Euthanasia:

where are we now?

Following the recent murder trial of a British GP, *Triple Helix* reviews some headline issues in the worldwide euthanasia debate

In late 1992, after Dr Nigel Cox had been found guilty of attempting to murder a patient in a euthanasia scenario and after the first court ruling that food and fluid could be withdrawn from Tony Bland, the Hillsborough victim in a persistent vegetative state, the UK House of Lords set up an enquiry into euthanasia and related issues. Initially it was expected to favour legal moves towards euthanasia, or at least be divided, but in February 1994 it reported unanimously that 'there should be no change in the law to permit euthanasia'.[1] What has happened since then?

The Dr Moor case

Although the case came to trial this April, the story began in July 1997. Dr Michael Irwin, Chairman of the Voluntary Euthanasia Society, former GP and former medical director of the United Nations, made the front page of *The Sunday Times* under the heading 'Doctor admits killing 50 people'.[2] The same day an enterprising reporter in the north east asked local GP and media celebrity David Moor about his views. He too admitted helping patients to die - his claims in subsequent interviews ranging from 100-300 over 30 years - and one of these had been that week.

The police halted a planned cremation, began investigations, and Dr Moor was later charged with the murder of his patient, 85 year old George Liddell, a retired ambulanceman who had undergone surgery for bowel cancer. At the committal hearing in September 1998 the 'Friends of Dr Moor' with the support of the Voluntary Euthanasia Society hired a six piece Dixieland jazz band to perform outside the court: 'We wanted Dr Moor to be uplifted by what he saw'.[3]

The murder trial began in Newcastle this April. The prosecution alleged intentional killing with diamorphine and said of Dr Moor 'By all accounts he was a dedicated, caring and hard-working GP and well-liked. But no man, whatever his station in life or private views, is above the law'.[4] Dr Moor's defence in court was that his only intention had been to relieve Mr Liddell's suffering, a statement under oath inconsistent with his many claims in live interviews in July 1997 about ending patients' lives.

For a guilty verdict, two criteria had to be proved: Dr Moor's use of diamorphine had to have caused Mr Liddell's death, and he had to have intended that. The acquittal was largely because the prosecution failed to prove the facts of the cause of death, the judge late in the trial ordering the jury to ignore much of the toxicological evidence. This meant that the second aspect of the charge, Dr Moor's real intention, perhaps received less scrutiny. After 18 days the jury of eight women and four men took just 69 minutes to clear the 52 year old doctor.

Much of the media coverage that day and the next predictably called for changes in the law so doctors should not have to practise in fear of prosecution, but in the days to follow more reflective comment recognised the value of the present ethical

and legal position. Jeremy Laurance, the respected health correspondent of *The Independent*, wrote[5] reversing the paper's line of the previous day:

'Easing the passing of those at the end of their lives demands skill as well as sensitivity. Opponents of the present law, based on the double effect doctrine, claim it leaves doctors vulnerable and confused about what is permissible. But it does not. The intention to relieve suffering is clearly distinct from the intention to kill. The doctrine of double effect has the virtue of allowing doctors to bring life to a peaceful and dignified end without jeopardising the patients' trust. It may not be the ideal option - no law can accommodate every eventuality - but it is the least worst. No other country has shown conclusively that there is a better way.'

Whatever Dr Moor really intended, Melanie Phillips[6] recognised that 'By acquitting him, the jury effectively upheld "double effect" and the crucial legal principle that intention is what matters', and went on the offensive against the Voluntary Euthanasia Society:

'So the VES now faces two ways at once. Far be it for the cynical observer to suggest that having championed Moor as a possible martyr to the cause, the VES now finds itself stuck on the fact that his acquittal has upheld the very doctrine it has tried so hard to destroy.'

Triple Helix has already covered intention in an editorial[7] and explored some of its Christian dimensions. In terms of short-term propaganda we were bound to lose whichever way the Moor verdict went; in terms of professional and public understandings in the medium and long-term, the case has been helpful in endorsing this key ethical principle. We now need to put that principle into practice, honestly and openly, and we need to give better palliative care than Dr Moor did.

Physician assisted suicide

Because worldwide the euthanasia lobby is losing the battle for lethal injection euthanasia, there has been a marked shift of tactics towards physician assisted suicide (PAS). Most people can see no morally significant difference between the two, but some say they can. Perhaps they could tell us what that difference is?

The British Medical Association is currently committed to holding a conference 'to establish a consensus' on PAS and has to announce the arrangements for that conference at this July's Annual Representative Meeting. At its ARM in 1997 it 'overwhelmingly' rejected voluntary euthanasia. (Perhaps Michael Irwin's *Sunday Times* headlines a week or so later were a consequence of that decision?) It is unlikely the BMA can be persuaded to endorse PAS, but the arrangements for that conference are clearly of great significance . . .

PAS was of course what the citizens of the US State of Oregon voted for in 1994 when earlier referenda on voluntary euthanasia had failed in Washington (1991) and California (1992). The Oregon decision was put on the back burner for a while by an Appeal to the US Supreme Court, which in June 1997 decided unanimously (much against expectation) that US citizens do not have a constitutional right to physician assisted suicide.[8] And this in the most rights-based society in the world! Ironically that ruling had the effect of putting the decision back to the State of Oregon. In November 1997 its citizens voted 60-40 for PAS, and despite some further challenges, a double figure number of patients have now been helped to die under the new law.

Elsewhere in the USA, maverick Michigan pathologist Jack Kevorkian - 'Dr Death' - finally went too far when a video of him giving a lethal injection was shown on nationwide television. Whereas he had got off repeatedly before on assisting suicide charges this time he was found guilty in March 1999 of second degree murder and sentenced to 10-25 years in prison.[9]

It is arguable that Dr Philip Nitschke practised something between euthanasia and PAS under the Northern Territory of Australia's short-lived Rights of the Terminally Ill Act (in force between July 1996 and March 1997 when it was overturned by the Federal Senate). He connected seven patients up to a computer controlled pump that sent a lethal cocktail of drugs intravenously, but the patients themselves pressed the space bar three times in answer to on-screen questions to start the infusion. A critical *Lancet* review[10] of his cases emphasises disagreements about prognosis and the difficulty of assessing the effects of depression.

Withholding and withdrawing treatment

Although the practice of good healthcare means it may be perfectly proper not to start treatments, or to withdraw treatments which have been started if for example the burden of them comes to outweigh the benefit, the whole issue of withholding and withdrawing treatment can be related to the euthanasia debate if there is any suspicion of intention to kill.

A 51 year old British GP who withdrew a high protein food supplement from an elderly stroke patient (who died 58 days later weighing just 24.5 kg) escaped criminal charges but was found guilty this year by the General Medical Council of serious professional misconduct and suspended from the Register for six months.[11] (Like Dr Moor he too has retired from practice.)

This January *The Times*[12] ran a number of articles alleging that withholding food and fluids without court sanction from patients who were not at the ends of their natural lives had caused the deaths of at least 50 patients in five hospitals in Derby, Surrey, Kent and Sussex. Police and health officials are still investigating. Whilst probably some of those claims will turn out to be describing acceptable practice but poor communication with families and staff, the suspicion remains that in some there will have been an intention to kill.

In the light of these and (perhaps) other cases, in autumn 1998 the British Medical Association held a wide-ranging public consultation about withholding and withdrawing treatment. Its Report is expected this July. Christians have argued[13] we must all recognise that life has a natural end, but we continue to prohibit unnatural ends. They also expressed concern that rigid guidelines were not the answer, but rather there were time-honoured principles such as 'no intentional killing' which set

the boundaries within which the difficult and sensitive decisions can be taken in each individual case.

Mental Incapacity

Advance directives (advance statements, advance refusals, living wills) are statements people make while they are mentally competent about the treatments they would like to receive and the treatments they would not like to receive should they ever lose competence and be unable to express their wishes. They can be useful general indicators of patients' feelings but those opposed to euthanasia have argued they should not have the further force of statute law.[14,15]

If implemented too rigidly they can force doctors and nurses to practise with one hand tied behind their backs. If they seek to enshrine suicidal intention in law this could be a backdoor approach into legally sanctioned euthanasia. One of the most widely acccepted definitions of euthanasia ('the intentional killing by act or omission of a person whose life is felt not to be worth living'[16]) makes clear that patients can be intentionally killed by omissions as well as by positive acts.

The UK Law Commission held a series of consultations in the early 1990s on legal and medical aspects of mental incapacity, which led to draft legislation within a consultation document from the Lord Chancellor's Department[17]. There was widespread concern about backdoor euthanasia within the health aspects of the proposals and so far they have not appeared in Parliament as potential legislation.

On the other hand, of course, patients with mental incapacity do pose significant ethical and legal problems and deserve the very best care. British law dealing with these areas is patchwork and in need of modernisation and much that is uncontroversial in the proposals does need to be enacted.

Conclusion

There are many other euthanasia-related issues which cannot be covered in this brief five year review of the headlines. How novel, for example, to see no reference to the Netherlands! What is clear is that throughout the second half of the 1990s there has been increasing international recognition by the professions and by policymakers that euthanasia is fundamentally wrong, is unnecessary, and cannot be policed.

But even if the front door is safely closed that leaves issues like physician assisted suicide, withholding and withdrawing treatments, and matters related to mental incapacity as potential back door approaches.

We have done well in the 1990s but as long as patients have bad deaths there will be pressures for euthanasia. Let's leave behind all thoughts of intentional killing by act or omission and go forward into the next millennium committed to practising high quality palliative care. That way may appear costly - but the alternative will cost us all far more.

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