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EUTHANASIA: THE LAW REFORM QUESTION

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I INTRODUCTION

Upon introducing the Death with Dignity Bill to Parliament MP Peter Brown stated:[1]

> I believe that everybody who has led a decent, law-abiding life is entitled, when their time has come, to die with dignity—to die in the comfort of their friends and family, and not to die a suffering, lingering death.

It was based upon this belief that he introduced the Bill, assuming that it was a necessary piece of law reform to enable euthanasia to be lawfully carried out. This essay will consider whether this assumption that law reform is necessary to achieve this aim is correct, and whether legislation in the nature of the Death with Dignity Bill is the best way to achieve this law reform.

In order to consider this question it must be asked whether the courts are already dealing adequately with this issue. Many cases that are essentially euthanasia cases have come before our, and other common law, courts. The charges brought are often less than murder, and sentences given are generally very lenient, considering that the cases involved the death of a person. In light of this, it would appear that the restrictions on euthanasia in our law are not particularly harsh or stringent, and maybe legislation is not needed. This discussion occurs in the first part of this paper. It sets out the current law in New Zealand in relation to what are essentially situations of euthanasia. This is explored further in relation to examples from case law, examining how the courts have dealt with these situations. The problems with this current law are then discussed, with the aim of considering whether change to law, in the form of legislation, is required.

Given the problems identified with the law as it is presently operating the second part of this paper looks to the best way to deal with the legalising of euthanasia, and whether the Death with Dignity Bill is a good way to achieve this. An examination of the Bill as to what it attempts to implement is carried out. This

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[1] (30 July 2003) 610 NZPD.

is followed by a brief discussion of whether the Bill is an effective way of solving these problems identified.

This paper is not concerned with the morality of euthanasia.[2]

A The Terminology

Euthanasia is a strongly emotive topic. It is essential that any debate is carried out using widely accepted definitions, to ensure that the arguments are presented, and received, in a helpful way. The manipulation of the differing conceptions of euthanasia presents a real problem in working towards a reasoned and informed debate. Some basic definitions have become accepted in widespread writings on the topic of euthanasia.[3] Euthanasia generally is regarded to be the killing of a person because it is believed to be in their best interests.[4] Distinctions are drawn between voluntary, non-voluntary and involuntary euthanasia, as well as between passive and active euthanasia.[5] Most debate on euthanasia is only concerned with voluntary, and limited non-voluntary, euthanasia, and legislation (proposed or enacted) internationally has reflected that. This is also the scope of the Death with Dignity Bill.

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[2] For discussion of the moral issues good sources are John Keown (ed) *Euthanasia Examined* (Cambridge University Press, Cambridge, 1995); Margaret Otlowski *Voluntary Euthanasia and the Common Law* (Clarendon, Oxford, 1997); *A New Zealand Medical Association Report of Euthanasia* available from the NZMA.

[3] For further discussion of these definitions see the NZMA report; Otlowski; Nicola Lacey and Celia Wells *Reconstructing Criminal Law* (Butterworths, London 1998) 481.

[4] This immediately excludes from the debate issues that arise in the arguments opposing euthanasia with regards to the policies in Nazi Germany. While these cases were called euthanasia, they were not carried out in the best interests of the patients and so were no more than murder.

[5] Voluntary euthanasia is where euthanasia is requested, and carried out as a result of that request. Non-voluntary euthanasia is where the patient is incapacitated to a degree where they are not able to request, or consent to, euthanasia. Involuntary euthanasia is where euthanasia is practised on a patient against their express wishes, or where they were able to give consent, but it was not enquired whether they did consent. Passive euthanasia is the withdrawal or withholding of life-sustaining treatment. In contrast to this, active euthanasia is the when an active measure, like the administration of a drug, is taken to bring about a patient's death.

II THE CURRENT PROHIBITIONS ON EUTHANASIA

Currently, according to the Crimes Act 1961, euthanasia is illegal by virtue of provisions against murder, aiding and abetting suicide, and failure to provide the necessaries of life by those under a statutory duty.

Section 167 sets out the primary provision in relation to murder. It holds that if the offender intends to cause the death of the victim, or if the offender intends to cause the victim bodily injury and is reckless as to whether death ensues, they will be guilty of murder.

Aiding and abetting suicide is made illegal by virtue of section 179 of the Act. It provides for a maximum term of imprisonment of 14 years for anyone who helps any person commit suicide.

Some people, including:[6]

> [e]very one who has charge of any other person unable, by reason of detention, age, sickness, insanity, or any other cause, to withdraw himself from such charge, and unable to provide himself with the necessaries of life,

are under a duty to provide another with the necessaries of life. Any omission to perform that duty results in criminal responsibility. This liability for omissions clearly applies to doctors.

Another section of the Crimes Act applicable when discussing cases of euthanasia is section 164. This section provides that any person that by any act or omission hastens the death of someone suffering from some other disorder or disease, is legally responsible for killing that person.

Finally an important point with regards to euthanasia is that section 63 provides that "[n]o one has a right to consent to the infliction of death upon himself".

III THE CURRENT LAW IN ACTION

By examining the way the courts have dealt with euthanasia cases it is possible to assess whether this piece of legislation is necessary law reform. Few cases that come before common law courts are openly admitted to be euthanasia cases. However, this section examines cases, which are on their facts cases of euthanasia, explores how the court dealt with the issue, and whether this removes the need for legislation making euthanasia legal. These cases can be broadly grouped into four categories, cases of assisted suicide, compassionate killing of a loved one, so-called "passive" euthanasia cases, and cases of necessity.

A Assisted Suicide Cases

The first category of euthanasia cases that has faced determination in common law courts are those of assisted suicide. These cases can be classed as euthanasia because they are about people, who are suffering from some form of illness or injury, and who request help because they want to die but lack the ability to kill themselves. A classic example of this scenario is the case of *R v Ruscoe*.[7]

Warren Ruscoe was charged with aiding and abetting suicide after he helped his best friend Gregory Nesbit kill himself.[8] Nesbit suffered an accident on a building site in England that the pair was working on. He was rendered tetraplegic, with no hope of recovery. He often talked of killing himself, but given his lack of ability, starving himself was the only possible means. To avoid this the pair came up with a plan that involved the help of Ruscoe. Ruscoe placed about 50 pills in Nesbit's mouth and provided him with water, enabling him to swallow them. They then drank some whiskey together, reminiscing. Once Nesbit was asleep, Ruscoe placed a pillow over his face, to ensure death.

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[6] Crimes Act 1961, s 151.
[7] *R v Ruscoe* [1992] 8 CRNZ 68 (CA) Cooke P for the Court.
[8] The fact that he was not charged with murder in itself suggests something about the discretion being exercised by prosecutors in cases of this nature.

1 How the courts dealt with the case

Ruscoe was convicted of aiding and abetting suicide, which carries a maximum sentence of 14 years' imprisonment. He was sentenced to nine months in prison. Upon appeal, the Court of Appeal held that there was no requirement to impose imprisonment for charge of aiding and abetting suicide "nor indeed even for mercy killing".[9] He was therefore sentenced to one year's supervision and counselling and/or treatment as directed by probation officer. They regarded the cases that would not require a custodial sentence to be "very exceptional".[10]

The court based this decision on Ruscoe's compassionate motives and the problems he faced in his life, as a result of Nesbit's death.[11] Nesbit's family's support of Ruscoe was also mentioned. They considered the trial judge's ruling that he was under a duty "to demonstrate to you and to others who may be similarly minded that society by its law does not tolerate it and cannot excuse such behaviour".[12] They went on to deny that such a duty, based on the sanctity of life and deterrence, exists.

2 Issues raised by this judgment

The obvious problem with this result is that it provides no denunciation or general deterrence, factors which are generally given substantial weight in sentencing decisions. Ruscoe broke the law. He assisted in his friend's suicide, something that the law usually treats very seriously. However the treatment of his case by the Court of Appeal would suggest that in these circumstances assisting suicide is an acceptable thing to do. This leaves in doubt in what circumstances the crime of assisting suicide should go unpunished, which creates uncertainty as to the application of the law and presents a difficulty for people in a similar

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[9] *R v Ruscoe*, above, 72.
[10] *R v Ruscoe*, above, 71.
[11] The implication being that the depression and alcohol abuse problems that Ruscoe was suffering from after these experiences, stemming from the pain of helping his best friend die were punishment enough and that imposing a sentence of imprisonment would serve no purpose.
[12] *R v Ruscoe*, above, 71.

situation trying to predict their liability. Therefore, although the courts dealt effectively with this euthanasia case it has created the problem of uncertainty in the application of the law prohibiting assisting suicide.

There is also a difficulty reconciling the judge's reasoning with the general rule that motive plays no part in criminal liability. It would seem obvious that the fact that Ruscoe was attempting to help his friend out of an unhappy situation, and acted through feelings of love and compassion was taken into account by the judge when making his sentencing decisions.

B Compassionate Killing Cases

The second class of euthanasia cases that have come before our courts are the compassionate killing cases. In these cases the 'victim' is a relative or loved one of the person charged, and they are killed because the killer believes it is what they would have wanted. The element that distinguishes these cases from the assisted suicide cases is that the 'victims' are not able to express the desire to die themselves, due to incapacity.

A recent example of this class was the case of Rex Law, who killed his Alzheimer-suffering wife in 2002. The Laws had made a pact years earlier, agreeing that if either were to get Alzheimer's the other would 'do them in'. Mr Law gave his wife a quantity of sleeping pills, hit her over the head with a mallet, and held a pillow over her face. He then attempted to take his own life. The next morning he reported what he had done to the Police. He was found guilty of murder, but under the provisions of the Sentencing Act 2002 was given a sentence less than life, being sentenced to 18 months' imprisonment. [13]

The sentence imposed was given with regard to the purposes of sentencing. Randerson J focussed on denunciation of the acts done and deterrence for the wider community on as being the relevant and pertinent aims of sentencing

[13] *R v Law* [2002] 19 CRNZ 500 (HC) Randerson J.

for the facts of the case.[14] Randerson J's concern in sentencing came strongly from a point of view of condemning the act of euthanasia (not that he called it such) of Alzheimer's sufferers for the benefit of the public, not from any particular desire to punish Law or hold him to account, acknowledging that the loss of his wife was punishment greater than the court could impose and that he had taken responsibility for his actions.

The mitigating factors Randerson J identified included Mr Law's age and state of health, the compassionate and trying circumstances surrounding the case, Mr Law's guilty plea, his acceptance of responsibility, his evident remorse, and his previous good character.[15]

By the imposition of this sentence for a conviction for murder, the courts appear to be saying that while Law did not really need to be punished a sentence of imprisonment was required to illustrate the wrongfulness of killing another person. The problem with this is that Mr Law was sentenced to 18 months in prison to serve as an example for other people. The imprisonment was not designed to be a personal punishment. This would imply that there was nothing wrong with Law acting as he did, in those particular circumstances.

C The Withholding Treatment Cases

The cases of so-called "passive euthanasia" or the withholding treatment cases usually apply in relation to doctors. These cases are ones where the deceased had some form of life-threatening illness or injury but was being kept alive by the medical profession. The act of withholding treatment, like a life-support or ventilation machine, effectively brings about the death of the patient, however this is rarely prosecuted. In this way, "passive euthanasia" is part of our law. A problem in the way this operates now however, is that decisions to euthanise patients are generally carried out in line with what is medically best for

[14] This is especially interesting in the light of sentencing decision in *Ruscoe*, both judges seemed to feel similarly about the offender's culpability, yet while Cooke P ignored denunciation and general deterrence to allow Ruscoe to escape imprisonment, Randerson J felt that it was precisely because of these factors that he had to sentence Law to a sentence of imprisonment.

the patient, rather than based on any indication of what the patient might want, as would be more consistent with a true idea of euthanasia.

A very useful judicial discussion of this practice occurred in *Auckland Area Health Board v Attorney-General*.[16] This judgment of Thomas J was a declaratory judgment sought by the hospital and doctors treating Mr L. Mr L suffered from Guillain-Barre syndrome. This disease shuts down the body's nerves, rendering the sufferer completely paralysed, however, their brain remains functioning. Although the heart and lungs stop functioning the patient's brain stem is still active, meaning that medically the patient is still alive. Life support and ventilation systems are set up to keep the brain supported.

The doctors treating Mr L wanted to withdraw the ventilation system maintaining his brain. There was no chance of Mr L improving and once the treatment was withdrawn death would be painless and instantaneous. His doctors sought, and received, eight specialist medical opinions that the treatment was not medically justified. Mr L's wife also agreed with the withdrawal of treatment.

1 How the courts dealt with the case

Thomas J gave a declaration stating that if the doctors withdrew the treatment they would not be found guilty of culpable homicide. This determination required that they conclude that there was no reasonable possibility of Mr L recovering, there was no medical or therapeutic benefit to continuing treatment, withdrawing life support constituted good medical practice, and Mrs L and the ethics committee of Auckland Area Health Board agreed.

He based this decision on two major points: the duty to provide the necessaries of life, and the question of lawful excuse. He also discussed the question of whether the doctors, by removing the life support systems, would be causing Mr L's death, or whether his death would be caused by the underlying

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[15] *R v Law*, above, 509-10.
[16] *Auckland Area Health Board v Attorney-General* [1993] 1 NZLR 235 (HC) Thomas J.

condition, Guillain-Barre syndrome. He stated that if it was held that the life support did not constitute a necessary of life, or if it did but the doctors had lawful excuse in refraining from providing this necessary, they would be held to have not caused Mr L's death.

Thomas J ultimately concluded that the life support system was not a necessary of life, and therefore the doctors treating Mr L were not under a duty to provide that system. He stated that "the provision of artificial respiration may be regarded as a necessary of life where it is required to prevent, cure or alleviate a disease that endangers the health or life of the patient".[17] He went on to say that in this case, as Mr L was only alive because the system was inducing his heartbeat and breathing, and was otherwise beyond recovery, the ventilator could not be understood to be a necessary of life. This conception of a life support system as a necessary of life only if it maintains the body while there is a chance of the body recovering to regain this ability itself is very effective at drawing the line of when doctors are under an obligation to provide the artificial treatments that are available to patients.

This distinction is also helpful when considering ideas of acts or omissions, with regards to whether a doctor does a positive act, thereby causing a patient's death, or whether a doctor omits to provide treatment, thereby letting the underlying disease cause a patient's death. This case effectively classifies preservation of life for no therapeutic or medical purpose as death being deferred. In this way the treatment is only holding off what would naturally happen, and therefore an omission to provide this treatment results in death caused by the disease.

Despite finding that the doctors were not required to provide the life support Thomas J held that, in any case, the doctors would not be acting without lawful excuse. He based this on the decision that they have a lawful excuse when "there is no medical justification for continuing that form of medical assistance".[18]

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[17] *Auckland Area Health Board v Attorney-General*, above, 249.
[18] *Auckland Area Health Board v Attorney-General*, above, 250.

Discontinuation is lawful if it accords with "good medical practice". Thomas J acknowledged the difficulty of coming up with an acceptable definition of the concept of good medical practice so stated that it will depend on the circumstances of each case and the medical opinions prevailing at the time.[19]

The core concept that comes from this analysis is that acting within "good medical practice" could at no time be acting "without lawful excuse".[20] While this provides a very useful tool for deciding when doctors' actions that border on euthanasia are excused by the law it leaves open the question of whether doctors are required to do those actions in similar cases. The case does not answer the question raised by this scenario of whether had these doctors decided, against good medical judgement, to keep Mr L alive, his family would have been able to prosecute (perhaps on a charge of assault), based on the idea that they were acting without lawful excuse.

Thus, by holding that the life support system was not a necessary of life, due to the fact that it was not merely sustaining Mr L's body while he suffered from a condition that stood a good chance of improvement; and that by acting in accordance with good medical practice the doctors were not acting without lawful excuse, Thomas J held that the doctors would not be prosecuted for culpable homicide if they removed Mr L from the life support mechanism. He further discussed the impact of this on the question of causation by saying, [21]

> it can only be said that the withdrawal of the ventilatory system is not the cause of death as a matter of law if and when one or other of the two primary conditions have been met, that is, the doctor is not under a duty to provide the ventilator as part of the necessaries of life or has a lawful excuse for declining to do so.

On the basis of this case it would appear that New Zealand law allows passive euthanasia in the form of withdrawal of treatment where the condition the patient is suffering from is not going to improve, and where it is good medical

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[19] *Auckland Area Health Board v Attorney-General*, above, 250.
[20] *Auckland Area Health Board v Attorney-General*, above, 251.

practice (a determination of which is helped by other specialist opinions, the consent of an ethics committee and the consent of the patient's family).

2 Issues raised by this judgment

In this way the courts were able to effectively deal with this type of fact scenario. Through the doctors acting as they did Mr L was provided with relief and those treating him avoided criminal sanctions. However, the situation Mr L was in is very restrictive. It raises questions as to what would have happened had Mr L not been reliant on a ventilator to survive; would the doctors have been allowed to administer a lethal injection? It would also be a stretch to apply this analysis to terminally ill patients. Attempt could be made to argue that doctors would not be acting without lawful excuse if they were to provide lethal quantities of a drug to a terminally ill patient, based on there being no medical justification for keeping that patient alive. However, as the administration of the drugs would not be classed as neglecting to provide the necessaries of life, the argument that the doctors were not acting without lawful excuse would not provide relief.

Therefore, although the court's decision adequately protects those in the same situation as the doctors treating Mr L, this decision is not likely to provide relief on a wider scale. Another difficulty with this approach is that for a time the doctors treating these patients would have to bring applications to the court, as was done in this case, until enough of a body of cases was built up to enable them to accurately predict their liability. This would of course entail the requisite costs, and the time involved could be crucial for the patients.

A more fundamental issue raised by this scenario is that of consent. This decision raises the possibility that doctors, provided that the treatment is found to be not a necessary of life and that there is no medical justification for continuing treatment, could remove treatment from a patient regardless of whether they consented or without consideration of whether they would have consented had they had the ability. In *Auckland Area Health Board* Mr L's wife was in

[21] *Auckland Area Health Board v Attorney-General*, above, 254.

agreement with the withdrawal of treatment, and while the judge commented on this it is unclear how necessary this fact was to the final decision.

In these ways the current law, while dealing adequately with this specific fact situation, is insufficient to provide relief to the greater number of patients for whom relief would not just be a matter of removing treatment. It would therefore seem that although legislative reform may not be necessary to allow the withholding treatment cases analogous to this one, it is necessary for wider application.

D Necessity Cases

The fourth class of euthanasia case at common law are those involving questions of necessity. Most of the discussion involving necessity as a defence to euthanasia has come out of Canada, especially following the *Latimer* case.[22] The idea behind this class is that when someone is faced with treating a dying patient the weight of the circumstances should be taken into account in determining whether this should entail a defence to murder. In this way rather than legalising euthanasia it would be a means of fitting it under the structure of a defence already in existence.

It is commonly held that the defence of necessity does not apply to murder.[23] This is because one of the requirements of the defence is that the harm imposed cannot be greater than the harm sought to be avoided. This would mean that killing someone would never be a lesser harm than not gaining the benefit of your actions would be. However, it is not difficult to imagine situations where someone might say, "Death would be better than this". There are some instances where the harm caused to a person by keeping them alive is greater than the harm that killing them would cause. Opponents of this could argue that the harm to society is greater in carrying out euthanasia than letting them die without

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[22] *R v Latimer* [2001] 1 SCR 3 (SCC) Judgment of the Court.

[23] For a discussion of the development of the law relating to the defence of necessity see Brooke LJ's judgment in *In re A (Children) (Conjoined Twins: Surgical Separation)* [2001] Fam 147 (CA).

intervention. However, ignoring the plight of these sufferers for society's "moral good" raises questions about the cost of upholding this morality, and indeed whether such treatment of society's dying would in itself have a profoundly negative impact on society's "moral good".

A compelling example when looking at the necessity cases is that of Dr Nancy Morrison, a doctor from Nova Scotia, Canada. Her case involved the death of the patient Paul Mills, who was dying of cancer. Following several operations, one removing his oesophagus, Mr Mills was struggling with infection and other effects of the operations. The doctors treating him came to the decision that nothing more could be done for him, and it was agreed with his family that the dying process should be allowed. Mr Mills was extubated (the tube carrying air down his throat was removed) at 12:30 on 6 November 1996. Until 2:30 Mr Mills gasped for air, apparently in great distress and pain, despite the very large quantities of Dilaudid, Ativan and some morphine that were being administered to him through an IV line. Just before 3 pm Dr Morrison administered Mr Mills with a syringe of nitroglycerine, in an attempt to lower his blood pressure and reduce his distress. Then at around 3 pm she gave Mr Mills, via IV-push, 10cc's of potassium chloride, which has the effect of stopping a patient's heart. Potassium chloride has no pain relieving purpose, and generally its only use in medicine is to stop a patient's heart during open-heart surgery. Within seconds of Dr Morrison administering this via IV-push, Mr Mills' heart stopped and he died.

1 How the courts dealt with the case

At the preliminary hearing of Dr Morrison's case for murder[24] (although the Crown suggested that the actual charge would be manslaughter), Crown witness Dr Barker gave evidence that the amount of painkilling drugs being given to Mr Mills was within the lethal range and that it was extremely unusual and extraordinary that they were not having an effect on relieving Mr Mills' distress. He raised the possibility that the IV line had become dislodged from Mr Mills' vein, with the result that the drugs were merely going into his body cavity.

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[24] *R v Morrison* (27 February 1998) Nova Scotia Provincial Court 720188 Randall Prov J.

The preliminary inquiry judge, Judge Randall, held that there was not sufficient evidence that would allow a properly instructed jury to convict Dr Morrison, and therefore discharged the case. He based this on the question of causation. The defence argued that as it appeared that the massive doses of painkillers being administered to Mr Mills were not reaching his bloodstream, the IV line must have been detached, meaning that the potassium chloride was also not reaching Mr Mills' bloodstream, and therefore there were significant questions as to whether this actually caused his death. Presumably this is the argument upon which Judge Randall dismissed the case. Upon appeal to the Nova Scotia Supreme Court Hamilton J held that while this conclusion was wrong, it was entirely within the judge's jurisdiction and therefore could not be overturned.[25]

2 Issues raised by this judgment

The problem with this case is that the preliminary inquiry judge ultimately made a mistake. He distorted the test that he was required to apply in determining whether the case should go to trial thus allowing the case to be dismissed, presumably out of sympathy for Dr Morrison and a belief that she should not face charges because of her actions. Judge Randall undertook a weighing of the evidence and decided that she should not face charges, however, the fact remains that Mr Mills died within a minute of the potassium chloride being administered; a drug that was designed to stop his heart and, prima facie, had that very effect. While the dislodged IV causation argument perhaps held some merit, there were other theories as well.[26]

The case is also interesting in that when Judge Randall threw out the possibility of a murder charge, he also excluded from trial all lesser charges, including manslaughter and attempted murder. The attempted murder charge is especially interesting, given that even had the potassium chloride not caused Mr

[25] *R v Morrison* [1998] NSJ 441 (NSSC) Hamilton J.

Mills' death, Dr Morrison still injected him with it, presumably with the intent of killing him, as there was no other reason why potassium chloride would be administered to a patient in this situation.[27]

It has been argued that this case would have been covered by the defence of necessity, had it gone to trial.[28] Accepting a necessity defence in this case would have been a dramatic step for the courts, given that it is not regarded to be a defence for murder, however the argument would have run as follows.

The decision had been made that Mr Mills was going to die. Massive doses of painkillers were being administered to him in an attempt to relieve his distress and ensure that he died in no pain and as peacefully as possible, unconscious if need be. These painkillers were not having the expected effect and Mr Mills was dying in agony. The nurse responsible for treating him, Elizabeth Bland-MacInnis, gave evidence that his was the worst death she had ever experienced in her professional career. By injecting the potassium chloride Dr Morrison was making a conscious decision to administer a substance that was going to kill Mr Mills. In this way she was attempting to bring about the inevitable in a way that was faster and less distressing for all involved. This is obviously a case where one could argue that she was acting under necessity.

The three requirements of necessity (set out in *Perka*, the defence explained by Dickson J as that those actions which are "normatively involuntary" should not be punished) are that the accused faced a situation of imminent peril, there was no legal reasonable alternative, and that the harm caused was not disproportionate to the harm sought to be avoided.[29] In this case Dr Morrison certainly faced a situation of imminent peril. She was confronted with a patient dying a horrible death. As the doctor on duty in charge of treating Mr Mills it was

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[26] Barney Sneiderman and Raymond Deutscher "Dr Nancy Morrison and her dying patient: a case of medical necessity" (2002) 10 Health LJ 1.

[27] It has been on an attempted murder charge that other doctors who have administered KCl to dying patients have been prosecuted. See the discussion of *R v Cox* in Sneiderman, above.

[28] Sneiderman.

[29] *R v Perka* [1984] 2 SCR 232 (SCC) Dickson J.

her responsibility to ensure that he did not have to suffer unnecessarily and to do her utmost to remove his distress.[30]

Given the circumstances it was obvious that merely increasing the volumes of painkillers being given to Mr Mills was not a viable alternative.[31] The question remains as to whether Dr Morrison should have checked whether Mr Mills' intravenous line had come loose from his vein. In *Perka* Dickson J said, on the question of reasonable alternatives, "the question to be asked is whether the agent had any real choice: could he have done otherwise?".[32] On this basis it is possible to suggest that the test is a subjective one; Dr Morrison could not be expected to check anything that she did not think would be a problem. In any case further evidence relating to the common practice of doctors regarding dislodged IV lines would be necessary before deciding whether she should have thought to check the line. There is also the argument that presumably if the line was dislodged the potassium chloride, which was administered by IV-push, would not have had such a rapid effect had the line not been leading to a blood vessel. This suggests that checking the line was not a reasonable alternative.

The question of proportionality generally provides a stumbling block to the application of the defence of necessity to serious crimes, and indeed has always prevented its application to cases of murder. However, in this case the different options facing Dr Morrison with regard to the death of Mr Mills are a lot more compelling. By administering the potassium chloride the harm caused (assuming that it was the cause of death) was the immediate death of Mr Mills. The harm avoided was Mr Mills further suffering to a long, drawn-out, distressing and painful death. In both cases death was unavoidable; the only variable was the

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[30] However, the problem with this is that generally it would be understood that this duty only extends up the point of those things that can be done for a patient short of administering a lethal injection.

[31] Also, given that the volumes being administered were already in the lethal range it is somewhat ironic that had she increased the volume and he had died as a result she would not have been charged with his murder.

[32] *R v Perka*, above, para 41.

suffering of Mr Mills. In these circumstances it is easy to imagine a court holding that the harm caused was not disproportionate to the harm sought to be avoided.[33]

Thus, although the discretion of the trial judge operated in this case to avoid placing Dr Morrison on trial, it is a possibility (albeit a tentative one) that had the case gone to trial the defence of necessity would have been extended to cover this case.

IV SO, WHY SHOULD WE CHANGE THIS?

It can be argued, based on the examples above, the law is working adequately to exercise the requisite leniency and ensure that those who commit crimes that are essentially euthanasia are not receiving excessive sentences. In the light of this the obvious question is, why is the argument being made that law reform is necessary? It is because it will achieve four main things: greater accountability, less uncertainty, prevention of further damage to the credibility of the legal system, and the reduction of the strain the law as it currently operates places on those involved.

A Accountability

Euthanasia is often performed by friends and relatives, often with a pecuniary interest in the estate, or by a doctor acting individually. A major benefit of legislative reform would be that the practice of euthanasia would be brought into greater scrutiny. As Sorell has said, "it is important for people to be able to justify to themselves and to other people what they are prepared to do".[34] Decisions would have to be made by the guidelines laid out in the Bill, and greater accountability would ensure that the decisions being made truly were in the best interests of the patients. It would also provide greater safeguards to ensure that

[33] A court, if they were looking to avoid the application of necessity to murder, could put the harm caused in terms of the damage caused to society by holding that doctors had the ability to administer a lethal injection in some situations. However a more realistic, and certainly more compassionate, way of looking at it would surely be to conceptualise the harm in terms of the individuals involved.

[34] Tom Sorell *Moral Theory and Capital Punishment* Blackwell 1987, p 2, in Lacey p 525.

those requesting euthanasia were not doing so as a result of depression or a mental illness.[35]

This need for openness and accountability is especially relevant with Alzheimer's when the concern is that when relative caregivers kill their charge it is to remove them of the burden of caring for someone who treats them badly and no longer recognises them. By bringing situations like this into a controlled, legislatively enacted, method it can only improve rational decision-making and accountability.

B Certainty

At this time anyone who carries out euthanasia then has to take their chances with the run of the justice system. A lot rests on the exercise of discretion by the prosecutors, judges and juries. Legislative law reform would clearly lay out what is acceptable and what is not, with systems in place by which euthanasia would be procured. Breaches of the procedural safeguards would be the cause of an offence, with penalties laid out in the legislation.

The major benefit of this certainty would be that the same requirements would apply to comparable patients regardless of the illness they are suffering from, and regardless of the treatment required to euthanise them.

C Credibility of the justice system

A major problem with the law as it stands is that the courts are continually manipulating and stretching the bounds of the criminal law in order to allow greater leniency for defendants in euthanasia cases. This was especially apparent in *Morrison* where the preliminary trial judge clearly acted outside the bounds of his duty, and in so acting allowed Dr Morrison to avoid trial.

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[35] This imposes a stricter standard on those requesting assistance under the Bill than those who are capable of committing suicide themselves, who are at law allowed to do so regardless of any mental illness. However, the policy concerns of a legislative regime that would allow mentally ill to receive euthanasia, rather than receiving assistance with their mental health issues, are obvious.

With legislative reform, further stretching between criminal theory and practice will no longer be necessary. The existing offences and defences will retain their present shape as they continue to do what they were drafted to do, without the danger of the courts inadvertently making legal more than they intended. To prevent this damage to the justice system through the case law it is better that the legislature provides the boundaries, and the express borders of euthanasia.

Also given that a large degree of discretion on the part of prosecutors, judges and juries is required to achieve the results that the justice system has been accomplishing, it is by no means likely that people carrying out euthanasia are receiving equal treatment by the system.[36]

D Strain on actors involved

A legislatively-established system would also reduce the level of strain situations like these place on those who feel compelled to help their loved ones. It would establish mechanisms, carried out by trained and supported professionals, to avoid placing friends or family in the difficult situation of having to break the law and risk punishment to help. Although Warren Ruscoe did not receive any time in prison, he was still left with a criminal record, and struggling to deal with what had happened. By bringing the process out into the open it enables all involved to deal with it less covertly and places less strain on friends and family.

There is also the factor that their lack of knowledge of how to best achieve results, or difficulties with access to effective drugs leads to euthanasia being carried out in a less than ideal manner. This is especially noticeable in the case of Olga Law. Under a legislative system of euthanasia she would have been killed in a non-violent, painless, peaceful and well-planned manner by a qualified person, without the extreme level of stress that this situation placed on her husband.

Another concern with the law as it presently stands is that these people who are acting out of compassion often have to carry the label of murderer, and many are spending time in jail. Doctors who help their patients in this way face losing their licence. Ideally a new system would give these people an option by which they can act in accordance with their conscience and compassion for the 'victim' and yet avoid criminal sanctions and labels.

V WHAT THE DEATH WITH DIGNITY BILL PROVIDES

So, if it accepted that legislative law reform is necessary, the next step must be to examine the Death with Dignity Bill towards the end of determining whether it is an effective tool for solving the problems in the current law.

The Death with Dignity Bill was first introduced to Parliament, and rejected, in 1995. Peter Brown MP reintroduced it in 2003. It failed to pass its first reading by 60 votes to 57. In essence the Bill would allow for physician-implemented euthanasia for terminally and/or incurably ill people who request it. The inclusion of relief for incurably (and not just terminally) ill people and the provisions to allow for advance directives as consent to euthanasia set the Bill apart from many other examples of euthanasia legislation that have at various times been touted, or passed, around the world. The Bill requires consent from the patient on the basis of full knowledge of the disease, its effects, the treatment to be given and its result. It requires a determination by two physicians, with input from a psychiatrist and a counsellor.

Clause 9 sets out the requirements of the practitioner that the request is made to. S/he would be responsible for initially determining whether the patient has a terminal or incurable illness, determining whether the request was made voluntarily, informing the patient of their diagnosis, prognosis, risks of the medication, the probable result of the medication and feasible alternatives,

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[36] As discussed above, this is very noticeable in a comparison of *Ruscoe* with *Law*. The sentence they each received was dependent on the judge exercising his discretion, and resulted in two

referring the patient to a consulting medical practitioner, a psychiatrist and a counsellor, requesting that the patient notify next-of-kin, informing the patient of their right to rescind the request, verifying before the final step that the request is voluntary and informed, and ensuring that the Act is followed.

The consulting medical practitioner would be required to confirm the diagnosis and prognosis and that the patient is suffering from a terminal or incurable illness, verify the request is voluntary, and advise the patient of alternatives. If the consulting medical practitioner disagreed with any of the findings made by the attending medical practitioner the request is void.

The Bill would also require that the patient be referred to a psychiatrist, who would conduct an assessment of the patient's mental state. If the patient was found to be suffering from a mental disorder, or clinical depression that would impair judgement the request is void. A counsellor must discuss the request and its implications with the patient.

A major provision in the Bill, and one that is unusual in proposed euthanasia legislation, is that providing for the ability to be euthanised on the basis of an advance directive. There are several operational, and ideological, problems with this provision; however it is a solution to problems that arise from someone's incompetence or inability to communicate their wishes.

Schedule 2 of the Bill provides the template for an advance directive. It enables someone to request for themselves euthanasia in the event of them being rendered mentally incompetent as a result of four different conditions. It sets out that the requester, if they should develop "senile, severe, degenerative brain disease", "serious brain damage", "advanced terminal malignant disease that renders any intelligible or understandable communication with others void", or "severely incapacitating and progressive degenerative disease of the nerves or muscles", and that they have become mentally incompetent to express their

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different outcomes for comparable offenders.

opinion about their condition, and that two independent doctors regard their condition to be irreversible, will be euthanised.

VI WILL THE DEATH WITH DIGNITY BILL FIX THE PROBLEMS?

In order to examine how the Bill would apply in practice this section returns to the examples used above to enable a determination on whether it improves the situation of the law as it stands.

A Gregory Nesbit

If the Death with Dignity Bill had been in force Nesbit could have requested that his doctor end his life, on the basis that he was suffering from an incurable illness and experiencing pain, suffering and distress to an extent unacceptable to himself. This fact situation outlines the benefit of incurable illness being included in the Bill, rather than just the terminal illness requirement that is common in many jurisdictions.

There may be some question as to whether paralysis comes under the definition of incurably ill. The Bill sets out that incurably ill means "a medical condition which is generally accepted by the medical profession as seriously impairing the person's quality of life and unlikely to be capable of cure, either at the present time or in the reasonable future". Nesbit's tetraplegia was seriously impairing his quality of life, and no cure is available now or likely in the reasonable future. On this basis it can safely be assumed that the Bill will cover cases of paralysis.

As many paralysed people suffer from some form of depression, the requirement that by requesting assistance under the Bill he would have been assessed by a psychiatrist would have been a good thing. This would have ensured that Nesbit's requests to die were not due to a mental illness, which hopefully could be treated through less extreme measures.

B Olga Law

To obtain relief under the Death with Dignity Bill, Olga Law would had to have signed an advance directive, prior to her developing Alzheimer's. If she did not have an advance directive there would not be any legal option for Mr Law and if he was not prepared to let the disease take its natural effect he would have faced exactly the same situation. If he followed the same course it would be up to the courts to decide how they would deal with this situation, however, it is possible to conceive that the courts would take a much less lenient stance on euthanasia if there was a legal route of achieving the same objectives. However, the presence of a law would not change the moral righteousness of what Mr Law did, and the court, by setting out the reasons for prescribing the penalty it did implied that Mr Law was acting in a morally unobjectionable manner. The argument could be raised that he should not face greater punishment just because of the presence of an Act. Although, the courts may find that the general deterrence factor is of even greater effect by using this case to highlight to the public that it is only within the confines of the law that euthanasia may be practised.

This scenario also raises another point about the medical method of euthanasia that the Bill provides for. Many objections to euthanasia come from the point of view that doctors, who primarily are responsible for saving lives should not be involved in procuring the death of a patient.[37] Either due to this belief, or through a desire for a loved one to administer their death it is not unimaginable that someone who wanted euthanasia might want it to be carried out by a family member. This raises further questions about the extent for euthanasia outside of the mechanism provided for in the Bill, should it become enacted.

This is where a large measure of the 'wait-and-see' approach becomes necessary. Until cases of euthanasia that were not carried out within the framework of any reforming legislation came before the courts it would not be possible to predict how leniently the courts would view any cases of this nature.

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[37] Margaret Otlowski *Voluntary Euthanasia and the Common Law* (Clarendon, Oxford, 1997); *A New Zealand Medical Association Report of Euthanasia* available from the NZMA.

However, given that a great benefit of having cases of this type brought inside a euthanasia law is that there would be greater accountability in the actions of those assisting people who request help to die, it would seem incongruous if the courts were to allow the practice to continue to occur outside the safeguards provided by legislation.

C Mr L

Under the Death with Dignity Bill Mr L would either had to have made his request at a stage earlier than this application was filed in the courts, or have written an advance directive. If Mr L had completed an advance directive the situation he was in at the time the application to the court was filed would have been sufficient to activate the directive due to part (d) of the Schedule 2 form: "severely incapacitating and progressive degenerative disease of the nerves or muscles". His doctors and family would have no difficulty in fulfilling the rest of the requirements in the Bill and Mr L would be eligible for euthanasia.

If Mr L did not have an advance directive to obtain relief under the Bill he would had to have made a request for euthanasia at the stage where he could still communicate. The difficulty with this is that in making the request the patient needs not only to be suffering from a terminal or incurable illness, which Mr L was, but needs to be "experiencing pain, suffering, or distress to an extent unacceptable to the patient". If Mr L made a request at a stage when he could still communicate it is conceivable that any suffering or distress he was experiencing was a result of the anticipation of what he would be going through in the future. It seems unlikely that this would be held to fulfil the conditions under the Bill. However, in reality this request would take the form of an advance directive, the only concern being that he would then have to undergo a degree of distress as his nerves gradually shut down and he lost the ability to communicate.

Providing that the courts ignored this obstacle Mr L should have been able to obtain relief under the Bill. However, this is an unattractive solution. Given the delicacy of the subject matter of this Bill ideally it would result in euthanasia

being carried out strictly within the guidelines set out by the Bill. It would be a disagreeable situation to require the courts to adopt an approach that required them to examine the intent behind the words, rather than allowing everyone the security of what being allowed set out strictly in the Bill.

Of course there remains the possibility that should euthanasia legislation be passed, and there is a difficulty fitting cases of this nature into that legislative structure, the courts continue to classify these situations as something other than euthanasia, and continue to apply the law as set out in this case.

D Paul Mills

Mr Mills' situation is similar to that faced by Mr L in *Auckland Area Health Board*, in that he would either had to have signed an advance directive, or have requested assistance prior to the time when Dr Morrison was required to act, as he was not mentally competent at that stage. Had Mr Mills signed an advance directive he would have been eligible for help, as he was suffering from an "advanced terminal malignant disease", rendering "any intelligible or understandable communication with others void". If he did not have an advance directive he would had to have requested assistance to die at a stage when he could still communicate. Once again, like Mr L, the question is raised as to whether the "pain, suffering, or distress to an extent unacceptable to the patient" that led to him making the request is more attributable to his knowledge of future distress. However, given that he had cancer, had undergone several operations, and had major infections in his abdomen, it is likely that at the time when he could still communicate he was already in large amounts of pain. Therefore, it appears that the Death with Dignity Bill would cover situations such as Mr Mills' effectively.

E An improvement?

The legislative reform would certainly ensure greater accountability in situations of euthanasia. By providing for a medical model for the legalisation of

euthanasia it ensures that the system must operate in a transparent manner. Safeguards would be in place to prevent abuse. It is also considerably safer in terms of the categories of people who could be euthanised given that medical personnel are involved with regard to every step of the process, including the mental and emotional state of the patient.

The law reform would provide greater certainty to some degree. A measure of certainty would be provide by virtue of the fact that a reading of the legislation would enable the actors to discover whether their conduct would be legal or not. However, some uncertainty would still exist in that it is unclear to what degree euthanasia carried out outside the bounds of the legislation would still escape the harshest penalties by virtue of an application of the earlier law.

Law reform would prevent further damage to the credibility of the justice system. The danger of reading the current law in ways that allow the practise of euthanasia yet could conceivably alter the criminal law to encompass unintended exceptions would be avoided. Legislation would enable the courts to work in accordance with clearly set out law, preventing the distortion of existing law and ensuring even-handedness throughout the decisions.

Possibly the greatest benefit of legislation of euthanasia however, would be in removing the strain it currently places on those involved. By instituting the practice in a medical way it removes the need for individuals to take the sole responsibility for making these decisions. Training and support would be provided to those who are responsible for carrying out the procedure, thereby making it less stressful for both themselves and those who are being euthanised. But perhaps the biggest effect will be that those who act with compassion in carrying out this procedure will no longer need to fear the consequences that the criminal justice system may impose.

VII CONCLUSION

While on first glance it might appear that our courts are dealing with cases of euthanasia in a fair and just manner, a deeper analysis of the problems behind these decisions reveals a need for more substantive law reform. Given the uncertainty, the lack of accountability, the danger of distortion of our criminal justice system, and the extreme level of stress the current system places on those involved, legislative reform is necessary.

The Death with Dignity Bill is not wholly without issues. Anyone who is already suffering from illness or injury that renders them incompetent to make decisions or unable to communicate their decisions at the time the Bill comes into force will have to take their chances with the run of the justice system, a justice system that the passing of the Bill would make even more unpredictable. The same applies to anyone who chooses to seek euthanasia outside the medical parameters provided for in the Bill.

However, it does go a long way towards reducing the problems that are currently embroiling this area of the law. It is understood that the Bill is currently undergoing revision, prior to being resubmitted into the ballot. Therefore, it remains to be seen what form this legislation will be in when it next comes before our parliament.

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LEGISLATION

Crimes Act 1961.

Death with Dignity Bill 2003, no 37-1.