

Chapter 11

The law in relation to end-of-life issues

Learning objectives

Core knowledge

- Definitions of brain-stem death and PVS
- The law in relation to homicide

Clinical applications

- Withholding and withdrawing treatment in PVS patients
- Organ donation

Background principles and case law

- Physician-assisted suicide and intentional killing
- *Tony Bland* (1993)
- *Diane Pretty* (2002)

Introduction

All clinicians will be involved in the care of dying patients and decisions regarding resuscitation and palliative care. It is important to understand the law in relation to homicide as it is applied to any form of 'medical killing' in the form of physician-assisted suicide or 'mercy killing'. Competent adult patients have a right to accept or refuse life-sustaining treatment. However, decisions have to be made on behalf of premature infants and severely handicapped children by their parents and occasionally by the courts. Decisions may also have to be made regarding the treatment of incapacitated patients who are terminally ill or chronically sick, or who are in the persistent or

permanent vegetative state (PVS) or less serious comatose states.

In Scotland, Welfare Attorneys have the power to make decisions on behalf of incapacitated patients. Otherwise it remains the responsibility of doctors, in conjunction with the patient's relatives and other carers, to decide what is in the 'best interests' of the patient.

Definitions

Brain-stem death

In Britain, death is defined clinically as the irreversible destruction of brain-stem function ('brain-stem death'), and can be distinguished from conditions like PVS. Currently there is no statutory definition of death in UK law, although the criteria for brain-stem death have been accepted by the courts throughout the UK and by Coroners. In the rare 'locked-in state' the patient remains conscious but is unable to communicate.

The underlying conditions and diagnostic tests for confirming brain-stem death were defined in the Report of the Conferences of Medical Royal Colleges in 1976 (Table 11.1). The Department of Health issued a Code of Practice for the diagnosis of Brain Stem Death in 1998 that was prepared by the Royal College of Physicians and reiterated the underlying causes of death and diagnostic criteria, while distinguishing death from PVS.

Table 11.1 Diagnosis of brain-stem death

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| <p>A. Predisposing conditions:</p> <p>1 The patient should be deeply comatose.</p> <p>(a) There should be no suspicion that this state is due to depressant drugs.</p> <p>(b) Primary hypothermia as a cause of coma should have been excluded.</p> <p>(c) Metabolic and endocrine disturbances that can be responsible for or can contribute to coma should have been excluded.</p> <p>2 The patient is being maintained on a ventilator because spontaneous respiration had previously become inadequate or had ceased altogether.</p> <p>3 There should be no doubt that the patient's condition is due to irremediable structural brain damage. The diagnosis of a disorder that can lead to brain-stem death should have been fully established.</p> <p>B. Diagnostic tests for the confirmation of brain-stem death</p> <p>'All brain-stem reflexes are absent:</p> <p>(i) The pupils are fixed in diameter and do not respond to sharp changes in the intensity of incident light.</p> <p>(ii) There is no corneal reflex.</p> <p>(iii) The vestibulo-ocular reflexes are absent.</p> <p>(iv) No motor response within the cranial nerve distribution can be elicited by adequate stimulation of any somatic area.</p> <p>(v) There is no gag reflex response to bronchial stimulation by a suction catheter passed down the trachea.</p> <p>(vi) No respiratory movements occur when the patient is disconnected from the mechanical ventilator for long enough to ensure that the arterial carbon dioxide tension rises above the threshold for stimulation of respiration.'</p> <p>'Diagnosis of Brain Death', <i>BMJ</i> 1976;1187.</p> |
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Additional considerations:

- The diagnostic tests should be repeated at an interval dependent upon the underlying pathology, so as to obviate observer error. The interval between tests might be as long as 24 hours.
- Confirmatory investigations, such as electroencephalography (EEG), cerebral angiography or cerebral blood-flow measurements, are not necessary for the diagnosis. The presence of spinal reflexes does not exclude a diagnosis of brain-stem death.

Table 11.2 Diagnosis of Persistent Vegetative State (PVS)

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| <p>'A clinical condition of unawareness of self and environment in which the patient breathes spontaneously, has a stable circulation, and shows cycles of eye closure and opening which may simulate sleep and waking. This may be a transient stage in the recovery from coma or it may persist until death.'</p> <p><i>J R Coll Physicians Lond.</i> 1996;30:119–21</p> |
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- The diagnosis ought to be made by an experienced clinician, usually a consultant. A specialist neurologist or neurosurgeon is not normally required except when the primary diagnosis is in doubt.
- The decision to withdraw artificial support should normally be made by a consultant (or his suitably experienced deputy who has been registered for at least 5 years) and one other doctor, once the diagnosis has been made.

Persistent vegetative state

PVS is a rare disorder that is diagnosed on the basis of clinical examination and observation. PVS has been defined by a Working Group of the Royal College of Physicians (Table 11.2).

A diagnosis of a permanent vegetative state may be made when a patient has been in a continuing vegetative state following head injury for more than twelve months or following other causes of brain damage for more than six months.

The cardinal features of PVS are that the patient displays a sleep-wake pattern, responds to stimuli only in a reflex way, and shows no meaningful responses to the environment. The patient may be awake, but lacks awareness.

The diagnosis of PVS is clinical. There are no specific diagnostic tests to diagnose PVS or to predict the potential for recovery. Indeed, the main problem in the diagnosis is the need to prove a negative—the absence of awareness of self and the environment, particularly as it is recognized that (un)awareness is part of a continuum. In the words of the original description of PVS, there must be 'no evidence of a working mind'. The Royal College stresses that the diagnosis is essentially clinical.

cal, and must take into account the observations of the carers and family.

A structured systematic approach is recommended to make a diagnosis of PVS, which includes examination for:

- Sustained, reproducible, purposeful or voluntary behavioural responses to noxious visual, auditory, or tactile stimuli.
- Language comprehension or expression.
- Any spontaneous meaningful motor activity (including vocalization).

Patients in PVS may have spontaneous roving eye movements, or look towards the source of a noise or a new visual stimulus, and may even 'track' objects. However, they should not show evidence of responding to direct visual stimuli, as this is considered to require a higher degree of cortical processing. If the patient shows a startle response to a sudden noise, careful observation will be required to determine if the patient can obey simple commands, particularly if the patient is showing signs of spontaneous movement. Indeed some motor activity, e.g. limb movements, grimacing and yawning, is not unusual, both spontaneously and in response to sensory stimuli. Nevertheless, the clinician must determine if there is any co-ordinated movement in relation to nursing manoeuvres or other aspects of care that might signify some residual awareness.

The difficulty in both diagnosing the vegetative state and predicting the outcome of severely brain-damaged patients is illustrated by the finding that of 40 patients referred to the Royal Hospital for Neuro-disability between 1992 and 1995, having been diagnosed as being in a vegetative state by the referring doctor, it was found that only 10 (25%) remained in a persistent or permanent vegetative state, 13 (33%) slowly emerged from the vegetative state during rehabilitation, and 17 (43%) were considered to have been misdiagnosed.

Brain-stem death and organ donation

The law governing cadaveric organ transplantation is the Human Tissue Act 1961, and for dona-

Table 11.3 Human Tissues Act 1961

Under the Act:

- A person may request in writing or orally, in the presence of two witnesses, that his body or any specified part may be used after his death for therapeutic purposes, medical education or research (s.1(1)).
- The person who is 'lawfully in possession' of the body may authorize the removal from the body of 'any part, or, as the case may be, the specified part' to be used in accordance with the request, unless he has reason to believe that a request was subsequently withdrawn (s.1(1)).
- The person 'lawfully in possession of the body' may authorize the removal of any part of the body for therapeutic, education or research purposes (s.1(2)) and may authorize a post mortem examination even if 'not directed or requested by the coroner or any other competent legal authority' (s.2(2)), if having made such 'reasonable enquiry as may be practicable' he has no reason to believe that the deceased person had expressed an objection that has not been withdrawn or that the surviving spouse or any surviving relative of the deceased objects (s.1(2)).

A feature of the Act is the absence of any penalty for non-compliance.

tions from live donors the Human Organ Transplants Act 1989.

The Human Tissue Act 1961 (Table 11.3)

This enables organs and tissues to be used for therapeutic purposes, including transplantation. The Act does not provide a comprehensive regulatory framework. It does not explicitly require consent for the taking, storage or use of organs or tissues. However, 'reasonable enquiry' should be made of relatives to establish a lack of objection where the deceased has not made known his or her wishes. Where a patient dies without expressing their wishes as to whether a post mortem can be carried out and organs can be removed, the Act requires the person 'lawfully in possession of the body' (usually the hospital authorities) to determine whether the 'surviving spouse' or 'any surviving relative' does have any objection. Where the views

of the deceased are known, the legal position is clear. However, in practice, doctors tend to respect the views of the relatives if they object to the removal of organs.

The Human Organ Transplants Act 1989

This regulates live organ transplants and commercial dealings for transplantation where organs have been removed from either living or dead people. Under s.1 it is an offence to deal commercially with organs from either living or dead donors where the organs are intended for transplantation.

Euthanasia, assisted suicide and related issues

Deliberate acts of ‘mercy killing’

The current state of the law regarding so-called ‘mercy killing’ was stated by Lord Goff in the case of *Bland v Airedale NHS Trust* (Table 11.4).

Lord Goff said:

‘It is not lawful for a doctor to administer a drug to his patient to bring about his death, even though that course is prompted by a humanitarian desire to end his suffering, however great that suffering may be. So to act is to cross the Rubicon which runs between on the one hand the care of the living patient and on the other hand euthanasia—actively causing his death to avoid or end his suffering. Euthanasia is not lawful at common law.’

Lord Goff in *Bland*

Table 11.4 The case of Tony Bland

Tony Bland was a victim of the Hillsborough Football Stadium disaster in 1989. He developed anoxic brain damage as a result of crush injuries and was subsequently diagnosed as having PVS. His doctor and parents had sought declaratory relief from the Court that the deliberate withdrawal so as to end his life of food and fluids administered through a naso-gastric tube would be lawful.

Airedale NHS Trust v Bland (1993)

Furthermore, the consent of the victim would not render ‘mercy killing’ lawful:

‘That “mercy killing” by active means is murder was taken for granted in the directions to the jury in *R v Adams* (Bodkin) (1957), *R v Arthur* (1981) and *R v Cox* (1992) and has never so far as I know been doubted . . . so far as I am aware no satisfactory reason has ever been advanced for suggesting that it makes the least difference in law, as distinct from morals, if the patient consents to or indeed urges the ending of his life by active means.’

Lord Mustill in *Bland*

Omissions that are intended to end life

In the case of *Bland* the issue was whether or not hydration and nutrition, delivered by tube, might be withdrawn from Tony Bland, who suffered from PVS, with the knowledge and intent that this would bring about his death (Table 11.1). Five Law Lords sat on the case.

The life of a patient in PVS may lawfully be terminated by a deliberate omission to provide life-sustaining treatment or sustenance. There remains, in law, a distinction between acts and omissions. As explained by Lord Mustill there is:

‘a distinction drawn by the criminal law between acts and omissions, and it carries with it inescapably a distinction between, on the one hand what is often called “mercy-killing”, where active steps are taken in a medical context to terminate the life of a suffering patient, and a situation such as the present where the proposed conduct has the aim for equally humane reasons of terminating the life of Anthony Bland by withholding from him the basic necessities of life. The acute unease which I feel about adopting this way through the legal and ethical maze is I believe due in an important part to the sensation that however much the terminologies may differ the ethical status of the two courses of action is for all relevant purposes indistinguishable.’

Lord Mustill in *Bland*

Lord Goff also distinguished between the administering of a lethal drug and the non-provision of treatment:

‘The law draws a crucial distinction between cases in which a doctor decides not to provide, or to continue to provide, for his patient treatment or care which could or might prolong his life, and those in which he decides, for example by administering a lethal drug, actively to bring his patient’s life to an end. As I have already indicated, the former may be lawful, either because the doctor is giving effect to his patient’s wishes by withholding the treatment or care, or even in certain circumstances in which (on principles which I shall describe) the patient is incapacitated from stating whether or not he gives his consent. But it is not lawful for a doctor to administer a drug to his patient to bring about his death, even though that course is prompted by a humanitarian desire to end his suffering, however great that suffering may be’:

Lord Goff in *Bland*

The law of murder requires both a guilty intent (*mens rea*) and a guilty act (*actus reus*). In this case it was said that where there is no legal duty of care, there can be no legal *actus reus*, even though the intention of the omission is to bring about the death of the patient. This was an unusual way to put the issue since, under Lord Atkin’s neighbour principle in *Donoghue v Stevenson* (1932), everyone has a duty of care not to injure his neighbour by negligence, still less deliberately (albeit by omission). That duty is all the greater, as we have seen, for a doctor having care of a patient. Moreover, in the law of homicide, an omission as well as acts of commission can give rise to criminal liability. It may be for this reason that Lord Mustill later said that the law had been left in a ‘misshapen state’ after the *Bland* decision.

In the case of Tony Bland it was held that there was no longer a duty of care because of his PVS state—he had no ‘best interests’, because he had no interests at all. This was graphically stated by Lord Keith:

‘It is, however, perhaps permissible to say that to an individual with no cognitive capacity

whatever, and no prospect of ever recovering any such capacity in this world, it must be a matter of complete indifference whether he lives or dies.’

Lord Browne-Wilkinson concluded that, while there was the *mens rea* of murder, there was no *actus reus*. Therefore the withdrawal of hydration and nutrition from Tony Bland was not unlawful.

‘Murder consists of causing the death of another with intent so to do. What is proposed in the present case is to adopt a course with the intention of bringing about Anthony Bland’s death. As to the element of intention or *mens rea*, in my judgment there can be no real doubt that it is present in this case: the whole purpose of stopping artificial feeding is to bring about the death of Anthony Bland. As to the guilty act, or *actus reus*, the criminal law draws a distinction between the commission of a positive act which causes death and the omission to do an act which would have prevented death. In general an omission to prevent death is not an *actus reus* and cannot give rise to a conviction for murder. But where the accused was under a duty to the deceased to do the act which he omitted to do, such omission can constitute the *actus reus* of homicide, either murder (*Rex v. Gibbins* (1918) 13 Cr.App.R. 134) or manslaughter (*Reg. v. Stone* [1977] Q.B. 354) depending upon the *mens rea* of the accused.’

Lord Browne-Wilkinson in *Bland*

Lord Browne-Wilkinson then neatly side-stepped the problem by finding that clinicians had no duty of care to Tony Bland to continue his feeding by tube, and so there was no *actus reus*. In order to achieve this outcome tube-feeding was re-classified as ‘treatment’ for PVS patients, albeit the actual feeding (which kept Bland alive) was not strictly speaking a form of treatment, since true PVS is permanent and incurable.

This re-definition has not surprisingly resulted in calls for such tube-feeding to be similarly re-classified for other serious comatose conditions. The courts have not been prepared to go that far, although the decision in *Bland* to remove tube-

feeding so that death ensued was later held by Dame Elizabeth Butler-Sloss, President of the Family Division of the High Court, to be compatible with Articles 2 and 3 of the European Convention on Human Rights (see *Re: H, Re: M* (2000)).

Practice Note of the Official Solicitor concerning the Vegetative State

Following the Bland judgment, the withdrawal of hydration and nutrition from patients in PVS requires application to the court (Table 11.5).

Physician-assisted suicide

According to Lord Bingham in the case of *R (Pretty) v DPP* (2002):

‘The law confers no right to commit suicide. Suicide was always, as a crime, anomalous, since it was the only crime with which no defendant could ever be charged . . . Suicide (and with it attempted suicide) was decriminalized because recognition of the common law offence was not thought to act as a deterrent, because it cast an unwarranted stigma on innocent members of the suicide’s family and because it led to the distasteful result that patients recovering in hospital from a failed suicide attempt were prosecuted, in effect, for their lack of success.’

Physician-assisted suicide is undoubtedly unlawful. According to s.2(1) of the Suicide Act 1961:

‘2(1)—A person who aids, abets, counsels or procures the suicide of another, or an attempt by another to commit suicide, shall be liable on conviction on indictment to imprisonment for a term not exceeding fourteen years.’

While suicide itself was decriminalized for the victim, aiding or abetting suicide remains an offence, as was explained by Mr Justice Woolf in *A-G v Able* (1984) (the ‘EXIT’ case):

‘S1 of the Act having abrogated the criminal responsibility of the suicide, s.2(1) retains the criminal liability of an accessory at or before the fact. The nature of that liability has, however,

Table 11.5 Practice Note of the Official Solicitor concerning the Vegetative State

In July 1996 the Official Solicitor issued guidance concerning applications to the court before the withdrawal of hydration and nutrition from those with PVS. In summary it said:

1 The termination of artificial feeding and hydration for patients in a vegetative state will in virtually all cases require the prior sanction of a High Court judge.

2 The diagnosis should be made in accordance with the most up-to-date generally accepted guidelines of the medical profession . . . It is not appropriate to apply to court for permission to terminate artificial feeding and hydration until the condition is judged to be permanent. The diagnosis of PVS is not absolute, but based upon probabilities, and should not be made within 12 months of a head injury or within 6 months for other causes of brain damage.

3 Normally the application is for a declaration; but applications to court in relation to minors should be made within wardship. In such cases the applicant should seek the leave of the court for the termination of feeding and hydration, rather than a declaration.

4 The originating summons should be in the following form:

‘It is declared that despite the inability of X to give a valid consent, the plaintiffs and/or the responsible medical practitioners

(i) may lawfully discontinue all life-sustaining treatment and medical support measures (hydration by artificial means) designed to keep X alive in his existing permanent vegetative state; and

(ii) may lawfully furnish such treatment and nursing care whether at hospital or elsewhere under medical supervision as may be appropriate to ensure X suffers the least distress and retains the greatest dignity until such time as his life comes to an end. . . .

5 The hearing will normally be in open court, with steps taken to preserve the anonymity of the patient and the patient’s family. An order restricting publicity will continue to have effect notwithstanding the death of the patient, unless and until an application is made to discharge it.

6 The applicant may be the next of kin or an individual closely connected with the patient or the relevant health authority or NHS trust. Those close to the patient cannot veto an application, but they must be taken fully into account by the court.

7 The Official Solicitor will normally be invited to act as

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Table 11.5 Continued

guardian *ad litem* of the patient, or where he does not represent the patient, he should be joined as a defendant or respondent.

8 There should be at least two independent medical reports on the patient from doctors experienced in assessing disturbances of consciousness.

9 The Official Solicitor's representative will normally be required to interview those close to the patient as well as seeing the patient and those caring for him.

10 The views of the patient may have been previously expressed. The High Court may determine the effect of a purported advance directive as to future medical treatment. The patient's previously expressed views, if any, will be an important component in the decisions of the doctors and of the court, if they are clearly established and intended to apply in the circumstances which have arisen.

Summarized from Practice Note of the Official Solicitor on Vegetative State, July 1996

Table 11.6 The case of Diane Pretty

Mrs Diane Pretty suffered from motor neurone disease and was paralysed from the neck downwards. She wanted to have control over the manner of her death. She was no longer able to commit suicide, and wished her husband to assist her. He agreed. However, the Director of Public Prosecutions (DPP) refused to undertake not to prosecute him for the offence of assisting in her suicide under s.2(1) of the Suicide Act 1961. He therefore sought to challenge the Director's refusal. The case went on appeal to the House of Lords, and eventually was heard in the European Court of Human Rights, which gave judgment shortly before she died in a hospice in England. All judges in all courts unanimously refused to overturn the Director's decision to refuse the advance immunity from prosecution.

R (Pretty) v DPP (2002)

changed. From being a participant in an offence of another, the accessory becomes the principal offender.'

Mr Justice Woolf (now Lord Chief Justice) went on to explain what was the minimum necessary to make a person an accessory before the fact, quoting from *Russell on Crime*:

'... the conduct of an alleged accessory should indicate (a) that he knew that the particular deed was contemplated, and (b) that he approved of or assented to it, and (c) that his attitude in respect of it in fact encouraged the principal offender to perform [and I would here add "or to attempt to perform"] the deed.'

Quoting a former Lord Chief Justice, Lord Widgery, from *A-G's Reference* (1975), he defined procurement as:

'To procure means to produce by endeavour. You procure a thing by setting out to see that it happens and taking the appropriate steps to produce that happening. You cannot procure an offence unless there is a causal link between what you do and the commission of the offence.'

The case of Diane Pretty (Table 11.6)

In the *Pretty* case the House of Lords held that the Convention did not oblige a state to legalize assisted suicide.

Article 2:

- did not acknowledge that it was for the individual to choose whether to live or die, nor did it protect a right of self-determination in relation to issues of life and death; and
- enunciated the principle of the sanctity of life and provided a guarantee that no individual should be deprived of life by means of intentional human intervention, but did not provide or protect a 'right to die'.

The European Court of Human Rights held:

- the convention did not guarantee a right to assisted suicide;
- no right to die could be derived from the right to life;
- there was no ill-treatment by the Government, and the medical authorities were providing adequate care;
- there was no breach of the prohibition of inhuman or degrading treatment (Article 3);
- the blanket ban on assisted suicide under the Suicide Act 1961 was not disproportionate.

Table 11.7 The case of Ms B

Miss B, a 43-year-old former social worker, suffered a bleed from a spinal haemangioma. She was admitted to hospital in 1999 for about 5 weeks, and her condition improved. She recovered to the extent that she was able to go back to work. However, at the beginning of 2001 she had a further bleed that caused severe cord damage, and she became tetraplegic. She was placed on a ventilator, upon which she was entirely dependent for survival. She subsequently asked for the ventilation to be discontinued. Dame Elizabeth Butler-Sloss, President of the Family Division of the High Court, ruled that she had the 'necessary mental capacity to give consent or to refuse consent to life-sustaining medical treatment'. She held that Miss B could be transferred to another hospital and the ventilator could be withdrawn in accordance with her wishes, with any treatment necessary to 'ease her suffering and permit her life to end peacefully and with dignity'.

She died on 29 April 2002 after ventilation was withdrawn.

B v An NHS Trust (2002)

The case of Ms B (2002)

In contrast to Diane Pretty, who wanted the assistance of her husband actively to bring about her death, Ms B was on a ventilator and wished it to be withdrawn as treatment (Table 11.7).

A crucial question was posed by her counsel, Mr Francis QC, who asked whether it was her wish to die, or not to remain alive in the present condition, to which she replied: 'The latter . . . given the range of choices, I would want to recover and have my life back, or significant enough recovery to have a better quality of life. I am not convinced from the evidence that that is going to happen, and I find the idea of living like this intolerable.'

Hence there was a significant difference between wishing positively to end a life (in effect a suicidal wish) and not wanting to continue living attached to a ventilator (in effect a legitimate refusal of treatment by a competent patient). It was decided that she was mentally capable of making a decision regarding the withdrawal of ventilation. As it was her clear wish to discontinue ventilation, this wish was granted by the court in accordance with established legal principle.

Cases

A number of doctors have been on trial before the courts or the GMC for helping patients to die. Their cases are illustrative.

Dr John Bodkin Adams (1957)

Dr John Bodkin Adams was an Eastbourne GP who was charged with the murder of an elderly patient. He was accused of administering pain-relieving drugs in order to cause her death. During the trial at the Old Bailey, it was alleged that he had benefited from her will to the tune of £157,000. He was acquitted. The case is important for a recognition by Mr Justice Devlin (later Lord Devlin) of the principle of double or dual effect, when he held that:

' . . . a doctor is entitled to do all that is proper and necessary to relieve pain even if the measure he took might incidentally shorten life by hours or perhaps longer'.

Dr Leonard Arthur 1981

Dr Leonard Arthur stood trial at Leicester Crown Court for the attempted murder of John Pearson, a newborn baby with Down's syndrome. His mother had rejected him, and Dr Arthur, a highly respected paediatrician, had written in the notes after seeing both parents: 'Parents do not wish the baby to survive. Nursing care only.'

Baby Pearson was then given dihydrocodeine (DF118) 'as required' in dosages of up to 5 mg at four-hourly intervals (the firm manufacturing the drug does not recommend that it be given to any baby under 4 years old). John died about 54 hours after birth. The stated cause of death was bronchopneumonia as a result of Down's syndrome.

There was doubt as to the cause of death, and Mr Justice Farquharson directed that the charge should be one of attempted murder. The judge said that the distinction between acts and omissions was crucial, and that it was for the jury to say whether ' . . . there was an act properly so called on the part of Dr Arthur, as distinct from simply allowing the child to die'.

He also stated that: ‘However serious the case may be, however much the disadvantage of being a mongol, indeed, any other handicapped child, no doctor has the right to kill it.’

In accordance with the *Bodkin Adams* case, the judge stated that the administration of a drug by a doctor when it is necessary to relieve pain is a proper medical practice even when the doctor knows that the drugs will themselves cause the patient’s death, provided the death is not intended. Therefore, if the purpose of giving DF118 was to prevent suffering, it might be justified on this principle. However, there was some evidence that the effect of the drug would be to stop the child seeking sustenance—something that Dr Arthur had admitted to the police. In the event Dr Arthur was acquitted.

Dr Nigel Cox (1992)

Dr Nigel Cox, a consultant rheumatologist, was charged with, and found guilty of, the attempted murder of 70-year-old Mrs Lillian Boyes. She was a long-standing patient of Dr Cox with intractable pain due to vertebral fractures, leg ulcers and severe rheumatoid arthritis. Dr Cox gave her an injection of potassium chloride. The charges were brought after cremation of the body, and it was never possible to prove that the injection had caused the death. The 12 months’ sentence was suspended, and the GMC subsequently allowed Dr Cox to continue to practise medicine after a reprimand.

Dr Nigel Cox remains the only doctor ever to be convicted in the UK of attempting to perform a so-called ‘mercy killing’.

Dr Ken Taylor (1995)

Mrs Ormerod, who was 85 years old, had suffered from a series of strokes, senile dementia and mild Parkinson’s disease. She was bed-bound. Her GP, Dr Ken Taylor, had taken a decision to withhold nutritional supplements from her, and she died weighing less than 4 stone two months later, although she had been fed by the nurses at the home contrary to the doctor’s orders. Dr Taylor was found

guilty of serious professional misconduct by the GMC, and suspended from the medical register for six months. He had failed to perform an adequate assessment of the patient and to take into consideration the views of others involved in the patient’s care. He also should have recognized the limits of his professional competence and should have sought a second opinion.

Dr David Moor (1999)

A Newcastle GP, Dr Moor, was accused of giving a lethal dose of diamorphine to an 85-year-old patient, Mr George Liddell, who was thought to be in the terminal stages of bowel cancer. The stated purpose of the injection was to ensure that Mr Liddell had no breakthrough pain. What was unusual in this case was that Dr Moor had told a journalist that he had agreed with the views of Dr Michael Irwin in an article in *The Sunday Times* that had appeared only the day after Mr Liddell’s death, in which Dr Irwin had admitted to participating in physician-assisted suicide. Dr Moor said that he had given many of his patients diamorphine to help them have a pain-free death. ‘Basically, you address their problems and address their needs and if they have a lot of pain, if they have a lot of suffering, and if the patient’s relatives are suffering then you address that with care, compassion and consideration—I would certainly say that over the years I have helped a lot of people to die.’ However, although he admitted that he had given Mr Liddell diamorphine to relieve pain, he said that he had not deliberately set out to kill him.

Dr Moor had retired by the time of his trial, and died in 2000.

Dr Harold Shipman (2000)

Dr Harold Shipman was convicted in 2000 of murdering 15 elderly patients and sentenced to prison for life. The later investigation said Shipman had murdered at least 200 other people since 1975, and raised questions about how he was able to evade detection for so many years. High Court Judge Janet Smith, who investigated Shipman’s activities after he was jailed, concluded in 2002 that he had

killed 215 of his patients, including 171 women and 44 men.

Judge Smith said that she also found a 'real suspicion' that Shipman was responsible for 45 other deaths, and that there was insufficient evidence to form any conclusion in another 38 deaths.

Dr Shipman was later found to have hanged himself in Wakefield Prison in June 2003.

Conclusion

Lord Mustill in *Bland* expressed the view that it was for Parliament to consider the ethical, legal and social issues surrounding cases such as *Bland*. The House of Lords Select Committee in 1993 opposed legalizing euthanasia and assisted suicide. English law now accepts that the lives of those in PVS can

be terminated by omission of assisted hydration with the sanction of the courts. 'Mercy killing' remains illegal, together with assisted suicide, and both the English Courts and the European Court of Human Rights have ruled that there is no 'right to die' under Article 2 of the Convention of Human Rights.

Keypoints

- Brain-stem death is regarded as death in the UK.
- The courts have sanctioned the withdrawal of hydration and nutrition for patients with PVS.
- 'Mercy killing' remains unlawful.
- The European Court of Human Rights in Strasbourg has not sanctioned a right to assisted suicide.