EQUAL JUSTICE PROJECT

The Euthanasia Debate

WHO ARE WE?
WHAT DO WE DO?

THE EQUAL JUSTICE PROJECT

Founded in 2005, the Equal Justice Project (EJP) is the brainchild of Auckland Law School students Eesvan Krishnan and Peter Williams. Ten years later, EJP continues to flourish under the leadership and participation of students from the Faculty of Law who share a passion for social justice. Rt. Hon E.W. (Ted) Thomas DCNZM QC, the patron of EJP, has often discussed the importance of inculcating a "pro bono ethic" among law students. If law students appreciate the importance of pro bono services from an early stage, Sir Ted hopes that we will see a shift toward law as a profession instead of a business.

The goal of the Equal Justice Project is to empower and support communities by addressing issues of equality, access to justice, redress, representation and knowledge. The five different limbs of the EJP – Pro Bono, Community, Education, Outreach and Communications – work together to achieve this goal; volunteers contributing their time, creativity, skills and knowledge for the benefit of the wider community.

THE OUTREACH TEAM

The Outreach team has the mission of increasing awareness of legal issues on campus and in communities. Its portfolios include raising knowledge about EJP within the student body, hosting a range of thought provoking events for students and the community, raising funds for our community partners through creative avenues and presenting written and oral submissions on parliamentary bills. Today's Symposium is simply the latest episode in the busy life of the Outreach team.

That life was no less busy than usual in 2014. A symposium on drug reform was held in April at the Faculty of Law with the panel comprising of Khylee Quince (senior lecturer at the Faculty of Law) and MP Simon O'Connor. The panel expressed a variety of perspectives when addressing controversial issues and concerns.

The team also made submissions on the Buildings (Earthquake-Prone Buildings) Amendment Bill and the Education Amendment Bill (No 2); voicing objections to allowing circumvention of the usual requirements for disability access and in support of more diverse members on tertiary education councils.

In relation to our community partners, Women's Refuge and Blind Foundation, the team raised close to $500 through bake sales. Moreover, the team has encouraged students to donate clothes and books for Women's Refuge.

Outreach also supported the Auckland Women's Centre by completing further research on Family Law for women going through the Family Court process, and gave a seminar on bias in the system for the Women's Centre to present to MPs.

At the end of August, Outreach held a political candidates forum on sexual offending law reform, at which speakers from 8 of the 10 major political parties were present. Volunteers also wrote a symposium paper in conjunction with the event. Outreach also submitted on the Crimes (Match-fixing) Amendment Bill, which proposed to make match-fixing in sport a crime.

In 2015, Outreach has continued to work across all of these areas; hosting an unprecedentedly successful symposium on miscarriages of justice and, in a first, combatting prisoner illiteracy through collecting books for the Mt Eden Prison library; aiding prisoner rehabilitation and reintegration.

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The Euthanasia Debate

Paper Prepared by Equal Justice Project Outreach
for the Symposium "The Euthanasia Debate"
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*Readers are advised that **this paper contains discussion of suicide**. The Equal Justice Project recognises that the content discussed in this symposium paper is highly sensitive and may distress some people. **If you or someone you know is contemplating suicide or is contemplating suicide, help is available through the several support services whose details are listed on Page 9.***

1. Introduction

The euthanasia debate has been ignited following Lecretia Seales' public plight to clarify the state of New Zealand's law on euthanasia. In June of 2015, the High Court ruled that medical assistance to help Ms Seales die at a time of her own choosing would be against the current law, and that the doctor(s) concerned would be committing culpable homicide pursuant to section 160(2)(a) and (3) pf the Crimes Act 1961, and/or aiding and abetting suicide pursuant to section 179(b). The Court made it clear that it is for Parliament to clarify or change the law. Following a petition from the Voluntary Euthanasia Society to Parliament, the Health Select Committee will be holding an inquiry into voluntary euthanasia.

The aim of this symposium paper is to offer a broad picture of the law as it stands and as it may develop in the future, from the perspective of several common law jurisdictions. It will discuss the current legislation and the common law as it has evolved over several decades. It sets out possible future developments and considers policy arguments on either side of the discussion.

This paper will focus on the past, present, and proposed legal developments in physician-assisted active euthanasia. Passive euthanasia is a voluntary choice to end life through ceasing life-prolonging medical treatment completely. This concept is widely recognised and accepted across most jurisdictions whereas active euthanasia, the direct act of inducing death, is more controversial. This paper will consider only voluntary euthanasia, that is, where a person is wholly competent and capable of consenting to the act. This paper also discusses the apparent leniency towards friends or family members who have helped to end a life by request. However, it will centre on the concept of physician-assisted death as a means to confine the proposed legislative changes.

2. Current Law

Legislative Landscape

The discussion surrounding the criminalisation of euthanasia is often contrasted with human rights-focused legislation. In New Zealand, the Bill of Rights Act 1990 upholds the right to life and allows people to refuse medical treatment.[1] It is by this right that death by passive euthanasia is commonly accepted. The UK Human Rights Act 1998 upholds both the right to life and the right to privacy.[2] Relevant articles of the European Convention on Human Rights are also given effect in the UK jurisdiction.[3] In Canada, the criminalisation of assisted suicide under section 7 of the Criminal Code is arguably in conflict with the Canadian Charter of Rights and Freedoms which enshrines the right to "life, liberty and security of the person".[4] These pieces of human rights legislation all promote the right to life and autonomy of the person but none provide specifically for the right to die. There is considerable tension between enforcing someone's right to autonomy yet denying their choice to die due to the sanctity of life.

The general position of legislation across many jurisdictions sees that both euthanasia and assisted suicide are criminal acts. Such legislation makes aiding and abetting suicide an indictable offence and prevents a person from consenting to death at the hands of another.[5] The New Zealand Crimes Act contains provisions which criminalise both aiding and abetting suicide and acceleration of death.[6] Similar provisions exist in the Australian Criminal Code, and euthanasia is illegal in six Australian states.[7] Both the New Zealand and Australian legislation also imposes a duty to provide the necessities of life, which essentially prevents assisted suicide by way of omission.[8] In the United Kingdom this is done by section 1 of the Suicide Act (and its new amendment in 2009 via the Coroners and Justice Act).[9] There have been a number of unsuccessful attempts in New Zealand to legalise assisted suicide by statute, such as the Death with Dignity Bill which was proposed in 2003. In Canadian legislation, the relevant provisions prohibiting euthanasia are codified in the Criminal Code. The Netherlands jurisdiction also contains provisions which render euthanasia illegal under their 1881 Penal Code.[10] However, in the Netherlands, doctors are granted much more freedom under the law to assist a patient in terminating their life both by ceasing treatment, or accelerating death. The actions of physicians must comply with the provisions of the Termination of Life on Request and Assisted Suicide (Review Procedures) Act 2002. This sets Netherlands apart from other jurisdictions as it provides a legislative framework under which assisted suicide may occur, as opposed to a blanket criminalisation.

Common Law

A- New Zealand

In all jurisdictions the Courts have faced the challenge of reconciling the tension between human rights legislation and the criminal law as it stands in statute. Faced with this conflict, the New Zealand Courts have chosen to uphold the sanctity of human life over the right to die with dignity. However, they have demonstrated leniency towards people who have assisted in another's death by consent. There are a number of examples where judges have enforced lighter sentences in cases of assisted suicide where they were recognised as acts of mercy.[11] However, in a manner similar to the United Kingdom, the New Zealand Court refused to declare criminalisation of euthanasia as a breach of the New Zealand Bill of Rights Act. *Auckland Area Health Board v Attorney General* established that doctors cannot be held criminally liable for turning off life support when the patient can no longer live without full reliance on it.[12] This is as far as the courts have been willing to go with respect to physician-assisted dying; and therefore as far as passive euthanasia extends in New Zealand. The leniency in sentencing bears some similarity to the discretion evident in the United Kingdom in the *R(Purdy) v DPP* case and shows that courts are willing to apply less than the full penalty available under the law in instances of assisted suicide.[13]

B- Foreign Jurisdictions

In Australia there was an attempt to legalise euthanasia in the Northern Territory. However, this law was overturned by the federal government two years after it was passed. The Courts in Australia have also adopted a practice of lighter sentencing in instances of assisted suicide.[14] The Courts made a declaration in *Brightwater Care Group (Inc) v Rossiter* that it is lawful to discontinue the provision of medical care at the insistence of the patient even if this causes the patient's death.[15] A common law right to autonomy and self-determination was recognised, allowing mentally capable adults to choose what they want to happen to their own body. The Court concluded that sections 259 and 262 did not alter this common law position, although the two principles seem at odds with each other. This is another example of a jurisdiction that allows for passive euthanasia but has not yet recognised the legality of active euthanasia.

In the United Kingdom, the opinion of the Courts is that the denial of a right to die does not infringe on human rights such as those contained in the Articles of the European Convention on Human Rights.[16] The reasoning behind this seems to be that the Suicide Act affords discretion to the Director of Public Prosecutors (DPP) in choosing whether or not to prosecute for assisted suicide. The specifics of this discretion were determined after the Court's ruling in *R(Purdy) v DPP*.[17] The DPP may refrain from prosecuting for assisted suicide where it would not be in the public interest to do so. This means that even in cases where there is sufficient evidence to prosecute for assisted suicide, the prosecution may choose not to bring a charge. In this case, the Crown chose not to prosecute the parents of Daniel James despite the fact that they had clearly aided their son in ending his life.[18] The Courts also made a distinction between passive and active euthanasia; the former being legally allowed.[19] As is evident across most jurisdictions, medically assisted death may be legal if it involves an omission and not an act. These two qualifications to the laws around assisted death appear to rectify the potential human rights violation according to the Courts of the United Kingdom.

In Canada, the Courts took a very different approach to that of the UK. In a unanimous decision, the Supreme Court of Canada in *Carter v Canada* held that the laws prohibiting physician-assisted suicide were in breach of section 7 of the Canadian Charter of Rights and Freedoms.[20] The Courts essentially declared that section 241(b) of the Criminal Code was unlawful, although in doing so they suspended their declaration for a year to allow the legislature to respond. This ruling was made in 2015 and as of yet there do not appear to be any dramatic legislative changes in the pipeline. This suggests that, at least judicially, the ruling of the Supreme Court in *Carter* will likely apply from February 2016. Assisted suicide will therein be legally justified for a competent adult, provided they give clear consent to their termination and have a grievous and irremediable medical condition which is causing them intolerable enduring suffering.[21] This reasoning was evident in 1993 by the minority judgments of *Roudriguez v British Colombia* where 4 of the 9 judges ruled in favour of striking down section 241(b) of the Criminal Code.[22] The opinion of those four judges seems to have now become the dominant reasoning as the judges in *Carter* ruled unanimously in favour of striking down section 241(b).

Because the Netherlands has developed a statutory scheme for regulating instances of assisted suicide, their case law focuses on the interpretation of when it is appropriate to give effect to that legislation. The case of *Postma* was significant in igniting the originating legal debate on euthanasia.[23] In this case, a physician was convicted of murder after facilitating the death of her mother following repeated requests. Despite that conviction, the Court provided criteria for when doctors would not be required to keep a patient alive. A subsequent case, *Schoonheim*, formed the basis of the legal acceptance of euthanasia.[24]

3. Future Developments

New Zealand

The issue of euthanasia in New Zealand has been one of great controversy so far, and as a result the Courts have been unwilling to change the position of the statutory scheme. Rather, they suggest that it is the role of Parliament to make such changes. It may be considered that the minor sentences given for otherwise clear breaches of the criminal law signify opportunity for change in the law itself. There have been numerous attempts to legalise euthanasia but as of yet none have made it through the select committee process. It is yet to be seen whether the ground swell of support for Lecretia Seales' case will continue to effect meaningful debate over law reform on voluntary active euthanasia.

Foreign Jurisdictions

The issue has followed a similar trajectory in Australia, with courts treating offenders leniently but nonetheless following the legislature's lead. Australia too makes the distinction between active and passive euthanasia, only allowing the latter. The development of the law on euthanasia is more complex in Australia than New Zealand, characterized by the repercussions from the Northern Territory's enactment of the Rights of the Terminally Ill Act 1995.[25] This law was overturned, demonstrating that the decision to legalise euthanasia would need to be fully affirmed by the federal government.

In the United Kingdom, two private members bills are currently before Parliament. The bills, titled Assisted Dying Bill and Assisted Dying Bill (no 2), have both passed their first readings.[26] These bills propose to allow doctors to administer a fatal dose of medicine to patients with an estimated less than six months to live. More details as to the provisions of the bills will be released closer to their second readings. These bills propose to make active euthanasia legal in specific cases alongside the passive euthanasia already legalised by the court in *Airedale*. If an Assisted Dying Bill were to be in effect alongside the *Airedale* ruling, doctors would be given the opportunity to assist terminally ill patients in ending their lives. Some issues have been highlighted regarding the willingness of doctors to perform acts of assisted suicide. However, it is generally accepted that there would be adequate medical support to make an Assisted Dying Bill practically viable.[27]

Canada is awaiting legislative response to the ruling of the Supreme Court in *Carter v Canada*. Any related legislation will be required to address the role of the medical profession in instances of assisted suicide.[28] Terms such as "intolerable, enduring suffering" will need to be clearly defined, as well as formulating guidelines to determine whether a patient is competent and clearly consenting.[29] This could be defined by legislation, but it is likely that these determinations will occur judicially if there is no legislative response to the Supreme Court's ruling in *Carter*.

In the Netherlands, perhaps unsurprisingly, there have been teething problems with the legal developments in this area. Some cases have seen lives being ended without sufficiently explicit requests. These nearly always involve patients who are very close to death and are incapable of consent at the time, even though the hastening of death had been previously discussed. Section 2(2) of the Act permits doctors to comply with prior requests despite patients no longer being capable of giving consent, although this provision has been heavily criticised.[30] The Act does not provide a specific procedure for comatose or persistently vegetative patients. There are also difficulties in interpreting and applying the term "unbearable suffering" because it is so imprecise.[31] Any development of the law would be likely to address these concerns including those of terminology.

4. Policy Arguments

Across these five jurisdictions there are number of policy arguments for and against the legalisation of euthanasia. While some arguments are specific to a particular jurisdiction, there are a number which occur across all five. The key policy tension seems to be in striking the balance between upholding the right to life against a number of other rights such as a corresponding right to die, a right to refuse medical treatment, and a right to autonomy over one's own body.

In the Netherlands, the legalisation of euthanasia acted to realign the law with current medical practice. Euthanasia was widely practiced prior to the Termination of Life on Request and Assisted Suicide (Review Procedures) Act 2002. The statute codified procedures which had been used by the Dutch medical community for over twenty years.[32] The government hoped that the legislation would encourage greater reporting and minimise concerns around actions or omissions in euthanasia. This appears to have been successful.

The notion of individual choice and the right to autonomy over one's body is a key argument in favour of legalising euthanasia. The idea is that a person should have the right to decide when their life should end whether or not they are physically capable of giving effect to that choice. This line of argument focuses on the fact that a person suffering a terminal illness should have the right to be freed from cruel and degrading effects of their disease. One line of reasoning may be that the current law discriminates against those who are incapable of committing suicide without the assistance of a doctor by denying them the same right to die that is afforded to able bodied people. McLachlin J in *Roudrieguez v British Colombia* was the first to phrase the argument in this manner, and the opinion has been reflected in the UK.[33] Another notion is that legalising euthanasia could minimise the effects on a patient's family suffered by witnessing a slow and agonising death at the hands of a terminal illness.

On the other hand, there are concerns that legitimising assisted suicide will unjustifiably undermine the right to life. In the Canadian jurisdiction this is described as a worry that vulnerable people will be pressured or manipulated into agreeing to assisted suicide.[34] In the UK the concern is that people suffering from a terminal condition will feel that they are a burden to those around them and opt for assisted suicide to avoid this feeling rather than out of a legitimate desire to end their life.[35] A further strand of the argument is that if euthanasia is allowed, pressure would mount for society to extend euthanasia to other categories of the vulnerable (including, for example, the elderly or handicapped infants.)

In conjunction with these arguments is the policy argument which focuses on protecting the vulnerable. The law is designed to protect a vulnerable person who opts for suicide at a time when extreme depression may provoke an irrational and emotional decision by that person to end their life. The law is therefore seen to be life-affirming as opposed to life-denying and directed at discouraging suicide as a response to the emotional changes of life. If the state is supposed to have a duty to protect vulnerable members of society then arguably the legalisation of euthanasia would be contrary to such a duty.

Another consideration against the legalisation of euthanasia is that medical alternatives are already sufficient. For example, hospice teams are doing a commendable job of relieving the suffering of the terminally ill. Hospices and modern pain-medication regimes may be seen to obviate the need for euthanasia. Another strand of this argument, evident in the Canadian jurisdiction, is that legislation of assisted suicide will redirect money and resources from institutions which provide palliative care.[36] Care focused on improving the quality of life for terminal patients and their families could lose out at the expense of legalised assisted suicide.

5. Conclusions

The euthanasia debate in New Zealand has become increasingly prominent following the Lecretia Seales case and will likely be the source of much controversy in coming years. The law surrounding active physician-assisted dying is inherently unstable. Even in jurisdictions where the legal right to assist in ending a life is widely accepted, such as the Netherlands, there remain concerns surrounding interpretation and application, such as when a competent adult ceases to act in a 'voluntary' consenting capacity. In New Zealand, the current position demonstrates that the Courts are unwilling to act in a manner so clearly contrary to statute. It remains that Parliament must determine whether it is appropriate to amend the law to allow doctors to assist in ending the lives of those suffering terminal and intolerable illnesses.

If you or someone you know is contemplating suicide or is contemplating suicide, help is available through the several support services whose details are listed below:

- Lifeline: 0800 543 354 (available 24/7)
- Suicide Crisis Helpline: 0508 828 865 (0508 TAUTOKO) (available 24/7)
- Youth services: (06) 3555 906
- Youthline: 0800 376 633
- Kidsline: 0800 543 754 (4pm to 6pm weekdays)
- Whatsup: 0800 942 8787 (1pm to 11pm)
- The Word Depression helpline: 0800 111 757 (available 24/7)
- Rainbow Youth: (09) 376 4155
- CASPER Suicide Prevention

6. Endnotes

1. New Zealand Bill of Rights Act 1990, s 8 and s 11.
2. Human Rights Act 1998, art 1 and art 8.
3. European Convention on Human rights, art 2,3,8,9 and 14 are discussed in *Pretty v UK* (2002) 35 EHRR 1 (ECHR).
4. Constitution Act 1982, part 1 Canadian Charter of Rights and Freedoms, s7.
5. Criminal Code RSC s214(b) and s 14.
6. Crimes Act 1961, s 179 and s 164.
7. Criminal Code 1995.
8. Crimes Act, 1961 s 151 and Criminal Code 1995 s 262.
9. Suicide Act 1961, s 1 and Coroners and Justice Act 2009.
10. Penal Code 1881, art 293 and 294.
11. *R v Martin* [2005] HC Whangarei T035895, 28 July 2014 and *R v Ruscoe* (1992) 8 CRNZ 68.
12. *Auckland Area Health Board v Attorney-General* [1993] 1 NZLR 235.
13. *R(Purdy) v DPP* [2009] UKHL 45.
14. *R v Shirley Justins* [2008] NSWSC 1194, *R v Mathers* [2011] NSWSC 339.
15. *Brightwater Care Group (Inc) v Rossiter* [2009] WASC 229
16. *Pretty v UK* (2002) 35 EHRR 1 (ECHR).
17. *R(Purdy) v DPP* [2009] UKHL 45.
18. The Crown Prosecution Service "Decision on Prosecution – The Death By Suicide Of Daniel James" (9 December 2008)< www.cps.govt.UK>
19. *Airedale NHS Trust v Bland* [1993] 1 All ER 821 (HL).
20. *Carter v Canada (Attorney General)* [2015] SCC 5, [2015] 1 SCR 331.
21. *Carter v Canada (Attorney General)* [2015] SCC 5, [2015] 1 SCR 331.
22. *Roudriguez v British Colombia* (Attorney General) [1993] 3 SCR 519.
23. Raphael Cohen-Almagor "Euthanasia in the Netherlands: The Legal Framework" (2001) Michigan State University-Detroit College of Law Journal of International Law 319 at 328.
24. Jurriaan De Haan "The New Dutch Law On Euthanasia" (2002) 10 MLR 57 at 59.
25. Natasha Cica research paper 4 1996-97 http://www.aph.gov.au/About_Parliament/Parliamentary_Departments/Parliamentary_Library/pubs/rp/RP9697/97rp4#magic_tag_16
26. Assisted Dying Bill (HL) 2015 (UK) and Assisted Dying Bill (no 2) 2015 (UK).
27. Alexandra Mulloch "The Assisted Dying Bill and the Role of the Physician" (2015) J Med Ethics 41 621 at 622.
28. "Euthanasia and Assisted Death (update 2014)" CMA Policy Report.
29. Sheryn Ubelacker "What are the Rules of Assisted Death in Canada? Doctors Respond" (13 February 2015) Huffington Post <www.huffingtonpost.ca>
30. De Haan, above n 14.
31. Donald G. van Tol, Judith A.C. Rietjens and Agnes van der Heide "Empathy and the application of the 'unbearable suffering' criterion in Dutch euthanasia practice" (2012) 105 Health Policy 296.
32. David C Thomasma, Thomasine Kimbrough-Kushner, Gerrit K Kimsma and Chris Ciesieski-Carlucci (eds) *Asking to Die: Inside the Dutch Debate about Euthanasia* (Kluwer Academic Publishers, New York, 2002) at 135.
33. *Roudriguez v British Colombia* (Attorney General) [1993] 3 SCR 519 per McLachlin J.
34. Robert Young 'Debating the Morality and Legality of Medically Assisted Dying" (2013) 7 (1) Criminal Law and Philosophy at 151.
35. "About Care Not Killing" <http:// about care not killing.org.UK/about/>.
36. Jocelyn Downie, Kenny Nuake and Chantelle Rajotte "Problematic Principles: the CMA on public/private health care" (2007) 15(2) HLR 15(2).

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