

Euthanasia: Law and Morality

Paul Key

Introduction

At the basis of all modern legal systems lies the fundamental assertion that human life should be protected. Legal systems, regardless of specific variations in cultural or social context, recognise the value of human life by prohibiting homicide and punishing acts which constitute a danger or serious threat to the lives of other human beings. However, New Zealand law does not regard the preservation of life as an absolute value in itself. Any person who is not under a duty of protection may refuse to save another person's life regardless of the certainty of death. Further, attempted suicide is not an offence and homicide committed in self-defence goes unpunished. Nevertheless, the instances in which the law fails to penalise actions intended to terminate human life are exceptional.

In recent years medico-legal issues of a moral character have arisen for consideration by law reform agencies in a variety of situations. One such arises because medical advancements have considerably reduced the rate of premature mortality, but have at the same time substantially increased the number of individuals who may survive in a condition marked by an unsatisfactory quality of life. Terminally ill patients, those who are in a coma, seriously defective newborns – all may have their lives prolonged by means of modern technology in situations where the decision is based largely on technical criteria rather than on considerations for the patient himself.¹ An increasing and significant number of patients are demanding that their life be ended to overcome irrepressible pain or lack of basic human faculties.

¹ All non-specific personal pronouns of either gender are intended to be read as referring to both sexes equally and interchangeably.

The modern law reformer faces two central questions. First, does an individual have a right to die? Second, do individuals have a right to let someone else die? There is an inherent tension between the public interest in improving community health standards and preserving life, on the one hand, and the individual's right to personal autonomy on the other.

This paper aims to provide an overview of a number of moral and legal problems posed by euthanasia. The writer will assert the right of an individual to choose death free from all restraint or interference by others.

The Meaning of Terms Used in this Paper

The term most commonly associated with the right to die is "euthanasia". In using this term distinctions may be made on the basis of the means of causing death and the voluntariness of the victim. The usual distinction drawn is between active and passive euthanasia.

Active euthanasia is best defined as the positive act of causing the death of another for compassionate reasons. Passive euthanasia is best defined as the omission to act to save the life of another. Again, the omission to act is inspired by compassion. An example is omitting to operate on a person who will certainly die without the operation.

A further distinction may be drawn between voluntary and involuntary euthanasia on the basis of whether or not the victim consented to his or her death. This distinction applies to both active and passive euthanasia. In this paper the term "euthanasia" shall refer to voluntary euthanasia only.

The New Zealand Position

The relevant New Zealand law is found in Part VIII of the Crimes Act 1961 and associated case law. Here, distinction is made between killing and allowing to die. The former is considered more reprehensible and deserving of greater punishment; the latter is only punished in those circumstances where the inaction constitutes a breach of a legal duty to act.

Section 164 of the Crimes Act provides that:

Everyone who by any act or omission causes the death of another person kills that person, although the effect of bodily injury caused to the person was merely to hasten his death while labouring under some disorder or disease arising from some other cause.

Homicide is defined in s 158 as: "The killing of a human being by another, directly or indirectly, by any means whatsoever." Culpable homicide is either murder or manslaughter; the difference between the two being the intent of the agent which, in the case of murder, is to cause death or bodily harm known to be likely to cause death. The definition of murder contained in s 167(a) is a clear and absolute prohibition of active euthanasia; culpable homicide is murder if the offender means to cause the death of the person

killed, irrespective of motive. Thus a person will be guilty of murder whether he means to cause the death of another for reasons of vengeance, greed, compassion, or charity.

Furthermore, s 63 provides that:

No-one has a right to consent to the infliction of death upon himself; and, if any such person is killed the fact that he gave any such consent shall not affect the criminal responsibility of any person who is a party to the killing.

Neither the patient's consent, request, extremity of his suffering, nor the imminence of his natural death serves as a defence.² Indeed, it appears that merely asking to be killed may be criminally culpable under s 174.

The liability of a person who has performed passive euthanasia is less clear. One difficulty is determining whether an action is in fact active or passive euthanasia. For instance, does a doctor, when he turns off a respirator with knowledge that the patient will die, act or omits to act. This situation is commonly classified as an omission rather than as an act.³ Although the argument used to prove this proposition has a certain logical appeal, it is submitted that the better view is that the agent has caused the death by the act of turning off the respirator. The doctor, after all, has not permitted the death to occur without active intervention. If this is so, the situation should be viewed as an act within the meaning of the Crimes Act and will be actionable.⁴ This analysis is also theoretically consistent with the legal concept of causation: the act is a substantial and operating cause of death.

Prima facie, an omission to act will only be criminally culpable if death has been caused, as stated in s 160(2)(b), by "an omission without lawful excuse to perform or observe any legal duty."⁵ In this context, legal duties imposed on certain persons assume real significance. Section 151 imposes a legal duty on any person who has charge of any other person to supply the necessaries of life when that other person is unable, by reason of detention, age, sickness, or other cause to withdraw himself from such charge to provide himself with the necessaries of life. Thus, the failure by a doctor to provide treatment for an unconscious patient might in certain circumstances result in prosecution under ss 151 or 160.⁶

Sections 155 and 157 deal with two different but complementary duties. Section 155 requires everyone undertaking to administer surgical or medical

² Williams, *The Sanctity of Life and the Criminal Law* (1958) 283-284.

³ See for instance Fletcher, "Prolonging Life: Some Legal Considerations" in Steinbock (ed) *Killing and Letting Die* (1980) 48-55; Williams, "Euthanasia and the Physician" in Kohl (ed), *Beneficent Euthanasia* (1975) 153-154; and the judgment of Hughes CJ in *In re Karen Quinlan* 355 A 2d 647.

⁴ It should be noted that a benevolent judge or jury may always adopt the view of Hughes CJ in *In re Karen Quinlan*, *ibid*, and determine that the act was not unlawful within the meaning of s 160(2)(a).

⁵ Section 160(2)(b). See for example *R v Steel* and *R v Malcherek* both [1981] 2 All ER 422.

⁶ Canadian Law Reform Commission, *Euthanasia, Aiding Suicide and Cessation of Treatment* (1983) 16. The relevant Canadian legislative provision is s 215 of the Criminal Code.

treatment or any other lawful act which may be dangerous to life to use reasonable skill and care in doing so. The use of the word reasonable in s 155 places particular importance on the circumstances of each case. In medical terms it involves consideration of current medical practice and liability will only be imposed if the action was unreasonable in the particular circumstances of the case. For instance, a doctor who makes no attempt to resuscitate a person in an irreversible coma will probably be absolved, since a court would consider his action reasonable.⁷ On the other hand, a doctor who undertakes to treat a defective newborn and then subsequently decides not to perform a minor but life-saving treatment on his own or the parent's initiative would most likely be liable under this section.

Section 157 imposes the general duty to continue an act, once undertaken, if an omission to do the act may be dangerous to life. This section is of particular importance. Cessation of treatment which may be dangerous to the life of a patient comes directly under this provision. It has been suggested⁸ that the duty imposed by s 157 may be qualified by s 61 which protects from criminal liability anyone performing a surgical operation upon any person where reasonable to perform the operation, having regard to the state of health of the patient. The proposition put forward is that the conduct on which the law is based is the reasonableness of the act under the circumstances. Not every case of negligence will result in criminal liability. Rather, it is only those instances which demonstrate a wanton or reckless disregard on the part of the agent which will attract criminally liability. Case law on this section supports the above approach and it appears that:⁹

In order to establish criminal liability the facts must be such that . . . the negligence of the accused went beyond a mere matter of compensation between subjects and showed such disregard for the life and safety of others as to amount to a crime against the State and conduct deserving punishment.

Thus a breach of the duty prescribed in s 157 will lead to criminal liability only if the omission to act reflects wanton or reckless disregard for life on the agent's part. In this case one may conclude that a doctor who has assured himself using standard medical procedures and texts that the patient within his care is in a state of irreversible coma and refuses to administer penicillin to prevent pneumonia will not attract liability. The treatment is not reasonable having regard to the condition of the patient and, furthermore, his action does not reflect wanton or reckless disregard for life.

It should be noted that statutory liability for negligence imports the higher criminal standard of negligence only if the section itself does not specify the requisite standard of behaviour. Section 155, which requires a person to use reasonable knowledge, skill, and care, creates liability for negligence at a level

⁷ But liability may still arise under s 151.

⁸ *Supra* at note 6, at 17.

⁹ *R v Bateman* (1925) 18 Cr App Rep 8, 11-12.

lower than the criminal standard.¹⁰

If it has been established that there is an omission without lawful excuse to perform or observe any legal duty which results in the killing of any person then culpable homicide,¹¹ at the very least manslaughter,¹² will have been established.

Issues of causation can arise in situations of both active and passive euthanasia. To constitute homicide the act or omission must be shown to have caused the death of the person.¹³ An example illustrating the difficulty is where a fatal dose of a drug has been administered where this dose is in fact the minimum necessary to deaden pain. A doctor may prescribe the minimum dose of a drug necessary to kill pain if a patient is suffering from an incurable and agonising disease and ordinary quantities of the drug will fail to render the pain bearable. The prescription will be given in the knowledge that the quantity is an amount likely to kill the patient. This is known as the "double effect" situation and involves a choice between doing nothing and killing both the pain and the patient.¹⁴ If the latter option is taken then clearly the doctor has accelerated the death of the recipient and is, *prima facie*, liable for murder.¹⁵ As was pointed out by Devlin J in the prosecution of Dr John Adams for murder in 1957, shortening life amounts to murder and the law knows no special defence of preventing severe pain. However, he proceeded to add:¹⁶

If the first purpose of medicine – the restoration of health – can no longer be achieved there is still much for a doctor to do, and he is entitled to do all that is proper and necessary to relieve pain and suffering even if the measures he takes may incidentally shorten life.

In an unreported section of his Honour's direction, he continues:¹⁷

That is not because there is any special defence for medical men . . . what I have said to you rests simply upon this: no act is murder which does not cause death. [A jury] would say that the cause of [the victim's] death was the illness or the injury, or whatever it was, which brought her into hospital, and the proper medical treatment that is administered and that has an incidental effect of determining the exact moment of death, or may have, is not the cause of death in any sensible use of the term.

In practical terms this may achieve what many would consider to be a just result; however, in terms of pure legal theory the conclusion reached by Devlin J is doubtful.¹⁸ If the death of a patient is a natural consequence or a

¹⁰ *R v Storey* [1931] NZLR 417.

¹¹ Section 160(2)(b).

¹² Section 171.

¹³ Section 164 determines that merely hastening a person's death while he is labouring under a disorder or disease arising from some other cause constitutes homicide.

¹⁴ *Supra* at note 6, at 11; Williams, *supra* at note 2, at 285.

¹⁵ CLRC, *ibid*.

¹⁶ [1957] Crim LR 365, 367.

¹⁷ See Williams, *supra* at note 2, at 289.

¹⁸ The doctrine has been dealt with severely by some eminent philosophers. See for instance Hart, *Punishment and Responsibility* (1968); Foot, "The Problem of Abortion and the Doctrine of the Double Effect" in Steinbock (ed), *supra* at note 3, at 156.

foreseeable probability of the doctor's actions then he must be held to have caused the death.¹⁹ Administration of the drug would be a substantial and operating cause of death at the time of death and fulfil the requirement for causation. The above statement of Devlin J has, however, been accepted as representing the law. Nevertheless, it does possess clearly defined limits. A physician would not legally be permitted to anticipate matters by administering a fatal dose in order to save a patient from living out a numbed, miserable, and hopeless existence.

Both legal opinion and case law indicate that where an individual of sound mind refuses treatment and death results, a person who modifies his actions in accordance with the request to remove treatment will not be criminally liable.²⁰ While prima facie this appears to be culpable homicide under s 160(2), the right to self-determination is taken to obviate any liability.²¹ This may be justified on the basis that it is not criminally negligent (under ss 151-157) to omit to perform a legal duty when one is so instructed by the patient. Such a finding is consonant with the respect for man's right to self-determination that the law has traditionally shown, while still protecting and promoting the maintenance of life as a fundamental value. It is submitted that although this approach is correct and laudable there should nevertheless be a clear and formal statutory recognition of a patient's absolute right to refuse medical treatment or demand its cessation even if death will inevitably result.²²

Of peripheral importance to this area of the law is the offence of aiding and abetting suicide contained in s 179. This section makes it an offence punishable by imprisonment for fourteen years to counsel or aid suicide. The difficulty here is to determine whether an action is one of aiding suicide or direct participation in homicide. For instance, does a person who, at a dying man's request, prepares a poison and leaves it on the bedside table for him to take commit a crime different from a person who helps the man to drink it or who administers it directly at the request of a dying man unable to take it himself? These are questions of causation, and in any given situation it must be asked whether the actor caused the death of the person killed. If the answer is in the affirmative then the offence will be culpable homicide.

¹⁹ And have intended the consequence. See *R v Moloney* [1985] AC 905, and *R v Hancock* [1986] 1 All ER 641; cf the view of Beattie J who considered that the problem could be resolved on an absence of mens rea: Beattie, "The Right to Life" in NZ Law Society 16th Triennial Conference, *Papers To Be Discussed* (1975) 94, 102.

²⁰ See for instance supra at note 6, at 35; Williams, supra at note 2, at 158; *Smith v Auckland Hospital Board* [1965] NZLR 191, 219 per Gresson J.

²¹ The usual example given is that a member of the Jehovah's Witness may legitimately refuse consent to a blood transfusion even though death will inevitably result from this refusal. Some implicit recognition of this situation is given by s 165 Crimes Act.

²² Supra at note 6, at 55-57; Keyserlingk, *Sanctity of Life or Quality of Life* (1979) 189.

Application of the Law

Proceedings based upon ss 151-168 in respect of compassionate murder or voluntary euthanasia are extremely rare. Where charges have been laid acquittal rates have been high. The dearth of criminal convictions, particularly in respect of doctors or hospital staff, would seem to indicate that such people have little to fear in practice. There are several reasons for this.

First, a charge of murder against a physician who has administered a lethal dose or has killed a patient in some other unobtrusive manner is inherently difficult to prove.²³ As an evidential matter, it will often be difficult to establish an adequate causal relationship between the act and the ensuing result. For example, if a patient has been receiving large doses of a drug over a considerable period it may be difficult to determine the amount of the final dose, whether such a dose was so large as to be unlawful, and whether death was caused by it.

Second, the system of criminal justice contains a series of filtering processes.²⁴ Not only must cases come to the attention of the authorities, but also a decision to prosecute must be made: a decision that is influenced by moral as well as evidential factors.

Third, juries are often reluctant to convict doctors or others on trial in such circumstances.²⁵ They may seize upon a defect in the evidence as a reason for acquitting. Moreover, they may even acquit when the evidence and the judge's direction leave them with no legal reason for doing so.

Fourth, a person convicted of a lesser crime than murder will often be shown clemency on the part of the sentencing judge and be imprisoned for a period considerably less than the maximum imposed by the law.²⁶

In spite of such factors, uneasiness among medical specialists and the public is justified. Present legislation casts serious doubt on the legality of current medical or hospital practices. Doctors who assist with voluntary euthanasia will always be subject to a potential prosecution, and countervailing factors such as angry relatives or informants may be present. Consequent uncertainty may lead to a complete split between legal practice and legal rule or may have the opposite effect and lead to conservative medical practice conforming to the strictest standards which it believes the law establishes.

It is therefore desirable for the law to take a position and clearly indicate whether or not a given medical practice is acceptable. While a precise answer may not be set out for every act that a doctor will perform, it is submitted that the law could and should be formulated in a manner that establishes general parameters which are still specific enough to delineate clearly between what is

²³ Williams, *supra* at note 2, at 291.

²⁴ *Supra* at note 6, at 21-22; Williams, *supra* at note 2, at 292.

²⁵ Cantor, "Law and the Termination of an Incompetent Patient's Life Preserving Care" in Bok (ed), *The Dilemmas of Euthanasia* (1975) 69, 74; Williams, *supra* at note 2, at 292.

²⁶ See generally Humphry, *The Right To Die* (1986).

considered acceptable and what is not.

Imminent Changes

The Bill creating a new Crimes Act has now been introduced into Parliament which will alter the provisions of ss 158-168. In particular there will be a single offence of culpable homicide in place of what is presently the offence of murder.²⁷ The present manslaughter cases will no longer be punishable under the homicide provisions unless the act or omission was intended to cause harm²⁸ or showed reckless disregard for others.²⁹ In addition, the punishments for unlawful killing will be discretionary with a maximum penalty of life imprisonment;³⁰ the penalty for a dangerous act or omission will be a maximum of fourteen years imprisonment.³¹ The failure to observe a legal duty will be punishable only where there is gross negligence, thus abrogating *R v Storey*.³²

The resultant legal position will be similar to that at present. Active euthanasia will be punishable as culpable homicide, while passive euthanasia will be punishable as a dangerous omission. The positive, albeit limited, features of this reform are the requirement for gross or criminal negligence in all cases concerning a breach of a legal duty, and the greater discretion now permitted in sentencing. However, issues of causation and whether a situation constitutes an act or an omission will remain.

The Moral and Philosophical Argument

Many people today find existing laws regarding euthanasia and the right to die illogical and untenable. In most situations the law recognises that a patient has the right to refuse treatment. Is it not consistent, it is asked, to recognise that the same ground of self-determination may allow the positive act of killing? Prima facie, the terminally ill patient is allowed to choose death by demanding that life-preserving treatment be stopped. He may also commit suicide. However, he is not permitted to consent to be killed by a positive act of another, even in situations where the patient is physically unable to kill himself and where inaction will lead to a painful death or may result in the individual becoming overburdensome to others. In view of this it has long seemed to some people that euthanasia – the merciful extinction of life – is morally permissible where the patient consents and where it is the only way of

²⁷ Culpable homicide is also to include those situations where murder is reduced to manslaughter on account of provocation.

²⁸ Clauses 130(1)(a) and 132(1)(a).

²⁹ Clauses 130(1)(b) and 132(1)(b).

³⁰ Clause 123.

³¹ Clause 130.

³² [1931] NZLR 417. Liability is consequent upon falling within clauses 122, 130 or 132.

relieving his suffering.³³

Traditional approaches to the problem of euthanasia have been based on the concept of "sanctity of life". This principle is the bedrock upon which our law has placed its foundations. It takes two forms. The first, which I shall term "vitalism" is that life, in itself, is to be preserved at all costs. The second is a more flexible version, incorporating considerations of one's quality of life: life itself is a relative, rather than absolute, value.

Vitalism

Vitalism holds that human life is an absolute value in itself and that every effort must always be made not only to preserve it but to prolong it with all available means.³⁴ The principle derives support from theology, and by reference to intuition and experience.

THEOLOGY

The Judeo-Christian belief in a benevolent God has created the offspring belief that: "man's dignity, worth and sanctity are from God, and not due to some quality or ability in man."³⁵ Life is not sacred because it is life; rather, it only gains true meaning because it has been created and gifted by God. It is given on trust for God's purposes.³⁶ Man does not have dominion over it and no man can be an absolute master over his life and body.³⁷ The power to take an innocent human life is reserved for God and any direct killing of the innocent without the authority of God is wrong and against the natural law. That an individual consents to being killed does not alter the turpitude of the act.

The most serious difficulty faced by those proposing a rule of law based upon religious dogma is that it will only be convincing to those who accept the religious viewpoint; that is, those who are already believers. A large number of people are not and never have been religious. It is argued convincingly by Glanville Williams that a prohibition based purely upon a religious belief should not be extended to a person not sharing that belief where this is not required for the welfare of society generally.³⁸ Moreover, modern law is not and, it is submitted, should not be, dictated by popular religion. Attempted suicide has been removed as an offence from New Zealand law, as have offences prohibiting extra-marital sexual intercourse and contraception. Legal prohibition of euthanasia should not remain on this basis alone.

³³ Williams, *supra* at note 2, at 277. For an instructive survey of views on this subject throughout history see Humphry, *supra* at note 26.

³⁴ *Supra* at note 6, at 4.

³⁵ Keyserlingk, *supra* at note 22, at 11.

³⁶ *Ibid.*

³⁷ See for instance Ramsay, in Rachels (ed), *Moral Problems: A Collection of Philosophical Essays* (1971) 11-12.

³⁸ Williams, *supra* at note 2, at 278.

INTUITION AND EXPERIENCE

Intuition and experience also support the tenet that human life is an absolute value in itself.³⁹ As Edward Shils states:⁴⁰

The idea of sacredness is generated by the primordial experience of being alive, of experiencing the elemental sensation of vitality and the elemental fear of its extinction. Man stands in awe before his own vitality, the vitality of his lineage and of his species.

Our very experience of being alive and the elemental fear of death common to mankind demonstrates that life is sacred.

The simplest argument that can be put forward in reply is that life is not always a good in itself.⁴¹ Experience and intuition indicate equally that in some situations life is not to be protected at all costs.⁴² In comparing Hitler's camps with those of Stalin, Dimitri Panin observed that in the latter the method of extermination was made worse by agonies that could stretch out over months.⁴³

Death from a bullet would have been bliss compared with what many millions had to endure while dying of hunger. The kind of death to which they were condemned has nothing to equal it in treachery and sadism.

To save or prolong a person's life is not always to do him a service.⁴⁴ To deny this is to promote the assertion that every life, no matters its quality or circumstances, is worth living and must be lived. But is the value of existence of itself to be asserted even when all activities that give meaning to life are absent, or when personality has disintegrated due to the effects of illness?⁴⁵

Sanctity of Life

Neither justification for vitalism is entirely satisfactory, and thus legislating on the sole basis of this principle cannot be correct. In essence, it is not possible to demonstrate conclusively that life is the most primordial of experiences. Nevertheless, it may validly be argued that support for euthanasia does not require one to adopt vitalism. The need remains to examine and determine the precise nature and applicability of the principle of sanctity of life. In effect, there are two questions. First, what role, if any, does the principle have in determining the moral principle validity of euthanasia? Second, what is the

³⁹ See generally Keyserlingk, *supra* at note 22, at 14-16.

⁴⁰ Shils, "Sanctity of Life" cited in Keyserlingk, *ibid*, 15.

⁴¹ See for instance Foot, "Euthanasia" in Cohen (ed), *Medical and Moral Philosophy* (1981) 276, 279-303; Kohl, "Voluntary Beneficent Euthanasia" in Kohl (ed), *supra* at note 3, at 130.

⁴² For instance, when a retreating army has to leave behind wounded or exhausted soldiers in the wastes of an arid or snowbound land and where the only prospect is death by starvation or at the hands of a notoriously cruel enemy it seems that the prolongation of life is not a good.

⁴³ Panin, *The Notebooks of Soloquin* (1976) 67.

⁴⁴ See Foot, *supra* at note 18, at 279.

⁴⁵ Williams, *supra* at note 2, at 282; Fletcher, "The 'Right' to Live and the 'Right' to Die", in Kohl (ed), *supra* at note 3, 45 at 46.

relationship between this principle and the quality of life?

Although sanctity of life is a concept of abstract and indeterminate nature, in determining whether one should adopt a particular rule one needs a principle which operates at a higher level in order to judge the validity of that rule. Sanctity of life provides such a principle. A number of values come under its broad cover. As David Callahan states:⁴⁶

The sanctity of life involves a spectrum of values ranging from the preservation of the species to the inviolability of human bodies, from man in the aggregate (present and future) to man as an individual (present and future).

Viewed in this way, the principle of sanctity of life points towards the inherent value of human life, but it is not an absolute principle. It is thus distinguished from vitalism.⁴⁷ It does not preclude the need for human judgment, for example in medical decisions to treat or not to treat. Indeed such decisions are necessary. Inherent in the principle is the concept of the relative quality of life.⁴⁸ Today, technological advances render necessary choices about acceptable levels of quality of life. Not to choose is to choose.

Ultimately, consideration of one's quality of life should not involve a comparison of different human lives. The comparison is that between the qualities each particular patient has now, and those deemed by that patient to be normative or desirable – whether or not these are present or attainable. Decisions to cease, or not to initiate, life-saving treatment need not be made as if any type of life were an improvement over death. In some circumstances, to prolong or postpone death can reasonably be seen as non-beneficial to the patient. One such circumstance is where there is excruciating, intractable, and prolonged pain and suffering. Another is the lack of even a minimal capacity to experience or relate to other human beings. To allow death to occur in such a case may be to demonstrate respect both for the individual and for human life in general.

Is Active Euthanasia Morally Justifiable?

It is traditionally argued that, notwithstanding that it may sometimes be morally justifiable to allow a person to die, it can never be morally acceptable to kill another. Although killing usually involves positive actions to cause death, there are some cases of killing where death is caused by an omission. An example is the case of parents who do not feed their child, thus allowing the child to starve to death.⁴⁹ Responsibility simply turns here with the failure to comply with a legal and moral duty. Similarly, there are cases where positive acts do not directly cause a person's death, but ensure that death cannot

⁴⁶ Callahan, "The Sanctity of Life" in Cutler (ed), *Updating Life and Death* (1968) 185, 208.

⁴⁷ Fletcher, *supra* at note 45, at 46.

⁴⁸ Keyserlingk, *supra* at note 22, at 58-59.

⁴⁹ Steinbock, *supra* at note 3, at 1.

be avoided, as when someone conceals a lifeline which could save a drowning person.⁵⁰

The distinction between active and passive euthanasia does appear to affect one's assessment of the moral blameworthiness of the agent. This may be seen in the areas of law, theology and medicine. While it is illegal to kill another person, the law is usually indifferent to letting die. In the Judeo-Christian tradition the Sixth Commandment, on which so much of the theological interpretation of the sanctity of life is based, explicitly enjoined killing but is silent about letting die. The Hippocratic Oath explicitly enjoined doctors from giving deadly medicine to anyone but did not provide any clear guidelines concerning when treatment may be stopped or a patient allowed to die.

The writer accepts that the distinction between killing and letting die often makes a practical difference. However, it is not always an appropriate distinction. It is submitted that certain features usually connected with but not essential to the distinction determine when a moral and practical distinction should be made. The first is the motivation of the agent: in cases of killing, the motivation of the killer will often be more obviously reprehensible than the motivation of a person who merely lets someone die.⁵¹ The second is the certainty of the outcome: in most cases death is more likely when one is endeavouring to kill, rather than when one is merely refraining from preventing a death.⁵²

It follows that one would indeed normally consider the behaviour of a killer to be more repugnant than the inaction of one who lets a person die. In certain cases, however, the features described above will be symmetrical or irrelevant. The motivation for both active and passive euthanasia is compassion, and the likelihood of death will often be the same for both cases. It is submitted that there is no inherent moral significance enabling one to distinguish passive from active euthanasia. Indeed, once passive euthanasia is accepted, maintaining any such distinction can have appalling and inhuman consequences. As an example, choosing not to initiate life-extending treatment for a terminally ill patient, who dies after a day of excruciating agony, would then be morally preferable to killing that patient quickly and painlessly.

This writer's view is consistent with the ethical theory of consequentialism, which determines the moral value of an action in terms of the moral blameworthiness of its consequences. Opponents of this view must and do maintain that the manner in which the consequences are brought about is morally relevant, and that there are certain ways of bringing about consequences which are absolutely forbidden. However, if killing and letting die are morally equal apart from the manner in which death occurs, then it is submitted that a

⁵⁰ *Ibid.*, 1.

⁵¹ See for instance the analysis of Tooley, "An Irrelevant Consideration: Killing Versus Letting Die" in Steinbock (ed), *supra* at note 3, at 59-60.

⁵² *Ibid.*, 60.

moral distinction is, in these circumstances, unsound.

If, as argued above, passive euthanasia or letting die is sometimes morally legitimate then so too must active euthanasia or killing be in some circumstances morally legitimate. There will of course be practical considerations making passive euthanasia more acceptable than active euthanasia. These will be considered in the next section.

Practical Objections

The Difficulty of Obtaining Consent and Ensuring its Validity

The first objection to legislation permitting euthanasia is that a patient's consent to euthanasia may not always be free and full. The assumption behind legislative proposals for euthanasia is that terminally ill patients are lucid, intelligent, and informed. However, there may well be many seeking to consent to euthanasia whose faculties have been weakened by disease or drugs, who are suffering from both mental and physical anguish, and who may see themselves as a burden on their loved ones. In these circumstances there will inevitably be grounds for suspicion that requests to be killed do not in fact reflect the real and stable wishes of those making the request.

Law reform proposals allowing euthanasia must include some process of ensuring that the patient's consent is free and informed, and that he is in fact suffering from an incurable disease. In essence, supporters of euthanasia must strive for a goal which seems inherently inconsistent; a procedure for death which both provides ample safeguards against abuse and mistake, and yet at the same time is quick and easy in operation.⁵³

An acceptable legislative solution must strike a balance between providing safeguards for and facilitating euthanasia.⁵⁴ For instance, legislators may abandon cumbersome safeguards and give to the medical practitioner a wide discretion and trust in his good sense.⁵⁵ Such a balance could only be established at some expense to the certainty that each consent was valid. The writer would adopt these remarks of Glanville Williams:⁵⁶

[The] problem can be exaggerated. Every law has to face difficulties in application, and these difficulties are not a conclusive argument against a law if it has a beneficial operation. . . . The physician, conscious of the need to protect himself against malicious accusations can devise his own safeguards appropriate to the circumstances; he would normally be well advised to get the patient's consent in writing, just as is now the position before operations.

⁵³ Kamisar, "Euthanasia Legislation: Some Non-Religious Objections" in Downing and Smoker (eds), *Voluntary Euthanasia* (1986) 110, 140; Williams, *supra* at note 2, at 306.

⁵⁴ See Williams, "Euthanasia Legislation: Rejoinder to Non-Religious Objections" in Downing and Smoker (eds), *ibid*, 156, 157-160.

⁵⁵ See Williams' suggestion for a euthanasia statute, *supra* at note 2, at 302-309. In essence the argument becomes that it is better to permit some people to have their life extinguished on the condition of form filling than not to allow it at all.

⁵⁶ Williams, *ibid*, 307. See also Barrington, "The Case For Rational Suicide" in Downing and Smoker (eds), *supra* at note 53, 230 at 241.

Sometimes the patient's consent will be particularly clear because he will have expressed a desire for ultimate euthanasia while he is still clear-headed. . . . If, on the other hand, there is no such settled frame of mind, and if the physician chooses to administer euthanasia when the patient's mind is in a variable state, he will be walking in the margin of the law and may find himself unprotected.

The "Wedge" Argument

The wedge argument proceeds from the consideration that a course of action that would injure humanity if followed generally should therefore not be followed even in an individual case.⁵⁷ It states that euthanasia should never be allowed, for to permit in a single instance the direct killing of an innocent person would be to admit a most dangerous wedge that might eventually put all life in a precarious position.⁵⁸ Although any proposal may be innocuous as it stands, if accepted it might lead to further legislative proposals and ultimately to a complete breakdown of accepted standards. There is no way of ensuring that the wedge does not advance.

Thus, if euthanasia were legalized at a later date another bill for compulsory euthanasia might be passed.⁵⁹ In this context the actions of Nazi Germany are often referred to.⁶⁰ First there was the acceptance of the belief, basic to the euthanasia movement, that there is such a thing as a life not worthy to be lived.⁶¹ Initially this was confined to the severely and chronically sick. Gradually, however, it was enlarged to encompass the socially unproductive, the ideologically unwanted, and the racially impure. In effect, a procedure which was originally developed to allow the death of those who were a burden to themselves was diverted from its original purpose, and was eventually used to eliminate those who were a burden to others or to society. Although administering euthanasia to a particular patient might benefit that patient, the consequent risk of gradually eroding society's respect for the sanctity of life may ultimately be a greater cost than that incurred by continuing the suffering of one person.

The importance and application of this principle is susceptible to overstatement. No proposal for reform is immune from the wedge objection; it is the trump card of conservatives and traditionalists.⁶² Virtually every type of human conduct can have undesirable consequences, if imagined in inappropriate contexts.⁶³

⁵⁷ Sullivan, *Catholic Teaching on the Morality of Euthanasia* (1949) 54, cited in Williams, *supra* at note 2, at 280; Keyserlingk, *supra* at note 22, at 22-23. For a thorough analysis of the principle see Chesterton, "Euthanasia and Murder", *American Law Review* 8 (1937) 486, cited in Downing and Smoker (eds), *supra* at note 53, at 142.

⁵⁸ Sullivan, "The Immorality of Euthanasia" in Kohl (ed), *supra* at note 3, at 12.

⁵⁹ *Ibid.*

⁶⁰ See Keyserlingk, *supra* at note 22, at 23; Sullivan, *supra* at note 58, at 25.

⁶¹ Kamisar, *supra* at note 53, at 140.

⁶² Williams, *supra* at note 54, at 165.

⁶³ Williams, *supra* at note 2, at 280-281.

It is submitted that the fundamental question is whether the possibility that euthanasia laws might be broadened in the future should affect their adoption at the present time. The present proposal is to allow euthanasia only to assist in the termination of a person's life, *at his request*, on the grounds of compassion. One should not refrain from acting justly today for fear that one may not act justly tomorrow.

The Risk of Mistake in Diagnosis

This objection is that no one suffering from an apparently fatal disease should be deprived of life because there is always the possibility that the diagnosis is wrong. To practise euthanasia is to preclude any chance of correcting such error or eventuality.⁶⁴ Instances abound of patients who have been given little time to live by medical advisers and yet have survived for many years. To prevent any likelihood of misdiagnosis it is often suggested that the administration of euthanasia be restricted to diseases where the percentage of correct diagnoses is particularly high. Cancer is an example. Alternatively, euthanasia should not be permitted at all.

Additionally, there is always the possibility that some measure of relief or even a complete cure may have been developed in what would have been the lifetime of the patient.⁶⁵ If the control given to a patient by a partial cure were to cause an improvement sufficient to enable him to retake his place in society then the grounds for euthanasia would have been removed.⁶⁶

It is submitted in reply that all that can be expected of any moral agent is that he should do his best on the facts as they appear to him. It is equally possible to err by doing nothing as by acting. Clearly, before deciding upon euthanasia in any particular case, the risk of mistaken diagnosis would have to be considered. That risk could be minimised by requiring the opinion of more than one doctor before euthanasia was authorised. Further, it could be mandatory that the risk be brought home to the patient before consent is considered effective.

It is always possible that a new medical discovery will give an opportunity for remission or cure and will put an end to the requests for euthanasia from victims of a particular disease. However, this possibility is relevant only to those patients who would have been administered euthanasia just before the discovery became available for use.⁶⁷ When any new medical discovery is claimed, some time elapses before it becomes tested sufficiently to justify large-scale production of the drug or training in the techniques involved. It is expected that during this period euthanasia in that particular class of cases

⁶⁴ Keyserlingk, *supra* at note 22, at 126.

⁶⁵ Kamisar, *supra* at note 53, at 125.

⁶⁶ *Ibid*, 127.

⁶⁷ Williams, *supra* at note 54, at 163.

would be halted.⁶⁸

The Qualitative Need for Euthanasia

This objection is that there is no longer a great need for euthanasia. It is suggested that modern pain killers obviate the need for euthanasia⁶⁹ and that medical science has advanced to a stage where dying patients no longer have to endure extremes of physical pain. It is also said that the need for euthanasia could be minimised by directing resources to other areas of the medical profession. For instance, more hospitals for the care of terminally ill patients could be provided, existing medical staffing levels could be increased, and additional research could be funded into the prevention, therapy and cure of disease, and into the improvement of analgesics.

Nevertheless, although modern medicine saves many patients from extreme pain it often fails to save them from "an artificial twilight existence, with nausea, giddiness, extreme restlessness as well as the long hours of consciousness of a hopeless condition."⁷⁰ The control of pain will often only be possible by keeping the patient "continually asleep".⁷¹ The question legislators must face is whether the unintelligent brutality of such an existence is to be imposed upon one who wishes to end it. It seems highly probable that of the people dying in this condition each year, a significant number would accept voluntary euthanasia if it were available.⁷² By a comparatively simple change in the law these people would be allowed an easy death instead of a hard one.

Doctors as Killers

The principal objection from doctors is that while many accept the morality of voluntary euthanasia it is wrong for doctors to take any part in it. The role of the physician has traditionally been that of healer. To alter this role could adversely affect the patient/doctor relationship.⁷³ The knowledge that physicians will neither kill them nor let them die is an essential component of patients' trust in physicians.⁷⁴ Without such knowledge that trust would be seriously undermined.

⁶⁸ Bok, *supra* at note 25, at 8; Singer, "Taking Life; Euthanasia" in Arras (ed), *Ethical Issues in Modern Medicine* (2nd ed) 210, 212.

⁶⁹ Kamisar, *supra* at note 53, at 129.

⁷⁰ Williams, *supra* at note 54, at 164.

⁷¹ Saunders cited in Gillon, "Suicide and Voluntary Euthanasia: Historical Perspective" in Downing and Smoker (eds), *supra* at note 53, at 224.

⁷² British National Opinion Polls taken in 1964 and 1965 revealed that 48.6 percent of the doctors who replied, answered "yes" to the question: "Have you ever been asked by a dying patient to give him or her final release from suffering which was felt to be intolerable?" See Williams, "Euthanasia and the Physician" in Kohl (ed), *supra* at note 3, at 146. See also Gillon, *ibid*, 224-225 and the citations therein.

⁷³ Steinbock, *supra* at note 3, at 11.

⁷⁴ See for example, Keyserlingk, *supra* at note 22, at 128.

Although two parts of a doctor's duty are to preserve life and cure disease, an important third part is to allay suffering. Voluntary euthanasia is concerned primarily with situations in which life cannot be saved nor disease cured; it is submitted that in these situations the third obligation is primary. Moreover, it should be emphasised that proper legislation would not impose a duty to kill upon doctors who refused to do so. It would merely give the doctor the legal right to accede to his patient's wishes.⁷⁵ The fear that people might perceive doctors as killers has been overstated, since euthanasia legislation would be based on the concept of consent and would be restricted to a narrow range of situations.

Summary

It is clear that voluntary euthanasia suffers from very real practical objections. These objections have been met to some degree by proponents of euthanasia but it is recognised that they must be paid serious consideration in any legislative proposal. The challenge presented to law reformers is to create a proposal which reduces the practical objections to an acceptable level. This can be achieved by a careful balance between safeguards and discretion, and by restricting the administration of euthanasia to well defined situations.

Legislative Proposals

A variety of legislative proposals have been presented to law-making bodies around the world in answer to the demands of euthanasia proponents. The most noteworthy of these are outlined below. They illustrate the various approaches that law reformers have taken in an effort to meet objections to euthanasia.

Voluntary Euthanasia Bill of 1969 (UK)

In 1969 Lord Raglan, a Labour peer, introduced the Voluntary Euthanasia Bill into the House of Lords.⁷⁶ On a second reading in the House of Lords the Bill was rejected by a vote of sixty-one to forty.

The object of the Bill was to legalise voluntary active euthanasia. In effect the Bill authorised physicians to administer euthanasia to a consenting patient who was thought on reasonable grounds to be suffering from an irremediable physical condition of a distressing character. The patient desiring euthanasia was required to be over the age of majority. In addition, the patient must have been certified by two physicians to be suffering from:⁷⁷

[A] serious physical illness or impairment reasonably thought in the patient's case to be incur-

⁷⁵ Gillon, *supra* at note 71, at 226.

⁷⁶ An earlier Bill of 1936 is detailed and examined by Williams, *supra* at note 2, at 297.

⁷⁷ Clause 1(2).

able and expected to cause him severe distress or render him incapable of rational existence.

The patient must also have executed not less than thirty days previously, a declaration requesting the administration of euthanasia in the present circumstances.

The principal objections raised were practical rather than moral. In addition to the wedge argument, a number of specific objections were made:⁷⁸

- (i) There is no positive indication that as life goes on and becomes more painful the individual wishes to be destroyed.
- (ii) Most patients suffering from a chronic complaint will not be able to fulfil the requirement of having the requisite mental capacity to make a declaration.
- (iii) The consent of any patient is likely to be influenced by pressure from his family and given without complete knowledge of his health.
- (iv) There will be difficulty in obtaining a number of people around the country who would be prepared to administer euthanasia.
- (v) No method of killing was prescribed by the Bill.

These objections were supplemented by a more general feeling that the provisions of the Bill:⁷⁹

[R]epresent a reversion to a more primitive existence in which those who have outgrown their usefulness to the community should be dispatched as painlessly as possible.

The practical arguments against euthanasia have been considered earlier in this paper. As to the more general objection, it is noteworthy that apart from those supporting the Bill, several Members of Parliament who voted against it indicated that their objections were to specific details of the legislation rather than to the concept of voluntary euthanasia, which they supported in principle.

*The Netherlands' Solution*⁸⁰

The most complete recognition of the right to die is to be found in the Netherlands. A series of judicial steps since 1973 has meant that a physician who meets certain strict criteria now has the legal right to lethally inject a dying patient who has requested death. In 1981 the Rotterdam Criminal Court detailed ten elements required before a court will recognise a case as "non-criminal aid-in-dying".⁸¹

- (i) There must be physical or mental suffering which the sufferer finds

⁷⁸ See in particular the speech of The Right Honourable Lady Edith Summerskill: Parliamentary Debates, *House of Lords* Vol 300, No 50 (1969) reprinted in Kohl (ed), *supra* at note 3, at 204-205

⁷⁹ *Ibid*, 208.

⁸⁰ See generally Humphry, *supra* at note 26, at 170-180.

⁸¹ *Ibid*, 177.

- unbearable.
- (ii) The suffering and the desire to die must be lasting.
 - (iii) The decision to die must be the voluntary decision of an informed patient.
 - (iv) The person must have a correct and clear understanding of his condition and of other options open to him; he must be capable of weighing these options and have done so.
 - (v) There must be no other reasonable solution to improve the situation.
 - (vi) The death must not cause avoidable misery to others.
 - (vii) The decision to give aid-in-dying must not be a one person decision. Consulting another professional is obligatory.
 - (viii) A medical doctor must be involved in the decision to prescribe the correct drugs.
 - (ix) The decision process and the actual aid-in-dying must be done with the upmost care.
 - (x) The person receiving aid-in-dying need not be a dying person. The ability to request and obtain aid-in-dying extends to paraplegics.

Although the most radical, the Netherlands' approach has echoes in other European countries.

Natural Death Acts

Many American states have opted for "Natural Death Acts". Such Acts allow a patient to execute a written directive to the effect that he does not wish to be provided with artificial means of prolonging life if he has a terminal illness and is unable to express his wishes. These directives may be revoked. The principal effect of a directive is that it protects doctors and hospital personnel from civil or criminal liability arising out of the refusal to initiate or to continue treatment.

The central objection to "Natural Death" legislation is that the very fact that a law is deemed necessary to ensure the recognition of patient's rights implies, and tends to reinforce, an erroneous presupposition as to the locus of decision-making in the physician/patient relationship. The physician becomes more a servant of the statute than of the patient, and is encouraged to assure the decision-making role in place of the patient or his family. The main danger appears to be that physicians will assume that those who could have signed a directive, but did not do so, wish extraordinary life-preserving treatment to be initiated and continued.⁸² An onus will then be placed upon the patient to write a formal directive. The Canadian Law Reform Commission, when investigating the subject of cessation and refusal of treatment, considered that the right to refuse treatment, even if death would inevitably result,

⁸² See generally *supra* at note 6, at 22-26.

was embodied in the common law and suggested that this principle should be clearly expressed and formally recognised in the Canadian equivalent of the Crimes Act.

Concluding Remarks

The problems posed for law and morality by an assertion of a right to die are complex. They are of more than theoretical or academic interest since they arise in situations experienced daily by patients, doctors, and hospital staff around the world. Moral dilemmas arise when life is supplied by modern machinery to dying human beings, whose existence is often almost an intolerable burden to themselves, their families, and to the community in general. Consequently, some have demanded that society recognise a right to die.

The response of New Zealand law has been to maintain the distinction between active and passive euthanasia, directly prohibiting the former while in general allowing the latter. In essence, this is a *de facto* recognition of a right to die since a conscious patient may refuse permission for life-preserving treatment to be initiated or continued. However, active euthanasia remains illegal, even where its application would seem preferable to merely allowing a person to die; that is, where the process of allowing a person to die will be so prolonged and painful that active euthanasia may be seen to be the preferred alternative.

Theoretical opposition to euthanasia is derived from vitalism. This concept is itself supported by theology and experience and intuition. It has been submitted that neither ground is a valid support for legislation based upon this concept: rather, the bedrock upon which any argument regarding euthanasia must be based is the more general principle of the sanctity of life. In essence, while the latter approach regards human life as precious and worthy of respect and protection, it also includes considerations of quality of life. For one person to choose voluntary euthanasia on the basis of quality of life is consistent with this principle of sanctity of life.

A distinction is often drawn and maintained between active and passive euthanasia, based upon a claimed moral and ethical distinction between killing and letting die. It is contended in this paper that no inherent moral distinction can in fact be made. On a moral and philosophical analysis the right to die may in theory encompass both active and passive euthanasia.

Practical difficulties attach to any proposal for euthanasia, and particularly to active euthanasia. It is commonly argued that on these grounds alone a right to die should not be recognised. The challenge the law reformer is to create a system which recognises a right to die by allowing euthanasia, yet which removes the potential dangers of such a system to an acceptable level.

To the various objections mounted there remains a simple humanitarian and utilitarian answer: a person is entitled to ask for an end to a life devoid of

quality. A doctor who provides this relief should be legally absolved from blame.

Law reform in this area must implement objective standards in order that hospitals and doctors can be confident of the legal ramifications of any given situation. In addition, the community also needs security and protection against excessive power being vested in the medical profession to decide survival or death without restraint. The difficulties of the law reformer's task should not dissuade us from facing questions made even more pressing by an ever-increasing array of technology with which to combat human frailty. It is to be hoped that our new knowledge and power will not cause us to lose sight of our limitations or our humanity. Death may be both a friend and an enemy. As humans, we all have a basic right to decide for ourselves when death is one rather than the other. Confronted with this choice, we should be allowed the dignity of making it. It is to be hoped that, freed from the cosy indoor warmth of tradition, mankind might embrace the fresh air of rationality and devise a system which recognises and implements this right.