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Final Exit: Should the Double Effect Rule Regarding the Legality of Euthanasia in the United Kingdom be Laid to Rest?

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Final Exit: Should the Double Effect Rule Regarding the Legality of Euthanasia in the United Kingdom be Laid to Rest?

ABSTRACT

This Note explores the double effect rule that currently governs physician-assisted suicide cases in the United Kingdom. Recent events in the British medical and legal community have raised serious questions about the rule's adequacy, and have arguably created an environment in which Parliament must reexamine the validity of both the double effect rule and the laws governing active euthanasia.

After providing some historical background regarding the origins and development of the double effect rule, this Note surveys recent developments such as changing attitudes towards euthanasia and the public reaction to the Moor verdict, both of which have created an environment that is highly critical of the double effect rule. It then analyzes these criticisms in light of the widespread confusion that application of the rule has caused in both the medical and legal community, and the conspicuous failure of Parliament to respond by legislating on this topic.

This Note argues that the United Kingdom should move away from a rule that essentially turns a blind eye to euthanasia and toward one which makes physician-assisted suicide legal only when it is carried out under a number of stringent, well-defined procedures and safeguards. It then provides a legal framework designed to aid Parliament in creating a balanced law that provides doctors with clear guidelines regarding their conduct, while ensuring that patient and societal interests in curbing potential abuses in this area are addressed.

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I. INTRODUCTION

There is currently a lack of specific law in Britain dealing directly with voluntary active euthanasia.¹ Rather than address the issue through legislation, British Parliament directs courts to apply the principle of double effect in suspected voluntary active euthanasia cases in order to distinguish situations where a physician's actions intentionally hasten the death of a patient from those in which the death of the patient occurs as an unintentional secondary effect of treating a terminally ill patient's pain with drugs. Under the double effect principle, physicians may engage in an action which has both a positive and negative effect without prosecution if the action is undertaken with the intention of achieving only the possible good effect (pain relief), without intending the possible bad effect (death of the patient) even though it may be a foreseen consequence.² Although this principal attempts to allow those who are morally opposed to assisted suicide a framework in which to provide adequate pain relief without violating the integrity of traditional medical morality or their consciences, its application to end-of-life decisions has been met with widespread criticism from the British medical, legal, and general community. Among the biggest criticisms of the present system is that it allows physicians to comply with patient requests for death and avoid prosecution by misstating their primary intention in terms of pain relief.

This Note will examine both the historical and recent events that have led many to call for a change in the law regarding voluntary active euthanasia in Britain. Part II of this Note will explore the origins of the double effect principle and its initial application to euthanasia by the courts in the case of *Adams*.

1. *The Legal Position (England and Wales)*, in VOLUNTARY EUTHANASIA 266 (A.B. Downing & Barbara Smoker eds., 1986).

2. Daniel P. Sulmasy & Edmund D. Pellegrino, *The Rule of Double Effect*, 159 ARCHIVES INTERNAL MED. 545, 545 (March 22, 1999).

Part III will look at the changing attitudes regarding euthanasia which led many groups to present legislation to Parliament calling for a reexamination of the law. It will also explore the conspicuous failure to legislate by Parliament, especially in light of the recent decision in *Moor* and the tremendous reaction to its verdict by physicians, the Voluntary Euthanasia Society, the British Medical Association, and legal experts. Part IV will examine the specific criticisms that have been lodged against the double effect principle, from its naïve reliance on subjective intentions to the harsh punishments that result from prosecuting doctors for murder after they fail to meet the principle's requirements. Finally, Part V will focus on the arguments for changing the current system from a rule, which is inconsistently applied and confuses physicians to one which legalizes voluntary active euthanasia and allows the government to regulate its practice. It will also discuss many of the procedural requirements that should be implemented into the new law to ensure that it clarifies the current confusion and does not create further inconsistencies in the treatment of physicians dealing with end-of-life decisions.

II. HISTORICAL BACKGROUND

Euthanasia, derived from two Greek words meaning *good* (*eu*) *death* (*thantos*)³, is the "deliberate production of the death of a human being on the grounds that in his situation it is considered that it is better that he should be dead than that he should continue to live."⁴ English law focuses on two types of voluntary euthanasia: passive and active.⁵ Passive euthanasia is defined as the shortening of human life by the non-commencement or withdrawal of treatment or life support.⁶ Under English law, doctors may honor a patient's request for passive euthanasia if either made to the doctor personally or by an advance directive ("living will")⁷ in cases where the patient is unable to

3. MARGARET C. JASPER, *THE RIGHT TO DIE* 1 (1996).

4. John Wilkinson, *The Ethics of Euthanasia*, 6 J. LAW SOC'Y, SCOTLAND 243, 243 (1990), LEXIS, News Library, Non-U.S. File.

5. Pat Tate, *What the Law Says About GPs and Euthanasia*, PULSE, July 19, 1997, at 80, LEXIS, News Library, Non-U.S. File.

6. *Id.*

7. An example of a living will is found in the Voluntary Euthanasia Act 1969. In part, it reads as follows:

If I should at any time suffer from a serious physical illness or impairment reasonably thought in my case to be incurable and expected to cause me severe distress or render me incapable of rational existence, I request the administration of euthanasia at a time or in circumstances to

communicate.⁸ The legality of passive euthanasia, as set forth in a 1993 court judgement in the *Tony Bland* case, is derived from the fact that suicide has been legal in the United Kingdom since the 1960s.⁹ Thus, if patients wish to end their lives prematurely by declining life-sustaining treatment, the law will respect their decision to do so.

Active euthanasia, however, is forbidden under current English law.¹⁰ Active euthanasia is defined as taking positive steps, which shorten the life of an ill person, usually by means of administering drugs.¹¹ Any doctor who performs active euthanasia at the request of a patient is guilty of murder under English law.¹² Likewise, if a doctor takes active steps to help a patient take their own life, such as providing the patient with drugs, then they will be guilty of the crime of assisting a suicide.¹³

English law does not consider it euthanasia, however, when a doctor's active steps are taken with the intention of relieving a patient's pain and suffering, even if these steps also shorten the life of the patient.¹⁴ This distinction is made possible by the ethical principle of double effect, which currently serves, as the United Kingdom's legal stance on the permissibility of euthanasia. The rule of double effect states that an action which has two possible effects, "one good and one bad, is morally permissible if the action: (1) is not in itself immoral, (2) is undertaken only with the intention of achieving the possible good effect, without intending the possible bad effect, although both effects are foreseen, (3) does not bring about the possible good effect by

be indicated or specified by me or, if it is apparent that I have become incapable of giving directions, at the discretion of the physician in charge of my case.

In the event of my suffering from any of the conditions specified above, I request that no active steps should be taken, and in particular that no resuscitatory techniques should be used, to prolong my life or restore me to consciousness.

This declaration is to remain in force unless I revoke it, which I may do at any time, and any request I may make concerning action to be taken or withheld in connection with this declaration will be made without further formalities.

EIKE-HENNER W. KLUGE, *THE PRACTICE OF DEATH* 154 (1975).

8. See *id.*; Andrew Woodcock, *Most GPs Get Patient Requests to Assist Death*, SCOTSMAN, July 21, 1997, at 5, LEXIS, News Library, Non-U.S. File.

9. Twelve people have had artificial feeding withdrawn since the landmark case of Tony Bland that authorized the removal of food and water to patients in a persistent vegetative state.

10. Tate, *supra* note 5, at 80.

11. *Id.*

12. *Id.*

13. *Id.*

14. *Id.*

means of the possible bad effect, and (4) is undertaken for a proportionately grave reason."¹⁵ First formulated in seventeenth century Christian ethical thought by Roman Catholic moral theologians, the principle which underlies the law of double effect has been applied to a wide variety of situations in which a foreseeable bad consequence creates a moral dilemma.¹⁶ The rule has attempted to play an especially important role in the care of the dying, allowing those who are morally opposed to assisted suicide a framework in which to provide adequate pain relief without violating the integrity of traditional medical morality or their consciences.¹⁷

In the abstract, treating a dying patient in pain with diamorphine¹⁸ appears to satisfy the four criteria for double effect.¹⁹ The use of diamorphine (1) is not itself immoral; (2) is undertaken only with the intention of relieving pain, not of causing death through respiratory depression; (3) will relieve pain without first killing the patient; and (4) the relief of terminal pain is a proportionately grave reason for risking the hastening of death.²⁰ The application of this rule to the care of the dying, however, has been highly criticized because it relies so strongly upon the subjective positive intention of the health care provider.²¹ Without scrupulous honesty and clinical integrity, the principle of double effect is open to specious abuse by those who take active steps specifically designed to end a patient's life.²²

The rule of double effect was first applied by the English courts to physician-assisted suicide in the trial of Dr. John Bodkin Adams.²³ Dr. Adams was arrested on December 19, 1956 and charged with the murder of Edith Morrell, an eighty-one year old patient who had been suffering from arteriosclerosis and the effects of a stroke.²⁴ Morrell had been a patient of Dr. Adams

15. Sulmasy & Pellegrino, *supra* note 2, at 545.

16. Winkinson, *supra* note 4, at 243.

17. Sulmasy & Pellegrino, *supra* note 2, at 545.

18. Diamorphine is another name for heroin and is the most common way that doctors treat the pain of their dying patients. Cherry Norton, *Doctor Will You Help Me Die?*, SUNDAY TIMES, November 15, 1998, at 14, 1988 WL 21853258. The use of diamorphine to alleviate pain is entirely legal. The result of high dosages, however, is often death. *Id.*

19. Sulmasy & Pellegrino, *supra* note 2, at 545.

20. *Id.*

21. Cherry Norton, *An End Soon to Hypocrisy of Treating the Dying?*, INDEPENDENT, May 12, 1999, at 3, 1999 WL 15745301.

22. *Id.*

23. Henry Palmer, *Dr. Adams' Trial for Murder*, 4 CRIM. L. R. 365, 375 (1957); Raanan Gillon, *Suicide and Voluntary Euthanasia: Historical Perspective*, in VOLUNTARY EUTHANASIA 222 (A.B. Downing & Barbara Smoker eds., 1986).

24. Michael Watson, *A Case of Medical Necessity?*, 149 NEW L. J. 863 (1999), LEXIS, Secondary Legal Library, The New Law Journal File.

since 1948.²⁵ In charging him with murder, the prosecution stated that Dr. Adams had injected Morrell with heroin and morphia with the intention of shortening her life, not alleviating her pain, so that he could allegedly benefit under her will.²⁶

In speaking for the court, Justice Devlin first explained to the jury that murder is:

an act or series of acts, done by the prisoner, which were intended to kill, and did in fact kill. It did not matter whether Mrs. Morrell's death was inevitable and that her days were numbered. If her life was cut short by weeks or months it was just as much murder as if it was cut short by years. If the first purpose of medicine the restoration of health could no longer be achieved, there was still much for the doctor to do, and he was entitled to do all that was proper and necessary to relieve pain and suffering even if the measures he took might incidentally shorten life by hours or even longer.²⁷

This statement called for the jury to examine Dr. Adams' subjective intent in medicating Mrs. Morrell to determine whether his intention was to relieve the patient's pain or end her life. Although the jury acquitted Dr. Adams of the murder of Edith Morrell in only forty-two minutes, this case first established the double effect principle, which currently serves as the United Kingdom's legal stance with regards to physician-assisted suicide.²⁸ This precedent was later codified in the Suicide Act of 1961 which states that a doctor who "aids, abets, counsels or procures the suicide of another" may be charged with murder and sentenced to life in prison upon a determination of guilt.²⁹

III. RECENT DEVELOPMENTS CALLING FOR A CHANGE IN THE LAW

A. *Changing Attitudes Toward Euthanasia and the Adequacy of the Double Effect Rule*

In November of 1998, the *Sunday Times* released the results of a study which showed that many family doctors secretly hasten

25. Palmer, *supra* note 23, at 365.

26. The prosecution attempted to show that Morrell was not suffering from severe pain or restlessness to such an extent as to justify the dosage levels that Adams gave to her. *Id.* at 365-68; Jeremy Laurance, *Death on Prescription?*, INDEPENDENT, May 13, 1999, at 1, 1999 WL 15745641.

27. Palmer, *supra* note 23, at 375.

28. *Id.* at 377; Watson, *supra* note 24, at 863.

29. Suicide Act, 1961, 9 & 10 Eliz. 2, c. 60, § 2(2)(Eng.). The Act, however, also notes that "no proceedings shall be instituted for an offence under this section except by or with the consent of the Director of Public Prosecutions." *Id.* at § 2(4).

the deaths of their terminally ill patients, while even more believe that this practice should be legal.³⁰ Of the 300 General Practitioners (GPs) interviewed by the *Sunday Times*, one out of seven (fifteen percent) admitted to helping patients die at their request.³¹ On average, these GP's admitted to assisting five deaths.³² The implications of this study suggested that hundreds, most likely thousands, of patients in the United Kingdom were dying each year with the aid of a physician.³³

The study also stated that sixty percent of doctors who replied to the questionnaire believe that a doctor should be able to administer large doses of painkillers in full knowledge that death is likely to result without fear of prosecution.³⁴ An even higher number (sixty-eight percent) felt that doctors should be able to assist death by withdrawing or withholding treatment.³⁵ Additionally, eighteen percent of those GPs surveyed stated that doctors should be able to prescribe lethal medication that patients can take with the intention of killing themselves.³⁶ The results of the *Sunday Times* survey suggested that many GPs and hospital doctors would like to see a change in the law regarding euthanasia and physician-assisted suicide.³⁷ While the results of the *Sunday Times* survey received a great deal of attention in the media, most likely due to the *Lindsell* and the *Moor* case (discussed below), they were merely demonstrative of the growing change in physician attitudes over the last decade regarding euthanasia, a trend which had already been reflected in earlier surveys.³⁸ For example, a 1987 National Opinion Poll of 301 GPs conducted by the Voluntary Euthanasia Society (VES) stated that thirty percent of GPs agreed with the concept of voluntary euthanasia.³⁹ The results of this survey also showed that a large percentage of GPs would consider practicing euthanasia if a patient requested it, despite their personal disfavor of it.⁴⁰ A 1994 survey by the British Medical Journal (BMJ) also showed that forty-six percent of doctors would consider taking active

30. Norton, *supra* note 18, at 14.

31. *Id.*; Watson, *supra* note 24, at 863.

32. *One In Seven GPs Admits Illegally Hastening Death*, PULSE, November 28, 1998, at 8, LEXIS, News Library, Non-U.S. File.

33. Norton, *supra* note 18, at 14.

34. *Id.*

35. *Id.*

36. *Id.*

37. *What GPs Really Think About Hastening Death*, PULSE, November 28, 1998, at 32, LEXIS, News Library, Non-U.S. File; Simon Macklin, *Mercy Killing Debate*, SOUTH CHINA MORNING POST, May 18, 1999, at 15, LEXIS, News Library, Non-U.S. File.

38. *What GPs Really Think About Hastening Death*, *supra* note 37, at 32.

39. *Id.*

40. *Id.*

steps in bringing about a patient's death if the law was changed.⁴¹ The BMJ survey also stated that forty-five percent of doctors had been asked to take active steps to hasten death, and of these, thirty-two percent had complied with such a request.⁴² Similar results were also reflected in subsequent surveys by the Medical Law Unit at the University of Glasgow and the British Medical Association.⁴³

A similar change in attitudes regarding euthanasia was also seen in the British public. According to polls, support for euthanasia has grown from around fifty percent in the 1950s to eighty-two percent in a 1996 British Social Attitudes survey.⁴⁴ In addition, all of the main religious denominations in Britain also show a majority preference for the legalization of active voluntary euthanasia.⁴⁵ Self-declared Roman Catholics show seventy-three percent approval, members of the Church of England eighty percent, and the Jewish community sixty percent approval.⁴⁶ Not surprisingly, atheists are most in favor of active voluntary euthanasia with ninety-three percent approval.⁴⁷ In spite of all this public support for voluntary euthanasia, however, Parliament still refuses to change the law.

The results of these surveys highlight many of the issues that are important to the debate regarding the adequacy of the double

41. B.J. Ward & P.A. Tate, *Attitudes Among NHS Doctors to Requests for Euthanasia*, 308 BRIT. MED. J. 1132, 1134 (1994) (reporting the result of a survey which explored NHS doctors' attitudes to competent patients' requests for euthanasia and estimates the proportion of doctors who have taken active steps to hasten a patient's death).

42. *Id.* at 1332.

43. *What GPs Really Think About Hastening Death*, *supra* note 37, at 32. A 1996 postal survey of 1,000 medical practitioners' attitudes (12% of which were GPs) conducted by Professor Sheila McLean of the Medical Law Unit at the University of Glasgow showed that 55% of the respondents believed it should be legal to aid in the suicide of a patient who is either terminally ill or suffering from severe mental or physical pain. *Id.* Likewise, a 1996 survey of 750 GPs published in the British Medical Association News Review found that 46% of doctors supported changing the law to allow doctors to carry out a euthanasia request from a terminally ill patient. *Id.*

44. Laurance, *supra* note 26, at 1. These percentages are based upon surveys of the middle classes. *Id.* The poor and partly educated are more likely to be in support of euthanasia than the elderly, who despite being the beneficiaries of a swift and painless death, are the class least likely to support it. *Id.*

45. *The Voluntary Euthanasia Society*, in VOLUNTARY EUTHANASIA 259 (A.B. Downing & Barbara Smoker eds., 1986).

46. Jean Davies, *The Case for Legalising Voluntary Euthanasia*, in EUTHANASIA EXAMINED 83, 93 (John Keown ed., 1995). The high numbers found in the Jewish Community are interesting in light of the Nazi misuse of the word "euthanasia." *The Voluntary Euthanasia Society*, *supra* note 45, at 259. The Nazis misused the word euthanasia to mean the destruction of handicapped people regardless of their wishes. *Id.* In these discussions, however, the word is used in its original Greek-derived sense of a gentle death. Davies, *supra*, at 84.

47. See Davies, *supra* note 46, at 93.

effect rule. The first is the high number of incidences in which a doctor is asked to take active steps to hasten the death of a patient. In each of the surveys, nearly half of the doctors had received such a request. A second issue is the high number of GPs who have complied with these patient requests and have avoided prosecution either through a lack of discovery or a misstatement of primary intent in accordance with the double effect principle. A final issue is the increase in the number of practitioners who said they believe the law should be changed from thirty percent in 1987 to sixty percent in the 1998 *Sunday Times* survey.

B. *Legislative Inaction and Attempts to Change the Law*

Despite the widespread support of the public and the medical community for a change in the law regarding active voluntary euthanasia, there has been a surprising lack of support for changing the law in the British Parliament. In the past sixty years, seven bills have been presented to Parliament, all of which were met with a refusal to legislate.⁴⁸ Critics claim that this legislative inaction is due to the heavy influence of the Church of England, the Roman Catholic Church in England, and much of the British Medical Association (BMA).⁴⁹ Thus, because of the strong influence of these groups over Parliament, only a few hours of debate on a bill are permitted to keep up appearances of fairness before the matter is quietly dropped.⁵⁰ Like politicians everywhere, those who comprise the British Parliament desire to distance themselves from moral issues.⁵¹ Thus, the British establishment prefers to allow assisted deaths to be carried out covertly rather than take a stance on the issue of the legality of euthanasia that may enrage religious or other support groups.⁵²

The first bill to be heard by Parliament was the Voluntary Euthanasia (Legislation) Bill that was prepared by the VES and presented to the House of Lords in November 1936 by Lord Ponsonby.⁵³ Although rejected upon its second reading, the Bill was successful in generating considerable public debate and attracting new members and supporters to the VES, many of whom were distinguished in the arts, sciences and professions.⁵⁴

48. DEREK HUMPHRY & MARY CLEMENT, *FREEDOM TO DIE* 164 (1998).

49. *Id.* Despite the widespread support for change throughout both religious communities and the British medical community, the official sanctioning bodies of these groups use their power to assert their opposition to change. *Id.*

50. *Id.*

51. *Id.*

52. *Id.*

53. *The Voluntary Euthanasia Society, supra* note 45, at 256.

54. *Id.*

Despite this growing awareness and support, the next Voluntary Euthanasia Bill was not introduced until some thirty-three years later in 1969⁵⁵ and was again met with the same lack of enthusiasm and support from the legislature.⁵⁶ It was during this period, however, that the Suicide Act was passed giving the society some hope that Parliament may listen to further pleas to change the law.⁵⁷ This hope was destroyed in 1976 when Parliament struck down a very moderate Bill regarding mostly passive euthanasia measures.⁵⁸

Although the Suicide Act of 1961 was a logical response to the court's opinion in the *Adams* case, it began to fall under heavy criticism in the House of Commons in the mid-1980s as attitudes towards physician-assisted suicide changed globally.⁵⁹ In 1985, the House of Lords proposed a bill that would amend the Suicide Act to remove penalties for "compassionate assistance" of death.⁶⁰ The amendment, however, was rejected.⁶¹ The issue came before the House of Commons again in 1991 when a 10-Minute Rule bill on voluntary euthanasia was also rejected.⁶² In response to heightened political and social scrutiny, the House of Lords appointed a special committee on medical ethics in 1994 to deal with the issue of euthanasia and the doctrine of double effect.⁶³ The committee reaffirmed its stance against euthanasia,

55. For the complete text of the Voluntary Euthanasia Bill 1969, see *Voluntary Euthanasia Bill 1969*, in VOLUNTARY EUTHANASIA app. 1 at 275-83 (A.B. Downing & Barbara Smoker eds., 1986).

56. *The Voluntary Euthanasia Society*, *supra* note 45, at 256.

57. *Id.*

58. *Id.* This bill, known as the Incurable Patients Bill, was introduced to the House of Lords by Baroness Wootton. *Id.*

59. See Louise Robson, *UK: House of Commons to Debate Right-To-Die Legislation*, AAP NEWSFEED, November 21, 1997, LEXIS, Nexis Library, AAP File.

60. *Id.*

61. *Id.*

62. *Id.*

63. *Id.* The committee's terms of reference were:

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 that person's best interests;

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

Id. Although the word "euthanasia" was not used, the first paragraph describes passive euthanasia, while the second paragraph describes voluntary euthanasia. Davies, *supra* note 46, at 83. The Voluntary Euthanasia Society heavily criticized the Committee for failure to take into account the British Medical Journal survey that reported that half of the doctors who were asked by their patients for help to

and showed continued reliance upon the double effect principle in determining whether or not doctors should be prosecuted for murder when the alleviation of pain results in a shortened lifespan.⁶⁴ This report was seen by many as merely an attempt at consensus by the House of Lords rather than an attempt to address the real issue of whether euthanasia was being practiced surreptitiously under the guise of double effect.⁶⁵

British Parliament debated right-to-die legislation a final time in November 1997. The Doctor Assisted Dying Bill was introduced in response to extensive debate in England over euthanasia legislation in Australia's Northern Territory and the actions of Annie Lindsell, a dying woman who sought a High Court declaration that her doctor could alleviate her discomfort even if the treatment shortens her life.⁶⁶ Lindsell brought her case before the High Court after her GP, Dr. Simon Holmes, refused to administer her palliative care absent court assurance that he would not be prosecuted.⁶⁷ Although some questioned why it was necessary for Lindsell to bring her case in front of the Court since her situation was "clearly" addressed by the doctrine of double effect, her request to the court for clarification was demonstrative of the growing confusion over the adequacy of the doctrine.⁶⁸ Lindsell later withdrew her application for court intervention after two neurologists consulted for the case approved a diamorphine schedule proposed by Dr. Holmes and agreed to by Lindsell.⁶⁹

Although Lindsell's request did not ask the court to condone euthanasia, many people interpreted her petition that way,

die complied. John Oliver, *Letter: Why Choose Bad Death Before a Good One?*, THE OBSERVER, December 11, 1994, at 18, LEXIS, Nexis Library, Observer File.

64. Davies, *supra* note 46, at 93.

65. Oliver, *supra* note 63, at 18. Oliver, speaking on behalf of the Voluntary Euthanasia Society, felt the committee's report was misinformed as to present medical attitudes towards euthanasia and the prevalence of compliance among British doctors to requests from their patients for help to die.

66. Robson, *supra* note 59. The bill would allow doctors to prescribe lethal drugs to a patient if the patient requests them both to a doctor and to a consultant specialist. *Id.*

67. *High Court No Help to "Easing Death" GP*, PULSE, November 8, 1997, at 2, LEXIS, Nexis Library, Pulse File.

68. *"Loose Talk" Has Bred Confusion*, PULSE, November 1, 1997, LEXIS, Nexis Library, Pulse File.

69. Philip Johnson, *A Campaign of Confusion Over Right to Die*, THE DAILY TELEGRAPH (London), April 1, 1998, at 8, 1998 WL 3007831. The two neurologists consulted for the case stated that a five milligram dose of diamorphine every four to six hours would be appropriate to relieve pain while not incurring an undue risk of immediate death. *Id.*

including the VES.⁷⁰ According to a VES spokesperson, Lindsell brought her case because, "it was not clear in law that Annie could receive diamorphine to relieve her distress rather than just her physical pain."⁷¹ Because Dr. Holmes had first proposed administering diamorphine for Lindsell's mental distress caused by the onset of swallowing difficulties rather than for his patient's pain, the VES felt that clarification was needed on the issue of whether or not double effect would protect a doctor whose primary intention was to alleviate the *mental* suffering of his patient.⁷² The VES viewed the Lindsell case as a "major breakthrough" because it established in the minds of the public the case for euthanasia and impacted public opinion on the subject.⁷³ Their view was further supported by the fact that the judge in the case, Sir Stephen Brown, did not award any costs against Lindsell, as is customary in the British legal system.⁷⁴ Despite any breakthrough that may have resulted from the Lindsell case, the law remained unchanged.

C. *The Impact of a Confession: The Adequacy of the
Double Effect Rule is Taken to Court*

1. *The Irwin Case*

The widespread debate over the adequacy of the double effect principle in the United Kingdom peaked in 1997 with a wave of doctors confessing to giving lethal doses of drugs to hasten the deaths of their terminally ill patients.⁷⁵ The first of these doctors was Michael Irwin, a former medical director of the United Nations and current chairman of the Voluntary Euthanasia Society.⁷⁶ In speaking out about the double effect principle, Dr.

70. The Voluntary Euthanasia Society fully backed Lindsell throughout her proceedings. *Id.*; Marian Pallister, *The Law Versus Pain*, HERALD, October 28, 1997, at 13, LEXIS, Nexis Library, Herald File.

71. Johnston, *supra* note 69, at 8.

72. *Id.*

73. *Id.*

74. Melanie Phillips, *Euthanasia's Dose of Doublethink*, SUNDAY TIMES (London), May 16, 1999, at 17, 1999 WL 18874907. The Voluntary Euthanasia Society felt that Brown's decision not to award costs was indicative of a growing sympathetic climate regarding the issue of euthanasia. It has been argued that Brown's decision was based on a fear of a public outcry that may result if costs were awarded against someone in such a pitiful physical state as Lindsell. *Id.*

75. *Id.*

76. Lucy Patton, *Euthanasia Doctor Accused of Executions*, GUARDIAN (London), July 21, 1997, at 4, LEXIS, Nexis Library, Guardian File; Andrew Woodcock & Rachel Ellis, *Murder Quiz Call Into GPs' Mercy Killings*, WESTERN DAILY PRESS (Somerset, England), July 21, 1997, at 12, LEXIS, Nexis Library, Western Daily Press File.

Irwin stated that, "Most good doctors have done this. I have helped about 50 people in this manner. Doctors will never admit that they have given it to honor a patient's request to die. I am trying to expose the hypocrisy of the double effect."⁷⁷ He then stated, "I must admit that because these individuals repeatedly expressed a wish to die earlier than might have been expected—often only perhaps a matter of a week or two earlier—and were supported by their families in this matter, the intention of my actions was to end their lives and not only to ease their suffering."⁷⁸ Dr. Irwin's comments were in response to a vote at the 1997 annual British Medical Association (BMA) conference that opposed legalizing euthanasia.⁷⁹ These statements immediately sparked a national debate over euthanasia and the adequacy of the double effect principle.⁸⁰ Despite Irwin's clear intention to end his patients' lives and a call for action by Dr. Stuart Horner, the chairman of the BMA's medical ethics committee, Irwin was never prosecuted under the 1961 Suicide Act.⁸¹

2. The Moor Case

The first doctor in Britain to face murder charges under the 1961 Suicide Act for the mercy killing of an invalid was Dr. David Moor. Moor had been a popular general practitioner in northeast England for 30 years and had a reputation for being hard-working and well-liked.⁸² Dr. Moor was arrested after a press conference in which he had spoken in support of Dr. Irwin's views and stated that he had also helped an average of 10 patients a year to die throughout his medical career.⁸³ The prosecution used Moor's admissions to charge him with the murder of George Liddell, an 85-year-old retired ambulance driver who Moor had been treating for cancer of the colon.⁸⁴ It was alleged by the

77. Patton, *supra* note 76, at 4.

78. Woodcock & Ellis, *supra* note 76, at 12.

79. Rachel Ellis, *Euthanasia Case Doctor Bailed*, PRESS ASSOCIATION NEWSFILE, July 30, 1997, LEXIS, Nexis Library, Press Assoc. File.

80. Macklin, *supra* note 37, at 15.

81. Ellis, *supra* note 79. A spokesperson for the Sussex police stated that they were not going to launch an investigation into Dr. Irwin but were instead cooperating with the Crown Prosecution Service and British Medical Association. *Id.* In response, the General Medical Council said it would not take any action unless there was a conviction. *Id.* Thus, Irwin avoided prosecution through the mutual acquiescence of both sanctioning bodies. *Id.*

82. Macklin, *supra* note 37, at 15.

83. *Id.*; Patton, *supra* note 76, at 4.

84. Macklin, *supra* note 37, at 15. The connection between Moor and Liddell's death was made by Leonard Coyle, a Newcastle coroner, who was examining Liddell's details while Dr. Moor's views were being covered in the news.

prosecution that Moor had given Liddell a lethal dose of the pain killer diamorphine with the intention of shortening his life.⁸⁵ When confronted with the possibility of prosecution for his actions, Dr. Moor responded that he did not care because he thought, "there need[ed] to be a clarification of the law on this."⁸⁶

At trial, however, Dr. Moor denied ever having murdered anyone, claiming that he administered diamorphine to Mr. Liddell in accordance with the double effect principle.⁸⁷ In order to prosecute Moor for murder, it was necessary for the prosecution to show both that the dose of diamorphine administered to Liddell was beyond what would normally be required to ease suffering and that Moor had the primary intention of ending Liddell's life.⁸⁸ The case against Moor collapsed when expert witnesses disagreed about the level of diamorphine in Liddell's body, leading the judge, Mr. Justice Hooper, to instruct the jury to disregard the toxicology tests done on Liddell's body as unreliable.⁸⁹ Lacking proper evidence upon which a conviction for murder could be made, the jury returned with a unanimous verdict of not guilty and Moor was acquitted of the murder of George Liddell on May 11, 1999.⁹⁰ Hooper, however, only awarded Moor two-thirds of his defense costs because, in his opinion, Moor had brought the prosecution upon himself by making "silly remarks" to the press.⁹¹

D. *Reaction to the Moor Verdict and the Present Call for Clarification*

The acquittal of Dr. David Moor was met with a wide range of reactions from the general public, as well as both the British medical and legal community. Advocates of euthanasia were pleased with Moor's acquittal, stating that the verdict demonstrates that "euthanasia is alive and well"⁹² and that the refusal of the jury to convict Moor was demonstrative of the

Id. Seeing a number of similarities, Coyle contacted the authorities. See Jennifer Trueland, *The Moment of Mercy That Put a Doctor in the Dock*, SCOTSMAN (Scotland), May 17, 1999, at 12, 1999 WL 18796221.

85. See Trueland, *supra* note 84, at 12.

86. Patton, *supra* note 76, at 4.

87. Macklin, *supra* note 37, at 15.

88. Philip Johnston, *Doctor Talked Himself Into the Dock*, DAILY TELEGRAPH (London), May 12, 1999, at 5, 1999 WL 18463320.

89. Alan MacDermid, *Verdict Fuels Euthanasia Row in Medical World*, HERALD (United Kingdom), May 12, 1999, at 1, 1999 WL 17019278.

90. *Id.*; see also *A Matter of Life and Death*, DAILY TELEGRAPH (London), May 12, 1999, at 25.

91. See *A Matter of Life and Death*, *supra* note 90, at 25.

92. *Id.*

change in public attitudes regarding laws against euthanasia.⁹³ Still, others have stated that there is a real danger that the medical profession and the public will interpret Moor's acquittal as a step towards the decriminalization of euthanasia.⁹⁴ Regardless of how the verdict is interpreted, Moor's acquittal illustrates how vulnerable a prosecution is to the expressed intent and honesty of the defendant doctor under the double effect principle.⁹⁵

1. Physician Reactions

The trial of Dr. Moor was met with the strongest reaction from British GPs who used Moor's acquittal to again call for a change in the laws governing palliative care.⁹⁶ As a number of attitude surveys have shown, physician support for legalizing euthanasia in the United Kingdom has almost doubled within the last decade.⁹⁷ This increase in support for euthanasia has also increased awareness among GPs of the confusion caused by applying the double effect principle. Thus, doctors point out that many physicians already secretly hasten the death of terminally ill patients, but are then forced into the hypocritical position of saying that their prime intention is to alleviate pain rather than hasten death to avoid being prosecuted for murder.⁹⁸

Many doctors feel that the current law punishes them for what the *say* as opposed to what they *do*, with the *Moor* case serving as a prime example of what can happen when a doctor chooses to advocate his true intentions.⁹⁹ While the double effect principle offers a defense behind which the practice of mercy killing can hide, most doctors would rather see a change in the law so that they can practice medicine according to clear guidelines and honor patient requests without fear of prosecution.¹⁰⁰ As one euthanasia supporter pointed out, British

93. Timothy E. Quill, et al., *The Rule of Double Effect—A Critique of Its Role in End-of-Life Decision Making*, 337 NEW ENG. J. MED. 1768, 1770 (1997).

94. *Id.*

95. See generally, *We Can No Longer Duck Euthanasia Legislation*, INDEPENDENT (London), May 12, 1999, at 3, 1999 WL 15745451.

96. Norton, *supra* note 21, at 3.

97. *What GPs Really Think About Hastening Death*, *supra* note 37, at 32.

98. *Id.* Dr. Christopher Hindley, who has admitted to hastening the deaths of 10 patients at their request, believes that it is hypocritical that many GPs hide behind the doctrine of double effect when their true intention is to shorten life. Norton, *supra* note 21, at 3.

99. Laurance, *supra* note 26, at 1.

100. *Id.*; Veronica Cowan, *Last Rights: The Lawyers Involved in the Prosecution of Dr. Dave Moor For Mercy Killing Talk About the Implications of the Case*, LAW SOC'Y GUARDIAN GAZ., May 26, 1999, at 20, LEXIS, Nexis Library, Law Soc'y Guardian Gaz. File; Norton, *supra* note 21, at 3.

GPs "cannot have a half-law when it comes to this."¹⁰¹ Presently, if a physician does not do all he can to preserve the life of a terminally ill patient up to the last possible gasp, he renders himself liable to prosecution for murder.¹⁰² This risk has put physicians in a terrible position both morally and ethically.¹⁰³ Many feel that the only way to effectively deal with this situation is for the British Parliament to make up its mind whether or not voluntary euthanasia under proper safeguards is justifiable by legislating on the subject.¹⁰⁴

2. The Voluntary Euthanasia Society

Among the most vocal of doctors supporting euthanasia are those who comprise the Voluntary Euthanasia Society, the pro-euthanasia group currently led by Dr. Michael Irwin. Originally formed in 1935, the VES has dedicated itself to effecting a change in euthanasia laws and providing guidelines for doctors faced with end-of-life decisions.¹⁰⁵ The society feels that doctors are currently operating in a gray area without the benefit of guidelines, allowing them to provide medicine with the intention of ending a patient's life, provided they remain silent about it.¹⁰⁶ According to the VES, voluntary euthanasia in Britain today takes place in a "shadowy criminal world" where patients cannot be assured that they will get the relief they are asking for, and doctors are denied the open advice and consultation of their colleagues.¹⁰⁷ Thus, the VES feels that the legislative inaction and committee activity of the British Parliament is "naïve in failing to acknowledge that euthanasia is being practiced surreptitiously under the guise of the doctrine of double effect."¹⁰⁸

The VES claims that up to 100,000 patients die from active voluntary euthanasia each year, and that in light of the *Moor* verdict, doctors may continue to avoid prosecution as long as they claim they did not intend to shorten life.¹⁰⁹ Thus, it is evident

101. The statement was made by Dr. Peggy Norris, chairwoman of the anti-euthanasia group ALERT. See Clare Dyer, *Doctor Cleared of Murdering Patient*, GUARDIAN (London), May 12, 1999, at 1, 1999 WL 18924319.

102. W.R. Matthews, *Voluntary Euthanasia: A Christian View*, in VOLUNTARY EUTHANASIA 70 (A.B. Downing & Barbara Smoker eds., 1986).

103. Norton, *supra* note 21, at 3 (describing the difficulty family doctors have faced over the last 18 months when presented with a "terminally ill patient in great pain").

104. Matthews, *supra* note 102, at 70.

105. *The Voluntary Euthanasia Society*, *supra* note 45, at 255, 275-76.

106. Michael Horsnell, *Thousands of Doctors "Reassured by Verdict,"* TIMES (London), May 12, 1999, at 3, 1999 WL 7993481.

107. HUMPHRY & CLEMENT, *supra* note 48, at 164.

108. Oliver, *supra* note 63, at 18.

109. Horsnell, *supra* note 106, at 3.

from the VES's viewpoint that double effect is in effect a defense or loophole as opposed to the law that governs doctor actions in euthanasia cases.¹¹⁰ Despite the victory that the VES believes it won in the *Moor* case, the Society still feels that stringent guidelines, which have continually been promised by the British Medical Association, are necessary in order that doctors may effectively administer care to ease the pain of terminal illness without fear of prosecution.¹¹¹ As Dr. Irwin said, "[using drugs that hasten death] is legal as long as the intention is not to end life. But isn't this just society's wink to euthanasia?"¹¹²

3. The Response of the British Medical Association

Despite calls for a change or clarification in the law after the *Moor* verdict, the British Medical Association (BMA) insists that the *Moor* trial should not be seen as breaking new ground on the issue of euthanasia.¹¹³ Dr. Michael Wilks, who chairs the BMA medical ethics committee, stated that, "[euthanasia] is illegal in this country. The BMA supports the existing law and although there is a range of views amongst doctors, the majority opinion in the medical profession remains firmly opposed to euthanasia."¹¹⁴ Wilks feels that the current law is clear to both the public and physicians, and that the jury applied it properly to the *Moor* case in finding that Moor's intention was to relieve suffering.¹¹⁵ In addition, the BMA feels the current law is necessary to maintain the trust that patients have in their doctors.¹¹⁶

The BMA believes that the growing public support for euthanasia is based on a misapprehension that pain and suffering at the end of life is so severe that death is the only answer.¹¹⁷ The BMA, however, feels that no pain is so great that

110. *Id.* John Oliver, the general secretary of the society, said that after the *Moor* case, "[p]atients can be given sufficient pain relief even if this might hasten their deaths, as long as the doctors claim they did not intend to shorten life. This defense of double effect is a valid one." *Id.*

111. *Id.*

112. *Id.*

113. See MacDermid, *supra* note 89, at 1.

114. *Id.* The BMA had previously voted against changing the law regarding physician-assisted suicide in July of 1997 and November of 1998. Norton, *supra* note 18, at 4.

115. See Horsnell, *supra* note 106, at 3; Norton, *supra* note 21, at 3. Dr. Wilks stated that although "Dr. Moor's case has made many doctors nervous about their position, the majority of doctors are very clear about their intentions when treating terminally ill [patients]." Norton, *supra* note 21, at 3.

116. The BMA fears that patients will see doctors as "agents of death" if the law is changed and that vulnerable people who are terminally ill will not be able to trust doctors without the fear that the doctor could put pressure on them to end their lives. Laurance, *supra* note 26, at 1.

117. *Id.*

it cannot be controlled using modern medical practices.¹¹⁸ Therefore, the BMA states that the present law which distinguishes between hastening death and relieving suffering must be maintained, and that no plans to change it are in the works following the *Moor* verdict. This firm stance against changing the euthanasia law was also expressed by the Department of Health.¹¹⁹

4. Legal Experts' Predictions: The Next Netherlands?

Despite the widespread confusion over the impact of *Moor's* acquittal, legal experts have predicted that *Moor* could be the last GP in the United Kingdom to face prosecution under the law of double effect.¹²⁰ Some experts feel that the *Moor* case, when looked at in conjunction with the 1957 *Adams* case, will provide the Crown Prosecution Service with clear guidelines on the issue of double effect.¹²¹ These experts have attempted to draw a distinction between cases such as *Moor's* and that of Dr. Nigel Cox, a consultant rheumatologist who was prosecuted by the General Medical Commission (GMC) for attempted murder after bringing about the death of one of his patients using a substance with no therapeutic value at all: potassium chloride.¹²²

Although any change in the law regarding euthanasia should come from the legislature, other legal experts feel that a series of court judgements such as the *Adams*, *Moor*, and *Bland* cases could gradually establish the legality of euthanasia.¹²³ This is precisely what occurred in the Netherlands where euthanasia is technically illegal but has been decriminalized following a court ruling in 1981.¹²⁴ Termination of life is divided into three

118. *Id.*

119. Cowan, *supra* note 100, at 20; *GPs Need Not Fear Criminal Charges Over Double Effect*, PULSE, May 22, 1999, at 7, 1999 WL 11559990.

120. *GPs Need Not Fear Criminal Charges Over Double Effect*, *supra* note 119, at 7.

121. *Id.*

122. *Id.*; Dyer, *supra* note 101, at 1. Cox's patient of long standing, Lillian Boyes, "made her wish for a tranquil death very plain to him" before he gave her a lethal injection of potassium chloride. Davies, *supra* note 46, at 83. Despite a finding of guilt by the GMC, however, Cox was not suspended or banished from practicing medicine, but was merely reprimanded. See *GMC Guides Consultants but Pillories GPs*, PULSE, April 10, 1999, at 7, LEXIS, News Library, Non-U.S. News File.

123. *A Matter of Life and Death*, *supra* note 90, at 25.

124. Macklin, *supra* note 37, at 15. The case laid down the ten rules for non-criminal assistance in dying by saying, "[t]here must be physical or mental suffering which the sufferer finds unbearable." *Id.* The court also stated that it is not necessary for a person who requests euthanasia to be dying, but that mental suffering such as that inflicted by being a paraplegic was enough. See HUMPHRY & CLEMENT, *supra* note 48, at 148.

categories in the Netherlands,¹²⁵ all of which are considered felonies under the criminal code.¹²⁶ Under a doctrine known as *force majeure*¹²⁷ (which recognizes that the conflict between a physician's duty to preserve life and their duty not to allow a patient to suffer may give rise to a situation similar to necessity or duress), however, doctors are not prosecuted.¹²⁸ Thus, upon a showing of exonerating circumstances and compliance with preordained criteria,¹²⁹ physicians are granted immunity from prosecution.¹³⁰ This approach, which the Dutch government plans to codify into the official law legalizing euthanasia at the beginning of this year,¹³¹ was formalized after the Dutch government and medical and legal institutions recognized the extent of public sympathy for euthanasia.¹³²

If the Dutch example can provide a lesson for the English Parliament, it is that *they* must be the one to effect a change in the law regarding euthanasia.¹³³ Although euthanasia was first technically made legal in the Netherlands by a landmark 1981 court case, it was not until the Dutch Parliament approved guidelines in 1993 for physicians to follow that the law began to have any real effect.¹³⁴ Absent guidelines, many Dutch doctors

125. *Id.* at 143. The three categories of termination of life are: "(1) termination of life at the request of the patient (euthanasia); (2) assisted suicide: The doctor supplies a drug which the patient administers to himself or herself; and (3) termination of life without a request from the patient." *Id.*

126. *Id.*

127. Article 40 of the Dutch Penal Code provides the following defense: "Any person who [is] compelled by force majeure or duress to commit an offence shall not be criminally liable." Lesley Vickers, *Assisted Dying and the Laws of Three European Countries*, 147 *NEW L.J.* 610, 610 (1997).

128. HUMPHRY & CLEMENT, *supra* note 48, at 143.

129. *Id.* at 143-44. The criteria a doctor must observe are: (1) The patient must have made voluntary, carefully considered, and persistent requests (to his doctor) for euthanasia; (2) The attending physician must know the patient well enough to assess whether the request is indeed voluntary and whether it is well considered; (3) A close doctor-patient relationship is a prerequisite for such an assessment; (4) According to prevailing medical opinion, the patient's suffering must be unbearable and without prospect of improvement; (5) The doctor and the patient must have considered and discussed alternatives to euthanasia; (6) The attending physician must have consulted at least one other physician with an independent viewpoint who must have read the medical records and seen the patient; and (7) Euthanasia must have been performed by a doctor in accordance with good medical practice. *Id.*

130. Failure to comply with the strict guidelines would still result in prosecution and a maximum 12-year jail term. *See Officials Planning to Legalize Euthanasia*, CHI. TRIB., Aug. 11, 1999, at 6.

131. The Dutch plans to legalize mercy killing under strict guidelines were expected to gain parliamentary approval in 2000, which would make the Netherlands the first country in the world to legalize mercy killing. *Id.*

132. *See* HUMPHRY & CLEMENT, *supra* note 48, at 143-44.

133. *See* Johnston, *supra* note 69, at 8.

134. *See* HUMPHRY & CLEMENT, *supra* note 48, at 148-49.

and other health professionals simply took it upon themselves to determine when their patients should die.¹³⁵ Their actions often led to numerous incidents in which disabled newborns and elderly persons were put to death.¹³⁶ Once guidelines were introduced, however, the Dutch government witnessed a move towards compliance with the laws and away from the problems caused by the ambiguous language used in the 1981 opinion.¹³⁷ If Britain wishes to avoid the many problems that existed with the precedent-based euthanasia law during the 1980s, then Parliament must circumvent the courts and implement new euthanasia guidelines itself.

IV. SPECIFIC CRITICISMS OF THE DOUBLE EFFECT RULE

Before a solution to the present difficulties regarding the use of the double effect rule can be proposed, it is necessary to look at the specific criticisms that have been raised regarding its application to cases involving euthanasia. As demonstrated by the *Moor* verdict, the heavy emphasis that the rule places upon the subjective intention of the treating physician can lead to problems in cases involving a less than honest doctor or a physician who is unclear as to what exactly his or her primary intentions are. Likewise problematic is the application of the rule in cases of passive euthanasia which are found to be permissible under English law despite the clear motive of causing death through the removal of treatment. The rule has also been

135. *Id.* at 146; Linda Chavez, *When Assisted Suicide Becomes Compassionate Murder*, DENVER POST, April 3, 1998, at B-11.

136. Speden Graeme, *Choice Key to Laws's Death Bill*, DOMINION (WELLINGTON), August 16, 1995, at 10, LEXIS, News Library, Non-U.S. News File; Macklin, *supra* note 37, at 15; Joanne Welford, *She Must Have Suffered Untold Agony*, JOURNAL (Newcastle, UK), April 24, 1998, at 8, LEXIS, News Library, Non-U.S. News File.

137. For example, notification of cases of euthanasia were at eighteen percent in 1990, but rose to forty-one percent in 1995 after the Dutch Parliament approved guidelines for physicians to report assisted deaths to the coroner. Although this number is not very high, the survey was taken shortly after the guidelines were implemented. HUMPHRY & CLEMENT, *supra* note 48, at 147. Thus, many doctors still did not report cases due to fear of prosecution, unwanted publicity, and breaching the privacy of the patient-doctor relationship. *Id.* At the time of the survey (1995), Dutch doctors who report a voluntary euthanasia death expose the relatives of the deceased to a police investigation and themselves must face a "long period of suspense during which they do not know whether or not they will be prosecuted." Davies, *supra* note 46, at 92. The Dutch government has attempted to remedy this problem by ordering doctors to report all euthanasia cases to one of five regional committees which consist of legal, medical, and ethics experts which will ensure that the proper criteria are observed. HUMPHRY & CLEMENT, *supra* note 48, at 148.

criticized for its firm basis in religious tradition and the harsh and inequitable punishments that occur when a physician who responds to a patient's request for death is given the same sentence as a cold-blooded murderer. In order to clarify the current confusion, it will be necessary for any proposed change in the rules to take into account these important criticisms.

A. Problems Involving the Use of Subjective Intentions

In order to distinguish between proper medical practice and unlawful euthanasia, courts first look to the subjective intention of the treating physician. This heavy emphasis on intention has many implications for the moral character and clinical knowledge of those who must apply this principle to euthanasia because it demands scrupulous honesty in assessing one's own intentions as well as appropriate knowledge of the patient's clinical prognosis.¹³⁸ Without full honesty and integrity on the part of the physician regarding the intentions of treatment, the rule of double effect fails in its purpose.¹³⁹

From an idealized ethical perspective, intentions are clear and distinct.¹⁴⁰ In real life situations, however, clinical intentions are often complex, ambiguous, and contradictory.¹⁴¹ The rule of double effect has often been criticized for not acknowledging this complexity, and instead using the presence or absence of a clear purpose to judge intentions while ignoring the many foreseen consequences that occur with every human action.¹⁴² This is so because the distinction between what one intends and what one accepts as foreseen side-effects is significant.¹⁴³ The simplification of intent by the double effect rule has been described as "problematic, difficult to validate externally, and inconsistent with other analysis of human intention."¹⁴⁴ Thus, in order not to violate the rule of double effect in their own mind, many physicians have learned to express their intentions while performing ambiguous acts such as providing terminal sedation in terms of foreseen but unintended consequences.¹⁴⁵ Other

138. Wilkinson, *supra* note 4, at 243.

139. *Id.*

140. Timothy E. Quill, *The Ambiguity of Clinical Intentions*, 329 NEW ENG. J. MED. 1039, 1039 (1993).

141. *Id.* Quill points out that doctors are trained about intentions from the perspective of clinical medicine and psychodynamic psychiatry, in which intentions are viewed as multi-layered and complex. *Id.*

142. Quill, et. al., *supra* note 93, at 1770.

143. John Finnis, *A Philosophical Case Against Euthanasia*, in EUTHANASIA EXAMINED 28 (John Keown ed., 1995)

144. *Id.*

145. *Id.*

physicians, however, may reasonably interpret these same actions and intentions as clear violations of the rule.¹⁴⁶

This distinction between intent and foresight has also been used to show how the fundamental concept of intent is being defined inconsistently by the courts.¹⁴⁷ In the law, there is considerable overlap between these two notions.¹⁴⁸ The rule of double effect is founded upon the traditional definition of intent in which action X is done to bring about consequence Y.¹⁴⁹ Legal authority, however, also recognizes that a jury may infer intent if death or serious injury is a virtually certain or foreseeable consequence of the defendant's actions and the defendant realized this at the time the action was taken.¹⁵⁰ Despite this legal principle, courts hold that intent may not be inferred this way when applying the idea of double effect and that prosecutions may not be founded upon foreseeable consequences.¹⁵¹ Thus, practitioners such as Moor are being tried according to a different set of rules from anyone else who is prosecuted for murder.

Another criticism of the double effect rule is that it fails to take into account multilayered or partial intentions.¹⁵² Oftentimes, clinicians will not act with one exclusive intent in medicating a terminally ill patient, but will rather hold a variety of intentions which may or may not include offering the patient the possibility of death when suffering becomes overwhelming and no other acceptable means of escape are available.¹⁵³ Because the rule of double effect views clinical intentions as being simplistic and one-dimensional, it fails to acknowledge the inescapable multiplicity of intentions which are present in most double effect

146. *Id.*

147. See Letter to the Editor from Christopher R. Morris, University of Durham Department of Law, *published in* 319 *Brit. Med. J.* 639, 639 (Sept. 4, 1999), 1999 WL 10992455.

148. *Id.*

149. *Id.*

150. *Id.* In addition, most moral, social, and legal realms hold people responsible for all reasonably foreseeable consequences of their actions, not just the intended consequences. *Id.* Physicians, argues Quill, should not be exempt from this expectation. *Id.* The inclusion of foreseeable consequences would encourage physicians to exercise due care in their actions by holding them responsible for all actions that are under their control. *Id.*

151. *Id.*

152. Quill, *supra* note 140, at 1039-40.

153. *Id.* at 1040. Quill states that "multilayered intentions are present in most, if not all, end-of-life decisions." *Id.* As an example, he lists many of the intentions that he has when prescribing barbiturates to a patient: (1) To relieve pain and suffering; (2) To ease the process of dying as much as possible; (3) To cause death; (4) To offer the possibility of death if suffering were to become overwhelming and there was no other acceptable escape; (5) To allow the patient to kill themselves; (6) To enhance the patient's range of choice and degree of control as much as possible, given the reality with which the patient is faced; and (7) To cause the patient to die alone. *Id.*

situations where one intention may not rise above the rest to become the true purpose of a practitioner's actions.¹⁵⁴ Therefore, unless the ethical and legal status of actions such as treating terminally ill patients with barbiturates is clarified to reflect the inherent complexities and contradictions present in these types of situations, many physicians may retreat from aggressive palliative treatment for fear of being prosecuted.¹⁵⁵

B. *Living Wills and the Movement Toward Legalizing Euthanasia*

As previously discussed, it is not a crime under English law for a doctor to honor a patient's request for passive euthanasia if the request is either made to the doctor personally or by advance directive in cases in which the patient is unable to communicate.¹⁵⁶ This rule regarding the legality of "passive euthanasia" was established by the 1993 *Bland* case that authorized the withdrawal of food and water to patients in a persistent vegetative state.¹⁵⁷ Although the "clinical, ethical, and legal consensus that patients have the right to refuse life-sustaining treatment is well-established, such decisions are often problematic when analyzed according to the rule of double effect."¹⁵⁸

For example, one patient who is terminally ill may decide to discontinue mechanical ventilation knowing that there is a risk of death but hoping that they will be able to live without the support of medical technology. In this case, the rule of double effect would permit the physician to remove the ventilator because the primary intention is to sustain the patient's life without the use of medical means.¹⁵⁹ Other patients, however, may make the decision to remove the mechanical ventilator with the explicit intention of escaping suffering by a quick death. In these cases, the rule of double effect would *not* allow the physician to remove the ventilator because of the intention to cause death.¹⁶⁰ This is contrary to what the Court of Appeal (Civil Division) held in the *Bland* case.¹⁶¹ Therefore, from a moral and ethical perspective, there is no difference in intention between a doctor who fails to provide life-saving medical treatment of a patient, in full knowledge that this will result in the patient's death, and a doctor

154. *Id.*

155. *Id.*

156. Tate, *supra* note 5, at 80; Woodcock, *supra* note 8, at 5.

157. Woodcock, *supra* note 8, at 5.

158. Quill et. al., *supra* note 93, at 1769.

159. *Id.*

160. *Id.*

161. Woodcock, *supra* note 8, at 5.

who actively kills a patient through the use of lethal agents.¹⁶² In both cases, the motive is the death of the patient rather than the treatment of pain.¹⁶³

This inconsistency in the law has been interpreted by many as a movement towards the legalization of euthanasia since it allows a physician to intentionally hasten the death of a patient, even if only under certain circumstances.¹⁶⁴ As Lord Browne-Wilkinson said in the House of Lords, "How can it be lawful to allow a patient to die slowly, although painlessly over a period of weeks, from lack of food, but unlawful to produce his immediate death by lethal injection?"¹⁶⁵ Given the movement towards autonomy for patients in modern day medicine, many feel that the legalization of voluntary active euthanasia is the final area where patients are not yet given any control over their treatment.¹⁶⁶ Autonomy is central to Western medical ethics and law, and many who give considerable weight to patients' rights to determine their own care believe that a patient's informed consent to an action that may cause death is more important than whether or not the physician intends to hasten death.¹⁶⁷ Thus, those who support a change in the law regarding euthanasia argue that the patient's right to self-determination and bodily integrity, informed consent, the absence of less harmful alternatives, and the severity of the patient's suffering should be

162. Christiaan Barnard, *The Need for Euthanasia*, in VOLUNTARY EUTHANASIA 178 (A.B. Downing & Barbara Smoker eds., 1986). Barnard compares the active versus passive euthanasia distinction to that of a railroad signalman who wants to cause a train crash by stating that there is no ethical distinction between his actively turning the light to green and, alternatively, his passively not turning it to red. *Id.* See also *Medical Use of Controlled Substances, 1999: Hearings on H.R. 2260* (testimony of Thomas J. Marzen), 1999 WL 20009420.

163. Barnard, *supra* note 162, at 178.

164. Jennifer Trueland, *Activists Say New Guides Give Doctors Right to Kill*, SCOTSMAN, June 24, 1999, at 22, LEXIS, News Library, Non-U.S. News File. Michael Willis, the chairman of the Pro-Life Alliance, said, "I think the BMA's statement is a disturbing development which indicates a softening on the present position which could lead to involuntary euthanasia. It would mean that the medical profession had a free hand to kill at will without protection of law." *Id.*

165. Luisa Dillner, *Doctor at Large: The Dignity of Death*, GUARDIAN (LONDON), July 22, 1997, at T16, LEXIS, News Library, Non-U.S. News File.

166. *Trial May Prompt a "Serious Look" at Euthanasia Debate*, PULSE, May 22, 1999, at 8, LEXIS, News Library, Non-U.S. News File.

167. Quill et. al., *supra* note 93, at 1770. Advocates of euthanasia who argue from an autonomy standpoint state that patients ought to have the right to take their own lives or have them be peacefully ended by a physician. Looking to the legality of suicide by one's own hand, advocates argue that if the patient's right to freely choose to die in suicide is accepted, there can be no moral drawback in the exercise of this right if the choice is executed by another. GERALD DWORKIN ET. AL., EUTHANASIA AND PHYSICIAN-ASSISTED SUICIDE 110 (1998).

the focus of evaluating a physician's behavior, not their expressed intent.¹⁶⁸

C. *The Rule of Double Effect is Too Based in Religious Tradition*

The rule of double effect has also been criticized for its origins in the context of a particular religious tradition: Christianity.¹⁶⁹ Because modern-day societies incorporate multiple religious, ethical, and professional traditions, it is necessary for medicine to accommodate various approaches to assessing the morality of end-of-life decisions.¹⁷⁰ Not every religion accepts the position that death should never be intentionally hastened, yet the double effect rule's absolute prohibition against deliberately taking human life is based on the assumption that all intentional direct killing is wrong.¹⁷¹ Because multiple religious and spiritual beliefs directly affect the interactions that occur between physicians and their patients, the law must recognize the various situations that may arise instead of imposing a "religiously correct" view of death and dying upon the medical community that is firmly rooted in one religion.¹⁷²

168. Quill et. al., *supra* note 93, at 1770.

169. *Id.*; In Christianity, suicide is as much murder as the killing of another, and is considered worse since it also goes against the God-given duty of self-preservation. *Id.* For additional history on Christianity and the prohibition of suicide, see GERALD DWORKIN ET. AL., *supra* note 167, at 97-99. Religiously motivated arguments from the Christian tradition usually take the form of a variation on one of seven themes: (1) the argument from the command of God (stating that God has forbidden us categorically to take human life); (2) the argument from the general moral code given by God (stating that God's general moral code "contains as a fundamental tenet the law that it is immoral to kill, deliberately and of set purpose, any person except an unjust aggressor"); (3) the argument from the chance for merit (stating that instead of hastening someone's death, we ought to accept this time of suffering as an opportunity for the person to develop the very virtues that God finds pleasing); (4) the teleological argument (God, as the supreme creator of the universe, is also the planner for those procedures and situations which occur and thus should not be interfered with); (5) the argument from the gift of God ("Man's life is not his own to dispose of, nor is it the prerogative of anyone to shorten it or to take it away."); (6) the argument from the appropriateness of death (God decides who should die and when, and we must not interfere); and (7) the argument from eschatological considerations (stating that those who engage in euthanasia and go against God's word will be punished in eternal life). KLUGE, *supra* note 7, at 133-40.

170. Quill et. al., *supra* note 93, at 1770.

171. *Id.*

172. *Id.*; Timothy P. Daaleman & Bruce Frey, *Spiritual and Religious Beliefs and Practices of Family Physicians*, J. FAM. PRAC., Feb. 1, 1999, at 98. This article describes a study that attempted to identify the personal, religious, and spiritual beliefs and practices of family physicians and test the validity and reliability measure of religiosity that would be useful in physician populations. *Id.* See also David H. Clark, *Doctor's Dilemma Today*, in VOLUNTARY EUTHANASIA 196 (A.B. Downing & Barbara Smoker eds., 1986).

D. *The All-or-Nothing Approach of the Double Effect Rule Results in Harsh Punishments*

Because there are currently no specific laws in Britain relating directly to voluntary euthanasia, the actions of physicians are punished according to ordinary homicide laws dealing with murder, attempted murder, and manslaughter.¹⁷³ Given the conditions under which many instances of voluntary euthanasia arise, many critics suggest that treating voluntary euthanasia as murder under British criminal law is absurd.¹⁷⁴ Murder consists of taking the life of another person with deliberate intention or with "malice aforethought."¹⁷⁵ In the typical instance of voluntary euthanasia, however, there is no malice in the heart of the physician who is hastening death, the life being ended is one which the patient wishes to end, and the community is not deprived of any valuable service.¹⁷⁶ Thus, none of the qualities that characterize the crime of murder are present in voluntary euthanasia, and therefore it should not be treated the same.¹⁷⁷ Viewed in light of the various problems the current law has in assessing a physician's true intent, punishing a doctor who allegedly ended a patient's life for murder (which carries a life sentence) seems especially alarming.

The Criminal Law Revision committee recognized this inconsistency in the law and in 1976 attempted to create a new offense of "mercy-killing" which carries a penalty of only two years imprisonment as opposed to the mandatory life sentence for murder.¹⁷⁸ Mercy-killing was defined as "unlawfully killing an incurable patient out of compassion, not necessarily at the patient's request."¹⁷⁹ The idea behind the creation of this new offense was to avoid a conviction for murder or manslaughter in cases where a doctor acted out of compassion or in response to a request by a patient, as opposed to the deliberate intention or malice aforethought found in murder cases.¹⁸⁰ The adoption of this offense, however, was rejected by the Committee in 1980 when it discovered that it was impossible to distinguish at law

173. *The Legal Position (England and Wales)*, *supra* note 1, at 266. Manslaughter is only applicable when there are extenuating circumstances or the act was carried out as part of a suicide pact. *Id.* Extenuating circumstances might include diminished responsibility with medical evidence to back it up. *Id.* at 267.

174. Matthews, *supra* note 102, at 69.

175. *Id.*

176. *Id.*

177. *Id.* at 69-70.

178. *The Legal Position (England and Wales)*, *supra* note 1, at 267.

179. *Id.*

180. *Id.*

between mercy-killing and other kinds of homicide.¹⁸¹ Despite this rejection, those who advocate changing the law still point to the unfairness of punishing mercy-killings as murder and argue that the present law regarding euthanasia in England must be changed.

V. HAS THE TIME COME FOR PARLIAMENT TO ADDRESS THE
INADEQUACIES OF THE DOUBLE EFFECT RULE AND THE
LEGALITY OF ACTIVE EUTHANASIA?

If the past ten years have demonstrated anything to the British government with regard to the application of the double effect rule to euthanasia, it is that something must soon be done to clarify the confusion that the rule has caused in both the British medical and legal community. Although Parliament and the British Medical Association strongly oppose any change in the law, neither group can deny that the current law has created an atmosphere of confusion in which many doctors already perform euthanasia but escape prosecution by falsely stating that their primary intentions were to simply relieve the patient's pain and not to end their life.¹⁸² Despite countless scholarly articles and proposed legislative bills attacking this inconsistency, there has been a conspicuous failure to legislate on the part of Parliament when dealing with the issue of euthanasia.¹⁸³ In light of the strong reaction to last year's *Moor* verdict and changing attitudes in both the medical and general community towards the legality of active euthanasia, however, it is unclear how much longer Parliament can continue to duck the issue. The need for a legislative change in the law is even stronger when one considers the many problems created in the Netherlands by unclear court precedents which arose after the Dutch Parliament failed to address the true legality of physician-assisted suicide.¹⁸⁴ If ever there existed an appropriate time for Parliament to change the law governing the legality of active euthanasia, that time is now.

181. *Id.*

182. Horsnell, *supra* note 106, at 3.

183. HUMPHRY & CLEMENT, *supra* note 48, at 164.

184. *Id.* at 148-49.

A. *Inconsistencies and Confusion: Why the Existing
Rule Must Be Changed*

As previously discussed, the application of the double effect principle to the treatment of terminally ill patients has been highly criticized for its deficiencies. The most widely criticized of these deficiencies is how the principle utilizes a vision of intent which many feel is inconsistent with the real-life clinical intentions found in situations involving end-of-life decisions.¹⁸⁵ As Dr. Timothy Quill point out, clinicians do not usually act with one exclusive intent in medicating a terminally ill patient, but rather with a variety of intentions that may or may not include offering the patient the possibility of death.¹⁸⁶ Thus, when the multiple and complex intentions doctors experience while treating a terminally ill patient are viewed against a law that unrealistically defines those intentions as being independent and straightforward, the potential for confusion is overwhelming.

1. Physician Confusion

Clarifying physician confusion created by the double effect rule is the first reason why the English law regarding euthanasia must be changed. The present lack of sufficient guidelines and fear of prosecution has created an atmosphere where doctors are unsure of how to act when faced with a patient who requires palliative care. Unlike most laws, which at least provide abiders with a clear idea of what is permissible, the double effect rule is so ambiguous that doctors can interpret it a number of ways depending on their ethical, moral, and religious views. One way that many physicians have learned to deal with this ambiguity is by learning to express prosecutable intentions such as death as foreseen but unintended consequences.¹⁸⁷ Like in the *Moor* case, this "intention-shifting" allows a doctor to avoid prosecution by classifying any punishable intent as a mere foreseeable consequence rather than an intention of the treatment. It is these doctors who are the most controversial figures in the euthanasia debate, regardless of whether they are heralded as martyrs by one side and criminals by the other.

Even more controversial, however, from the patient's perspective, are those doctors who do not give adequate amounts of pain relief to terminally ill patients out of fear of being

185. Quill, *supra* note 140, at 1039-40.

186. *Id.* at 1040.

187. *Id.*

prosecuted for murder if the patient dies while under treatment.¹⁸⁸ Although operating under the same principle of double effect as those doctors willing to carry out "unintentional euthanasia," these doctors remain unwilling to prescribe sufficient doses of diamorphine because they cannot morally or psychologically distinguish between actions performed with the intention of causing death and those performed with the foreseen possibility of causing death.¹⁸⁹ From a patient's standpoint, this can be just as dangerous as an overzealous doctor. Withholding medicine undermines the central premise of the doctor-patient relationship: that the doctor will do everything reasonably in his power to provide the best healthcare possible under the circumstances.¹⁹⁰ Thus, it is evident that confusion over the double effect rule not only leads physicians to overstep their medicinal responsibilities, but may also lead to a failure to meet them.

2. General Medical Council Confusion

Confusion over what actions are permissible under the double effect rule is not just confined to physicians. The General Medical Council of Great Britain (GMC)¹⁹¹ has been heavily criticized for its inconsistent application of the double effect principle in the two cases that have come before it involving euthanasia.¹⁹² In 1992, the GMC heard the case of Dr. Nigel Cox, a consultant rheumatologist who was convicted of attempted murder after giving a lethal injection of potassium chloride to an elderly patient who had requested death.¹⁹³ The GMC found Cox guilty of serious professional misconduct, stating that he had administered "a lethal substance with no therapeutic value whose only purpose [was] to shorten the patient's life."¹⁹⁴ Despite the

188. Anne Mullens, *Death Debate Splits Doctors*, TORONTO STAR, October 19, 1994, at A25.

189. Quill et. al., *supra* note 93, at 1769.

190. HUMPHRY & CLEMENT, *supra* note 48, at 35.

191. Prosecution by the GMC is separate from prosecution by the Crown Prosecution Service (CPS). See *GMC Guides Consultants but Pillories GPs*, *supra* note 122, at 7. The GMC acts as a sanctioning board for British doctors who are found guilty of malpractice, while the CPS will bring separate criminal actions against doctors who they feel clearly violated the law, such as Dr. David Moor. *Id.* In some instances, such as the case of Dr. Michael Irwin, the GMC will not act absent a conviction by the CPS. See Ellis, *supra* note 79, at 4. In Taylor's case, he did not face criminal charges due to a decision by the CPS that the profession was evenly divided over Taylor's actions and that they would not be able to get a conviction. See *GMC Guides Consultants but Pillories GPs*, *supra* note 122, at 7.

192. *GMC Guides Consultants but Pillories GPs*, *supra* note 122, at 7.

193. *Id.*

194. *Id.*

strong disapproval of his actions evidenced in this statement, however, Cox was neither suspended nor removed from the practice medicine.¹⁹⁵

Doctor Ken Taylor was not so lucky. Taylor was also found guilty of serious professional misconduct by the GMC in April 1999 after he withdrew treatment from a patient who was starving as a result of a series of strokes.¹⁹⁶ Unlike Dr. Cox, however, Taylor received a six month suspension from the practice of medicine for his actions.¹⁹⁷ The inconsistent treatment of Cox and Taylor alarmed an already confused medical community. Critics have suggested that this inconsistency was the result of the composition of the two GMC committees that heard each doctor's case.¹⁹⁸ The committee who heard Dr. Taylor's case was composed of a high number of specialist physicians. This fact was significant because one of the charges the committee found Taylor guilty of was failure to get a second opinion, a requirement in cases of permissible passive euthanasia.¹⁹⁹ Although Taylor had discussed his case with other GPs in an attempt to comply with the law, the committee found him guilty for failing to get a *specialist* opinion.²⁰⁰ While the law had never previously stated that a consultant geriatrician is more competent than another experienced GP to decide the morality of withdrawing treatment, the GMC's decision in the *Taylor* case appears to make this distinction the line between compliance and violation of the law.²⁰¹

This inconsistency is a threatening situation for all general practitioners. Although a finding of guilt by the GMC does not result in incarceration, doctors still need the confidence that they are being backed by the GMC in their actions and that their license to practice medicine will not be revoked in situations where they make a good faith effort to comply with the law.²⁰² Absent clear guidelines from Parliament on what constitutes acceptable practice, however, the GMC will remain free to

195. *Id.*

196. Taylor was suspended for withdrawing the medical substance Fresubin from a patient. *Id.* Taylor was acting with the support of the family, and claimed to remove the substance because the intake was never sufficient and often made the patient "cough and splutter." *Id.*

197. *Id.*

198. *Id.*

199. The committee that heard Dr. Taylor's case consisted of a retired consultant hematologist, a retired professor of surgery, a professor of ophthalmology, a consultant geriatrician, two lay people, and "for the sake of fairness," one general practitioner. *Id.* (emphasis added).

200. *Id.*

201. *Id.*

202. *Trial May Prompt a "Serious Look" at Euthanasia Debate*, *supra* note 166, at 8.

interpret the law in any way it sees fit, much to the detriment of physicians such as Ken Taylor who do not attempt to violate or push the boundaries of the law.

3. Confusion in the Courts

Establishing when a physician acted with sufficient intent for prosecution under the double effect rule has also proved to be quite confusing for the courts. In the *Moor* case, charges were originally brought against Moor after he stated that his primary intent in treating many patients was to hasten their death.²⁰³ When he was later charged with the murder of George Liddell, however, Moor provided the prosecution with a different account of his intentions in an effort to claim protection under the double effect rule.²⁰⁴ Detecting that Moor was being less than scrupulous about his true intentions, the court went forward with the prosecution. In order to prove that Moor's intentions were contrary to what he claimed, it was necessary for the prosecution to show that the dose of diamorphine administered to Liddell was beyond what would normally be required to ease suffering and that Moor had the primary intention of shortening Liddell's life.²⁰⁵ This proved to be a tremendous burden on the prosecution, with Moor's previous declarations of his true intentions carrying very little weight in court.²⁰⁶ In the end, the prosecution lost after the judge excluded all medical evidence which could lead the jury to believe that Moor acted contrary to his stated intentions.²⁰⁷

If the *Moor* case demonstrates one thing to British prosecutors, it is the difficulty of trying to prove a doctor's true intentions when delivering palliative care to a terminally ill patient. Although sufficient medical and toxicology evidence could have presumably resulted in a conviction for murder in the *Moor* case, is a jury trial really necessary for every case in which a physician is suspected of committing active euthanasia? This would prove to be a tremendous burden on the British legal system's time and money. There must be some better alternative to the current system that places entirely too much weight upon the expressed subjective intentions of the defendant physician, even if they are changed after the threat of prosecution is realized.

If confusion persists over what is permissible behavior under the double effect rule, the British courts are likely to hear more

203. Trueland, *supra* note 84, at 12.

204. Macklin, *supra* note 37, at 15.

205. Johnston, *supra* note 69, at 5.

206. The Judge dismissed Moor's remarks as simply "silly remarks" to the press. *A Matter of Life and Death*, *supra* note 90.

207. MacDermid, *supra* note 89, at 1.

cases like that of Annie Lindsell, the woman whose GP refused to treat her at all without first obtaining assurance from the court that he would not be prosecuted if she were to die during treatment.²⁰⁸ Cases like that of *Irwin* and *Moor* will also become more prevalent and doctors will use the courts as an opportunity to push the boundaries of the double effect rule towards the legalization of euthanasia. As the Dutch process has shown, however, allowing doctors the opportunity to change the law through the judicial system could actually make the problem worse by having court precedents attempt to reinterpret a law whose language and meaning is already confused enough by the medical community. Thus, the only answer is for Parliament to legalize euthanasia through the adoption of clear guidelines that are easily interpretable by doctors, prosecutors, and most importantly, the patients themselves.

B. *The Law Legalizing Euthanasia: What Should it Look Like?*

If British Parliament were to legalize euthanasia tomorrow, it would make the United Kingdom the only country in the world where active euthanasia could be performed without fear of prosecution. It would, however, not be the first country to attempt to legalize the practice. In 1996, Australia became the first country to legalize euthanasia by statute when its Northern Territory passed the Rights of the Terminally Ill Act after long debate.²⁰⁹ Only four terminally ill people²¹⁰ were able to take advantage of the new law, however, before it was overturned by a senate vote on March 24, 1997.²¹¹ Although opinion polls indicated that more than two-thirds of Australians support voluntary euthanasia, the House of Representatives of the federal government in Australia used its powers to override the territory's

208. *High Court No Help to "Easing Death" GP*, *supra* note 67, at 2.

209. *Senate Votes to Overturn Pioneering Bill on Euthanasia*, IRISH TIMES, March 25, 1997, at 10. The Northern Territory is a small territory (twice the size of Texas) in Australia that has not yet qualified to be a full state. *Id.* In 1998, Australia was comprised of a federal government, five full states, and three territories that will eventually become states, including the Northern Territory. *Id.* Each territory has its own legislature and is largely self-governing. *Id.* It is important to note, however, that the federal government may override the decisions of the territories. HUMPHRY & CLEMENT, *supra* note 48, at 154-55.

210. All four people who died under the law were patients of Dr. Philip Nitschke, who earned the nickname "Doctor Death" through his outspoken campaign in support of the Rights of the Terminally Ill Act. Robert Milliken & Alice Springs, *Canberra Kills Off the World's First Right-to-Die Legislation*, INDEPENDENT, March 25, 1997, at 14, LEXIS, News Library, Non-U.S. News File.

211. *Senate Votes to Overturn Pioneering Bill on Euthanasia*, *supra* note 209, at 10.

law.²¹² Many believed the repeal of the law was more of a political dispute over states' rights than a consideration of the moral, legal and medical issues surrounding the euthanasia debate.²¹³ Regardless of the reasoning behind the senate's action, the world's first active euthanasia law was struck down less than a year after its enactment. With plans to legalize active voluntary euthanasia later this year, however, the Netherlands may soon fill the void left by the repeal of Australia's law.

In the United States, doctor-assisted suicide, backed by a referendum, has been legal in Oregon since 1997.²¹⁴ This practice is not the same as voluntary active euthanasia because it is the action of the patient, not the doctor, which directly brings about the death. The Oregon Death with Dignity Act allows "a competent adult, who is a resident of Oregon, and has been determined by the attending physician and the consulting physician to be suffering from a terminal disease, and who has voluntarily expressed a wish to die, to request medication for the purpose of ending his or her life in a humane and dignified manner."²¹⁵ Under the Oregon law, the patient must initially request suicide assistance by two oral and one written request.²¹⁶ After making an initial oral request to the attending physician, a patient must wait at least fifteen days before reiterating the request.²¹⁷ The patient must then wait forty-eight hours to make the written request, which must be signed, dated, and witnessed by at least two individuals who confirm that the patient is competent, acting voluntarily, and has not been coerced into signing the request.²¹⁸ Only after all these requirements are fulfilled may the physician write the prescription for the lethal drugs.²¹⁹

Although laws regarding the legality of euthanasia in Australia, the Netherlands, and the United States are tailored to address particular legal, moral, and practical concerns specific to each country, they are still useful in drafting legislation to legalize euthanasia in the United Kingdom. By studying the laws regarding euthanasia in other countries, the United Kingdom can

212. Milliken & Springs, *supra* note 210, at 14. The House of Representatives overturned the law by passing a bill sponsored by Kevin Andrews thirty-eight votes to thirty-three. *Senate Votes to Overturn Pioneering Bill on Euthanasia*, *supra* note 209, at 10.

213. Milliken & Springs, *supra* note 210, at 14.

214. Norton, *supra* note 21, at 3. Euthanasia remains illegal in the other forty-nine states. *Id.*

215. HUMPHRY & CLEMENT, *supra* note 48, at 256. For the complete text of the Oregon Death With Dignity Act, see *id.* at app. C.

216. *Id.* at 256.

217. *Id.*

218. *Id.*

219. *Id.*

hopefully avoid many of the problems and concerns that led to the repeal of the Australian law and the slow development of official law in the Netherlands. In addition, the many guidelines required by the Oregon Death with Dignity Act may also help British Parliament to foresee what issues need to be addressed in making physician-assisted suicide legal under the new legislation.

It is also important when discussing British legislation concerning euthanasia to look at the many proposals that have already been made to the British Parliament regarding the changing of the double effect rule. For example, the VES has presented Parliament with a number of Voluntary Euthanasia Bills that have continually been redrafted and updated after their systematic rejection from Parliament.²²⁰ Proposals similar to those of the VES have also come from individuals. For example, in August 1995, Michael Laws presented his Death With Dignity Bill to Parliament without success.²²¹ Despite its rejection, the bill, which was modeled after the Northern Territory's Rights of the Terminally Ill Act and Oregon's Death With Dignity Act, presented many new guidelines which could serve as checks that would have to be passed before a request for death could be met.²²² Proposals such as those of the VES and Michael Laws should be granted serious consideration by British Parliament in rethinking its current stance against voluntary active euthanasia since they were specifically tailored to address the euthanasia situation in the United Kingdom.

As previously mentioned, recent events regarding euthanasia in Britain have created an environment in which Parliament may no longer be able to avoid the issue of the legality of euthanasia without giving proposed changes fair consideration. The purpose of this Note is to provide a framework for Parliament to follow should it finally decide that the double effect principal is no longer acceptable to the medical, legal, and general community.

220. *The Voluntary Euthanasia Society*, *supra* note 45, at 255-59.

221. Graeme, *supra* note 136, at 10.

222. *See id.* Among the procedural requirements proposed by Laws's bill are: (1) doctors who agree to handle a request will have to tell the patient or the patient's representative the diagnosis and prognosis, the risks associated with euthanasia, and alternatives to death including hospice care and pain control; (2) Doctors must refer the patient to a consultant for a second opinion on the same matters; (3) The patient must undergo psychiatric assessment to determine whether they are competent to make a request for euthanasia; (4) Counseling would be compulsory, and there is to be at least a forty-eight hour waiting period after all the other requirements are met; (5) The doctor must request that the patient notify next-of-kin (the patient can refuse this step without making the request void); and (6) A patient may cancel the request at any time. Laws's bill also suggests that anyone who attempts to exert "undue pressure or influence" on a patient or any medical staff involved with a death request could be jailed for up to five years and be fined \$250,000. *Id.*

To ensure that any change in the law will benefit the British medical community, however, it is important that new legislation addresses the many concerns and pitfalls illustrated by proposed British legislation and the legislation of other countries. Without addressing these concerns at the outset, the new law will suffer from the same uncertainties and confusion that plague the present system and have led to its widespread criticism. In order to ensure the effectiveness of the new law, it should contain or address the following important procedural requirements.

1. Doctors Must Gain Fully Informed, Rational Consent

Among the most important of the proposed procedural requirements is that the treating physician first obtain the fully informed and voluntary consent of the patient. Not only does this requirement put control of euthanasia decisions into the hands of the patient, but it also draws a fine line between voluntary and involuntary active euthanasia. The importance of this requirement has already been recognized by Parliament in situations involving passive voluntary euthanasia that arose after the 1993 *Bland* decision. Under English law, doctors may honor a patient's request for passive euthanasia if either made to the doctor personally or by an advance directive in cases where the patient is unable to communicate.²²³ Therefore, this same voluntary consent requirement should also be implemented in situations involving the legality of active euthanasia.

The voluntary consent requirement was a central focus of the 1995 Death With Dignity Bill presented to Parliament by Michael Laws.²²⁴ Laws stressed that his bill concerned only the legalization of *voluntary* euthanasia and would allow doctors to take a patient's life only if such a request were made either during illness or in a "living will."²²⁵ Under Laws' proposal, a doctor who agrees to handle a request for a patient would have to first inform the patient or the patient's representative (in cases involving an advance directive/living will) of the patient's diagnosis and prognosis, the risks of the euthanasia dose and its effects, and the alternatives to death.²²⁶ These requirements ensure that a patient's consent is *fully informed* when given. A similar requirement was also included in the Provisional Draft 1983 of

223. Woodcock, *supra* note 8, at 5.

224. Graeme, *supra* note 136, at 10. Because Laws's bill was based on the Australian Northern Territory's Rights of the Terminally Ill Act of 1995 and the Death with Dignity Act of Oregon, it is important to note that many of the requirements he proposes address the concerns raised in other countries. *Id.*

225. *Id.*

226. *Id.*

the VES's Voluntary Euthanasia Bill, which states that, "It shall be lawful for a physician to give euthanasia to a patient whose condition has been diagnosed as irremediable if the patient has, not less than 30 days earlier, when of sound mind, made (and not subsequently revoked) a written and witnessed statement declaring that in the event of his suffering from such a condition he might wish to be given euthanasia."²²⁷

The VES bill brings up an important sub-component of the consent requirement. Before a patient's consent can be legally enforceable, it must also be determined that the patient was of sound mind when the consent was given. While the Voluntary Euthanasia Bill simply defines sound mind as being of "testamentary capacity,"²²⁸ Laws' Death With Dignity Bill attempts to objectify the procedure for determining soundness of mind by requiring all patients to undergo a psychiatric assessment.²²⁹ If the assessment reveals that the patient is suffering from a mental disorder or clinical depression that would prevent them from making a decision of this magnitude, then the request for euthanasia is determined void.²³⁰ This same requirement was also included into the Northern Territory's Rights of the Terminally Ill Act.²³¹ Thus, a psychiatric assessment to determine whether a patient has the capacity to consent to his or her death is invaluable in maintaining the boundary between voluntary and involuntary euthanasia.

In order to ensure that physicians have the proper motivation to obtain a patient's fully informed consent, it is also necessary that the new law include some sort of punishment for situations in which a physician acts with less than the full, valid consent of the patient. The Death With Dignity Bill suggests that, "Anyone attempting undue pressure or influence on patient or any medical staff involved with a death request could be jailed for up to five years and fined up to \$250,000."²³² The ambiguous language of the bill suggests that this punishment is applicable to anyone who attempts to sway a patient's decision on whether or not they want to die at the hands of their doctor.²³³ Penalties could apply to both anti-abortion protestors as well as those encouraging someone to die.²³⁴ In cases where the doctor is acting without

227. Voluntary Euthanasia Bill (Provisional Draft 1983), *reprinted in* VOLUNTARY EUTHANASIA 285 app. 2 (A.B. Downing & Barbara Smoker eds., 1986).

228. *Id.* at 287.

229. Graeme, *supra* note 136, at 10.

230. *Id.*

231. Geoffrey Lee Martin, *Euthanasia to be Legalized by Australian State*, DAILY TELEGRAPH, April 12, 1996, at 19, LEXIS, News Library, Non-U.S. News File.

232. *Id.*

233. *Id.*

234. *Id.*

any consent at all, the law should continue to prosecute the physician under criminal law. In order to ensure that physicians are not overly punished for their actions, perhaps the law could be changed to recognize the offense of "mercy-killing" which was suggested by the Criminal Law Revision in an effort to avoid prosecuting doctors for murder under the 1961 Suicide Act.²³⁵

2. A Second Opinion as to the Patient's Condition is Required

Although the informed consent requirement is the most important of the proposed procedural requirements, it is not effective absent other provisions which can deter abuse by doctors who may perform euthanasia with less than adequate consent by the patient. One such prevention was illustrated by the Death With Dignity Bill's requirement of a psychiatric assessment of the patient. This measure serves as an important check by taking the assessment of the patient's competence out of the hands of the person who will later end the patient's life and putting the decision into the hands of a neutral third party.

Concern with preventing abuse can also be seen in the varying witness requirements that have long been associated with advance declarations or "living wills"²³⁶ and are now included in the VES's Voluntary Euthanasia Bill.²³⁷ In the advance declaration context, two witnesses who are not members of the patient's family are required to be present when the request for death is made.²³⁸ Thus, the witness requirement prevents abuse by doctors who may have ulterior motives in hastening a patient's death by ensuring that the patient is capable, is acting voluntarily, and is not being coerced to sign the request.²³⁹ The witness requirement also prevents abuse by family members by prohibiting those who may possibly benefit from patient's death from becoming witnesses. Given the widespread reports of families in the Netherlands sending elderly relatives to premature deaths,²⁴⁰ a neutral witness provision appears to be a valid

235. *The Legal Position (England and Wales)*, *supra* note 1, at 267. Under the offense of "mercy-killing," physicians found guilty of ending a patient's life without consent would receive only 2 years in prison as opposed to a life sentence for murder. *Id.*

236. *The Advance Declaration*, in VOLUNTARY EUTHANASIA 288-89 app. 3 (A.B. Downing & Barbara Smoker eds., 1986); HUMPHRY & CLEMENT, *supra* note 48, at 256.

237. *Voluntary Euthanasia Bill (Provisional Draft 1983)*, *supra* note 227, at 285.

238. *The Advance Declaration*, *supra* note 236, at 289.

239. HUMPHRY & CLEMENT, *supra* note 48, at 256.

240. Graeme, *supra* note 136, at 10.

solution to ensuring that the patient's true wishes regarding death are honored.

Perhaps the most effective way of preventing abuse by doctors is to implement a second opinion requirement into the law that would require that the patient be referred to a consultant or independent doctor for a reevaluation of their condition. This requirement is mentioned in every bill that has been presented to British Parliament and was also made an integral part of both the Northern Territory's Rights of the Terminally Ill Act and the government-adopted guidelines found in the Netherlands.²⁴¹ A second opinion requirement is effective for many reasons. Besides preventing abuse by an overzealous doctor, requiring a second opinion ensures that a patient is fully informed about the choice they are about to make. Even if a doctor is not acting with ulterior motives in judging a patient's capacity for decision-making, it is entirely possible that one doctor may simply fail to give a patient important information that may influence their decision. Thus, by ensuring that the patient is aware of all treatment options and risks, the second opinion requirement protects the voluntary aspect of a patient's decision to die.

One necessary aspect of the second opinion requirement that will need to be addressed by new legislation is precisely who must render the second opinion. This issue was previously addressed in the discussion of Dr. Ken Taylor, the British GP who was suspended for six months by the GMC for a failure to get a second opinion in a passive euthanasia case.²⁴² Taylor's suspension caused a great deal of confusion in the medical community since Taylor had attempted to meet the second opinion requirement by discussing his case with other physicians. Taylor was suspended for failure to get a *specialist* opinion; a requirement that had not been previously imposed by the law. The second opinion requirement should clearly state on its face what type of secondary consultation is necessary to ensure the legality of the euthanasia.

The difficulty over who must render a second opinion also caused a great deal of difficulty in the Northern Territory. After the Rights of the Terminally Ill Act was put into effect in 1996, many euthanasia supporter felt that the law was rendered useless by regulations accompanying the act which required a second

241. *Id.* (Laws's Death With Dignity Bill); *Voluntary Euthanasia Bill (Provisional Draft 1983)*, *supra* note 227, at 285; Martin, *supra* note 231, at 19 (The Australian Northern Territory's Rights of the Terminally Ill Act); *Netherlands Planning to Legalize Euthanasia*, BUFFALO NEWS, August 11, 1999, at A1.

242. *GMC Guides Consultants but Pillories GPs*, *supra* note 122, at 7.

opinion by a specialist who is a territory resident.²⁴³ Because the Northern Territory of Australia has a population of fewer than 200,000, the territory has only a small number of medical specialists and no cancer specialist, therefore making it close to impossible for the euthanasia requirements to be met.²⁴⁴ Although the extensive population of the United Kingdom would preclude existence of such a problem, the Australian example remains important because it shows that specifying who renders the second opinion matters both in determining the effectiveness of a new law and in preventing physician confusion during compliance with it.

As discussed in the next section, one additional procedural requirement that should be included in the new law is that the patient be suffering from irremediable and unbearable pain. Thus, in order to assure that a determination of a patient's pain is accurate, perhaps it may be necessary that one or both of the determining physicians be a specialist in the area relevant to the patient's condition. The Australian Act addressed this concern by requiring that both physicians who examine the patient have at least five years experience in the area of the patient's condition.²⁴⁵ Therefore, if Parliament is concerned that inaccurate determinations may lead to a disproportionate number of patients seeking euthanasia, implementing a similar provision requiring doctors who give a second opinion to be specialists will help ensure that only patients whose conditions truly necessitate euthanasia will qualify to receive such service.

3. Additional Procedural Requirements

An additional procedural requirement that was mentioned in both proposed British legislation and foreign euthanasia laws was a mandatory waiting or "cooling off" period. The suggested length of this period varies from as little as forty-eight hours to thirty days.²⁴⁶ Regardless of what period of time is suggested by other laws, it is important that Parliament closely examines the competing considerations which argue for both lengthening and

243. See *Australia Split as Euthanasia Law Takes Effect*, CHI. TRIB., July 1, 1996, at 9.

244. *Id.*

245. Martin, *supra* note 231, at 19.

246. See *id.* (discussing Australia's nine-day waiting period); Graeme, *supra* note 136, at 10 (stating that Laws proposes a forty-eight hour waiting period); *Voluntary Euthanasia Bill (Provisional Draft 1983)*, *supra* note 227, at 285 (suggesting the application of a thirty day waiting period); HUMPHRY & CLEMENT, *supra* note 48, at 256 (stating that the Oregon law requires a total of seventeen days to pass between the initial oral request and the written request necessary for passive euthanasia to be carried out).

shortening this period of time. First, it must be ensured that the period is long enough to provide the patient with an adequate amount of time to reflect on this important decision. The period, however, should not be so long as to require patients confident with their choice to endure weeks of pain before their request may be carried out. The argument for a shorter reflection period is strengthened when it is considered that most patients who request death are fairly close to dying anyway, but desire euthanasia because the pain that they must endure is irremediable and unbearable. Perhaps an intermediate requirement, such as Australia's nine day "cooling off" period²⁴⁷ or the seventeen day period used in Oregon's Death With Dignity Act,²⁴⁸ would be an appropriate compromise between these competing considerations.

Another important procedural requirement necessary for an effective euthanasia law is that the patient must be suffering irremediable and unbearable pain. This determination should be the focus of both the initial examining physician and the physician who renders the secondary opinion. The Voluntary Euthanasia Bill defines irremediable as "a serious and distressing physical illness or impairment from which the patient is suffering without reasonable prospect of cure."²⁴⁹ A more specific definition may be required to prevent situations like that of Annie Lindsell, the woman whose GP went to court to seek a determination on whether double effect would protect a doctor whose primary intention was to alleviate the *mental* suffering of his patient.²⁵⁰ In light of the confusion that followed Lindsell's petition to the High Court, the new law should contain a much broader definition that will account for the wide variety of suffering that may lead a patient to seek euthanasia. Because the psychiatric assessment of the patient requires that the patient not be suffering from clinical depression when consent is given to the treating physician, it is very important that Parliament addresses the issue of what constitutes "mental distress" under the new legislation and that this determination be consistent in all provisions of the law.

One of the biggest concerns that arose when Australia passed the Rights of the Terminally Ill Act was that people would travel to the Northern Territory specifically to die.²⁵¹ In an effort to combat an influx of "one-way tourism," the Act implemented a

247. Martin, *supra* note 231, at 19.

248. HUMPHRY & CLEMENT, *supra* note 48, at 256.

249. *Voluntary Euthanasia Bill (Provisional Draft 1983)*, *supra* note 227, at 287.

250. Johnston, *supra* note 69, at 8.

251. Martin, *supra* note 231, at 19.

residency requirement that would prevent residents of other countries from availing themselves of the Territory's euthanasia law, regardless of whether all other procedural requirements were met.²⁵² This requirement proved to be effective; all four of those who died under the provisions of the Act were Northern Territory residents. In order to prevent an influx of terminally ill patients to the United Kingdom, a similar residency requirement should be imposed by the new law.

One final area that should be addressed by the new law is the implementation of reporting requirements. For example, in the Netherlands, guidelines adopted by the government required physicians to report each case of euthanasia to the coroner and to one of five regional panels, comprised of a lawyer, a doctor and an ethics expert.²⁵³ This panel would be responsible for reviewing the facts of each case and recommending prosecution in those cases in which the physician failed to meet all procedural requirements.²⁵⁴ Although reporting requirements ran into many problems in the Netherlands when they were first implemented, subsequent studies have shown that doctors simply failed to report cases of euthanasia because of fear of prosecution and the effects that a possible court trial could have on their reputation and financial situation.²⁵⁵ Since any change in the English law should come from Parliament and not confusing court precedent, under-reporting due to fear of prosecution should not be a problem for the British medical community, so long as the procedural requirements are met. By creating a panel in which legal, medical, and ethical interests are all represented, the British law should ensure that only clear cases of physician misconduct are prosecuted under the new principles.

It is also possible that additional procedural requirements may need to be implemented into the new law. For example, issues are sure to arise over age requirements under the law. While Australia and Oregon both require that a patient be eighteen years of age in order for consent to be valid, the requirements in the Netherlands are much more relaxed, allowing children as young as twelve to demand and receive euthanasia.²⁵⁶ It will be important for Parliament to address smaller issues such as the age requirement before it passes new legislation if it wishes

252. *Id.*

253. *Netherlands Planning to Legalize Euthanasia*, *supra* note 241, at A1.

254. *Id.*

255. HUMPHRY & CLEMENT, *supra* note 48, at 147.

256. See Seth Mydans, *Law Allowing Doctor-Assisted Suicide Stirs Passions in Australia*, DALLAS MORNING NEWS, February 9, 1997, at 22A; *Netherlands Moves to Legalize Euthanasia*, WASH. POST, August 11, 1999, at A16; Brad Knickerbocker, *Sanctioned Euthanasia: Lessons From Abroad*, CHRISTIAN SCI. MONITOR, December 3, 1998, at 1.

to avoid the many court cases seeking interpretation of the requirements that plague the current principle of double effect.

Most importantly, it is crucial that physicians understand the procedural requirements thoroughly so that there is no confusion as to when one's actions constitute illegal euthanasia. Thus, educational programs, such as those required by the Northern Territory,²⁵⁷ should accompany any proposed change in the law and clearly address potential areas of confusion such as the timing of informed consent. While similar educational programs have already been attempted by the BMA in England, the many inconsistencies in the law of double effect prevent even the clearest of instructions from adequately addressing the questions and concerns of British doctors. Therefore, without also changing the law regarding euthanasia, educational programs aimed solely at correcting physician conduct will continue to be useless.

VI. CONCLUSION

This Note has attempted to point out the various events and factors that underlie the current push for Parliament to change the law regarding voluntary active euthanasia. Since its introduction to the British legal system in the 1956 *Adams* case, the double effect principle has been criticized for its unrealistic assumptions regarding clinical intentions and its naïve reliance upon scrupulous physician honesty in the face of prosecution. While Parliament has been able to avoid legislating on euthanasia for decades by hiding behind the support of the Church of England, the Roman Catholic Church, and the British Medical Association, recent events such as the *Sunday Times* attitudes survey and the *Moor* verdict have created an atmosphere in which Parliament may no longer be able to avoid future attempts to pass legislation.

What Parliament will do next remains the ultimate issue in the case for legalizing voluntary active euthanasia in the United Kingdom. Supporters of changing the current law can only hope that recent events in the British medical and legal systems will lead Parliament and the BMA to sway their position in order to provide doctors with clear guidelines in euthanasia situations. While such a radical change can hardly be expected in light of years of inaction, the legalization of voluntary *passive* euthanasia after the *Bland* verdict provides hope that Parliament will respond to recent events before difficult and unclear court precedents

257. Martin, *supra* note 231, at 19.

begin to change the law of voluntary active euthanasia in the United Kingdom.

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