The regulation of euthanasia by the criminal law has tended to be one of the more contentious areas of medical law, and continues to be the subject of debate. Few areas of the criminal law have been so consistently the target of reformist pressure, and certainly few areas have so strongly resisted change. Understandably, legislators are unwilling to involve themselves in a matter of law reform which engenders such moral disagreement, and it is significant that only two jurisdictions — The Netherlands and the Australian Northern Territories — have made any substantial change in their legal practice in this area. In other countries, including the UK, the courts and legislators have consistently refused to remove the fundamental criminal law objection to the practice of euthanasia. This is not to say, of course, that the courts have failed to recognise the medical subtleties in medical treatment at the end of life; in several important decisions, the courts in Britain have considered the boundaries of the criminal law's protection of life and have offered guidelines for doctors facing the delicate issues associated with treating the dying patient. Yet, in spite of several helpful decisions from the courts, the basic principle remains firm: the criminal law does not countenance the taking of life, no matter how good the motive. This means that there are very clear legal limits to the extent to which doctors can follow their individual consciences in this area.

Direct acts of euthanasia

The criminal law regards as a potential offence of homicide any wrongful act which results in the loss of life. Such an act may be intended to lead to the death of another, or it may result from negligence, recklessness, or a culpable omission. The most serious homicide offence is murder, which in Britain involves a mandatory penalty of life imprisonment. Manslaughter (culpable homicide in Scotland) is less serious and will often attract a much less stringent penalty—in some cases no more than a relatively short term of imprisonment or other minor sanction.

When life is taken deliberately, the appropriate charge is murder. Thus, if a doctor responds to a request from a patient to end his life and administers a lethal injection, the doctor will have acted with the necessary mens rea for murder (mens rea is the mental element required
for conviction of a crime). It makes no difference from the legal point of view that the patient gave his consent to the doctor's act. Consent is no defence to a charge of murder, or indeed to the infliction of any substantial physical injury on another. Nor does the doctor's motive make any difference; the fact that this was a case of 'mercy killing' does not affect the status of the act as one of murder.

The prosecution of doctors for acts of euthanasia is rare, but there have been several cases in which the medical profession has been reminded of the law's determination to protect human life. In the two best-known earlier cases, that of Dr John Bodkin Adams\(^1\), and that of Dr Leonard Arthur\(^2\), the issue was complicated by the fact that one involved the administration of pain killers for which there was medical justification, and the other involved the withholding of treatment. More recently, however, in the case of Dr Cox\(^3\), the legal point was more focused. Dr Cox was convicted of the attempted murder of a patient to whom he had administered a lethal injection of potassium chloride. But for the technical reasons which restricted the charge to one of attempted murder, Dr Cox might have found himself faced with the more serious charge of murder, although it is far from certain what the outcome of such a charge might have been. The point which his conviction makes, though, is that juries are prepared to convict doctors who engage in consensual euthanasia, even in circumstances where a great deal of sympathy might be felt for the doctor. Dr Cox had treated his patient for some time and was sensitive to her suffering; his mistake, though, may have been to assume that acting in good faith and in accordance with the promptings of conscience would protect him from the rigours of the criminal law.

There are, of course, ways in which the severity of the criminal law can be mitigated, even where the act in question is one of intentional killing. In those cases where a relative or other person caring for a patient in extreme distress takes the patient's life, then a successful plea of diminished responsibility may reduce the charge from murder to the lesser charge of manslaughter (or culpable homicide). This can be done where there is medical evidence that the person who took life was suffering from a psychiatric illness at the time of the act. A reactive depression, brought about by the distress of caring for the dying relative, would clearly meet this requirement. Such a plea, however, is unlikely to be available to a doctor or nurse.

**Indirect or ‘passive’ euthanasia**

The administration of a fatal dose of drugs may not be necessary to achieve the goal of bringing a patient's life to an end. A decision to refrain
from embarking on a course of treatment, or a decision to withdraw a treatment already in progress, may have the effect of ending life, just as surely as the injection of a lethal substance. Such decisions are made regularly, and are an inevitable part of the humane and conscientious practice of medicine. They are strongly, and convincingly, defended by doctors, and indeed it has been pointed out by one paediatrician that such decisions are incorrectly called 'the withdrawal of treatment'; on the contrary, they constitute, in themselves, an integral part of the medical treatment of the dying patient.

The criminal law does not require doctors to persist in the treatment of a patient when no medical purpose is served by such persistence. All that is required, from the legal point of view, is that the patient be given such treatment as is medically appropriate in the circumstances. Deciding what is medically appropriate is clearly crucial. A decision to deny antibiotics to a young and otherwise healthy patient with a chest infection is quite a different matter from a decision not to treat a similar condition in an elderly patient with a very poor quality of life and a poor prognosis. In the former case, the withholding of treatment is potentially criminally culpable; in the latter, the law accepts that the limits of medical duty have been reached and there may be no further obligation to provide more than treatment which makes the patient comfortable. Such a view accords with our common sense of human limitation and our distaste for the vain pursuit of longevity beyond the natural measure.

Uncertainty about the circumstances in which it is proper to refrain from further treatment, or to limit treatment, has been considerably diminished in English law in a series of court decisions concerning infants. The two most important of these were the cases of Re C and Re J. In the first of these cases, Re C, the infant was moribund and the hospital sought authority to abstain from the setting up of naso-gastric feeding or the administration of antibiotics should either of these become necessary. The court confirmed that this was quite proper and that all that would be required was that the patient should be made comfortable and allowed to die with peace and dignity. By contrast, the child in Re J was not dying. He was severely brain-damaged and suffered from fits during which he required assistance in breathing. The court ruled that there was no hard and fast legal requirement that in such a case the child should be resuscitated; the decision was one for the doctors and parents to make in consultation with one another and with the child's best interests as the main consideration. In deciding what was in the child's best interests, the matter should be looked at from the point of view of what might be assumed to be the patient's point of view, and in this the issue of pain and suffering fell to be considered. At the same time, however, the court stressed that it was not authorising euthanasia. As the judge said:

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The court never sanctions steps to terminate life. That would be unlawful. There is no question of approving, even in the case of the most horrendous disability, a course aimed at terminating life or accelerating death. The court is concerned only with the circumstances in which steps should not be taken to prolong life.

These cases were concerned with patients who could not express their own wishes on the subject of their treatment. An unconscious or incapacitated adult might be in the same position, although in the case of an adult there might be evidence of what the patient’s previously-expressed views were. If it is the case that the patient has previously stated that he does not wish to be subjected to a particular form of treatment, then this evidence should weigh very heavily with a court. At present there are no decisions by UK courts in which the validity of advance directives (so-called ‘living wills’) is specifically ruled upon, but several judicial comments demonstrate a sympathetic attitude towards such statements of preference. In one case involving a mentally disordered patient, the court held that the surgery should not be performed on a man who, while still mentally competent, had expressed his antipathy to the operation. This case could be taken to indicate an acceptance of the advance directive, and it is likely that if a case comes before a British court in which the validity of a directive against treatment is considered, the directive will be upheld. The crucial matter, however, will be the question of whether the earlier statement can be taken to embody the current view of the patient. Clearly this is the major drawback with advance directives; people can change their opinions, and a view expressed while in good health may not represent what is wanted by one who is facing death.

A further objection to the concept of the advance directive is that it potentially limits the extent to which the doctor can use his own judgement to assess the needs of the patient in the context of the family. It may sometimes be necessary to carry out a subtle balancing of the interests of the patient and the family. It may mean a great deal to family members that the patient’s life be prolonged or that a particular treatment be attempted. Although ultimately it must be recognised that the patient’s autonomy, or right of self-determination, must be the deciding factor, this can be combined with a recognition of family feelings and a compromise between the patient’s known wishes and family desires might be achieved. In any event, a process of sympathetic discussion and sensitive accommodation of family wishes might be achieved more readily by a doctor who feels that he does not have his hands tied by the strict terms of a legal document that must be applied to the letter. The weight of this objection, however, is questionable, and in so far as there is a consensus of legal opinion on this matter, it
Euthanasia undoubtedly favours giving effect wherever possible to the patient's previously expressed preferences.

Withdrawal of nutrition and hydration

A particularly difficult problem is posed by those unconscious patients who are dependent on artificial feeding for their survival. While there may be no duty to persist with medical treatment past the point at which such treatment serves any useful purpose, there is a clear continuing obligation to provide for the basic needs of the patient. This has usually been taken to mean that the provision of essential nursing care—including the provision of food and water—is legally required until such time as death intervenes.

In the case of a patient who is capable of swallowing, this requirement poses no difficulties; such a patient must be given food and water even if medical interventions are abandoned. A patient in the persistent vegetative state (PVS) may, however, require nutrition and hydration by tube and may, therefore, be both irretrievably unconscious and entirely reliant on artificial methods for the provision of the necessities of life. Clinically such a person may not be diagnosed as brain dead because sufficient brain stem function remains to sustain spontaneous breathing and circulation: but the two states are similar in that in neither is there evidence of awareness, of any sort, and both are considered irreversible.

Litigation in England has now clarified the position of such patients, at least as far as civil law matters are concerned. In Airedale National Health Service Trust vs Bland, the House of Lords considered the position of a young man who had suffered severe brain injury in a football stadium disaster and who had entered into the persistent vegetative state. It was accepted by the patient's doctors and parents alike that there was no prospect of the recovery of consciousness and in these circumstances the hospital sought legal permission to withdraw the nasogastric feeding regime in order to allow the patient to die.

The resulting judgments, both at the Court of Appeal stage and in the House of Lords, are models of the sensitive legal treatment of an emotionally-charged issue and have met with broad, if not unanimous, approval. At their heart lay a view of the provision artificial feeding as an aspect of medical treatment rather than as a distinct duty. Once this was done, then the decision whether or not to continue with it could be resolved in exactly the same way as any other treatment decision, and for this purpose the 'best interests' test could be invoked. Was it in the best interests of Anthony Bland that his body be kept alive when his essential personality and humanity had been destroyed? The court answered no to
this question, and the patient, as a result, was allowed to die. Once again, euthanasia had not been authorised, but a clear signal was given that human life need not be maintained at all costs when no possible conscious enjoyment or value could result from such efforts.\(^{11}\)

Courts in other Commonwealth countries have taken a very similar approach to the type of problem considered in *Bland*. In New Zealand, a court authorised the withdrawal of artificial ventilation in the case of a patient suffering from the Guillain-Barré syndrome, on the grounds, amongst others, that artificial ventilation did not amount to a necessity of life where it could only defer certain death. In such a case, the court held, the manifestations of life are being preserved rather than life itself.\(^{12}\) The Canadian courts have also considered the matter, most notably in the *Nancy B vs Hotel-Dieu de Québec*\(^ {13}\), in which the court ruled on the right of another Guillain-Barré sufferer to request, whilst still competent, the withdrawal of respirator treatment.

**Assisted suicide**

If the criminal law is so rigid in its condemnation of the taking of any active step to end life, then can this legal obstacle be side-stepped by the provision of medical assistance to enable the patient to take his own life? The legal resolution of this depends on the nature of the assistance given, and the circumstances of the individual case. In England, suicide was a crime until the passage of the Suicide Act 1961. This legislation decriminalised suicide (which could obviously only be prosecuted as an attempted crime), but retained the criminal prohibition of aiding and abetting suicide. This means that a doctor who responds to a direct request of a patient to prescribe drugs which he knows the patient intends to use to take his life will be committing an offence under this statute. The position of one who offers advice to another on how to commit suicide is less clear-cut. The matter was considered in *Attorney-General vs Able*\(^ {14}\) in which the court expressed the view that the provision of such advice could constitute aiding and abetting suicide if it was sufficiently closely linked to the act of self-destruction. This view of the law successfully inhibited proponents of voluntary euthanasia in England from openly distributing booklets containing advice on methods of taking one’s own life, but did not prevent the Voluntary Euthanasia Society of Scotland from accepting a considerable number of English members, to whom the Scottish Society’s booklet was then sent.

The legality of offering such advice in Scotland is even less clear than in England. It is certainly the case that suicide has not been a crime in Scotland—at least in modern times—and, therefore, it is difficult to see
how there could be a conviction for being art and part guilty (the Scottish term for accomplice liability) to a non-existent crime. This does not preclude, however, charging a person who assists suicide with a common law crime, such as that of recklessly endangering life. This could even form the basis of a charge of culpable homicide, but whether such a charge, or any charge at all, would be brought in such circumstances would depend on prosecutorial discretion. It is clear, though, that Scots law is far from settled in this area. In practice, exponents of voluntary euthanasia in Scotland distribute their advice booklet responsibly and have not been faced with prosecution. Even in England, where the law is less opaque on this matter, a book published by an American euthanasia reform society is available in bookshops and has not been the subject of prosecution. Successful prosecution would depend, however, on establishing a clear link between the provision of the advice and the act of suicide; something which might be difficult to establish.

References

1 For an account of this trial, see Devlin P. Easing the passing. London: Bodley Head, 1985
2 &l: The Times 6 November 1981; p 1, 12
3 R. vs Cox Butterworths Medical Law Reports 1992; 12: 38
7 Note 2 supra at p 943
8 For example, such views were expressed in the House of Lords decision in Airedale National Health Service Trust vs Bland. All England Law Reports 1993; 1: 821
10 All England Law Reports 1993; 1: 821
11 The decision in Bland was followed by a further PVS case: Frenchay NHS Health Trust vs S. 1994
12 Auckland Area Health Board vs Attorney-General. New Zealand Law Reports 1993; 1: 235
13 Dominion Law Reports (4th) 1992; 86: 385
14 All England Law Reports 1984; 1: 277