INTRODUCTION

The expression “physician-assisted suicide” (or “physician aid-in-dying”) is increasingly finding its way into the news internationally, reflecting growing public exposure of the exceedingly difficult issues thrown up by the “right to die” debate. (The term “doctor-assisted” is also used but this commentary shall mainly run with “physician”.)

The notion of physician-assisted suicide is primarily being debated in the context of a mentally competent, terminally ill adult seeking the assistance of a doctor in bringing about his or her death. Such will be the primary focus of this commentary on the legal position in New Zealand, recognising however that the expressions “mentally competent” and “terminally ill” invite debate - and disagreement - over their precise meaning.

At least in modern times, there appears to have been no case of physician-assisted suicide brought before the courts in this country. There has however been recent commentary on the issue from a legal perspective. Mention should be made particularly of Downey: *Euthanasia: Life, Death and the Law* [1995] NZLJ 88, and Webb: *The Politics of “Medicide” in New Zealand: A Cautious Proposal for Physician Aid-in-dying* (1994) 5 Canterbury LR 438. No disservice is intended to either of these valuable contributions in observing that, primarily, they are concerned with the policy issues in physician-assisted suicide and treat of the currently applicable law only in passing.

Here, the aim is to assess, through analysis of current legislation, the legal status of physician-assisted suicide, whilst endeavouring to remain neutral on underlying policy considerations. As will shortly be apparent, the question is very much one of criminal, rather than civil, liability.

PERSPECTIVE OF THE MEDICAL PROFESSION

Advice provided to the writer is that the Medical Council of New Zealand – the regulatory and disciplinary body for the medical profession - has no formal stance on the issue of physician-assisted suicide. Otherwise with the New Zealand Medical Association – the profession’s “trade union”. [Note: The NZMA’s stated position as of 1996, current when this commentary was written, has been supplanted by its 2005 statement – see
http://www.nzma.org.nz/news/policies/euthanasia.html#_ftn2  Whilst declaring doctor-assisted suicide – and euthanasia – to be unethical, the NZMA “supports the right of patients to decline treatment, or to request pain relief, and supports the right of access to appropriate palliative care.” Moreover, “In supporting patients' right to request pain relief, the NZMA accepts that the proper provision of such relief, even when it may hasten the death of the patient, is not unethical.” (Emphasis added.) The legal relevance of this so-called “double effect” in administering palliative medication is considered below.

The analysis which follows assumes the likelihood that doctors in New Zealand are confronted with the same type of cases as those which have gone before the courts in other Western countries: the terminally ill patient in severe pain or distress who wishes to end his or her life and to engage the assistance of a physician to do so. Moreover, given similar cultural backgrounds and training, it is assumed that members of the New Zealand medical profession have similar perspectives on assisted suicide as their colleagues in countries such as Australia, England, the United States and Canada.

LEGAL POSITION IN OTHER COUNTRIES

Before considering the legal position with physician-assisted suicide in New Zealand, brief regard will be had to recent cases in some other countries sharing common origins and similar legal systems to our own.

(a)  The United States

The legal status of physician-assisted suicide was, in January 1997, argued before the Supreme Court in two separate cases, Washington v Glucksberg and Quill v Vacco. Opinions were delivered on 26 June 1997. In each instance, the Supreme Court unanimously reversed the US Court of Appeals (9th and 2nd circuits respectively) and declared that state laws criminalising assistance by a doctor in the commission of suicide do not infringe the “due process” clause in the 14th Amendment to the US Constitution.

[Subsequently, physician-assisted suicide was rendered lawful under specific statutory provisions (with attendant prescription) in Oregon and Washington states, but has not otherwise been specifically legalised under state or federal law in the United States. Many states criminalise assisted suicide by anyone; others have no such provision and rely on their laws of culpable homicide.]
(b) The United Kingdom

The practice of physician-assisted suicide, and its status in English law, was brought into focus in *R v Cox* (1992) 12 BMLR 38 (and noted with comment at [1993] Med. L. Rev. 232). Dr Cox was convicted of attempted murder after administering a life-ending quantity of potassium chloride to a patient in advanced stages of rheumatoid arthritis. It is surmised in the brief report on the case that the Crown decided to charge *attempted* murder in the knowledge that a conviction for murder would attract mandatory life imprisonment whereas attempted murder, while requiring the same intent to kill, is punishable at the discretion of the trial judge.

Dr Cox received a sentence of imprisonment for 12 months, suspended for one year. In disciplinary proceedings brought by the British Medical Council, he was admonished but received no further penalty.

There is some indication that the ensuing debate on this case contributed to a marked shift in public opinion in favour of assisted suicide where requested by terminally ill adults. Certainly, it aired in the media what had long been considered an “open secret” as to a widespread willingness amongst the medical profession to administer life-ending medication to distressed, terminally ill patients. (See the address of Lord Goff of Chieveley, *A Matter of Life and Death*, published at [1993] Med. L. Rev. 1.)

(c) Canada

The legal status of physician-assisted suicide was considered by the Supreme Court of Canada in *Sue Rodriguez v Attorney General of Canada* [1993] 3 RCS 519. In a decision which anticipated that very recently handed down by the US Supreme Court, it was held that the section in the Canadian Criminal Code which prohibits assistance in suicide - and which incidentally shares common ancestry with New Zealand’s criminal provision - did not violate the Charter of Rights and Freedoms of Canada.

More recently, in June 1996 a Toronto doctor Maurice Genereux became reportedly the first physician to be charged under Canada’s criminal law with assisting suicide. At the time of preparing this commentary, the matter had yet to come to trial. The prosecution relates to the death of a man in his 30s infected with HIV although not, according to media reports, at the time of his death suffering from AIDS-related illnesses. [Genereux was subsequently, in May 1998,
convicted on two counts of attempted murder. His sentence of two years’ imprisonment was upheld on appeal.

CIVIL LIABILITY IN NEW ZEALAND

In terms of possible civil law consequences for assisting suicide, applicable torts (such as battery) continue to be defined by the common law. It is possible that an action in tort could be maintained by the estate, or other representative, of a suicide for the assistance provided by a doctor in bringing about death. The fact of consent however renders such a civil action problematic. Unlike the position under the criminal law, where - as will shortly be noted - consent is unlikely to afford a defence, the fact that the patient requested and agreed to the life-ending measure is likely to constitute a complete answer to a civil claim.

APPLICABLE CRIMINAL LAW IN NEW ZEALAND

Under the criminal law, the starting point must be the rule, stated in section 9 of the Crimes Act 1961, that no one can be held criminally liable otherwise than for an offence created by a statute. It is thus not possible in New Zealand to be convicted of an offence at common law, regardless of any moral obloquy attaching to the conduct in question.

Assisting suicide

By section 179 of the Crimes Act 1961 it is a crime to:

- Incite, counsel or procure a person to commit suicide, if in consequence that person commits or attempts to commit suicide; or

- Aid or abet any person in the commission of suicide.

On the face of it, and subject to the following remarks, the role of the doctor in physician-assisted suicide is likely to fall squarely within the “aids or abets” limb to section 179.

In our first “home grown” penal statute, the Criminal Code Act 1893, and in its successor, the Crimes Act 1908, criminal liability attached to both assisting suicide and attempted suicide. Attempting to take one’s own life was decriminalised only in the current Act. Until 1961 the
crime of assisting suicide carried a maximum penalty of life imprisonment. Now, the maximum penalty is 14 years imprisonment.

Murder

The crime of murder is defined in section 167 of the Crimes Act as culpable homicide where the perpetrator “means to cause the death of the person killed”. Culpable homicide is defined (in section 160) as the killing of another person either by an unlawful act or by an omission without lawful excuse to perform a legal duty, or a combination of both.

Sections 151 to 157 of the Act identify a number of legal duties, breach of which will thus found criminal liability for culpable homicide. Of particular relevance in the present context is the duty in section 151 of anyone, doctor or otherwise, charged with the care of another person, to provide “necessaries of life” where that person is unable to withdraw from such charge and to himself provide such assistance.

Manslaughter

The crime of manslaughter is defined in section 171 as “culpable homicide not amounting to murder”. This commentary is not the place to delve deeply into the distinctions which have been developed in case law over a great many years. Suffice to say here that there is always a prospect of reduction of murder to manslaughter (either at the discretion of the prosecutor or a jury) where an intent to kill is somehow displaced or rendered doubtful but culpability in the death is otherwise established, because the relevant conduct was unlawful or a failure in a legal duty in terms of section 160.

Recent cases involving assisted suicide

Assisting suicide has been the subject of two recent reported cases, not however involving doctors. Both are appeals to the Court of Appeal against sentences imposed in the High Court.

In R v Stead (1991) 7 CRNZ 291, a sentence of 3½ years imprisonment was upheld for manslaughter, where the appellant had stabbed his mother to death after assisting her in several failed attempts to take her own life.
R v Ruscoe (1993) 8 CRNZ 68 was a successful appeal to the Court of Appeal against a sentence of eight months imprisonment imposed after the appellant had pleaded guilty to assisting the suicide of his best friend, rendered tetraplegic in a workplace accident. Following repeated requests from the deceased, the appellant had placed some 50 sedative and painkilling pills in his friend’s mouth and, after unconsciousness ensued, had applied a pillow over his head. The appellant subsequently, and voluntarily, reported his conduct to the police.

Whilst acknowledging that a conviction under section 179 should ordinarily attract a custodial sentence, the Court of Appeal in Ruscoe decided that this was an “exceptional case”, in which the “promptings of humanity” ought to find expression. The prison term was replaced with 12 months probation, with a special condition that the appellant undergo counselling.

Notwithstanding this outcome of the appeal, there can surely be no warrant for treating the crime under section 179 of the Crimes Act as in any way moribund and unlikely, if at all, to be invoked in the case of a physician-assisted suicide. Indeed, it is a moot point whether the administering of a lethal substance by a practising doctor, in whom society has reposed high levels of trust and integrity, would be seen in the same sympathetic light as the actions of a friend as in the Ruscoe case.

In Ruscoe, the accused had placed a lethal quantity of medication in the mouth of a tetraplegic person and provided water to assist swallowing. For good measure the person was then suffocated with a pillow. The crime charged was assisting suicide.

By contrast, in Stead the accused had stabbed his mother to death after assisting her in several failed suicide attempts. And in the English case of Cox, where the physician had injected his patient with potassium chloride, the charge was also (attempted) murder. It is not easy to see the distinction between the conduct in each of these cases and, particularly, between Ruscoe and Cox.

And, in his thought-provoking address to the University of Stockholm in 1993 Lord Goff of Chieveley observed that the “case of Dr Cox is perhaps more of human interest than legal interest, because the law there applied, which was the ordinary law of murder, was never in any doubt” ([1993] Med. L. Rev. at page 7, emphasis added).

[More recently, in the mid-2000s, Lesley Martin – a “death with dignity” campaigner and former nurse – was tried for attempted murder after revealing in her 2003 book that in 1999 she had twice attempted to kill her terminally ill mother (who died of a morphine overdose). Martin’s conviction on one of two counts of attempted murder was upheld on appeal to the Court of]
Appeal and subsequently the Supreme Court refused further leave to appeal. She was sentenced to – and duly served until parole – 15 months’ imprisonment.

**Liability for murder excluded?**

In the second edition of *Adams: Criminal Law and Practice in New Zealand* (1971), the eminent author Sir Francis Adams argued that there was no bar to conduct which may amount to aiding or abetting suicide under section 179 also amounting to murder. This position was resiled from in the third (and current) edition, published in 1991 after Adams’ death. It is there asserted that his view is wrong as a “general proposition” and that, where assistance is rendered in the commission of suicide, liability for murder is implicitly excluded by the existence of the crime in section 179. A contrary position, it is argued, “would leave prosecutors and Courts with no adequate guidance on the question whether murder or section 179 should be relied on”.

With respect, this proposition is unconvincing. There are many instances under the Crimes Act of the same conduct potentially constituting more than one crime under the Act, or a crime under the Act and an offence under some other statute. Excepting only the rule against “double jeopardy” (being prosecuted twice for the same conduct), there is no legal bar to the prosecutor making a decision as to which offence provision to invoke as part of the wider prosecutorial discretion. Such decisions are routinely upheld by the courts.

[The New Zealand Law Commission took an apparently similar view to that of the current editors of *Adams* in a 1997 report on the need for law reform as regards the succession entitlements of “homicidal heirs” (the report may be read at http://www.lawcom.govt.nz/sites/default/files/publications/1997/07/Publication_41_111_R38.pdf). The Commission saw a “a clear line between assisting suicide and murder: it is whether it is the killer or the victim who decides that the victim is to die.” (at para. 7 of the report). With respect, the distinction in law, at least in the context of physician-assisted suicide, is surely whether it is the doctor or the patient – or indeed both acting jointly - who has or have acted to bring about the death, irrespective of decision-making.]

It is considered that the view expressed in the second edition of *Adams* is the correct one and that, in an appropriate case of physician-assisted suicide – for example, where the doctor has actively participated by injecting a lethal dose of morphine, it would be open as a matter of law for the Crown to prosecute for murder rather than for aiding or abetting suicide under section 179, or to charge both crimes in the alternative, leaving the choice of verdict to the jury.
As just noted, the Crown’s decision is likely to be influenced primarily by the extent to which the physician took part in the life-ending measures. Cases are foreseeable where palliative treatment hitherto provided has reached the point of keeping the patient sedated on an ongoing basis, or where the patient – though cognate - is otherwise so incapacitated as to be unable to take any active part in the life-ending measures. In such cases it is questionable whether the ensuing death could be characterised as “suicide” at all and it is therefore in prospect that a criminal prosecution would be for the crime of murder.

AVAILABLE DEFENCES

The question then is what, if any, defences are available to the doctor whose actions have caused the death of a terminally ill and pain-ridden patient unable him or herself to administer the life-ending substance.

Assisting suicide

Implicit in section 179 is that the mens rea in aiding or abetting suicide requires knowledge that self-death is contemplated by the patient. Thus, for example, there could be no suggestion of liability on the doctor who is asked to prescribe a quantity of pain-killing or sedative medication unaware that the patient intends to use the medication, perhaps with other quantities previously obtained, to commit suicide.

Put another way, it is thought that the physician must by his or her actions intend to assist the patient to commit suicide. So that, even if the physician is aware that the patient is contemplating such action, it ought to be a defence that the physician’s actions were not directed to assisting its consummation. This might be the case where, for example, the physician knows or reasonably believes that medication prescribed will not of itself, in nature or quantity, suffice to bring about death and is not otherwise involved in any subsequent suicide.

These considerations aside, it is not obvious what grounds might exist for avoiding liability under section 179 in those cases where the physician plays an active, and informed, role in the patient’s death. Such would be the case where the physician administers an injection of a life-ending substance to a cognate patient unable him or herself to do so.
In particular, it is quite clear that the patient’s consent will not vitiate liability under section 179. The question of consent will be considered below, in relation to possible defences to a charge of murder. Suffice to say in the present context that the fact of consent is inherent in the very notion of assisting “suicide”. In the absence of clear evidence of the patient’s desire to die, and some participation by the patient in the process, there would be no warrant for invoking section 179 at all and the prosecution would undoubtedly be for murder.

Murder

(a) The need for intent to kill

In the event of a charge of murder, the prosecution must prove beyond reasonable doubt that the physician intended to cause death. (The word “means” in section 167(a) can be read as synonymous with “intends”.)

Intent is of course a state of mind and therefore a fact to be established by the prosecutor beyond reasonable doubt. At one time there was said to be a legal presumption that a person intends the natural consequences of his or her acts. Thus, the question of intent was examined objectively, the inquiry being directed to what a reasonable person in the place of the accused could be taken to have intended. Nowadays, such approach is considered wrong and a jury must be directed to decide what, on the evidence at trial, the accused in fact intended.

Nevertheless, it remains permissible for a jury to have regard to the consequences of the accused’s actions and to infer, in the absence of an admission or other evidence, the accused’s intent from those consequences. So that, if death is the inevitable consequence of such action, it is permissible for a jury to use that outcome as evidence of what the accused actually intended.

There is in medical ethics the notion of “double effect”. By this expression is meant that it may be sound medical practice to bring about a desired, and beneficial, result even if the means causes another, harmful, result. In context, a doctor’s objective in administering morphine may be to alleviate pain but in the knowledge that death will, or is likely to, ensue from the dosage prescribed or administered. It might therefore be argued that the physician has two intents, of which the beneficial (pain relief) displaces the harmful (death), or that for legal purposes he or she has only an intent to alleviate pain. [And, as noted at the outset, the New Zealand Medical Association’s stance is that it is not unethical for a physician to administer a fatal dose of palliative
medicine for the purpose of relieving pain or suffering. It can be presumed that a doctor so
doing would be aware of the “double effect”, or at least of its prospect.]

If such “displacement” of an intent to kill in “double effect” cases had any legal basis, it would in
principle allow for – even mandate – a charge of manslaughter rather than murder. Stead,
mentioned earlier, was a case where a son was convicted of manslaughter having stabbed his
terminally ill mother to death, after he had assisted her in several failed attempts at suicide. It is
however quite apparent that the son’s disturbed state was influential in the manslaughter verdict.
In any event, death by stabbing is about as far as may be conceived from the methods a trained
physician might select for palliative treatment also resulting in death.

Whatever comfort it affords in medical ethics, as a matter of criminal law the notion of “double
effect” at best invites characterisation as a defence of necessity. In other words, causing death is a
necessary consequence of alleviating pain. Viewed in that light, the physician who is motivated to
relieve intolerable pain by administering a fatal dose of pain-killing medication has no choice in
the matter. He or she must do it, so the argument would run. But there is no question of duress
here – the context in which a defence of necessity normally rises. There is no question of
voluntariness being suborned by either physical or psychological force so bearing down on the
doctor as to negate intent. Manifestly, a doctor does have a choice.

So far as is known, it has yet to be decided but it is thought most unlikely that the criminal courts
of New Zealand will recognise a defence of necessity in a case of physician-assisted suicide.

By contrast, necessity is the legal basis on which the courts in Holland have for a number of years
given their imprimatur to physician-assisted suicide although the statutory crime remains. And in a
recent case, Office of Public Prosecutions v Chabot (of which an abridged English language report is
published, with commentary, at (1995) 58 Modern Law Rev. 232), the availability of the defence
has been extended by the Dutch Supreme Court - in principle, though not on the particular facts
- to relief of purely mental distress of non-somatic origin (a mother grieving at the premature
deaths of two sons).

As indicated, it is thought highly improbable that a New Zealand court would recognise such a
defence and thus allow it to be left with a jury. Where murder is charged, the issue is likely to be
confined to an inquiry as to what the physician actually intended. It is at least in prospect that a
jury would be directed, and would find, that in the administering of a life-ending substance,
which duly resulted in death, the physician intended such death for the purposes of the crime of
murder. The object of alleviating pain would, in such circumstances, be relegated as a matter of criminal law to a motive and thus immaterial to the question of liability.

(b) The consent of the patient

Inherent in the notion of “physician-assisted suicide” is of course the likelihood of evidence that the patient requested termination of his or her life. Alternatively, a patient, whilst now unconscious or otherwise incompetent, may hitherto have executed an “advance directive” explicitly requesting life-ending measures in the very situation which has developed. In either scenario, it can be assumed that there will be evidence of consent by the patient to the administering of the life-ending substance or measure. Does such consent afford a defence to a charge of murder?

As a general proposition, the criminal law has been slow to recognise consent as a defence. With crimes against the person, there are sound policy reasons for this stance (as, for example, in the case of the alleged consent of a child to sexual abuse). Nevertheless, there are many situations - such as contact sports - in which a person expressly or impliedly consents to an application of force. It thus cannot be said with total conviction that consent will never amount to a defence.

In the particular context of surgical operations the patient’s consent operates to immunise against criminal liability, by virtue of section 61A of the Crimes Act. The immunity is available to anyone, so long as “reasonable care and skill” is exercised, and not just members of the medical profession. There is no definition of “surgical operation” and it is doubtful that it would cover, for example, the giving of an injection per se.

In any event, the prospect of section 61A being called in aid in the context of physician-assisted suicide is precluded by section 63 of the Act. This states, in terms leaving little scope for argument, that no-one “has the right to consent to the infliction of death upon himself”. Further, that the fact of such consent “shall not affect the criminal responsibility” of a person charged as being a party to the killing.

The precise legal rationale for section 63 is a matter of conjecture but is in any event of less importance than its effect. And it is not apparent that it can be read otherwise than as excluding any possibility of a patient’s consent amounting to a defence to a charge of murder in a case of physician-assisted suicide.
(c) The need for an “unlawful act”

What is thought to remain, in terms of possible defences to a prosecution for murder, is the proposition that, in administering a lethal substance with intent to cause death, the physician nevertheless has not performed an “unlawful act” for the purposes of section 160(2)(a) of the Crimes Act. In consequence the conduct, though amounting to an intentional homicide, is not culpable.

The Crimes Act provides no express guidance as to what will, or will not, constitute an “unlawful” as opposed to a “lawful” act. It is arguable, consistently with a basic tenet of our law, that all acts are lawful unless rendered unlawful by some expression of the law. Moreover, an act is not rendered unlawful simply because society may disapprove the motive (ie, to cause death).

Arguably therefore, the prescribing or administering of what is known or expected to be a lethal dosage of morphine to a cancer-ridden patient is an act consistent with recognised practices in palliative medicine. This in turn embues the act with a quality which prevents its characterisation as “unlawful”. It may also be possible to bring such palliative medical treatment within the scope of the legal duty, in section 151 of the Crimes Act, to provide “necessaries of life”. In that event, it seems most unlikely that the prosecution could maintain that at the same time it amounted to an “unlawful” act.

This is the argument which most appeals to the writer as a legal matter in relation to physician-assisted suicide. It avoids reliance either on the patient’s consent or on the, at best highly dubious, defence of necessity arising from the notion of “double effect”.

The onus of course lies on the prosecution to prove all ingredients of the crime charged. With murder, the killing must be culpable which in turn requires proof of an unlawful act. Whilst in many cases proof of this ingredient is not called for, where the issue is put to proof it will be incumbent on the prosecution to do so and, of course, beyond reasonable doubt.

It is in this context that the medical profession itself ought to have a role in the resolution of what ultimately is a legal issue. Faced with a defence of no unlawful act, the prosecution might consider itself obliged to adduce expert evidence that the administering of a lethal dose of palliative medication could not be said to conform to recognised medical practice. Such testimony could then be challenged in cross-examination and the accused could seek to present a contrary opinion, if such be available.
It is thought that, unless the Crown could negate any possibility of such conduct conforming to recognised medical practice, the way is open for a defence that, *in the particular case*, such conformity was at least a possibility. It ought then to follow as a matter of law that the Crown has failed to prove an ingredient of murder (or, for that matter, manslaughter), namely, the unlawfulness of the act causing death. This proposition is thought to hold because an act which is not rendered explicitly unlawful by a statute should not attract that status where it is, *or may be*, consistent with recognised precepts of medical practice.

In *R v Trounson* [1991] 3 NZLR 690, an appeal against a conviction for murder, the Court of Appeal considered whether cessation of emergency life support for a severely beaten victim was “treatment … in good faith” occasioned by the assault. By section 166 of the Crimes Act, such treatment would thus be prevented from constituting a new, intervening cause of death. The court noted that it was unnecessary to decide the question in the particular case but nevertheless expressed the view that removal of the life support system “did form a proper part of [the victim’s] treatment” in the particular circumstances.

With due allowance for the *obiter* nature of this observation, *Trounson* arguably represents judicial acknowledgment that, in at least some circumstances, conduct by a physician which results in death is nevertheless proper medical treatment.

It must be stressed that the foregoing analysis is directed solely to the administering of recognised medical practice and, in particular, palliative treatment. In the English case of *Cox*, the substance administered was potassium chloride, as used in those American states whose capital punishment is by lethal injection. It seems likely that the use, in physician-assisted suicide, of a substance having no recognised remedial or palliative function, and the ingestion of which can result only in death, will have little prospect of avoiding characterisation as an “unlawful act” for the purposes of the criminal law relating to murder.

**SUMMARY OF ANALYSIS**

To summarise to this point, it is thought that, in respect of the type of physician-assisted suicide which has been examined judicially in other countries, there is a real prospect of such conduct resulting in a prosecution in New Zealand either for assisting suicide, contrary to section 179 of the Crimes Act, or for murder.
Possible defences to such a charge have been examined. With one exception, the assessment is that these are likely to fail. That which holds promise is the proposition that the administering of a life-ending quantity of a recognised palliative medicine would not constitute an unlawful act and would not therefore be “culpable” homicide. This proposition would however seem to be irrelevant to a charge under section 179.

**IMPACT OF THE NEW ZEALAND BILL OF RIGHTS ACT 1990?**

Is the prospect of such criminal liability relevantly impacted by the New Zealand Bill of Rights Act 1990 (from this point referred to as “BORA”)?

Although to some extent inspired by the Canadian Charter of Rights and Freedoms, our “Bill of Rights” is at best a pale imitation. Whereas the Canadian charter (in common with the United States constitution) affords a means of challenging the validity of a statute for violation of rights stated in the charter, section 4 of BORA stipulates that no court may treat as invalid, or decline to apply, a provision of an Act of Parliament “by reason only that the provision is inconsistent with any provision of this Bill of Rights”.

Thus is excluded any prospect that section 63 of the Crimes Act, in stating that no person has the right to consent to die, would be ignored or read down in the context of physician-assisted suicide even if the court is disposed to find it inconsistent with one of the civil rights stated in Part II of BORA.

In any event, the rights stated in BORA do not encompass the language upon which the case for physician-assisted suicide was mounted, unsuccessfully, in the *Sue Rodriguez* case in Canada and in *Washington v Glucksberg* and *Quill v Vacco* in the United States. Section 7 of the Canadian Charter of Rights and Freedoms prohibits unreasonable interference with the “right to life, liberty and security of the person”. The Due Process Clause in the 14th Amendment to the United States Constitution applies similarly as regards the right to “life, liberty, or property”.

In the North American jurisprudence, there is a primary focus on the “liberty interests” thus protected. In both the United States and Canada it has proved to be the express right to personal liberty which has founded the challenges to prohibitive or restrictive legislation affecting a range of asserted “liberty interests”. It has long been settled that the liberty protected by the Due Process Clause in the US constitution goes considerably further than the absence of physical
restraint. Notably, violation of such interests has been found in relation to abortion (the still controversial Roe v Wade) and refusal of medical treatment (the Cruzan case).

By contrast, section 8 of BORA states a prohibition only against deprivation of life. Thus, even if the section were to be elevated to the same constitutional status as pertains in Canada and the United States, the stipulation that “no one is to be deprived of life” is not an obvious basis for asserting a right to die.

In Tobin, The Incompetent Patient’s Right to Die [1993] NZ Recent Law Review 103, the author considers whether section 11 of BORA affords an alternative right of terminally ill patients to exercise control over their deaths. Section 11 is the right to refuse to undergo medical treatment. Ms Tobin’s proposition is that this “right” affords a basis for advance directives which, where relied upon to discontinue medical treatment, would relieve the physician of the duty under section 151 of the Crimes Act to provide necessaries of life.

Whatever may be the impact of section 11 of BORA in “life support” cases, plainly it can have no application to an advance directive which transparently functions as a request for life to be terminated in certain circumstances. The making of such request - or, more to the point, the consent thus conveyed for life to be terminated - is expressly stated in section 63 of the Crimes Act to be a right not enjoyed by a citizen of New Zealand. As just noted, there is nothing in BORA which provides a means for affording primacy to any right to die which may be discerned in its section 11 and, to the contrary, the courts are expressly constrained from any such application of that statute.

By contrast, in its recent rejection of a “right to die” having constitutional protection, the US Supreme Court considers that it has nevertheless left the door open to ongoing debate on the issue. As Justice Stevens was at pains to stress in his concurring judgment, the constitutional challenge in the Glucksberg case failed because the petitioners could not demonstrate that there were no imaginable circumstances in which the prohibition on assisting suicide would be valid. It did not follow that all possible applications of the statute would be valid, thus leaving open the prospect of further constitutional challenges on a case-by-case basis.

**CONCLUDING REMARKS**

Physician-assisted suicide enjoys no special status under New Zealand law. Participation by a person - whether or not a doctor - in the death of another carries with it the prospect of criminal
liability. There is a discretion available to the Crown as to the bringing of a prosecution in any such case but this discretion is likely to be directed to the nature of the charge rather than whether or not to prosecute. It is likely that a case of physician-assisted suicide which becomes known to the authorities by some means will almost certainly result in a criminal prosecution.

In that event, and of course allowing for the particular circumstances, it may be possible to argue that the means by which death was caused was not “unlawful”, and thus not culpable homicide, although this seems immaterial in the case of assisting suicide. In either case the fact of consent will not afford a defence.

There is little room for criticising the law in New Zealand as leaving some “grey area”, into which a well-intentioned physician may blunder through ignorance. Such a doctor may choose to be guided by his or her conscience, and remain ignorant of the law, but could not be heard to complain that the law is unclear. On the contrary, unless and until changed by legislative means, the criminal law of New Zealand is firmly intolerant of physician-assisted suicide.

Whether that should be so, or whether the law should be changed, has of course not been the subject of this commentary. But it is a feature of New Zealand’s political and constitutional systems that change to, or even review of, existing laws is almost exclusively in the hands of political representatives. Controversial moral issues such as thrown up by the “right to die” debate are anathema to politicians. The wholesale rejection in 1995 of the private member’s “Death With Dignity” bill, and the Australian senate’s reversal early in 1997 of the Northern Territory’s Rights of the Terminally Ill Act 1995, demonstrate the very great obstacle faced in seeking legislative sanction for physician-assisted suicide.

In other jurisdictions, notably Canada and the United States, the means is afforded for private citizens to seek to challenge the status quo in contentious areas. Until New Zealand adopts such means it seems most unlikely that there will be any change to the law relating to physician-assisted suicide.