry by the Select Committee on Euthanasia" (1995).

I Parsons and Dr C Newell *Managing Mortality : Euthanasia On Trial* (Villamanta Publishing Service, Victoria, 1996).

President's Commission for the study of Ethical problems in Medicine and Biomedical and Behavioural Research. *Defining Death, Medical, Legal and Ethical Issues in the Determination of Death* (US Government Printing Office, Washington, 1983).

JR Vevaina, RC Bone and E Kassoff (eds) *Legal Aspects of Medicine* (Springer-Verlag, New York, 1989).

Digests

Black's Medical Dictionary (37ed, A&C Black, London, 1992).
Butterworths Law Dictionary (4ed, Spiller, Wellington, 1995).
Halsbury's Laws of England (4ed, Butterworths, London, 1980).
NZ Commentary on Halsbury's Laws of England (4ed, Butterworths, Wellington, 1985).
The Laws of New Zealand (Butterworths, Wellington, 1992).

Media Articles

"Anti-Euthanasia Vote Brings Bitterness" *The Dominion*, Wellington, New Zealand, 25 March 1997.

"Brain-Damage Man Not to be Revived" *The Weekly Telegraph*, London, England, 1 May 1996.

"Coma Victim Can Die, Rules Judge" *The Weekly Telegraph*, London, England, 1 May 1996.

"Doctor Death" *Time*, Auckland, New Zealand, 31 May 1993.

"Euthanasia Doctor Plans 'Coma Machine'" *The Dominion*, Wellington, New Zealand, 15 May 1997.

"First and Last, Do No Harm" *Time,* Auckland, New Zealand, 15 April 1996.

"Knowing When to Stop" *Time*, Auckland, New Zealand, 11 December 1995.

"Home Help is Cleared of Widow's 'Mercy Killing'" *The International Express*, London, England, 3 April 1997.

"Life and Death Struggles: Should a Brain-Dead Woman be Kept on life Support to Save Her Unborn Child?" *Listener*, Wellington, New Zealand, 10 February 1996.

"Man Who Killed Ill Wife Goes Free" *The Dominion*, Wellington, New Zealand, 10 May 1997.

"Voluntary Euthanasia Supporters Prepare For Long Battle " *The Dominion*, Wellington, New Zealand, 26 March 1997.

VICTORIA
UNIVERSITY
OF
WELLINGTON

LIBRARY

A Fine According to Library
Regulations is charged on
Overdue Books.

LAW LIBRARY

e
l Lewes, Alison
Folder Euthanasia
Le