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Euthanasia

Research Paper 93/69

21 June 1993

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Introduction

There is currently much interest in the subject of euthanasia and related issues such as "advance directives" and withholding consent for treatment. This brief Research Paper aims to set the debate in context and to give an outline of recent events. It does not attempt a full discussion of the ethical or legal issues involved.

What is euthanasia?

The Oxford Reference Concise Medical Dictionary (3rd Edn 1990) defines euthanasia as follows:

"the act of taking life to relieve suffering. In *voluntary euthanasia* the sufferer asks for measures to be taken to end his life. This may be accomplished by active steps, usually the administration of a drug; or by *passive euthanasia* - the deliberate withholding of treatment. In *compulsory euthanasia* society or a person acting on authority gives instructions to terminate the life of a person, such as an infant, who cannot express his wishes".

The Department of Health, in evidence to the House of Lords **Select Committee on Medical Ethics** says:

"Euthanasia, as literally defined, means 'an easy death'. But the term is commonly used and understood to mean 'mercy killing' - the deliberate killing of someone in a terminal condition and usually in severe pain, at his own request 'to put him out of his misery'".

[HL 91-i of 1992-3]

It can be seen that the dictionary definition is somewhat broader than that used by the Department of Health. The latter is essentially what the former refers to as "voluntary euthanasia". In this paper the term is used in the way the Department of Health uses it.

The Law

The Home Office evidence to the House of Lords Select Committee sets out the legal position as follows under the heading "The Law as it Stands".

3. At present, the criminal law prescribes that the unlawful deliberate killing of another person is murder in all but a few circumstances. Most existing defences to murder rely on an absence of intention or an absence of responsibility for the act committed, with the result that the necessary *mens rea* does not exist. What is critical in this context is that the law allows no defence to murder on the basis of motive. A person who kills, with that as their clear intention and in their right mind, is guilty of murder even though they may have been motivated by a desire to end another's suffering or to give effect to their victim's clearly and honestly held wishes. The Scots law of murder is in certain respects different from that of England and Wales. However, it also recognises that, where the necessary intent to kill can be proved, there will be no defence to murder based on the consent of the victim or the motive of the accused.

J K Mason and R A McCall Smith note that "mercy killing" has never been regarded as a separate legal entity" and go on to quote one authority as saying "The law does not leave the issue in the hands of the doctors; it treats euthanasia as murder" [**Law and Medical Ethics** 1983, quoting G Williams]. They go on to say that:

"While the doctor's motive in shortening life is irrelevant, intention is all important. If a doctor intends to kill he is as liable to prosecution as is the layman; if, however, he intends to treat the patient symptomatically and, thereby, shortens his patient's life he may properly be regarded as being not guilty of murder".

The recent case of Dr Nigel Cox attracted considerable attention. Dr Cox, a consultant rheumatologist at the Royal Hampshire County Hospital Winchester, injected his patient Mrs Lillian Boyes with a large dose of potassium chloride and she subsequently died. Mrs Boyes had been in extreme pain from rheumatoid arthritis; pain which treatment had failed to relieve. Dr Cox was convicted of attempted murder and given a 12 month suspended sentence. The charge was attempted murder rather than murder because of the difficulty of deciding whether Mrs Boyes' illness or the drug killed her. The General Medical Council (which oversees professional standards in the medical profession) did not impose any disciplinary sanctions on him and he was allowed to return to his job subject to conditions [Guardian 21.9.92. BMJ 28.11.92]. Had the conviction been for murder then a life sentence would have been automatic, although evidence given by the Home Office to the House of Lords Select Committee on Medical Ethics records hardly any cases where this has happened. In the relatively few cases recorded the most common consequence was a conviction for manslaughter [HL 91-i p 18].

Arguments about euthanasia

Euthanasia is, of course, a subject on which there are deeply held opposing views. These are illustrated by the following quotations from articles under the "free speech" banner in The Independent on 12 May 1990:

"Despite the rapid advances in medical technology in recent years it is a sad fact that many people are still dying in great distress ...

There is now a swelling tide of public opinion in favour of medical help to die when the time comes. This indicates a demand for the basic human right to die with dignity and also reflects the growing awareness among individuals of their autonomy and their right to make decisions concerning their own life - and death. When this reform is achieved ... we will look back on this era with total incomprehension. Although the majority may never have need of it, the fact of its availability will have great comfort to many people who now dread the prospect of a slow, distressing death"

[John Oliver, General Secretary of the Voluntary Euthanasia Society]

"The fatal tide of permissiveness is trying to persuade us that euthanasia - so clearly condemned as a criminal act and for centuries specifically spurned by the Hippocratic oath - may now be acceptable or even caring ... Having spent two decades looking after patients dying in my general practice I must disdain it as fundamentally wrong, entirely unnecessary when good practice takes place, and so widely open to abuse that it must continue to be highly unethical and illegal ...

The strongest argument against euthanasia - apart from the essential moral one - is that there has never been greater ability to relieve pain and cherish those in need. In our wealthy society there should be no need for termination of the sick."

[Dr Adrian Rogers]

In a pamphlet The Last Right the Voluntary Euthanasia Society argues as follows under the heading "Is voluntary euthanasia necessary?":

The hospice movement has improved the care of the dying and some of its supporters claim that it has eliminated the need for voluntary euthanasia. While we welcome and admire the work of hospice doctors and nurses, we regard the giving of voluntary euthanasia, when the time comes, as the final act of care and respect for the autonomous patient.

The VES believes that voluntary euthanasia should be just one of a range of options at the end of life. Hospices represent another available option. But at the end, we believe it is a human right to have a choice about the manner of your death.

Even with hospice care, some terminally ill people have to suffer severe and continuous distress. Pain can be reduced by the repeated use of narcotics and sedative drugs, but often at the cost of nausea, constipation, deterioration of the personality, and other side effects. But sadly, not everyone can be kept free from pain.

Palliative care experts, often hospice doctors, accept that approximately 5% of terminal pain cannot be controlled.

In addition to pain, feelings of nausea, of suffocation or of being desperately ill cannot always be relieved. Cancer patients may have to suffer the mental misery associated with the presence of a foul growth, obstruction of the bowels, or incontinence, and the utter frustration that makes each day and night a death in life. Diseases of the nervous system all too often lead to crippling paralysis or inability to walk, to severe headaches, to blindness and to the misery of incontinence and bedsores. Bronchitis, with its interminable cough and progressive shortness of breath, can have its special terrors which medical treatment can do little to abate in the late stages. Likewise, patients with a stroke may be conscious but helpless. Their misery is frequently overlooked.

It is accepted by hospices that any claims that patients can always avoid distressing symptoms are exaggerated.

The VES receives a great many letters (some examples of which are given in the Appendix) telling of prolonged pain and considerable distress endured by dying friends and relatives. These stress the continuing reality of the problem, despite all recent medical advances.

When the alternatives are death with dignity and peace, or death accompanied by prolonged pain and distress, common sense as well as compassion support our demand that the choice should belong to individuals. As the law now stands, they have no choice: their wishes count for nothing.

In a Briefing on Euthanasia LIFE say the following under the heading "Why euthanasia is unacceptable":

"Euthanasia will undermine the advances made in good palliative and hospice care. 'Mercy killing' will directly lead to the dehumanisation of the dying, especially for those in terminal conditions associated with AIDS/HIV illnesses.

It is clear that AIDS/HIV issues are being used to attempt to justify euthanasia. Under the guise of 'compassion', death-on-demand is being promoted for people living with AIDS. This is a thinly veiled effort to cut the costs involved in providing good, palliative care for dying AIDS patients. Each 'AIDS' case that is used to promote euthanasia is yet another step towards the second class system of palliative care which will inevitably be offered to those people living with AIDS who choose not to solve society's problem by 'voluntary euthanasia'.

People of good will everywhere should instinctively oppose direct killing by medical personnel. Recent history has shown the horrors that can follow when the medics are encouraged to dehumanise and end the lives of the elderly, the handicapped, the unwanted and the unproductive. We must reject all euthanasia proposals. We do not want or need doctors who are licensed to kill. What we need is good medical practitioners, since good doctors do not kill patients they kill pain and alleviate suffering.

Euthanasia is not withholding or discontinuing heroic, unnecessary, futile or experimental treatments from the patient. Euthanasia is an action or omission (including the withholding of food and fluids) designed specifically to kill. To withhold food and fluids is to condemn the patient to death through starvation and dehydration. That is not death with dignity. It is brutal agonising death by design and neglect.

It is hard to watch loved-ones suffer pain and death - however that does not give us the right to kill them. Even when the sick are incurable they are never untreatable. Whatever their condition, they should always be given appropriate loving care. Even in the most serious of situations patients should always be shown respect, made comfortable, fed (as appropriate to the condition) and should be given all reasonable medical treatments. No drugs or other medical treatments should ever be administered (or withheld) if the prime purpose is to bring about premature death.

That doesn't however mean that those who oppose euthanasia believe that we should strive officiously to artificially keep alive someone who has a condition incompatible with independent living - that would be equally indefensible. As patients and the next of kin, we already have the legal right to refuse those types of treatment which only prolong a burdensome and precarious existence - we do not therefore need legalised euthanasia, nor do we need 'advanced directives' ('living wills')."

Both the British Medical Association and the Royal College of Nursing oppose euthanasia. The report of a BMA working party on the subject was approved by the Association's Council in 1988. The Report concludes:

"The law should not be changed and the deliberate taking of a human life should remain a crime. This rejection of a change in the law to permit doctors to intervene to end a person's life is not just a subordination of individual wellbeing to social policy. It is instead an affirmation of the supreme value of the individual, no matter how worthless and hopeless that individual may feel".

In March 1992 the Royal College of Nursing endorsed a 1985 position statement on "What the RCN stands for":

"The RCN believes that the practice of euthanasia is contrary to the public interest and to medical and nursing ethical principles as well as to natural and civil rights and is opposed to the introduction of any legislation which would place on doctors and nurses a responsibility to respond to a demand for termination of life from any patient suffering from intractable, incurable or terminal illness or from the relatives of such a patient".

The Government is also opposed to a change in the law. The Department of Health written evidence to the House of Lords Select Committee on Medical Ethics says:

6.The Department of Health considers it essential to draw a clear distinction between *euthanasia*, which is a positive intervention to end life, and the *withholding or withdrawal of treatment which has, or will have, no curative or beneficial effect*. Euthanasia is illegal, even when the patient requests it. In no circumstances can a doctor be justified in taking positive steps with the intention specifically to bring about, or to hasten, the patient's death, even where he believes he is acting in the patient's best interests and with his consent. Such action is against the code of ethics of the medical and nursing professions. There is general agreement among professional healthcare organisations and those concerned with health ethics that euthanasia cannot be accepted. The Department agrees. The Government has no plans to change the law in this area.

Consent to treatment and advance directives

With a few exceptions any adult patient has a right to refuse consent to treatment. As recent NHS Management Executive Guidance puts it:

"A patient has the right under common law to give or withhold consent prior to examination or treatment This is one of the basic principles of health care. Subject to certain exceptions the doctor or health professional and/or health authority may face an action for damages if a patient is examined or treated without consent".

[A Guide to Consent for Examination or Treatment. 1990]

Exceptions covering adult patients include:

- life saving treatment where the patient is unconscious;
- treatment for a physical disorder where a patient is incapable of giving consent because of a mental disorder and treatment is in the patient's best interest;
- some treatments under statutory powers eg on public health grounds;
- some treatment of patients compulsorily detained under the mental health act.

One way that has been put forward of the patient not receiving unwanted treatment that he or she is not in a position to refuse at the time is the **advance directive** or the similar **living will**. The advance directive has been defined as "a mechanism whereby a competent person gives instructions about what he wishes to be done if he should subsequently lose the capacity to decide for himself" [**BMA statement on advance directives**, May 1992]. The Voluntary Euthanasia Society advocates the use of the advance directive and has published a form which can be filled in by those who wish to do so. The BMA statement "strongly supports" the principle of the advance directive and considers that a written directive, in the absence of contrary evidence "must be regarded as representing the patient's settled opinion". **Life** considers them to be "the cruel political exploitation of the natural human fear of pain, ill health and incapacitation".

Patients in a "persistent vegetative state"

The case of Tony Bland, the Liverpool football fan who was severely injured in the Hillsborough stadium disaster focused attention on the issue of patients who are said to be in a "persistent vegetative state". That is to say, the cerebral cortex is dead; they are comatose; they have no prospect of regaining consciousness; their bodily functions can continue without mechanical help but they need to be artificially fed. The Bland case reached the House of Lords after appeals by the official solicitor against rulings in lower courts. The Lords decided that:

"It was not unlawful for doctors to withdraw life supporting medical treatment, including artificial feeding through a nasogastric tube, from a patient in a persistent vegetative state who had no prospect of any recovery or improvement when it was known that the discontinuance of treatment would cause the patient's death in a matter of weeks.

However, medical practitioners should apply to the court for a declaration in each case as to the legality of any proposed discontinuance of life support where there was no valid consent on the part of the patient".

The Lords upheld declarations granted by the High Court:

"That despite the inability of the defendant to consent thereto, the plaintiff and the responsible attending physicians:

(a) may lawfully discontinue all life-sustaining treatment and medical supportive measures designed to keep the defendant alive in his persistent vegetative state including the termination of ventilation nutrition and hydration by artificial means; and

(b) may lawfully discontinue and thereafter need not furnish medical treatment to the defendant except for the sole purpose of enabling him to end his life and die peacefully with the greatest dignity and the least of pain suffering and distress".

[as quoted in The Times Law Report of 5.2.93]

The Lords also said that there was a need for Parliament to review the law on the subject. The Bland case turned on whether artificial feeding was to be considered medical treatment or not. The withholding of medical treatment judged to have no therapeutic purpose is acceptable medical practice. If artificial feeding had not been held to be treatment but as provision of basic care decision to withhold it would have been harder to justify but the Lords held it did constitute treatment.

Parliamentary activity

The House of Lords has established an ad hoc Select Committee on Medical Ethics, from which evidence has already been quoted. It is essentially looking at euthanasia and related issues rather than broader questions of medical ethics. The Lords agreed the Committee's terms of reference on 16 February 1993 [HL Deb col 491] and to the membership on 24 February [HL Deb col 225]. The terms of reference are:

"To consider the ethical, legal and clinical implications of a person's right to withhold consent to life-prolonging treatment, and the position of persons who are no longer able to give or withhold consent;

and to consider whether and in what circumstances actions that have as their intention or a likely consequence the shortening of another person's life may be justified on the grounds that they accord with that person's wishes or with that person's best interests;

and in all the foregoing considerations to pay regard to the likely effects of changes in law or medical practice on society as a whole".

Evidence is being published as HL91 of 1992-93. The Committee hopes to produce a report at about the end of the year.

Also in the Lords, two Bills are currently before the House. The **Medical Treatment (Advance Directives) Bill** [HL Bill 73] presented by Lord Allen of Abbeydale seeks to provide a legal framework for advance directives. The **Termination of Medical Treatment Bill** [HL Bill 70] seeks to create a legal framework for authorising the discontinuance of medical treatment in cases such as that of Tony Bland. Neither Bill has yet had a 2nd Reading debate.

In the Commons Piara Khabra presented the **Voluntary Euthanasia Bill** [Bill 207] on 10 June 1993. The long title is "to enable incurably ill patients to ask for euthanasia; and for connected purposes". Mr Khabra was to have introduced the Bill under the 10 minute rule the preceding day but in the event he did not move the motion.

The previous occasion when a euthanasia Bill was before the Commons was on 8 May 1990 when Roland Boyes sought leave to bring in a Voluntary Euthanasia Bill under the 10 minute rule [HC Deb col 43]. Leave was refused by 101 votes to 35.

The Netherlands

There has been considerable interest in the position in the Netherlands. The position is that euthanasia remains illegal. However provided doctors follow agreed procedures they are unlikely to be prosecuted. This position developed over a number of years. The Royal Dutch Medical Association accepted the principle of euthanasia in 1984. Since November 1990 a notification procedure has been in force under which cases must be reported to the Office of the Public Prosecutor who checks the doctors against a list of 25 conditions. The Rummelink Commission which reported in November 1991 found that there were 2,300 cases of euthanasia a year - 1.8% of all deaths. Legislation recently passed by the Dutch Parliament will give legal backing to the notification procedure [BMJ 4.1.92; Lancet 10.3.90; Guardian 10.2.93; Medical Practice with Regard to Euthanasia Results of an inquiry and the Government view. Netherlands Government, Nov 1991].