EUTHANASIA, THE RIGHT TO DIE AND THE BILL OF RIGHTS ACT

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I Introduction

The issue of euthanasia has assumed prominence throughout the world because of a number of social and legal developments. These include: the advent of modern medical technology and the availability of artificial measures to prolong life; landmark court cases challenging laws criminalising euthanasia; the growing elderly population and the increase in the number of people affected by HIV/AIDS; and the declining influence of organised religion. In New Zealand, a sharp focus to the euthanasia debate was provided recently by the introduction of the Death with Dignity Bill which was debated by Parliament in July 2003. During the course of the debate, the Attorney-General advised Parliament that the Bill contained provisions that were inconsistent with the New Zealand Bill of Rights Act 1990.¹

This paper will explore the issue of euthanasia under human rights law and examine the constitutional arguments for and against the ‘right to die’. Because many of the issues raised cannot be appropriately explained in the abstract, the paper will examine the Death with Dignity Bill describing the concerns that the Attorney-General had with the details of the proposal to allow terminally ill patients to request medical assistance to voluntarily end their lives. The paper will conclude that although the Bill was defeated, the Bill of Rights Act would not preclude legislation being enacted which

legalised active voluntary euthanasia so long as meaningful and effective safeguards are included to protect the vulnerable and the infirm.

II The Euthanasia Debate

Throughout history, philosophers have strenuously debated whether people have the right to end their lives, and under what circumstances they may do so. The euthanasia debate has at time been quite intense, which is explained to a large extent by the very nature of the subject matter with which it is concerned. It touches upon people’s most fundamental interests, their morality, spirituality and well-being, and hence provokes the most passionate emotions. Given that most constitutional arguments for and against euthanasia are rooted in philosophy, medicine and religion, any discussion on the right to die must first examine how each discipline has addressed the question, dating back to ancient times.

The term euthanasia derives from the Greek eu, meaning well, and thanatos, meaning death. The ancient Greeks viewed illness as a bothersome affliction and allowed sick individuals to seek the approval of the state to commit suicide. According to Plato, Socrates considered the agony of painful disease and suffering as just reasons not to “cling to life.” Socrates “did not want to lengthen out good-for-nothing lives... Those who are diseased in their bodies, [physicians] will leave to die, and the corrupt and incurable souls they will put an end to themselves.”2 True to his beliefs, Socrates took his own life to avoid being executed after being found guilty of corrupting youth and committing religious heresies. While most Greek philosophers condoned the practice of euthanasia, Socrates’ view on suicide was not widely supported. To Aristotle, suicide was an offence against the state, as he considered the practice to be contrary to the civic duty citizens owed to the state.3

The Stoic philosophers were probably the first to accept suicide when deprivation or illness no longer allowed for a natural life.4 Death became a morally neutral issue, while suicide was seen as not only a reasonable

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2 Plato “Phaedo” in Five Great Dialogues 90 (Benjamin Jowett trans, Walter J Black 1942) at 90-91.
alternative to life’s hardships and burdens but a noble expression of human freedom. After the Roman conquest of Greece, the Stoic philosophy of death dominated philosophical and legal thinking. Under Roman law, it was acceptable to end one’s life because of a terminal illness, lunacy or fear of dishonour. Suicide was punishable only when the act was considered irrational: although for economic and military reasons soldiers, criminals, and slaves were forbidden to take their own lives.5

Stoic views prevailed until the third century: thereafter the influence of Christianity began to erode the arguments supporting suicide, which was seen as an unforgivable transgression of God’s will. St Augustine declared that suicide violated the function of church and state, and that it was against the Sixth Commandment, “Thou shall not kill”. According to him, human suffering was decreed by God, and it was the responsibility of man to bear his burden. No matter what hardship or calamity befell an individual, St Augustine’s interpretation of the holy edict was unwavering: suicide was never permissible.6

In the 13th century, Christian opposition to euthanasia peaked when philosopher Thomas Aquinas published his *Summa Theologica*. Sharing St Augustine’s view that suicide was a violation of the Sixth Commandment, Aquinas denounced suicide as unlawful, contrary to the laws of nature and “the worst sin an individual could commit”.7

By the sixteenth century, philosophers began to challenge the generally accepted religious condemnation of suicide and, once again, asked whether the ancient concept of an ‘easy death’ was something to strive for.8 In 1516, for instance, Sir Thomas More wrote *Utopia* in which patients living in an ideal society were encouraged to commit suicide if they were suffering from a terminal illness or experiencing unrelenting pain.9 Other writers began to reconsider the issue of euthanasia for terminally ill patients, resulting in a


\[\text{6 Ibid, 3.}\]

\[\text{7 Ibid.}\]

\[\text{8 New York Task Force, *supra* note 4, at 80.}\]

slow shift in attitude towards the practice. During the early 1900’s, legislation seeking to legalise and regulate euthanasia was introduced in Britain and some American states, although none were enacted.\textsuperscript{10} Thereafter, private euthanasia societies were established to promote the concept of “mercy killings”.

While public support for euthanasia steadily increased through the 1930’s and early 1940’s, the Nazi’s adoption of the word “euthanasia” to describe its “mass extermination programme” eroded most of this support. In Nazi Germany, euthanasia was employed to murder over 100,000 men, women, and children who were physically handicapped, mentally disabled or genetically inferior. The Nazis’ idea of euthanasia differed to historical and present day interpretations, as their euthanasia programme never had the goal of providing physician assisted suicide to a terminally ill patient. All the killings were committed without the patient’s consent and generally without the patient being aware of the impending act. But the damage had been done and, following the defeat of Nazi Germany, the General Assembly of the World Medical Association, for instance, adopted a resolution “suggesting all national medical associations condemn euthanasia under any circumstances.”\textsuperscript{11}

Euthanasia continues to draw much attention and debate. However, in the last two decades the focus of the discussion has shifted from the political to the legal arena, particularly in countries with a common law legal tradition where the issue has been taken up by ‘cause lawyers’. Through a number of high profile court cases ‘right to die’ proponents have challenged laws prohibiting euthanasia and have asked the courts to define the circumstances in which a patient may receive assistance to die.\textsuperscript{12} Although they have


\textsuperscript{11} Ibid, 220.

achieved only moderate success, these cases have moved the issue of euthanasia to the forefront of public debate, which in turn has resulted in euthanasia being legalised in a limited number of jurisdictions (most notably in the Netherlands, Belgium, Australia’s Northern Territory (although the federal government invalidated the law less than one year after it was passed) and the US State of Oregon). Nonetheless, the euthanasia debate remains as controversial today as it was in ancient times. Both sides of the argument are well established and entrenched in their views. It is unlikely that the debate will be resolved in the foreseeable future.

III Legality and Morality of Physician Assisted Suicide

Given the shift in the debate’s focus, many commentators have sought to clarify the confusion that has arisen – particularly amongst lay people – around the meaning of the term “euthanasia”. Actions that result in the withdrawal of life-sustaining treatment are often referred to as passive euthanasia, while those that involve the positive act of causing death of another are referred to as active euthanasia. A further distinction can be made between voluntary euthanasia, where the consent of the patient is first obtained, and non-voluntary euthanasia, where consent is not obtained: for instance, when a patient is in a persistent vegetative state or otherwise lacks the capacity to give informed consent. In addition, there is physician-assisted suicide which involves the provision of a lethal substance to a patient by a physician for the patient to self-administer in order to commit suicide in a painless manner. Finally, the doctrine of double effect covers the administration of drugs to relieve a terminally ill patient’s pain and suffering despite the physician knowing that this might have the incidental effect of hastening the patient’s death.


This form of euthanasia differs from active voluntary euthanasia as the patient administers the drug provided by the physician, whereas in active voluntary euthanasia the physician provides and administers the drug to the patient. L Bradbury, supra note 10, at n6.
Although the law (as will be explained below) has responded differently to the various forms of euthanasia, the moral arguments for and against each form are essentially the same. Many opponents continue to appeal to the Sixth Commandment to support their position that all forms of euthanasia are morally wrong. Others claim that physicians – who swear to abide by the Hippocratic Oath and thus are required to treat patients, not harm them – should not have a ‘Godlike’ power to decide between life and death. They fear that patients may lose trust in their physician and question their primary motive for a treatment regime. Allowing euthanasia may also undermine the commitment of physicians to saving lives and may discourage the search for new cures and treatments for the terminally ill. Many fear that the legalisation of euthanasia may lead to a diminished respect for the sanctity of life and increase the perception that some lives (those of the disabled and sick) are worth less than others. Further concerns arise over the fact that the introduction of one form of euthanasia will invariably lead to less acceptable forms where individuals who are thought to undesirable are killed in a more coercive manner (the ‘slippery-slope’ argument). For instance, in the Netherlands there have been recent moves to extend the country’s euthanasia laws to allow patients who are not terminally ill but are ‘suffering from life’ to request assistance to end their lives.

Those opposed to the practice also regard the possibility that economic factors – particularly spiralling health costs – may cause medical institutions to lend support for euthanasia, particularly for hopeless ill patients who are unlikely to recover when these resources could be better utilised on other patients with a greater chance of survival. That is, euthanasia may become

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16 Scherer and Simon, supra note 5, at 20.
19 Scherer and Simon, supra note 5, at 21.
a cost-effective way to treat the terminally ill. Economic factors may further influence the decision made by patients, particularly those who do not want to be a burden on their families (particularly a financial one) or be seen as weak, selfish or irrational and thus may be prone to suggestion. At the time when they are most dependent on their close family for emotional support, they may be vulnerable to suggestions that ending their life is the best option for everyone concerned: that is, they have an obligation to die.20

Conversely, proponents of euthanasia base their position on two fundamental principles: ‘mercy’ and ‘self-determination’. They argue that for many individuals, quality of life is important, not the sanctity of life or its length. If quality of life is unbearable because a patient is suffering from intractable, untreatable or intolerable pain, the patient should receive mercy and compassion from a physician by direct assistance in the dying process.21 More importantly, patients have the right to dictate the course of their own lives and it is an “unjustifiable encroachment upon individual liberty to prevent a competent terminally ill patient and a co-operative doctor from acting upon the patient’s desire to end life.”22 That is, patients have a right to request assistance from a physician to end their lives without the possibility of criminal penalties applying to the physician’s actions.

Regardless of the arguments in support of the practice, most forms of euthanasia are unlawful, no matter what the motivation.23 Under section 167 of the Crimes Act 1961, the administration of medication by a physician – which would cover both forms of active euthanasia (voluntary and involuntary) – done with the intent of causing death would, on proof of an unlawful act, constitute murder. The fact that a person consents to their own death is no defence to a charge of murder.24 Nor is consent, in general, a defence to a charge of causing serious injury.25 At common law, suicide was

20 Ibid, 22.
21 Ibid, 17.
23 See also Airedale NHS Trust v Bland [1993] AC 789, 865 per Lord Goff (confirming that “euthanasia is not lawful at common law”).
24 Crimes Act 1961, section 63.
a crime but this was abrogated by statute. Consequently, individuals who are capable of taking their own lives may do so legally, while those who procure the assistance of others place the helper at risk of criminal liability.\footnote{Crimes Act 1961, section 179.} The offence of aiding and abetting suicide will be committed when a person assists a patient to die by, for example, providing lethal drugs.

The illegality of other forms of euthanasia is less clear as there has been a series of court decisions granting consent to withdraw life support and nutrition from patients who are in a vegetative state from which they are unlikely to recover.\footnote{See Auckland Area Health Board v Attorney-General (1992) 8 CRNZ 634; Re G [1997] 2 NZLR 201; Auckland Healthcare Services Ltd v L (1998) 5 HRNZ 748.} The courts have also recognised the doctrine of double effect as a defence to criminal charges,\footnote{Airedale NHS Trust v Bland [1993] AC 789; R v Cox (1992) 12 BMLR 38; Auckland Area Health Board v Attorney-General (1992) 8 CRNZ 634.} but have restricted the defence to physicians as in their opinion physicians have the requisite expertise to assess the effects, good or bad, of the painkillers.\footnote{R v Martin (No 3) 3 NZLR 69 (2004) at 71.}

In New Zealand, attempts have been made to legalise active voluntary euthanasia. In 1995, former MP Michael Laws (National) introduced a Bill which would have allowed euthanasia in certain limited circumstances. The Bill was soundly defeated (29 to 61 votes) and an attempt by the MP to force a referendum on the issue was scuttled following his resignation from Parliament.\footnote{The referendum sought to ask the following question: “Should people aged 18 years and over who are terminally or incurably ill be permitted to have their lives ended if they request this, in a humane manner and in accordance with the procedures to be determined.”} However, the issue of euthanasia stayed in the public spotlight following a number of high profile court cases involving individuals accused of killing their life partners. In 2000, a New Zealand Herald DigiPoll survey of 756 people indicated that 61 percent supported the legalisation of euthanasia.\footnote{Voluntary euthanasia gaining support, \textit{Evening Post}, 28 December 2000.} This figure may not have reflected the true support for euthanasia, however, as a Massey University survey of 1,000 New Zealanders conducted in August and September 2002 found 73 percent
supported physician assisted suicide for someone with a painful, incurable disease.\textsuperscript{32}

It was against this background of increasing public support for euthanasia that Peter Brown MP (New Zealand First) introduced the Death with Dignity Bill to Parliament on 6 March 2003. The Bill sought to allow terminally ill patients who were experiencing pain, suffering or distress the opportunity of requesting assistance from their physician to voluntarily end their lives.\textsuperscript{33} The Bill also provided for a request to be made by a representative appointed under an advance directive. An advance directive made by a patient would come into effect if the patient became incapable of making and communicating their wishes regarding their medical treatment.\textsuperscript{34}

In his speech to Parliament, Brown went to great lengths to stress that the Bill was not simply about the painless killing of a patient suffering from an incurable disease, but was concerned with allowing patients to make their own decisions about the manner of their death: to allow them to die with dignity – in a peaceful and dignified way and not with prolonged suffering and discomfort.\textsuperscript{35} For this reason, he stressed the importance of the procedural safeguards that were contained in the Bill to ensure the authenticity and reliability of the patient’s decision to terminate life.\textsuperscript{36}

Like all legislation introduced to Parliament, the Bill was examined by the Attorney-General for the purposes of determining whether it was consistent with the Bill of Rights Act. The Attorney-General concluded that the Bill contained provisions that were inconsistent with the right not to be deprived of life and the right to freedom of expression\textsuperscript{37}, and reported her findings to the House of Representatives on 30 July 2003. Later that day, at the first reading debate, the Bill was defeated by a vote of 58 in favour and 60 against (1 abstention) and, therefore, was not referred to a select committee. While we can never be exactly certain what impact the Attorney-General’s report

\textsuperscript{33} Death with Dignity Bill, clause 5(1).
\textsuperscript{34} Death with Dignity Bill, clause 5(2).
\textsuperscript{35} Death with Dignity Bill: First Reading, \textit{Hansard} 30 July 2003, at 7482.
\textsuperscript{36} Death with Dignity Bill: First Reading, \textit{Hansard} 30 July 2003, at 7483.
\textsuperscript{37} Attorney-General’s Report, \textit{supra} note 1, at 4.
Euthanasia as a Human Right?

The narrow defeat of the Death with Dignity Bill is clear sign that the issue of euthanasia will continue to attract the public’s attention, and the probability that further attempts will be made to legalise the practice seems quite high. It is, therefore, important to consider the possibility of the ‘right to die’ being a constitutional right in the sense that the State must refrain from doing anything that may unjustifiably limit the exercise of the right.

The ability of patients to choose how they may die and have those choices respected is revered as a way of maintaining control, which can in turn help preserve personal dignity in dying. But by characterising this issue in terms of rights, proponents have managed to bring euthanasia within the panoply of existing human rights despite the fact that the ‘right to die’ is not and has never been protected as a constitutional right. No express provision is made in the Bill of Rights Act for such a right and to date there have been no cases where the New Zealand courts have been called upon directly to consider the implications of the Bill of Rights Act on the issue of euthanasia. The closest was the case of \( R \ v \) Martin, where the defendant was charged with the attempted murder of her mother, who was suffering from terminal cancer. Responding to the Crown’s argument that physician assisted suicide intrudes on the sanctity of life, Wild J commented that “a patient has no legal right to insist upon medical intervention that would end the patient’s life. Medical care may be refused by a patient, but the patient cannot insist upon medical steps that end life.”\(^39\) It is nevertheless likely that in the future a case will be brought seeking to challenge the existing criminal law prohibition on assistance in dying on the grounds that such laws are inconsistent with the rights and freedoms protected in the Bill of Rights Act, relying on one or more of a number of possible arguments.

The right to life – which is protected by section 8 of the Bill of Rights Act – is the most fundamental of human rights, particularly as it is “the one right on

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\(^{38}\) See Death with Dignity Bill: First Reading, \textit{Hansard} 30 July 2003, at 7482 to 7494.

\(^{39}\) \( R \ v \) Martin (No 3) [2004] 3 NZLR 69, at para 15.
which all other rights depend.”

The right’s importance is demonstrated by the pre-eminent position it was given in the Bill of Rights Act. But the right is expressed in negative terms – it is a ‘right not to be deprived of life’, rather than a ‘right to life’. Rishworth notes, however, that “not too much should be made of this distinction.” In his opinion, as death is inevitable for all persons, the only way the right to life can be succinctly affirmed is to prohibit the wrongful deprivation of life.

On its face, it seems that a claim for euthanasia would be inconsistent with the right to life. But it is possible to argue that in order to be meaningful the right to life must be capable of waiver and, thus, protect a person’s right to choose whether or not to go on living. Some support for this view can be found in the case of Rodriguez v British Columbia (Attorney-General). In that case, the Supreme Court of Canada was asked to consider whether the prohibition on assisted suicide was contrary to the provisions of the Canadian Charter of Rights and Freedoms. Although most of the judges relied on other constitutional rights to reach their decision (the judges deciding five to four that the legislation in question did not violate the Canadian Charter), Cory J (dissenting) opined that dying was an integral part of living and, thus, was entitled to the constitutional protection provided by the right to life. He concluded that the right to die with dignity should be as well protected as any other aspect of the right to life and accordingly held that this protection extended to incapacitated persons seeking assistance to die.

This case is an interesting example of how an expansive interpretation might be given to the ‘right to life’. But the idea that this right protects not only the

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41 P Rishworth et al The New Zealand Bill of Right (Oxford University Press 2003) 220.
42 Ibid. This view is supported by van Dijk and van Hoof who explain: “The right to life does not afford a guarantee against all threats to life, but against intentional deprivation and careless endangering of life.” P van Dijk and G J H van Hoof Theory and Practice of the European Convention on Human Rights (3rd ed 1998) 297.
43 Otlowski, supra note 15, at 196.
44 Rodriguez v BC (AG) [1993] 3 S C R 519.
‘right to life’ but also the right to choose not to go on living has been rejected by international courts and academics alike. For instance, in Pretty v United Kingdom, the European Court of Human Rights held:

\[ \text{Article 2 cannot, without a distortion of language, be interpreted as conferring the diametrically opposite right, namely a right to die; nor can it create a right to self-determination in the sense of conferring on an individual the entitlement to choose death rather than life.} \]

Rishworth has been more forthright in rejecting this argument, describing the idea that the ‘right to life’ can be interpreted as involving a negative aspect as a ‘hopeless argument’. While some human rights appear to imply their opposite – such as freedom of association which involves the right not to associate – this is simply a means of exercising the right in question. That is, the notion of a freedom implies some measure of choice as to its exercise. The right to life is phrased in different terms. It is unconcerned with issues to do with the quality of living or what a person chooses to do with their life.

A stronger argument in support of euthanasia is that a decision to end one’s life is fundamental to human dignity, security and personal autonomy: concepts that are protected by various international human rights instruments. Although the right to liberty and security of the person has been given a limited interpretation and thus far has been restricted to freedom from arbitrary arrest and detention, notions of personal autonomy may in the future influence the development of overseas human rights jurisprudence in this area. But this argument is not sustained in the context of section 8 or elsewhere in the Bill of Rights Act due to the absence of a right to liberty and security of the person.

46 Ibid, 39.
47 P Rishworth, supra note 41, at 236.
48 Ibid.
49 Dr A Brown “What Can We Learn From the Pretty Cases?” Human Rights & UKP 3.3(8) (2002).
50 Pretty v United Kingdom, application no 2346/02 (29 April 2002) at 31.
51 Rishworth, supra note 41, at 236.
Further support for human rights recognition of euthanasia might be based on the right to privacy – particularly as this right has been used to permit the disconnection of artificial life support systems in hopeless cases involving both competent and incompetent patients. It has, for example, been suggested that Article 8 of the European Convention – which states, _inter alia_, that everyone has the right to respect for his private life – may be raised as a basis for protecting a patient’s right to seek assistance to die. Nothing could be more intimately connected with how a person lived their life than the manner and timing of their death. Indeed, the European Court has recognised that laws preventing patients exercising their choice to avoid an undignified and distressing end to life may constitute an interference with their right to respect for private life.

But the protection afforded by this provision is not absolute. The right to privacy under the European Convention is qualified by a provision that countenances interference with this right if it is in accordance with the law and necessary in a democratic society for the protection of health or morals, or the protection of the rights and freedoms of others. Likewise, the right to privacy provision in the International Covenant on Civil and Political Rights only protects against ‘arbitrary or unlawful interference’. These qualifications allow judges to consider policy arguments justifying the prohibition on physician assisted suicide.

Of particular relevance would be whether the prohibition was a necessary and proportional response to safeguard human life and protection against abuse. As the European Court noted in the _Pretty_ case:

_The law in issue in this case [...] was designed to safeguard life by protecting the weak and vulnerable and especially those who are not in a condition to take informed decisions against acts intended to end life or assist in ending life. Doubtless the condition of terminally ill individuals will vary. But many will be vulnerable and it is the vulnerability of the class which provides that rationale for the law in question. It is primarily for States to assess the risk_

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53 C de Than “No Convention Right to Die” 66 _JoCL_ 312 (2002).

54 _Pretty, supra_ note 45, at 67.

55 _Otlowski, supra_ note 15, at 199.
and the likely incidence of abuse if the general prohibition on assisted suicides were relaxed or if exceptions were to be created. Clear risks of abuse do exist, notwithstanding arguments as to the possibility of safeguards and protective procedures.\textsuperscript{56}

In any case this discussion is moot. Although the rights and freedoms contained in the Bill of Rights Act (particularly the right to refuse medical treatment and freedom from unreasonable search and seizure) protect some aspects of the privacy of an individual, the drafters of the Bill recommended against inserting a general right to private life. In their opinion, although privacy was protected to a limited degree by specific rules of laws and legislation “it would be inappropriate […] to attempt to entrench a right that is not by any means fully recognised now, which is in the course of development, and whose boundaries would be uncertain and contentious.”\textsuperscript{57}

Another possible argument in support of an individual’s right to seek assistance to die might be based on section 19(1) of the Bill of Rights Act, which provides the right to freedom from discrimination on the grounds set out in section 21 of the Human Rights Act 1993. These grounds include disability, which covers both physical and mental disability. It is possible to argue that the prohibition on physician assisted suicide breaches a patient’s non-discrimination right in its application: it prevents persons physically unable to end their lives unassisted from choosing to do so when that it is an option in principle available to other members of the public without contravening the law. This line of argument was supported by Lamer CJ and Cory J (dissenting) in the Rodriguez case: the Chief Justice commenting:

\[P\]ersons with disabilities who are or will become unable to end their lives without assistance are discriminated against since, unlike persons capable of causing their own deaths, they are deprived of the option of choosing suicide.\textsuperscript{58}

While the argument was also raised in the Pretty case, the European Court held that any discrimination that did arise would be justified as the State was

\textsuperscript{56} Pretty, supra note 50, at 74.

\textsuperscript{57} The White Paper, A Bill of Rights for New Zealand (1985) AJHR A6, para 10.144.

\textsuperscript{58} Rodriguez, supra note 44, at 54.
entitled to regulate through the operation of the general criminal law activities which are detrimental to the life and safety of other individuals. In the Court’s opinion, building into the law an exemption for those judged to be incapable of committing suicide would seriously undermine the protection of life and greatly increase the risk of abuse.\(^{59}\)

A somewhat tenuous argument may be made based on the right to thought, conscience, religion and belief, which is protected by section 13 of the Bill of Rights Act. It has been claimed that this right covers a patient’s belief in assisted suicide. The courts have rejected this argument. For instance, in *R (on the Application of Dianne Pretty) v DPP and Secretary of State for the Home Department* Lord Steyn noted that the right “was never intended to give individuals a right to perform any acts in pursuance of whatever beliefs they may hold.”\(^{60}\) This view was endorsed by the European Court who commented that “not all opinions or convictions constitute beliefs in the sense protected by [the right].”\(^{61}\)

An even less persuasive argument is that the prohibition on euthanasia limits a patient’s right not to be subjected to cruel or degrading treatment. It has been suggested that the distress, pain and suffering that a terminally ill patient faces qualifies as degrading treatment, and, even though it was not directly responsible, the State is obliged to protect its citizens from such treatment. The main issues that arise for consideration are whether the State is under a positive obligation to provide protection against cruel or degrading treatment; whether the State’s conduct in prohibiting assistance in dying constitutes ‘treatment’; and, if so, whether the State is subjecting a person to it by merely prohibiting help. Consideration of the interpretation given to a similar provision in the European Convention in the *Pretty* case is instructive. There it was unanimously held that the right imposes a positive obligation on the State to provide protection against cruel or inhuman treatment. The European Court commented that the suffering which flows from naturally occurring illness may be covered by this right but only where it is, or risks being, exacerbated by treatment flowing from measures for which the

\(^{59}\) Pretty, *supra* note 50, at 89.

\(^{60}\) *R (on the Application of Dianne Pretty) v DPP and Secretary of State for the Home Department* [2002] 1 All ER 1.

\(^{61}\) Pretty, *supra* note 50, at 82.
authorities can be held responsible. This requirement proved decisive, particularly as there was general agreement that the State had not inflicted any ill-treatment on the applicant or deprived her of receiving adequate medical care. The Court thus concluded that the right did not impose a positive obligation requiring the State to permit or facilitate assisted suicide.

From this discussion, it is clear that a number of arguments can be made in support of the view that the interests at stake with regard to euthanasia should be recognised as a right. However, in the absence of any case-law in support, it is doubtful that such recognition will be given on the basis of the Bill of Rights Act or other human rights instruments.

V The Death with Dignity Bill

Of course, the absence of any ‘right to die’ in the Bill of Rights Act does not prevent the legislature from enacting such a right in legislation. The question then becomes whether anything in the Bill of Rights Act precludes such legislation, or dictates certain procedural safeguards to prevent abuses. This was the very issue facing the Attorney-General when she examined the Death with Dignity Bill for consistency with the Bill of Rights Act.

The Attorney-General first considered whether the procedures proposed in the Bill deprived a person of their life. She acknowledged that by adopting one possible meaning of the word – namely to take without permission – an element of consent may be read into the right not to be deprived of life. Accordingly, an argument could be made that the protections provided by this right were discretionary and could be waived by patients who consent to the termination of their lives. However, the Attorney-General rejected this argument after noting that there was jurisprudence to the contrary. For instance, the Court of Appeal stated in Shortland v Northland Health Ltd that the right guaranteed by the right not to be deprived of life was fundamental and therefore “should be given full effect and generous interpretation.”

62 Ibid, 52.
63 Ibid, 56.
64 Attorney-General’s Report, supra note 1, at 2.
65 Ibid.
This suggests that while not absolute the right transcends the individual and therefore cannot be waived in this way. Similarly, in *R v Brown* the House of Lords held that consent ceases to be legally effective when the consensual infliction of serious harm is involved.  

The Attorney-General thus concluded that it was “extremely unlikely that the courts would adopt this meaning of the word” and took the view that consent would by-pass the protections conferred by this provision.

The Attorney-General then turned to the issue of whether such deprivation was “on such grounds as are established by law and are consistent with the principles of fundamental justice.” Although the New Zealand courts have had little opportunity to develop comprehensive and definitive jurisprudence on the scope and definition of the term “fundamental justice”, their Canadian counterparts have held that the principles of fundamental justice are to be found in the basic tenets of the legal system. Such an approach was adopted to ensure that the determination of fundamental principles was the “domain of the judiciary as guardian of the justice system”, as opposed to being left to general public policy informed by philosophy and social science. But despite the criticisms that have been raised regarding the role the courts have taken for themselves on this issue, the approach proposed means that the law must be substantively just and applied in a procedurally fair manner. Whenever a law permits an individual to be deprived of life, the legislature must from the substantive point of view strike the right balance between the competing values that need to be reconciled. From the procedural perspective, the legislature must ascertain that the law affords sufficient legal protection against potential abuse.

In the *Rodriguez* case, the Supreme Court considered whether providing medical assistance to end life was consistent with the principles of fundamental justice. In that case, the court asserted that ‘fundamental’ principles were those that had ”general acceptance among reasonable

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68 Attorney-General’s Report, supra note 1, at 2.
70 *Rodriguez*, supra note 44, at 503.
people. The court recognised the need to balance an individual’s right to personal autonomy in the sense of being allowed to seek assistance in dying, against the state’s obligation to preserve life and protect the infirm and vulnerable. The majority of the court concluded that the blanket prohibition on assisted suicide existing at the time in Canada was not arbitrary or unfair, and was reflective of fundamental values at play in society, namely the concern with preserving life and protecting the vulnerable.

Responding to the claim that Article 2 of the European Convention was, in essence, a right to self-determination over life, the House of Lords noted that this argument was inconsistent with two principles deeply embedded in English law. The first principle being the distinction recognised in law between taking one’s own life by one’s own actions and the taking of life through the intervention or help of a third party. The second being the distinction between the cessation of life-saving or life prolonging treatment and the taking of action lacking medical, therapeutic or palliative justification but intended solely to terminate life on the other. The European Court subsequently commented that while the United Kingdom authorities were not binding on it there was nothing to suggest that they were inconsistent with the jurisprudence that has grown up around the European Convention.

The New Zealand courts have not yet been called upon to examine the issue of assisted suicide other than in prosecutions under the Crimes Act. But they have considered the competing values that arise when withdrawing life-support from a patient who is in an irreversible vegetative state. When

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72 Rodriguez, supra note 44. See also Florencia and Keller, supra note 13 at 246 (noting that a principle of fundamental justice requires more than vague generalisation, it requires general consensus among reasonable people that can be identified and applied).

73 Ibid, 188-190.

74 Ibid, 181-182.

75 Application of Dianne Pretty, supra note 60.

76 Ibid, 9.

77 Ibid.

78 Pretty, supra note 50, at 41.
carrying out this exercise, the courts have recognised that the values of human dignity and personal privacy are central to the concept of human life.\textsuperscript{79} Accordingly, the patient’s right to be free from pain and discomfort has been considered alongside the state’s interest in preserving life and protecting the infirm and vulnerable in such cases.\textsuperscript{80}

As the Attorney-General noted, the courts have acknowledged the distinction between desisting with life prolonging treatment and taking action lacking therapeutic or palliative value for the purpose of terminating life.\textsuperscript{81} Though their willingness to consider quality of life issues (i.e. unacceptable levels of pain, suffering and distress) as part of the balancing exercise associated with the substantive aspect of fundamental justice raises the possibility that the proposal to allow physicians to assist terminally ill patients terminate their lives – following strict procedural safeguards regarding competency and consent – may be considered substantively just. By allowing patients to seek the assistance of a physician to end their lives in a peaceful, dignified and relatively pain-free manner, society may be seen as showing mercy and compassion towards such persons. This is a consideration that the courts would no doubt take into account.

In order to be consistent with the right not to be deprived of life, any procedure that allows a physician to assist a patient end his or her life needs to contain robust procedural safeguards to ensure the authenticity and reliability of the patient’s decision. It was on this count that the Death with Dignity Bill failed.

The Attorney-General noted that the Bill contained comprehensive procedural safeguards where a patient requested the assistance of a physician in dying.\textsuperscript{82} These safeguards provided that the request could only be carried out after medical confirmation, a psychiatric assessment, counselling and personal reflection. In contrast, the safeguards in the advance directive process were not as robust – a feature that may affect the authenticity and reliability of the patient’s decision. The Attorney-General noted that there

\textsuperscript{79} See Auckland Area Health Board v Attorney-General (1992) 8 CRNZ 634.

\textsuperscript{80} See Auckland Healthcare Services Ltd v L (1998) 5 HRNZ 748.

\textsuperscript{81} Attorney-General’s Report, supra note 1, at 3.

\textsuperscript{82} Ibid.
was no mandatory requirement for the patient to consult with a psychiatrist – which would ensure that patients were not suffering from a mental disorder or clinical depression that may have impaired their judgement – or undergo counselling. Moreover, it would be extremely difficult for the physicians to verify whether a patient made the request voluntarily and was competent to do so, especially as the patient will lack the required mental capacity by the time they become involved.\textsuperscript{83} The author agrees with this point, particularly as in most cases the role of the physicians will be confined to simply checking that the directive was correctly witnessed. This will be especially the case where advance directives – which did not expire under the Bill – were made years before the physicians’ involvement in the patient’s treatment.

It is possible to conclude from the Attorney-General’s report that the Bill of Rights Act would not preclude legislation enabling a patient to seek medical assistance to die so long as the procedural safeguards contained in the Death with Dignity Bill were adequately strengthened. Possible additional safeguards include ensuring that there was an investigation of not only a patient’s psyche but also the patient’s family dynamics and the financial implications of his or her death. To ensure that requests are properly considered, both by the patient, the family and the authorities, a sufficient time-period for reconsideration should also be built into the procedure. The Death with Dignity Bill allowed only 48 hours for self-reflection, well short of the fifteen days that were allowed for in the US state of Oregon. Finally, proponents of euthanasia legislation should consider restricting euthanasia to only those patients who are terminally ill with a life expectancy of less than 6 months.

There is considerable disagreement, however, about the level of safeguards that would be sufficient. In fact, the House of Lords doubt the possibility that secure limits on physician assisted suicide can ever be set. In their opinion “it would be next to impossible to ensure that all acts of euthanasia were truly voluntary, and that any liberalisation of the law was not abused.”\textsuperscript{84} A number of commentators disagree. Florencio and Kelly note that the prevalence and abuse of euthanasia in jurisdictions that permit the practice do

\textsuperscript{83} Ibid.

\textsuperscript{84} HL Paper (1993-94) 21-I.
not support the hypothesis that the legalisation of active voluntary euthanasia for competent terminally ill patients would lead society down a slippery slope.\textsuperscript{85} However, a recent study from the Netherlands seems to undermine this assertion. The study reported that 22 mercy killings of terminally ill babies had occurred since legislation allowing euthanasia was introduced, despite that legislation limiting euthanasia to persons over 16 years, and to those over 12 in exceptional cases.\textsuperscript{86} In light of this, the issue of whether meaningful and effective safeguards can be identified to protect vulnerable patients will be, in the author’s view, one of the main issues that will need to be addressed by those proposing the adoption of euthanasia legislation.

But assuming that adequate safeguards can be identified and legislation was enacted legalising active voluntary euthanasia, the last issue that needs to be explored is what legal status, if any, should be given to the patient’s interest in choosing an earlier death: that is, should the ‘right to die’ be expressed in terms of a basic right or a legally enforceable right? This issue is important as it affects the type of duties that would be imposed on the State.

Categorising the ‘right to die’ as a basic right would oblige the various branches of government as well as those institutions performing a public function to refrain from doing any act that would unjustifiably limit a patient’s ability to request assistance to terminate his or her life. But it would not impose any positive obligations on the part of the State, which may arise if the right to die was expressed in terms of a legally enforceable right. Concern has been raised that in that case the State may be required to provide public funding for active voluntary euthanasia and, more importantly, physicians may be obliged to provide assistance despite the practice being contrary to their moral beliefs.\textsuperscript{87}

But the concerns about the way in which the right is described are overstated, particularly as the same arguments have been raised in opposition to abortion. First, medical students are given the option of forgoing training in abortion techniques if they have moral reservations about the practice. It is likely that

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\textsuperscript{85} See Florencio and Kelly, \textit{supra} note 13 at 252.
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training in the administration of euthanasia would be similarly optional. In this connection, the Death with Dignity Bill stated that no physician would be compelled to assist patients end their lives if the physician was morally, ethically, religiously or ideologically opposed. Second, overseas courts have noted that the government is “free to make funding decisions that reflect a preference for the preservation of life.” While the denial of public funds for active voluntary euthanasia may impede access to the practice for a large proportion of society, such a limitation would not preclude private institutions from offering this service.

VI Conclusion

Euthanasia is without doubt one of the most complex issues facing New Zealand, especially given its ethical, legal, medical and religious dimensions. Since aiding and abetting suicide is illegal, New Zealand’s justice system is an essential player in the debate. Similarly, if patients request a physician to end their lives, the medical community is involved. Further, most religions consider life to be sacred: terminating a life, for whatever reason, not only infringes religious beliefs but may transgress divine activities beyond the reach of human beings.

Although euthanasia is unlawful, there is an increasing movement towards legalisation, particularly in jurisdictions overseas. Since the early 1990s, “serious political and legal actions taken by euthanasia advocates and their lawyers have brought assisted suicide to the brink of legal assistance.” In fact, legislation allowing voluntary euthanasia has been passed in a small number of jurisdictions, and domestic courts in other countries are being repeatedly asked to consider whether the interests at stake with regard to the right to die should be recognised. New Zealand has not been left out of this

88 Death with Dignity Bill, clause 8.
89 Gifford, supra note 87 at 1580 (referring to Harris v McRae 448 US 297, 315 (1980) and Mather v Roe 432 US 464, 474 (1977)).
90 Grifford, ibid.
debate. The introduction of the Death with Dignity Bill along with the trial of Lesley Martin has raised public awareness of the issue and it seems likely that further attempts will be made to legalise active voluntary euthanasia.

Based on overseas experience, human rights will continue to play a prominent role in the euthanasia debate, particularly as those on either side of the debate have framed many of their arguments in rights language. Although the rights and freedoms protected in the Bill of Rights Act do not recognise the ‘right to die’, they do not appear to preclude active voluntary euthanasia either so long as appropriate procedural safeguards to protect the vulnerable are inserted in any regime allowing patients to request assistance to die. But human rights will not provide an answer to many of the concerns that have been raised about active voluntary euthanasia, particularly those relating to potential abuse by physicians and medical institutions, members of the patient’s family and society in general. It also will not resolve the struggles between divergent religious doctrines, social attitudes and philosophical beliefs concerning “the value and meaning of life, the redemptive virtues of suffering and the moral and societal taboo against the act of suicide.”\(^{92}\) Unfortunately, there do not appear to be any easy answers to these issues.

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