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Medical Law

Topic 10(of 10): Death and 'dying with dignity'.

Lecture 2 (of 2):

Euthanasia and Physician-Assisted Suicide

Aim:
To outline the ethical issues relating to euthanasia and to provide a brief comparative account of the law relating to euthanasia and physician/doctor-assisted suicide in England, The Netherlands, Belgium and Switzerland; some American States; and the Northern Territory of Australia from 1 July 1996 to March 1997.

Objectives:
After carefully studying this handout and other prescribed readings for this lecture, you should be able to:

1. Explain the terms: voluntary; involuntary; and non-voluntary euthanasia; and discuss the difference and significance, if any, between active and passive euthanasia;
2. Explain the concept of 'double effect', primarily by way of referring to decided English case law; and
3. Discuss whether euthanasia should remain a crime - a procedure to which no one should be permitted to consent - or whether patient autonomy dictates that there should be a 'right to voluntary euthanasia' and/or doctor-assisted suicide.

Legal, Ethical and Religious Perspectives on Euthanasia.

The term 'euthanasia' means death without suffering or a 'good death.' It means more than merely 'passing away quietly' or dying from 'natural causes,' however. It refers to the intentional acceleration of death under the control of a registered medical practitioner so that (according to its advocates) a patient with a poor/no quality of life may 'die with dignity.'

Generally, a request for euthanasia may be thought of as the expression of voluntary consent being given by one person of 'adult years and sound mind' (the patient) to another (usually a doctor) for the doctor actively to *administer* life-terminating treatment. At present (2007) this is still unlawful in the U.K.: it equates with murder; *Adams* (1957); *Dr Cox's case* (1992); and *Dr Moor's case* (1999); and such a request would not provide a defence to a man who intentionally brought to an end the life of his severely disabled wife, even if done at her request: *Diane Pretty's case* (2001). By contrast, an autonomous patient's request that the doctor should ***refrain*** *from administering treatment* necessary for the preservation of the life of the patient, ***is*** regarded as an acceptable expression of self-determination which does

not attract legal liability: R v. Blaue (1975); Malette v. Shulman (1990); Re MB (1997); the case of Miss B, particularly as reported in: (2002) The Times, March 7th, pp1 & 3; and see, also: Airedale NHS Trust v. Bland (1993).

Moreover, there is a clash of fundamental ethical considerations which has to be overcome if euthanasia is to be accepted by society, and doctors in particular, in that, from the patients point of view, respect for the principle of autonomy dictates that the patient's wishes take precedence, whereas, from the doctor's point of view, *The World Medical Association* declares that voluntary euthanasia is contrary to the ***Declaration of Geneva***. The Declaration of Geneva (as amended at Sydney, 1968) includes the vow that:

> 'I will maintain the utmost respect for human life from the time of conception; even under threat, I will not use my medical knowledge contrary to the laws of humanity.'

Similarly, the ***International Code of Medical Ethics*** includes the premise that: '**A DOCTOR MUST** always bear in mind the obligation of preserving life.' [Emphasis as in the Code].

However, as abortion is lawful under certain conditions (as provided for in the Abortion Act 1967 as amended) and selective non-treatment of very young severely handicapped babies '... which would render death more or less likely' is permissible when it is 'in the best interests of the child,' it becomes difficult to see why 'The law ... treats euthanasia as murder' per ***Williams***, *Textbook of Criminal Law*, 2nd edn 1983. In response, ***Mason & McCall Smith***, in Law and Medical Ethics (6/e, 2002, Ch.18.3, pp528-29) said that:

> "The prohibition of the taking of human life is based on fundamental and deeply felt ethical convictions. These may have different roots, and may be expressed in a wide variety of ways, but whatever their basis, they form a fundamental part of our moral lives. Until recently, the prohibition against killing was most frequently expressed in religious terms, human life being seen as a gift over which we may have stewardship but no final control. That position is still widely supported in some societies but, even in societies where religious morality has been dethroned, the right to life is still accorded particular weight. This is reflected in the modern human rights debate, .. [which provides] in Article 2 [of the European Convention on Human Rights] that 'everyone's right to life shall be protected by law' … ".

Prima facie, then, there appears to be a great stress on the value of life; indeed, a belief in the sanctity of life. A couple of points qualify this belief, however. *Firstly*, the belief is difficult to reconcile with societies' acceptance of war, capital punishment (and, perhaps, as noted *supra*, abortion?); *secondly*, those who promote medical care that proclaims to have 'the utmost respect for human life' may take the focus away from the *quality* of life experienced by the patient: is life to be preserved (where possible) at all costs or should (say) the severely handicapped newborn and/or adults in pain with a terminal (or incurable?) illness, or in a persistent vegetative state (pvs) have their deaths hastened so they might 'die with dignity?'

The sanctity v. quality of life debate is addressed by an assessment of the issues relating to ***selective non-treatment of severely handicapped neonates*** (termination of the life of the

handicapped newborn by way of omission to treat in a medical setting) and ***euthanasia*** (of which selective non-treatment is a form). For discussion purposes, however, this assessment will be confined to the acceleration of death of a terminally ill *adult* patient to which the patient consents.

Three categories of Euthanasia

(i) If English law was to recognize euthanasia based on medical grounds the focus would be on *voluntary euthanasia*. ***Voluntary euthanasia*** is the implementation of a *patient's* specific request for his life to be terminated with the grounds for the request being based either on the *patient* complaining of intolerable pain or suffering from an illness which is regarded as being terminal. At present (March 2007) English law does not permit a person to consent to the intentional taking of his life by another. Any person intentionally depriving another of his life without lawful justification risks being charged with murder. Nevertheless, ***Maclean & Maher*** assert that:

> "Voluntary euthanasia would appear to be supported by arguments for the autonomy of the patient, for in such cases the patient has given his consent. Moreover, there appears to be little moral difference between voluntary euthanasia and suicide, except that in the former the agent causing the death is someone other than the person who is killed ... So why should there be any objection to voluntary euthanasia?
>
> "One argument is that we have no right to decide that we should die, and that suicide is equally as wrong as consenting that someone else should take one's life. In other words the right to decide upon our own death does not follow from our right to life.
>
> "The traditional religious prohibition of suicide rested on the belief that the decision as to the time of death was not for humans to make at all, but was God's prerogative. But this sort of reasoning is totally out of place in any system of secular ethics ... and in many countries the legal prohibitions against suicide have been removed in recent years. However, even if we do permit suicide, the permissibility of voluntary euthanasia may not follow. In other words, the right each of us has to decide upon our own death does not necessarily relieve other people of their duty not to take our life."

Indeed, in <u>Bland</u>, (1993) ***Lord Mustill*** said:

> " … 'mercy killing' by active means is murder … that the docror's motives are kindly will for some, although not for all, transform the moral quality of his act, but this makes no difference in law".

(ii) Involuntary Euthanasia.

If a *doctor* or a *close relative* of the patient believed that it was in the patient's best interests to terminate the patient's life and, accordingly, the doctor administered lethal treatment, albeit for a good motive, that would not be justifiable in the absence of the patient's consent. This paternalistic approach to ***involuntary euthanasia*** also equates with murder - i.e. the deliberate taking of another's life without lawful justification. The source of moral

condemnation of involuntary euthanasia is in autonomy-based ethics (i.e. deontological theories) rather than in consequentialism.

(iii) Non-Voluntary euthanasia.
Euthanasia may be described as non-voluntary when a patient lacks the capacity to know or to express his wishes as to his continued existence. As ***Maclean & Maher*** note:

> "Such cases would include infants [see notes on selective non-treatment of neonates], *the permanently comatose* and severe instances of mental illness. ... arguments about the quality of life are crucial here. Certainly, there appears to be little point in continuing to let remain 'alive' persons who will never again regain consciousness, and whose existence depends solely upon life-support machines. Likewise, there are some cases where handicaps, either physical or mental, are so severe (and, importantly, permanent) that there seems to be little or no value in such a life."

How Euthanasia may be effected: Active and Passive Euthanasia.

(i) Active Euthanasia.
Active euthanasia is promoted by some positive step which results in death where death would not have occurred without those steps. The law relating to a ***positive act*** of euthanasia is clear:

> "If the acts done intended to kill and did, in fact, kill, it did not matter if a life were cut short by weeks or months, it was just as much murder as if it were cut short by years" *per* ***Devlin J***, *R v. Adams* (1957).

(ii) Passive euthanasia.
Passive euthanasia involves the shortening of life through an omission to act, i.e. passive euthanasia is said to occur when there is a failure to use available steps (the omission) and this failure/omission leads to death which would have been avoided or postponed by their use. ***Maclean and Maher*** note that:

> "the importance of th[e] distinction [if there is one between active and passive euthanasia] lies … in the fact that whereas active euthanasia is explicitly repudiated by the medical profession, some doctors admit to practising passive euthanasia, at least in the sense that in certain cases they do not take all possible steps to sustain life.
>
> "One doctrine which has been adduced to give support to the distinction between active and passive euthanasia is the doctrine of acts and omissions, whereby there is a ***morally relevant*** difference between doing something on the one hand and on the other refraining from doing something else which has identical consequences."

By contrast, ***Kuhse*** disagrees with this argument - she maintains that any 'distinction' between a commission and an omission to act when both have the same effect is no more than an illusion: the responsibility and the intention of the actor are the same.

N.B.: (1) In Airedale NHS Trust v. Bland (1993), The House of Lords expressly acknowledged the difference between a positive act bringing about a patient's death (murder) and an omission which may be lawful in certain circumstances. To ***Lord Browne-Wilkinson***, however, the 'distinction' seemed to lack a discernible moral basis. He queried:

> "How can it be lawful to allow a patient to die slowly, though painlessly, over a period of weeks from lack of food but unlawful to produce his immediate death by a lethal injection, thereby saving his family from yet another ordeal to add to the tragedy that has already struck them? I find it difficult to find a moral answer to that question. But it is undoubtedly the law ... ".

N.B.: (2) In February 2004, Leslie Burke, a 44-year-old former postman, challenged the guidelines issued by the GMC in 2002 and published in '*Withholding and Withdrawing Life-Prolonging Treatment: Good Practice in Decision-Making*'. Counsel for Mr Burke claimed that stopping the supply of food and water breached Mr Burke's right to life: see (2004) *The Times*, February 27. Mr Burke won his case at first instance and the Court of Appeal affirmed that he would receive artificial nutrition and hydration (ANH), should he require it, because once a patient was accepted into a hospital the medical staff came under a positive duty at common law to care for him/her. However, the GMC won the appeal (in July 2005) in relation to its guidelines. In effect, the judgment meant that a competent patient who expressed a positive request to receive ANH would receive it, the presumption that an incompetent patient would also receive it if it was in his best interests was maintained, but the presumption could be displaced (i.e., the treatment could be withheld) if the incompetent's life was adjudged to be intolerable to him.

However, ***Gllon*** has noted at least three main grounds on which the simplistic acts and omissions doctrine is rejected by Roman Catholics, viz;

(i) '***An omission by definition is not simply any inaction but a morally culpable inaction***;'

So:

> "A failure on the part of the doctor to provide his patient with treatment thought to be appropriate to the circumstances might well be considered to be a morally culpable omission. Non-treatment of an infection in a young and otherwise healthy person would undoubtedly constitute such a failure whereas such treatment for a bed-ridden elderly patient whose prospects were only those of deteriorating health might, equally, be considered inappropriate" *per* ***Mason & McCall Smith***. [Moral culpability would then attach to the omission of ordinary treatment but not extraordinary treatment].

That a moral duty attaches to the administration of ordinary treatment but is absent from extraordinary treatment was confirmed by ***Pope Pius XII*** in 1957 when he said:

> "Man has a right and a duty in case of severe illness to take the necessary steps to preserve life and health. That duty ... devolves from charity as ordained by the Creator, from social justice and even from strict law. But he is obliged at all times to employ only ordinary means ..., that is to say those means which do not impose an extraordinary burden on himself or others."

However, there is no simple distinction between ordinary and extraordinary treatment: in fact, the Pope qualified 'ordinary' as "according to personal circumstances, the law, the times and the culture." Thus, the ordinary/extraordinary test should not and cannot be

applied as a general, all embracing rule. Accordingly, in pre-6th editions of their book, ***Mason & McCall Smith*** suggested:

> "that the comparison should be between *proportionate and disproportionate* therapy; [or] *productive and non-productive* means … [and that] … Factors such as the physical and psychological pain involved in the treatment, its claim on scarce resources and the general prospects for the patient and his family may all be taken into account in deciding whether or not a treatment is productive."

In such circumstances, then, the removal of a patient from a life support machine, even when death has ***not*** been diagnosed might not attract criminal liability if there is "no reasonable possibility of her ever emerging from her present comatose condition to a cognitive, sapient, state"; per ***Hughes CJ*** in the American case of *Re Quinlan* (1976). (Nor, of course, did any criminal liability attach to the doctors who disconnected the brain dead victims from artificial ventilation in *R v. Malcherek & Steel* (1983)).

(ii) ***Double Effect***. Gillon noted that Roman Catholic's second objection was that:

> "Not only does outcome matter when a moral judgment is made on a person's action but so too do preceding considerations, including pre-existing moral obligations and the understanding and intention with which the person acted. ... [i.e.] there is little doubt that both the consequences of an action and the agent's beliefs and intentions about what he is doing are relevant to its moral assessment. Here Roman Catholic theology has sought to differentiate between intended and unintended consequences of an action, notably in the principle of ***double effect***.
>
> [This principle, or doctrine, relates to] "the claim that we can justifiably differentiate between those consequences of our actions and inactions that:
> [i] we intend;
> [ii] those we foresee but do not intend; and
> [iii] those we do not intend or foresee at all."

To the Roman Catholics these appear to be important, though complex, distinctions. [see below].

(iii) "... certain sorts of action and inaction are absolutely forbidden, in particular, intentional killing of an innocent person, including bringing about death by omission, is absolutely forbidden".

The doctrine of 'double effect.'

The essence of the doctrine of 'double effect' is that an act which has a good objective may be performed despite the fact that the objective can only be achieved at the expense of a coincident harmful effect. ***Maclean & Maher*** say that:

> "It is a point worthy of note that the ethics of the Catholic Church, which adopts on the whole a strict view of the sanctity of life, would permit the administering of pain-killing drugs even though the consequences would be to shorten life, by an

application of the doctrine of double effect. [Here] double effect would allow the giving of lethal drugs, so long as the intention is to alleviate pain rather than to accelerate death. [Thus] it is sometimes claimed that the use of passive as opposed to active euthanasia is justified on this more practical ground of the difficulty of inferring intention from action."

R v Adams [1957] Crim LR 365

Dr. Adams was charged with the murder of an 81 year old patient who had suffered a stroke; it was alleged that he had prescribed and administered such large quantities of drugs, especially heroin and morphine, that he must have known that the drugs would kill her. During his summing up to the jury, the trial judge, ***Devlin J***, introduced the doctrine of double effect [at the end of this dictum], saying that: "... it does not matter whether her death was inevitable and her days were numbered. *If her life was cut short by weeks or months it was just as much murder as if it was cut short by years*. ... but that does not mean that a doctor who was aiding the sick and dying had to calculate in minutes, or even hours, perhaps not in days or weeks, the effect on a patient's life of the medicines which he would administer. If the first purpose of medicine - the restoration of health - could no longer be achieved, there was still much for the doctor to do and he was entitled to do all that was proper and necessary to relieve pain and suffering *even if the measures he took might incidentally shorten life* by hours or perhaps even longer."

HELD: Dr. Adams was acquitted.

The accuracy of ***Devlin J's*** analysis has been doubted by ***Lord Edmund-Davies*** who said: "Killing both pain and patient may be good morals but it is far from certain that it is good law." On the other hand, it has been supported by ***Professor Glanville Wllliams*** who says the proposition is easily justified by necessity. There seems to be considerable merit in this argument, given that a "responsible" body of medical opinion would support a treatment plan of a five-milligram dose of diamorphine every four to six hours to a woman suffering with motor neurone disease and that this would be more likely than not ... the start of a process [that would shorten life] even though the principal purpose of the drugs was to relieve pain.[1] The point being that necessity is based on a patient's best interests and this, in turn, is based on the *Bolam* standard - a standard practised by a responsible body of medical practitioners: *In re F* [1990] 2 AC 1.

[**N.B.:** w.r.t. the charge of attempted murder and subsequent conviction of ***Dr Cox*** (1992), the potassium chloride solution which he administered to his patient had no therapeutic value. Accordingly, there could be no defence based on the doctrine of double effect in his case. By contrast, in May 1999, ***Dr David Moor*** was cleared of the murder of 85-year-old George Liddell. Dr Moor had admitted giving Mr Liddell a lethal dose of diamorphine but he maintained he had done so only to relieve pain, not to kill him].

[1] "Dying woman granted wish for dignified end" (1997) *The Times*, October 29th. This refers to Annie Lindsell who sought a declaration from the High Court that her doctor, Dr Simon Holmes, would not be prosecuted for murder if he gave her potentially lethal painkillers when her condition deteriorated. After hearing that a "responsible" body of medical opinion supported Dr Holmes's treatment plan, Mrs Lindsell withdrew her application for the court's intervention.

A significant case involving the doctrine of double effect?

In February 2007, "a 30-year-old woman [terminally-ill with ***Eisenmenger's syndrome*** – a heart defect which causes a range of symptoms] launched a ground-breaking right-to-die case at the High Court arguing that doctors' refusal to give her pain-relieving treatment that will kill her violates her human rights.

"***Kelly Taylor***, who has been given less than a year to live, says the refusal to increase her morphine dose to sedate her into unconsciousness condemns her to live in pain and breaches the ban on '*inhuman or degrading treatment*' in the European convention on human rights. *She is also relying on the doctrine of double-effect* - a long-standing principle of English law - that doctors may lawfully administer treatment even if they know it will shorten the patient's life, if their intention is to relieve pain and not to kill.

"Mrs Taylor's solicitor, Richard Stein, said: "It is a straightforward case where, to alleviate the pain of her condition, *it may be necessary to use an amount of morphine which could bring about a coma and ... this would ultimately cause death*." She has drawn up a living will refusing artificial feeding and other treatment to keep her alive. Mrs Taylor has brought her claim against her GP, with doctors at United Bristol Healthcare NHS Trust and St Peter's Hospice in Bristol. She says *they are refusing to increase the dose on the ground that it amounts to euthanasia, which counts as murder under English law*[2]".

It would appear that as Mrs Taylor has said: "Enough is enough. I don't want to suffer any more", the worry is that the increased dosage of morphine would be administered *with the primary purpose of killing her*, ***not*** the pain – which is contrary to the purpose of the doctrine of double effect – and, so, tantamount to murder. A full hearing of this case is scheduled for March 2007.

Is There a Need for Legislation in England & Wales?

Brazier (1992) thought that a potentially major problem in introducing legislation was that:

> " ... voluntary euthanasia legislation could well contravene ***Article 2*** of the ***European Convention on Human Rights***, which provides that 'Everyone's right to live shall be protected by law. No one shall be deprived of life intentionally ...'

However, this has been shown to be not the case. In: *NHS Trust A v. Mrs M*; *NHS Trust B v. Mrs H* [2001] 1 All ER 801, ***Butler-Sloss P*** said that the phrase 'deprivation of life' had to import a deliberate act; and that *omission* to treat would not constitute a deprivation when continuance would, in fact, not be in the patient's best interests and the decision had been made in accordance with a respectable body of medical opinion.

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[2] Extracted from: "'*Allow me to die*', *terminally ill woman urges* court", by Clare Dyer, The Guardian, Tuesday February 13th 2007.

Even though ***Dignity in Dying*** (formerly the ***Voluntary Euthanasia Society***) continues to promote the legalisation of voluntary euthanasia there appears to be no obvious indication of popular support for such a move at present (March 2007). Indeed, on May 12th 2006, the House of Lords debated ***Lord Joffe's Assisted Dying for the Terminally Ill Bill*** – and rejected it. It is crucially important to note, however, that if a redrafted version of Lord Joffe's Bill was adopted it would **NOT** permit voluntary euthanasia: it would be limited to physician assisted suicide (see *infra*).

Legality of Anticipatory Decisions / Living Wills / Advance Directives.

It was decided in Re T (1992) and reaffirmed in Bland that a competent patient who *anticipates the possibility* of becoming incompetent in the future and in doing so specifies the circumstances in which he would not wish to receive particular medical treatment should be at liberty to refuse that medical treatment even where the decision leads to his death. In Bland, ***Lord Keith*** said:

> "Such a person is completely at liberty to decline to undergo treatment, even if the result of his doing so will be that he will die. This extends to the situation where the person, in anticipation of his, through one cause or another, entering into a condition such as PVS, gives clear instructions that in such event he is not to be given medical care, including artificial feeding, designed to keep him alive."

However, as ***Lord Goff*** pointed out:

> "Special care may be necessary to ensure that the prior refusal of consent is still properly to be regarded as applicable in the circumstances which have subsequently occurred."

Examples of Member States of the European Union that permit active, voluntary euthanasia, subject to conditions.

The Netherlands

The ***Termination of Life on Request and Assisted Suicide*** **(*Review Procedures*)** ***Act*** entered into force on the 1st April 2002. *Before that*, voluntary euthanasia in the Netherlands had been lawful for many years, *subject to certain procedural provisions*. A *relaxation* of some of those provisions (making euthanasia less traumatic for the doctor by way of *removing automatic scrutiny of his act by a public prosecutor*) was introduced by the ***Termination of Life on Request and Suicide*** **(*Review Procedures*)** ***Act*** which amended ***Art.293*** of the Dutch Penal Code to read:

> (1) A person who terminates another person's life at that person's express and earnest request shall be liable to a term of imprisonment not exceeding twelve years or a … fine.
> (2) The act referred to in the first paragraph shall not be an offence if it is committed by a physician who fulfils the due care criteria… and if the physician notifies the municipal pathologist of this …

In essence, a person has to be diagnosed as being terminally ill; the diagnosis has to be confirmed by a second doctor; the patient must have made repeated requests for voluntary euthanasia – and been deemed competent at the time of making the requests – and, following the euthanasia, the doctor must be able to meet the requirements of ***Art.293*(*2*)** of the ***Penal Code***.

Belgium

The Belgian Act on Euthanasia of May 28th 2002 absolves from criminal charges for intentionally terminating life, a doctor who has the full, free and uncoerced consent of a competent person who is in a medically futile condition and who has repeatedly sought euthanasia.

Legislation outside the EU

Legislation in the U.S.A.

Maclean & Maher noted that 'certain States in the U.S.A. have enacted so-called allowing-to-die legislation, the best known of these being the ***Natural Death Act of California***. The effect of this legislation is to relieve doctors of any legal liability for refusing to treat various cases where the patient had previously made a directive concerning his own terminal care.' [i.e. *passive* euthanasia].

Australian Northern Territory

The Australian Northern Territory enacted a Voluntary Euthanasia Act which came into force on 1 July 1996. This Act permitted the voluntary active euthanasia of a patient who had been diagnosed by two doctors as being terminally ill and would die unaided within a short period of time. A patient was first assessed physically and mentally to confirm his illness and that his wishes for euthanasia were his own voluntary, uncoerced wishes. If the patient was confirmed as someone who fitted the criteria, he would eventually be connected to a syringe driver which was connected to a laptop computer. The patient would have to answer up to ten questions before he was asked if he wanted to receive a lethal dose of a drug which would first render him unconscious and then kill him within 30 seconds. Prior to enactment of the legislation, ***Dr Phillip Nitschke***, a GP based in Darwin who helped to devise the programme said:

> "***The patient*** will determine when the plunger is pressed by the syringe driver and ***not the doctor***. *That's quite important*. I don't know any doctor who'd really want to press the syringe himself. We have to see this as voluntary euthanasia and it's essential *the individual is controlling it*.
>
> "What this does is bring [euthanasia] out into the open and make it available for all. I've seen people die such horrible deaths while they've been waiting for a starting date to be announced [i.e., date when the Act comes into force] so it will be a blessed relief for all when we can do this legally."

Physician-Assisted Suicide: Current / Latest Developments.

Australian Northern Territory.

First, it may be incorrect to refer to the Australian Northern Territory Act of 1996 as a 'Voluntary Euthanasia' Act. In euthanasia, the registered medical practitioner is the person who will *supply and administer*, or withdraw the administration of, medical treatment. In physician-assisted suicide, however, the registered medical practitioner is the person responsible for the *supply only* of either the medication or, during the time the Australian Northern Territory Voluntary Euthanasia Act 1996 was in force, the apparatus and medication to bring about euthanasia. It is the patient who has the final control in terms not only of deciding the time of death - or even whether, indeed, he still wants to pursue it - but actually in administering the treatment - providing he's capable of doing so. The doctor's may have no role beyond the 'supply stage': presumably his further assistance would: (a) be required only if the patient became physically incapable of administering the lethal substance; and (b) be lawful *only if expressly provided for*.

Physician-assisted suicide had a limited life under the Australian Northern Territory Act: it became lawful on 1st July 1996 but the Act was repealed on 24th March 1997 by which time four people had exercised their autonomy and terminated their own lives with the aid of the 'deliverance' system. 'Euthanasia via a machine and without other human intervention' *may* be legal in ***Israel*** this year (2006) and in ***England and Wales if*** Lord Joffe's Bill is enacted.

Oregon, USA.

The ***Oregon Death With Dignity Act*** **1994** finally came into force on 27th October 1997 after 'the voters of Oregon [had] twice voted for the law permitting physician-assisted suicide for the terminally ill (1994 and 1997)'.[3] "The Death With Dignity Act requires that two doctors certify that a terminally ill patient has less than six months to live. The patient must see a counsellor if either doctor thinks the patient's judgment is impaired by depression."[4] Moreover, from the time of the doctors' certification, the patient has to wait 15 days to obtain a lethal prescription. That these are, perhaps, over-cautious safeguards is debatable given that Dr Peter Rasmussen, an assisted-suicide proponent who received formal requests for lethal prescriptions from four patients, reported that: "So far, every patient has died before the 15-day waiting period, ... By the time these people were ready to think about ending their lives, they were already close to death."[5] He continued by expressing the view that the assisted-suicide process under the 1994 Act "is quite limiting and quite cumbersome, but I personally think it needs to be that way. It's not perfect, but I would feel frightened if people could make snap decisions."[6]

A further barrier for a competent but terminally ill patient to overcome arises from the decision of the Salem hospital, Oregon, not to allow nurses, pharmacists and other hospital employees to aid in the suicides. "This is a physician-patient decision and not a hospital-

[3] Email from ERGO (Euthanasia Research and Guidance Organisation), Tuesday 17th Feb 1998.
[4] Email from ERGO, Thursday 19th Feb 1998.
[5] ibid
[6] ibid.

patient decision," said the chairman of the hospital's board. "It's allowed under certain circumstances so we don't flatly prohibit it. The hospital will not get involved in it in any way." Given that doctors will be prevented from obtaining a lethal prescription at the hospital's pharmacy, this must restrict further restrict and frustrate the wishes of those who wish to be the recipients of euthanasia. Whether such control is necessary is debatable given that *under the 1994 Act doctors are limited to **writing** the prescriptions*: they are **not** allowed to **administer** them.

Switzerland

Article 115 of the ***Swiss Penal Code*** absolves from punishment any person who helps another to commit suicide providing that the person who helps the terminally ill person by way of, for example, obtaining a lethal substance, which the terminally ill person takes or administers without further assistance, is not motivated by any self-serving ends. Many Britons have taken advantage of this law and 'on the eve of her 67th birthday ***Dr*** [***Anne***] ***Turner*** became the 42nd Briton to die with the help of ***Dignitas*** [a Swiss euthanasia clinic]': (2006) *The Times*, 25th January.

It is noteworthy that the attitude of English law, in relation to anyone accompanying a competent UK citizen abroad for the purpose of committing suicide, is that it is possible, *but probably unlikely*, that the person who assists will face a criminal charge of aiding, abetting counselling or procuring suicide.

A Local Authority v Mr Z [2004] EWHC 2817
After a man informed his local authority that he intended taking his wife to Switzerland where she intended to commit suicide, the authority obtained an injunction preventing him from doing so.
Held: The woman was competent, so there was no basis in law for the court to prevent the wife from taking her own life. Whereas the husband could contravene s.2 of the Suicide Act 1961, the court would not of its own motion continue the injunction where no one of standing sought such an order and where the effect of the injunction would deny a seriously disabled but competent person a right that could not be exercised by virtue of the disability.

N.B.:
Article 115 of the Swiss penal code considers assisting suicide a crime if and only if the motive is selfish. Assisting suicide for altruistic reasons is condoned. In most cases the permissibility of altruistic assisted suicide cannot be overridden by a physician's duty to save life.

It has been reported (September 2006) that at least 54 Britons have travelled to Switzerland to commit suicide in a clinic run by Dignitas – a non-profit organisation set up in 1998 by Swiss lawyer, Ludwig Minelli. The relaxed provisions of Swiss law have lead some people to call Zurich a favourite place for "death tourism". A decision of the Swiss court in October 2007 will decide whether a person who is not terminally ill but who is suffering from severe depression will be able to exercise a right under Swiss law to end his life via assisted suicide. It should be noted that Article 115 does not require the involvement of a physician nor that the patient be terminally ill. It only requires that the motive be unselfish.

England & Wales.

First, ***Joe Ashton's*** ***Doctor Assisted Dying Bill*** was defeated after being debated in the House of Commons under the Ten Minute Rule on December 10th 1997 - Human Rights Day. Then, ***Lord Joffe's*** ***Assisted Dying for the Terminally Ill Bill*** was defeated in the House of Lords in May 2006. Lord Joffe first introduced a Bill in 2003, and the 2006 Bill attracted more attention (and support) than previous Bills. It should be noted that ***Clause 1*** of the Bill provided for the physician to prescribe medication and, where appropriate, provide 'such means of self-administration of that medication'. It was a 'physician-assisted suicide Bill': it did **NOT** provide for voluntary euthanasia.

Secondly, the conviction of ***Dr Harold Shipman*** in January 2000 for the murder of 15 patients illustrated nothing in respect of ending a patient's life with dignity. Nothing other than one man's abuse of power, greed and deceit were in evidence. His conviction for murder should not cloud the issue of euthanasia being seen by some as the ultimate expression of patient autonomy.

Third, if 'physician assisted suicide' can be interpreted as encompassing the doctrine of double effect and/or bringing about death by omitting/discontinuing treatment in the 'patient's best interests', then it is lawful in England and Wales. Positive acts that cannot be encompassed under such headings and which result in a patient's death remain unlawful. The cases of ***Diane Pretty*** (2002) and ***Miss B*** (2002) should be studied in detail. In essence, the distinction between acts and omissions remains an integral part of English law. ***Read the cases***.

(See very brief notes on Diane Pretty's case and Miss B's case in the appendix, *infra*).

References

Brazier & Cave, Medicine, Patients and the Law, 4/e. London: Penguin, 2007, Ch.20;
Gillon, Philosophical Medical Ethics. Chichester: John Wiley & Sons, 1985, Chs.20-22;
Mason & Laurie, Mason & McCall Smith's Law and Medical Ethics, 7/e. Oxford: OUP, 2005, Ch.17;
Stauch, M, Wheat K and Tingle, J. Text, Cases & Materials on Medical Law, 3/e. London: Routledge-Cavendish, 2006, Ch.12.

Pretty v. United Kingdom [2002] 2 FLR 45
Re B (adult: refusal of medical treatment) [2002] 2 All ER 449

Some Web Sites proclaiming to 'protect' patients' interests / anti-euthanasia
http://www.patientprotect.org
http://www.donoharm.org.uk/alert/index.htm
http://www.willtolive.co.uk/index.html

Appendix

Diane Pretty's Case: ***R (Pretty) v. DPP*** [2002] 1 All ER 1; [2002] 2 FLR 45

By November 2001, 42-year-old Diane Pretty, who was suffering from motor neurone disease had failed to get a declaration both in the High Court and in the House of Lords that it would not be unlawful for her husband to assist in the ending of her life. Diane Pretty was mentally competent but physically incapable of ending her own life. The DPP refused to grant Mr Pretty immunity from prosecution under ***s.2(1) Suicide Act 1961*** under which he could be jailed for up to 14 years for aiding and abetting the suicide of another person. The decision was upheld on appeal to the ***European Court of Human Rights*** where the Court agreed with the ***House of Lords*** that there had been no breach of the following Articles of the European Convention on Human Rights: ***Art.2*** (right to life); ***Art.3*** (prohibition of torture or inhuman or degrading treatment); ***Art.8*** (right to respect for private and family life); ***Art.9*** (freedom of thought); ***Art.14*** (prohibition of discrimination).

Miss B's Case: ***B v. An NHS Trust*** [2002] 2 All ER 449

In March 2002, Miss B, a 43-year-old woman who was paralysed from the neck downwards was deemed competent to decide that the ventilator to which she was attached and which was helping to keep her alive could be disconnected. ***Dame Elizabeth Butler-Sloss P*** conducted a hearing at Miss B's bedside in an intensive care unit. In response to Counsel for the NHS Trust that was caring for Miss B stating that Miss B's doctors were concerned to establish that she was competent to make it, because of the gravity of the decision, Dame Elizabeth said:

> "You seem to be saying that if you want something and the doctors don't think it is a good idea because they want to do something else, the more you disagree the more you will be regarded as unable to make a decision.
>
> "That is a dangerous concept. There is a very paternalistic element. It's a very 'doctor knows best' concept. I really bridle at that as a member of the public as well as a judge."

As well as affirming the right of a competent person to refuse medical treatment, even when that refusal would end in death, Dame Elizabeth awarded Miss B the nominal sum of £100 in respect of the unlawful administration of non-consensual treatment for the period in which Miss B's wishes had not been complied with.

Potential Examination Questions

1. 'Any competent person who has been diagnosed as having a terminal illness should have an inalienable right to voluntary euthanasia if he or she so wishes. No doctor who assists in the process should be subject to criminal sanctions.'

Discuss.

2. Mary is a 43-year-old quadriplegic. She has been paralysed and kept in hospital since being injured in a road traffic accident just over a year ago. Her life is being maintained by a computerised ventilator and the prognosis is that she will be unable to survive if she is removed from it. Nevertheless, Mary, an intelligent, former businesswoman, who has remained mentally alert throughout the period of her paralysis, has repeatedly requested that her life be ended by discontinuing the life-saving treatment. As the hospital authorities are reluctant to accede to her request, Mary has initiated court action to assert her 'right to die'.

Advise Mary of the ethical and legal issues that will guide the court in its decision-making process. How, if at all, would your answer differ if Mary was at home and she was seeking a declaration as to the lawfulness of her husband initiating and completing a life-terminating procedure on her at her specific request?