Just How Unlawful is “Euthanasia”?

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ABSTRACT Those who campaign for law reform to permit “euthanasia” may seek different things and at least some of what they seek may already be permissible under the criminal law of England and Wales. In this paper I examine one means whereby the criminal law delivers outcomes acceptable to the euthanasia lobby, that is the curious notion of “causation” deployed by the law, which adds a value override to the more usual notion of factual causation such that, for example, if medical treatment falls within the acceptable range as normal and proper, the pre-existing injury or illness is treated as exclusively the cause of death and the doctor escapes criminal liability, even where the medical treatment will shorten life to the certain knowledge, possibly even the wish, of the doctor. Thus the law may already be delivering a range of outcomes — euthanasia in a weak sense — acceptable to the euthanasia lobby. If so, it achieves this by stealth. That is inappropriate to the doctor-patient relationship, which is one of trust. So there is a strong case for greater transparency. Moreover, there are limits to the acceptable outcomes which an unreformed criminal law can deliver and in a range of cases the criminal law condemns the doctor to impotence and the patient to a prolonged, miserable and undignified death. So there is also a case for going beyond the current law and legalising euthanasia in a strong sense.

The question, “Should euthanasia be legalised?” rather assumes that euthanasia is currently illegal. That seems to me open to question. Much depends on how “euthanasia” is defined. There are circumstances in which a doctor may knowingly bring about a patient’s death without incurring any criminal liability. Certainly the Voluntary Euthanasia Society, albeit hardly an impartial observer, believes that in the United Kingdom up to 100,000 patients a year are quietly helped to die [1]. These may be regarded as instances of euthanasia by some and not by others. I favour the traditional, narrow definition of “euthanasia” as a merciful or “good” death for a terminally ill and dying patient, with consent, in order to spare the patient unnecessary or unnecessarily prolonged suffering.

In this paper, I seek to assess the extent to which euthanasia is currently contrary to the criminal law of England and Wales. My conclusion will be that much of what the euthanasia lobby advocates is not criminal as the law stands. That conclusion suggests that there is perhaps less of a case for radical law reform than there is for legal transparency. I remain committed to an Euthanasia and Terminal Care Act [2], but such legislation may turn out on close examination to be as much a restatement and reaffirmation of current law and medical practice than a radical reform. This may seem counter-intuitive and in order to make my case I will start from first principles.

Murder is causing the death of another human being with intention to cause death or really serious injury. Accordingly there are only three ways in which a doctor who
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has knowingly brought about a patient’s death can escape liability for murder. First, and this is the direction of my discussion, one can question the causal nexus between the doctor’s act and the death. Secondly, one can resist the imputation of intention by drawing a line between knowing that an outcome is virtually certain and intending that outcome. Here some deploy the doctrine of double effect to separate the intended and desired consequence (alleviating pain) from the unintended but foreseen, though not desired consequence (death); and attribute moral and legal liability only to intended and desired consequences. That is not how the criminal law of England and Wales ordinarily proceeds and whatever the philosophical merits or demerits of the doctrine of double effect its deployment in doctor-patient cases threatens the greatly prized but aspirational internal coherence of the criminal law.

Thirdly, one can deploy any relevant general or specific defence. For example, some criminal lawyers seek to deploy a supposed general defence of necessity [3]. Other commentators, however, have questioned whether the defence of necessity can be deployed, not least because whatever may be the case with lesser crimes, it is not recognised as a defence to murder [4], at least in other than the most remarkable of circumstances [5]. Elsewhere [6] I have explored a specific defence for doctors, based on professional ethics. Briefly the argument is that because a doctor has a professional duty to relieve a patient’s suffering, it is permissible for a doctor, when the patient is doomed shortly to die, to administer pain-killing drugs with the patient’s consent, even if they incidentally shorten life, although that would be not permissible for someone else. Although that is my preferred explanation of and justification for acquitting doctors charged with the murder of their ill and dying patients, I turn to an alternative argument based on the absence of causation. In doing so I am giving an account of reasoning from the internal perspective of the criminal law. Externally that reasoning may be open to criticism and indeed the legal meaning of “causation” has something of a “looking-glass world” about it. “When I use a word, “ Humpty Dumpty said . . . “it means just what I choose it to mean . . . “. “The question is”, said Alice, “whether you can make words mean so many different things”. “The question is”, said Humpty Dumpty, “which is to be master . . . ” [7]. The criminal law imposes its mastery on the word and makes “causation” simultaneously mean two very different things.

“Causation” in criminal law is a complex notion in that it involves a form of sequenced, two-tiered reasoning. First, there is what may be called “factual causation” and secondly there is so-called “legal causation”. Factual causation is akin to the general scientific notion of what constitutes the or a cause of an event and is sometimes referred to as “but-for causation” or a causa sine qua non meaning thereby that the consequence would not have occurred but for the accused’s conduct. In one case [8] a man put potassium cyanide into his mother’s drink with the intention of causing her death. However she died of a heart attack before she had consumed more than about a quarter of the drink. Here the son’s conduct was not a factual cause of death and the son could not be and was not convicted of his mother’s murder because he had not caused her death. Of course he was charged with and convicted of attempted murder. “Legal causation” adds an overriding condition of defeasance such that not every factual cause is a legal cause. The locus classicus is found in a passage in Professor Glanville Williams’s magisterial textbook: “When one has settled the question of but-for causation, the further test to be applied to the but-for cause in order to qualify it for legal recognition is not a test of causation but a moral reaction. The question is whether the
result can fairly be said to be imputable to the defendant . . . If the term ‘cause’ must be used, it can best be distinguished in this meaning as ‘imputable’ or ‘responsible’ or ‘blameworthy’ cause, to indicate the value-judgment involved” [9]. This has the obvious defect of fudging questions of fact and questions of value in that there is an implicit and sometimes explicit invitation to the jury to deploy the notion of “cause” functionally for the attribution of responsibility and guilt and not analytically as a finding of fact. Thus “moral instinct” is deployed to qualify “common sense” notions of but-for factual causation [10]. “Causation” in law is therefore “. . . like a portmanteau — there are two meanings packed into one word” [11].

Notwithstanding this duality, juries are frequently told that “causation” is wholly a matter of common sense. In 1956 Dr Adams was arrested and charged with the murder of Mrs. Morrell, an 81 year-old patient who had died six years earlier. There was evidence that Dr. Adams was a beneficiary under Mrs Morrell’s will and knew that he was, but had falsely affirmed in his cremation certificate that he was not and there was a second indictment against Dr. Adams for the murder of a Mrs Hullett. So there appeared to be legitimate grounds for concern and the invocation of the criminal process. At the committal stage evidence was led to show that Dr. Adams had prescribed and administered such large doses of drugs, including morphine, that he must have known they would cause death. As Devlin J. (later Lord) explained in his seminal direction [12]:

‘Cause’ means nothing philosophical or technical or scientific. It means what you twelve men and women sitting as a jury would regard in a commonsense way as the cause. Manifestly there must be cases in hospitals that are going on day after day in which what a doctor does by way of giving certain treatment prolongs or shortens life by hours or even longer. The doctor who decides to administer or not to administer a drug is not, of course, thinking in terms of hours or minutes of life. He could not do his job properly if he were. If, for example, because a doctor had done something or has omitted to do something, death occurs at eleven o’clock instead of twelve o’clock, or even Monday instead of Tuesday, no people of common sense would say ‘Oh, the doctor caused her death’. They would say that the cause of death was the illness or the injury, or whatever it was, which brought her into the hospital, and the proper medical treatment that is administered and that has an incidental effect on determining the exact moment of death is not the cause of death in any sensible use of the term.

The direction to the jury included other salient passages:

Murder is an act or series of acts done by the prisoner which were intended to kill and did in fact kill the dead woman. It does not matter for this purpose that her death was inevitable and her days were numbered. If her life was cut short by weeks or months, it is just as much murder as if it was cut short by years.

We have heard a good deal of discussion . . . about the circumstances in which doctors might be justified in administering drugs which would shorten life. Cases of severe pain have been suggested and generally approved by the witnesses . . . and also there have been suggested cases of helpless misery. It is
my duty to tell you that the law knows of no special defence of this character. But that does not mean that a doctor who is aiding the sick and dying has to calculate in minutes or even hours, and perhaps not in days or weeks, the effect on a patient’s life of the medicines which he administers or else be in peril of a charge of murder. If the first purpose of medicine, the restoration of health can no longer be achieved there is still much for a doctor to do and he is entitled to all that is proper and necessary to relieve pain and suffering even if measures he takes may incidentally shorten life.

That is not because there is any special defence for medical men; it is not because doctors are put into any different category from other citizens for this purpose. The law is the same for all and what I have said rests simply upon this, which is part of the definition of murder that I gave you: no act is murder which does not cause death . . .

But it remains the fact, members of the jury, and it remains the law, that no doctor, nor any man no more in the case of the dying than the healthy, has the right to deliberately cut the thread of life . . . [but if] the treatment that was given by Dr Adams was treatment that was designed to promote comfort and if it be the right and proper treatment in the case, the fact — if it be the fact — that incidentally it shortens her life does not give any grounds for convicting him of murder.

It was a pity perhaps that the word ‘justified’ was ever brought into it. ‘Justified’ suggests to the lawyer some legal justification and it suggests to you when we are talking of matters of life and death some moral justification. There is no legal justification and there is no moral justification that you have to consider in this case. The word ‘justified’, as I understand it, was used in a purely medical sense, in this way. If a doctor is going to prescribe the course of drugs that was prescribed in this case, we have heard the sort of dangers that may result: the patient may become semi-comatose; the effect on the patient who is semi-comatose may be that there are complications — pulmonary congestion and so forth — and it may lead to death, and therefore the doctor who is going to prescribe this course of treatment has to consider that, and he has to ask himself whether he is justified in a medical way in running that risk, there being in the case of a woman who is dying, always, I suppose, the risk to run that the treatment may not be the right one. And ‘justified’, as I understand it, in the medical evidence is used purely in that way.

The jury acquitted Dr Adams after 42 minutes deliberation. It follows from this that so long as a doctor does “all that is proper and necessary to relieve pain and suffering even if measures he takes may incidentally shorten life” the doctor cannot be guilty of murder because it cannot sensibly be said (when talking “law” rather than English) that normal and proper medical treatment legally caused the death even though it undoubtedly did so in the factual, but-for sense. This eccentric conception of “cause” is wholly consistent with the general common law approach that normal medical treatment, even if inept and ineffective, does not break the causal chain from the original injury to the resultant death. Deploying the conception of “cause” in the case of proper medical treatment which accelerates a dying patient’s death, exhibits the virtue of internal coherence in the criminal law.
For example, in the course of an argument in a fish and chip shop David shot Trevor in the leg and stomach, seriously wounding him. Trevor was taken to hospital where he was operated on and placed in intensive care. While in hospital he developed respiratory problems and a tracheotomy tube was placed in his windpipe to assist his breathing. The tube remained in place for four weeks. Trevor suffered further chest infections and other complications and complained of difficulty in breathing. More than two months after the shooting, while still in hospital, the deceased died of cardio-respiratory arrest because his windpipe had become obstructed due to narrowing where the tracheotomy had been performed, such a condition being a rare but not unknown complication associated with this operation. David was charged with murder. At his trial evidence for the defence was given by a consultant surgeon that the deceased’s leg and stomach wounds no longer threatened his life at the time of his death and that his death was caused by the negligent failure of the medical staff at the hospital to diagnose and treat Trevor’s respiratory condition. The trial judge directed the jury that David was responsible for Trevor’s death even if the treatment given by the hospital medical staff was incompetent and negligent and it was only if they had been reckless in their treatment of Trevor that David was entitled to be acquitted. David was convicted by the jury and he appealed. The Court of Appeal held that where the jury had to consider whether negligence in the medical treatment of injuries inflicted by the accused was the cause of death it was not the function of the jury to evaluate competing causes or to choose which was the dominant cause. The jury’s task in such a case was to decide whether they were satisfied that the accused’s acts could fairly be said to have made a significant contribution to the victim’s death. Accordingly, it was sufficient for the judge to direct the jury that they had to be satisfied that the Crown had proved that David’s acts caused Trevor’s death, that David’s acts did not need to be the sole or even the main cause of death, it being sufficient that his acts contributed significantly to that result, and that even though negligence in the treatment of the victim was the immediate cause of his death, they should not regard it as excluding the responsibility of the accused unless the negligent treatment was so independent of his acts and in itself so potent in causing death that they regarded the contribution made by his acts as insignificant. Accordingly the appeal was dismissed [13].

In one remarkable case [14] a man who had been convicted of murder sought leave to call further evidence about the cause of the victim’s death. The application was granted and evidence was received by the Court of Appeal that the stab wound from which the victim allegedly died eight days later was not in fact or in law the cause of the victim’s death. The victim had died from the effects of sensitivity to Terramycin which had been given to him after his intolerance to it was established and in abnormal quantity. The court considered that the introduction into the system of the victim of a substance known to be poisonous to him and in quantities which were so great as to result in pulmonary oedema leading to pneumonia were factors which ought to have been before the jury and which in all probability would have affected their decision. It is generally thought that this case establishes that “palpably wrong” medical treatment can break the chain of causation from the original wound or injury to the ultimate death. But it is always stressed that the treatment must fall very far short of the standard of care to be expected of competent medical practitioners. Moreover, this case is not readily treated as a precedent but as a very particular case dependent entirely upon its exact and extraordinary facts.

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In a later case [15] one soldier had been convicted at court-martial of the murder of another soldier by stabbing him. The victim had been dropped twice while being taken to the medical reception station and was subsequently given treatment which was said to be incorrect and harmful. Lord Parker CJ, giving the judgment of the Court-Martial Appeal Court, rejected a contention that his death did not result from the stab wound. He said,

It seems to the court that, if at the time of death the original wound is still an operating cause and a substantial cause, then the death can properly be said to be the result of the wound, albeit that some other cause of death is also operating. Only if it can be said that the original wounding is merely the setting in which another cause operates can it be said that the death does not result from the wound. Putting it in another way, only if the second cause is so overwhelming as to make the original wound merely part of the history can it be said that the death does not flow from the wound [16].

In two conjoined appeals [17] it was argued that the act of a doctor in disconnecting a life support machine had intervened to cause the death of the victim to the exclusion of injuries inflicted by the appellants. In rejecting this submission Lord Lane CJ said,

In the view of this court, if a choice has to be made between the decision in *R v Jordan* and that in *R v Smith*, which we do not believe it does (*R v Jordan* being a very exceptional case), then the decision in *R v Smith* is to be preferred [18].

Thus medical treatment, even if falling some way short of good medical practice, does not ordinarily break the chain of causation between the original injury and the ultimate death. Later in the same judgment Lord Lane CJ said,

There may be occasions, although they will be rare, when the original injury has ceased to operate as a cause at all, but in the ordinary case if the treatment is given *bona fide* by competent and careful medical practitioners, then evidence will not be admissible to show that the treatment would not have been administered in the same way by other medical practitioners. In other words, the fact that the victim has died, despite or because of medical treatment for the initial injury given by careful and skilled medical practitioners, will not exonerate the original assailant from responsibility for the death [19].

In these conjoined appeals it was not suggested that the actions of the doctors in disconnecting the life support machines were other than reasonably competent and careful. Accordingly, the court did not have to consider the effect of medical treatment which fell far short of the standard of care to be expected of competent medical practitioners. Thus, switching off the life support machines, being normal medical treatment in the circumstances, did not break the chain of causation running from the original injuries to the ultimate death.

In *Airedale NHS v Bland* [20] the House of Lords held that it would be lawful for a doctor to withdraw treatment from a patient in a persistent vegetative state, although death would inevitably be hastened. Somewhat quaintly to an external eye, the withdrawal of treatment was regarded by the judges as an omission and the question was therefore whether the doctor had a duty to continue life-supporting treatment when no
longer in the best interests of the patient, having regard to responsible medical opinion. Only if there was such a duty, and the judges found that there was none, could the conduct of the doctor constitute murder or manslaughter on the basis that failing to try to save a life which it is one’s duty to save grounds criminal liability for a homicide offence. In the context of the exposition of “causation” in law and its bearing on liability of doctors for the murder of their dying patients where pain-killing drugs had been prescribed in increasing dosages such as to accelerate death, Lord Goff referred to what he was pleased to refer to as the “established rule that a doctor may, when caring for a patient who is, for example, dying of cancer, lawfully administer pain-killing drugs, despite the fact that he knows that an incidental effect of that application will be to abbreviate the patient’s life. Such a decision may properly be made as part of the care of a living patient, in his best interests; and on this basis will be lawful. Moreover, where the doctor’s treatment of his patient is lawful, the patient’s death will be regarded in law as exclusively caused by the injury or disease to which his condition is attributable” [21]. This is exactly the rule that applies in cases of assaults leading to the death of the victim where better or more appropriate or earlier medical treatment would have saved the victim’s life. There is here a neat illustration of the law’s preference for more than one argument leading to the same conclusion. A doctor who knows that an “incidental effect” of the medication prescribed is to accelerate death may escape criminal liability under the benign umbrella of the doctrine of double effect. But such a doctor may also escape where the medical treatment falls within the acceptable range of treatment even if it factually causes death because, by an almost wilfully perverse legal fiction, where medical treatment is a factual cause the death is exclusively attributed to the pre-existing injury or illness. These two escapes sometimes merge into each other in legal arguments deployed in courts but they are logically distinct: the doctrine of double effect is scalar and proportional whereas the legal causation argument is polar and absolute. Moreover, the argument from legal causation is at its most effective where the doctrine of double effect is at its most implausible.

It follows as a sub-conclusion that so long as a doctor offers normal, medically justified treatment in order to relieve pain, with the consent of the patient, then a charge or conviction of murder is excluded, even though the factual effect is to hasten death and the doctor is fully aware of that consequence and perhaps even wants it. Just as the injury or wound remains the operative and substantial cause even though there has been some inept medical treatment “but-for” which the patient might well have recovered, so the terminal illness remains the operative and substantial cause even though the immediate factual cause of death is the pain-killing drugs which to the knowledge of the doctor were administered in such dosages as to render an accelerated death inevitable. In both scenarios treatment has to be “palpably wrong” to produce a different legal outcome. This is illustrated in the regular medical context by Jordan and in the context of “euthanasia” by the following case [22].

Dr Cox was indicted on a charge of attempted murder of his patient, on 16th August 1991. The patient was dying and in great pain. A short time before her death the accused intravenously administered to her an undiluted injection of two ampules of potassium chloride. The prosecution led evidence that, injected in that manner and that quantity, the drug had no therapeutic property and that the accused’s intention in so administering it was to end the life of his patient. The defence argued that the
primary purpose had been to relieve the pain of the dying patient and therefore that there was no intention to kill. The prosecution conceded that, having regard to the patient’s condition on the morning of the fatal day, they could not exclude the possibility that, in fact, she died of natural causes between the actual injection of potassium chloride and her death. For that reason the charge was not one of murder but of attempted murder. This may have done Dr Cox a disservice in that it was easier for a jury to convict him of attempted murder anticipating a moderate sentence than of murder where the sentence is mandatory life imprisonment.

In the course of his direction to the jury the trial judge paid tribute both to the “indomitable” and “resourceful” character of the deceased and the “exemplary character” of the accused. He mentioned the very special regard in which Dr Cox was held and the very close bond which had developed between doctor and patient over 13 years. The judge explained that there is an “absolute prohibition on a doctor purposely taking life” and that Dr Cox would be guilty “if he injected her with potassium chloride for the primary purpose of killing her, or hastening her death”. The judge also stressed that “if a doctor genuinely believes that a certain course is beneficial to his patient either therapeutically or analgesically, then even though he recognises that that course carries with it a risk to life, he is fully entitled, nonetheless, to pursue it. If in these circumstances the patient dies, nobody could possibly suggest that in that situation the doctor was guilty of murder or attempted murder”. Dr Cox’s duty to do all that he could for his patient was recognised but “what can never be lawful is the use of drugs with the primary purpose of hastening death”. Further, “it matters not by how much or by how little her death was hastened or intended to be hastened”. There was evidence that the patient was at best hours or possibly only minutes away from death when she received the injection. Even so, “no doctor can lawfully take any steps deliberately to hasten that death by however short a period of time”.

This patient had “signed her own death warrant” on 11th August by declining any further active medical treatment and specifying that she should receive only painkillers. (That she was wholly entitled to do so, as a matter of law, was illustrated recently by the case of Ms B, a tetraplegic patient being kept alive by ventilator who wished to have the ventilator turned off and who prevailed in the courts against a surprisingly recalcitrant and perhaps overly paternalistic national health service trust [23].) The following day Dr Cox reported to the patient’s sons that she had asked to be given something [to finish her off] and that he had told her that he could not do that but that he would certainly make her comfortable. By this time the patient was in great pain. She was receiving diamorphine at the rate of 60 mgs per hour having started at less than 1 milligram. Dr Cox was very distressed by his patient’s suffering. In that state he injected neat potassium chloride. It was common ground at the trial that in such a case this drug had no curative or analgesic properties, or clinical use, and, as “any doctor would know”, injected neat, one ampule, let alone two would certainly kill. In addition, there was expert testimony that since this drug was not a therapeutic option to alleviate pain from a purely physiological perspective, there could be no other purpose in its administration than the hastening of death. But that testimony also acknowledged that the probable effect of the injection was indeed to alleviate suffering only by bringing her life to an end. What we have here, therefore, is a case of death as a means to alleviating pain, rather than an instance of death as an effect only incidental to the alleviation of pain.

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Although Dr Cox had said nothing when cautioned and did not give evidence, defence Counsel argued passionately for his client. Perhaps he put the case for his client in a better light than the facts warranted but that was his professional duty. He suggested (and I agree) that, faced with a terminally ill patient in severe pain, there was an air of unreality, even absurdity, in asking what the doctor’s primary purpose was because the line to be drawn between alleviating pain which incidentally causes death and causing death in order to alleviate pain for however short a period was so fine and subtle as to be incapable of sensible application by any doctor confronted with this particular situation. This powerful point is very difficult effectively to counter. As Counsel put it, “Five minutes of peace is not very much but it was all Dr Cox could give, and he gave it”. Counsel also elaborated on the use by Dr Cox of other quite slow-acting drugs and on his openness in recording the use of the potassium chloride. What Counsel sought to persuade the jury was that all this was a way, albeit unorthodox, of relieving pain and suffering. Notwithstanding this passionate plea, the jury convicted Dr Cox, who was sentenced to one year’s imprisonment, which was then suspended. There were limits to the judge’s compassion, in that whereas he acknowledged that what could not be excused could be explained, he responded to Counsel’s plea for an unconditional discharge in view of the exceptional facts, “that deliberate conduct by a doctor aimed at bringing about the death of a patient required, as a matter of principle, to be marked by a term of imprisonment” [24], albeit in the event a short and notional term. But the line between what is permissible to ease the passing and that which is impermissible and criminal is shown by this case to be very fine indeed. Apparently “an expert medical witness at the subsequent General Medical Council Hearing said that Dr Cox’s mistake was to give potassium chloride; a large dose of sedative causing . . . [the patient] to lapse into a coma would have fallen on the right side of the law” [25]. The suggestion is that Dr Cox could then have credibly said or plausibly claimed that his purpose was to alleviate pain and not to cause death although the effect on the patient would have been precisely the same in all material respects and it has seemed to some that “… terminal sedation is a method of death that is ethically inferior to assisted suicide” [26]. In adopting an unorthodox means of alleviating pain Dr Cox lost the benefit of the fiction that medical treatment does not break the chain of causation from illness to death. In the eyes of the criminal law improper medical treatment breaks the chain whereas proper medical treatment does not. There was simply not enough evidence in play that many doctors in like circumstances would have treated their patient similarly although one expert who accepted that the deliberate shortening of life to alleviate pain is “not proper” nonetheless testified that the patient’s uniquely grave condition was such that there was no other way of controlling the pain. This witness expressed the hope that if he was confronted with such circumstances he “would have the courage to do what Dr Cox did”. If a significant number of doctors now share this view, it would be that much more difficult to convict a doctor of murder on similar facts. Indeed there is at least one directly comparable case, that of Dr Lodwig [27]. So one can regard Dr Cox as a moral pioneer trying, in the event unsuccessfully, to push the limits of acceptable and proper medical treatment beyond conventional limits. Perhaps that is to romanticise the case. There is a view that Dr Cox ought, perhaps, to have consulted more widely among suitable experienced medical colleagues and indeed some commentators suggest that in the context of “euthanasia”, team decisions are easier to justify and accept than are decisions of individual doctors:
decisions to cooperate with hastening patients’ deaths are discussed in

the semipublic arena of team decision-making and unit-conferences, thereby
giving physicians the opportunity to reexamine cases, to justify their decisions
to their peers, to raise additional considerations, and to voice objections. This
ongoing practice has allowed doctors and their institutions to accumulate
substantial experience in managing life-ending decisions. And because of the
generally satisfactory results, our society has come to trust doctors to cooper-
ate with patient decisions” [28].

If a doctor injects a severely ill patient with a powerful painkiller in the certain
knowledge that the drug will cause death with a matter of minutes, it is difficult to
accept that he or she intended to relieve the pain but did not intend to cause death.
It would be at least as plausible to say that the doctor intentionally caused the death
of the patient in order to prevent further suffering [29]. Two different cases can be
identified. In one case we can hypothesise two independent consequences, the reduc-
tion of pain and the incidental death; in the other we can hypothesise two related
consequences, death as the means to the reduction of pain [30]. In one case death is
causally contingent and in the other causally necessary. The criminal law and perhaps
current medical practice prohibits the pain-killing treatment in the second of these
categories and permits it in the first. But this means that doctors are medically and
perhaps legally prohibited from acting in cases where there appears to be the greatest
need to relieve pain. Morally, it is an unhappy conclusion that the point comes where
the doctor must cease treatment on pain of liability for murder. Of course, distinguish-
ing the two categories of case hypothesised above will not be at all easy in practice and
there is an obviously strong temptation to interpret cases of the second type as falling
into the first category and therefore apt cases for continued treatment. Whatever a
doctor’s innermost intention, he or she is well advised to say that the treatment was
calculated to kill the pain but not the patient and that death was an incidental and
unfortunate result. The doctor is ill-advised from a legal point of view to say that the
treatment was calculated to alleviate pain by killing the patient. Yet the two descriptions
may be equally appropriate on one and the same set of facts.

In contrast to Dr Cox’s case, which falls into the second category, Dr Moor’s case
falls into the first. Here a general practitioner, who apparently admitted helping up to
300 people to die [31], was charged with murdering a patient by administering a large
dose of diamorphine. The murder trial commenced on 14th April 1999 and concluded
with the defendant’s acquittal on 11th May 1999. The jury took only 65 minutes to
reach its decision and the verdict was greeted with “roars of approval and prolonged
applause within Newcastle Crown Court” [32]. Dr Moor stated his own position as
follows: “In caring for a terminally ill patient, a doctor is entitled to give pain-relieving
medication which may have the incidental effect of hastening death. All I tried to do in
treating [the patient] was to relieve his agony, distress and suffering. This has always been
my approach in treating my patients with care and compassion. Doctors who treat dying
patients to relieve their pain and suffering walk a tightrope to achieve this” [33]

Plainly, Dr. Moor saw this case as falling into the first category but since he also
expressly recognised, as confirmed in answers to a question from the judge, that the
patient’s death was “highly probable” there was little or no logical room for the con-
tingency or hope that his patient would survive. This suggests that it is not the degree
of certainty as to the consequence of death which is important, but whether or not the doctor in seeking to alleviate pain remains within the parameters of proper medical practice, established by and recognised within the medical profession but subject to incremental change over time. Indeed, the most distinguished commentator on the criminal law of England and Wales has concluded that Dr. Moor's case establishes a special defence for doctors in the following terms: “Although he knows his act will accelerate death significantly, the jury is not entitled to convict him of murder if his purpose is to give treatment which he believes, in the circumstances as he understands them, to be proper treatment to relieve pain”. [34] Externally this “doctor’s defence” finds its best justification in professional ethics; internally, this “doctor’s defence” is grounded in the law’s eccentric but coherent notion of “causation” which requires a covert value judgment as part of the answer to the question of whether someone caused another’s death. The criminal law thus runs together causation and responsibility and loses transparency and possibly respect by so doing.

Dr. Moor’s prosecution was seen by many as an abuse of the criminal law and even those who welcomed the prosecution were disappointed, even “appalled” by what they saw as a green light to what is called “backdoor euthanasia”, which is said to be favoured by 60% of doctors [35]. Dr. Moor’s acquittal was hailed by some as a victory for euthanasia but perhaps it was not and Dr. Moor himself certainly did not see it as such. And perhaps it was not a victory for euthanasia precisely because it maintained the distinction, however philosophically suspect, that there is a medical and a legal difference between prescribing pain killing drugs which may incidentally hasten death and causing death as a means to alleviating pain. On the other hand, had Dr Cox been acquitted one might have been able to hail that as a victory for euthanasia (in a strong sense) and the reduction of the charge to attempt, the modest penalty, and the condemnation of both the prosecution and the conviction all suggest that even 10 years ago the tide seemed to be running for euthanasia (in the strong sense).

In conclusion, whatever the definition of “euthanasia”, there is much easing the passing wholly consistent with the criminal law but where a doctor goes outside the realm of accepted medical practice there is a risk of prosecution and even conviction. Those who advocate radical reform have to show that there is something wrong with the law as it is. However, the law may well be delivering appropriate results in the majority of cases [36]. But if so, it is doing so by stealth, by subterfuge and by fiction. Regrettably, the criminal law of England and Wales requires hypocrisy, evasion, and untruth within what is a relationship of trust. And, which is far worse, sometimes it requires an extended, miserable and undignified death where both doctor and patient would prefer something more open, more truthful, and more in keeping with human dignity. Thus one patient is reported to have said “I have refused this option because this would be a slow and painful death and my view of this is not disputed by the doctors. I would also feel robbed of a certain amount of dignity. My wish is to be sedated. I would expect it to be a quick and painless death and less distressing for my loved ones . . . [this option] would mean watching me die over a series of weeks, the thought of this is painful for me to accept” [37]. For the same reason this patient refused a place in a hospice [38].

Just why should Dr Cox’s “indomitable and resourceful” patient be denied a lethal injection if that is her rational choice? One legal argument is provided by section 2(1) of the Suicide Act 1961: “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”. But that subsec-

tion is qualified by section 2(4): “No proceedings shall be instituted for an offence
under this section except by or with the consent of the Director of Public Prosecu-
tions”. There is an apparent overlap between assisted suicide and “euthanasia” where
it is a doctor who is assisting and the patient not only consents to death but requests
assistance in dying. One legal question which arises is in what cases if any might the
DPP withhold consent to prosecution? Apparently that is a question which can only be
answered after the event [39] but there is a powerful argument that the DPP should
publish criteria, otherwise health care workers and relatives have to act at their own
risk, in ignorance of the precise limits of the criminal law. In the absence of publica-
tion of a policy by the DPP, the Suicide Act remains seriously incomplete. Legal trans-
parency requires no less. At present “physician assisted suicide” does not constitute a
homicide offence because, so long as the treatment leading to the early death requested
by the patient falls within proper medical care in all the circumstances of the case, it is
not a legal cause of the patient’s death, however factually potent. Moreover, it seems
that doctors are de facto and perhaps de jure immune at common law from prosecution
under section 2(1) of the Suicide Act 1961. That is the implication of the following:
“... a patient of sound mind may, if properly informed, require that life support
should be discontinued . . . in cases of this kind, there is no question of the patient
having committed suicide, nor therefore of the doctor having aided or abetted him in
doing so” [40]. That Lord Goff thought it appropriate expressly to exclude suicide
suggests that otherwise it might be plausible in such circumstances to regard the
patient as committing suicide and the doctor as assisting.

The case for reform is a case for legal transparency as much as a case for very
different outcomes. With increased transparency, however, attention will increasingly
be focussed on the paper-thin distinction between administering increasing doses of
pain-killing drugs and sedatives, culminating in certain death on the one hand, and
intentionally causing death in order to alleviate pain, on the other. At present the first
does not incur criminal liability and the second does. That may be a difficult line to
hold under a more transparent legal regime, not least because one and the same set of
facts can plausibly be described in both ways, but that is where the line is currently
drawn by the criminal law as is illustrated by the case of Dr. Cox contrasted with
that of Dr. Moor. As to the definition of “euthanasia”, the question is whether what
Dr. Moor (or Dr. Adams) did (alleviating pain by a series of injections one of which
proves lethal, with the knowledge that accelerated death is virtually certain, neither intend-
ing nor desiring death) is even in a weak sense euthanasia. If so, then the criminal law
of England and Wales already permits euthanasia. If however, the term “euthanasia” is
reserved for what Dr. Cox did (intentionally causing death — in both the factual and
the legal sense — by lethal injection as the means to alleviate pain), then currently it is
contrary to English criminal law [41].

Richard H. S. Tur, Oriel College, Oxford, UK.
NOTES


[4] Dudley and Stephens (1884) 14 QBD 273, cf Bourne (1938) 3 All ER 615 which, by the way, differs significantly from the later report at (1939) 1 KB 687.


[6] DUDLEY AND STEPHENS (1884) 14 QBD 273, cf BOURNE (1938) 3 All ER 615 which, by the way, differs significantly from the later report at (1939) 1 KB 687.


[8] Dudley and Stephens (1884) 14 QBD 273, cf Bourne (1938) 3 All ER 615 which, by the way, differs significantly from the later report at (1939) 1 KB 687.


[11] DUDLEY AND STEPHENS (1884) 14 QBD 273, cf BOURNE (1938) 3 All ER 615 which, by the way, differs significantly from the later report at (1939) 1 KB 687.


[13] DUDLEY AND STEPHENS (1884) 14 QBD 273, cf BOURNE (1938) 3 All ER 615 which, by the way, differs significantly from the later report at (1939) 1 KB 687.


[16] DUDLEY AND STEPHENS (1884) 14 QBD 273, cf BOURNE (1938) 3 All ER 615 which, by the way, differs significantly from the later report at (1939) 1 KB 687.


[18] DUDLEY AND STEPHENS (1884) 14 QBD 273, cf BOURNE (1938) 3 All ER 615 which, by the way, differs significantly from the later report at (1939) 1 KB 687.


[21] DUDLEY AND STEPHENS (1884) 14 QBD 273, cf BOURNE (1938) 3 All ER 615 which, by the way, differs significantly from the later report at (1939) 1 KB 687.


[23] DUDLEY AND STEPHENS (1884) 14 QBD 273, cf BOURNE (1938) 3 All ER 615 which, by the way, differs significantly from the later report at (1939) 1 KB 687.


[25] DUDLEY AND STEPHENS (1884) 14 QBD 273, cf BOURNE (1938) 3 All ER 615 which, by the way, differs significantly from the later report at (1939) 1 KB 687.
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[39] R (on the application of Pretty) v DPP (Queen’s Bench Division, 18 October 2001) 63 BMLR 1, R (on the application of Pretty) v DPP (House of Lords, 29 November 2001) [2002] 1 All ER 1; Pretty v UK (European Court of Human Rights, 29 April 2002) [2002] 2 FCR 97.


[41] A version of this paper was presented at a conference addressing the question “Should Euthanasia be Legalised?” held in the University of Hull on 26th June 2002. I am grateful to Suzanne Uniacke for her invitation and to participants for their helpful and insightful comments.