Minutes of evidence taken before the Select Committee on Medical Ethics.

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HOUSE OF LORDS SESSION 1992–93

MINUTES OF EVIDENCE
TAKEN BEFORE THE

SELECT COMMITTEE ON MEDICAL ETHICS

Tuesday 20 April 1993

DEPARTMENT OF HEALTH

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TUESDAY 20 APRIL 1993

Present:

Colwyn, L.	Mishcon, L.
Flather, B.	Mustill, L.
Hampton, L.	Rawlinson of Ewell, L.
Llewelyn-Davies of Hastoe, B.	Walton of Detchant, L. (Chairman)
McColl of Dulwich, L.	Warnock, B.
McFarlane of Llandaff, B.	York, Abp.
Meston, L.	

Memorandum by the Department of Health

Introduction

1. The Department of Health welcomes the House of Lords Select Committee's review of this difficult and sensitive area, and offers the following evidence for the Committee's consideration. This paper also represents the views of the Welsh Office and the Scottish Office Home and Health Department.

2. The Committee's remit is to examine the issues surrounding the withholding of life-prolonging treatment, including the subject of euthanasia. Euthanasia, as literally defined, means "an easy death". But the term is commonly used and understood to mean "mercy killing"—the deliberate killing of someone in a terminal condition and usually in severe pain, at his own request "to put him out of his misery".

3. The deliberate taking of life, even to relieve suffering, may be murder or manslaughter. This is a matter for the Home Office, which is responsible for the criminal law. The Home Office will address this in their separate submission.

Department of Health's Interest

4. The primary interest of the Department of Health is in the circumstances in which life-prolonging treatment may be withheld or discontinued. Decisions to withhold or discontinue medical treatment are central to medical practice and are for the clinical staff treating a patient. On occasions the opinion of a Court is sought—as, for example, in the recent case of Anthony Bland.

5. The Department's overriding concern is to:

— protect the interests of patients, and to ensure that health care is provided in a way which is ethical, legal and humane;

— safeguard the patient's right to withhold consent to treatment (the Patient's Charter emphasises the right "to be given a clear explanation of any treatment proposed, including any risks and alternatives, before you decide whether you will agree to the treatment");

— ensure adequate protection is given to people in a vulnerable position—eg those who, by virtue of their medical condition, are unable to exercise their right either to consent to treatment or to withhold consent.

Euthanasia

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

Withdrawal of Treatment

7. The question of whether to withhold or withdraw life-prolonging treatment (including artifical nutrition and fluids) from someone who is not benefiting from it is quite different from euthanasia, although

it raises similar moral and ethical questions. Difficult decisions on whether to persevere with treatment are taken regularly by doctors, in discussion with the rest of the caring team, when their clinical judgment tells them that such treatment is futile.

8. It is a doctor's duty to advise and provide for his patient such treatment as is, in his professional judgment, in the best interests of that patient and which is consistent with a responsible body of medical opinion. But this duty is not an absolute one—it is subject to the patient's own right to self-determination, and in particular it does not include an obligation to seek to preserve the patient's life in all conceivable circumstances.

9. There are two sets of circumstances in which treatment decisions (or non-treatment decisions) might be taken, even though an inevitable consequence may be the shortening of a patient's life.

First, a patient has a fundamental right under common law to withhold consent to treatment—even life-saving or life-prolonging treatment. This assumes he is conscious, competent, and fully informed of the consequences. This right is one of the basic principles of health care. While the doctor must offer his patient such treatment as he judges to be in the patient's best interests, a patient who has the necessary mental capacity and has been properly informed of the nature of his condition and the implications of the treatment proposed is entitled to accept or decline that treatment as he sees fit, even where a decision to decline it may, when viewed objectively, appear irrational. The patient's right to self-determination regarding the treatment he will accept is paramount. Any departure from this basic principle will undermine patient's confidence.

Second, a doctor may conclude, in discussion with the care team and the patient, that a course of treatment (or non-treatment) is in the patient's best interests even though it may result in the shortening of life. For example, it is accepted that doctors will, when faced with a terminally ill patient in severe pain, need to administer sufficient doses of drugs to control the pain, even though an inevitable consequence may be the shortening of the patient's life.

10. The Department believes that the decision to continue or withdraw a treatment, in the patient's best interests, is one which should be taken by doctors (in consultation with the care team) in accordance with principles established by the Courts and such protocols as may be devised by the profession for the purpose. Where such principles have not been sufficiently well established to enable doctors to apply them with confidence in a particular case, the Department believes that an application should be made to the Court.

11. In the case of a patient who is unable to make or communicate a decision, doctors will, in reaching a decision, take account of the views of the patient's nearest relatives or others who have a close relationship with the patient.

Palliative Care and Hospices

12. When it is recognised that a patient's condition no longer responds to curative treatment, palliative treatment and care may be appropriate. Palliative care is active total care provided to a patient when it is recognised that the illness is no longer curable. Palliative care concentrates on the quality of life and on alleviating pain and other distressing symptoms, and is intended neither to hasten nor postpone death. It provides relief from physical pain and other symptoms, and addresses emotional and spiritual needs. It is a patient-centred approach which also provides emotional support to relatives and friends throughout the patient's illness and in bereavement. A fuller description is annexed to this paper.

Advance Directives

13. A person who loses the mental capacity to make decisions is effectively denied the opportunity to participate in decisions about his treatment. He can neither give consent nor withhold it. In recognition of this, some people draw up advance directives, requesting doctors not to administer life-prolonging treatment should they become incapable at some future date and be unable to express their views. This practice is fairly new in this country, though is well established in the United States. (Advance directives cannot, of course, authorise doctors to take positive action to end life.)

14. The Government acknowledges the right of individuals to draw up advance directives. These can be a useful indication of a patient's views, which health professionals will often regard as determinative when deciding on appropriate treatment. Directives are consistent with the Patient's Charter right that a patient may consent (or withold consent) to particular types of treatment.

15. An advance directive cannot require a doctor to provide treatment which is not appropriate to the patient's clinical condition. But a directive asking that treatment be withheld in particular circumstances must usually be complied with should these circumstances arise.

16. The Department shares the medical profession's view that the doctor concerned should remain free to interpret an advance directive in the light of the precise circumstances applying at the time. Where a doctor is satisfied that the circumstances envisaged when the patient drew up the advance directive match

the patient's condition, he should follow the patient's predetermined wishes as set out in the directive. But where the patient's condition does not match the directive, or there are other factors, the doctor ought not to be obliged to withhold treatment.

Medical Treatment (Advanced Directives) Bill

17. Lord Allen of Abbeydale introduced a Private Member's Bill on advance directives (Medical Treatment (Advance Directives) Bill) into the House of Lords on 16 March. The Department are aware that the Committee will be considering it, and await with interest the Committee's view on the matter.

18. The Bill seeks to enable persons to give directions (or arrange for them to be given) to their doctors regarding the withholding or withdrawal of life-sustaining treatment in a terminal condition. It does not seek to make advance directives legally binding on doctors.

19. The Bill contains provisions for immunity from prosecution for people who comply with an advance directive. It also includes provisions for offences and penalties for people who falsify or forge the advance directive of another. This falls within the responsibility of the Home Office.

Termination of Medical Treatment Bill

20. Lord Alport's Termination of Medical Treatment Bill received its First Reading on 25 February, and we understand the Committee will be considering it. The aim of the Bill is to legalise the withdrawal from a patient of medical treatment (including artificial ventilation, nutriment and fluids) in two separate circumstances:

> *Where a person's mental capacity has ceased, and there is no prospect of recovery*. In these circumstances, treatment may be terminated if authorised by two medical practitioners, the person's next of kin and a lawyer.
>
> *Where a person is suffering from a terminal illness and is able to make a rational decision and expresses the wish that treatment be discontinued*. In these circumstances, the decision must be recorded by the person in writing, and two medical practitioners must certify that the person is able to make a rational decision.

21. The Department sees a number of problems with the wording of the Bill. For example, the Bill restricts the right of a patient to refuse treatment. Under common law, any competent person can withhold consent at any time, without the need for a written request or certification by two medical practitioners.

22. The Department believes it essential that there are proper safeguards on the withdrawal of medical treatment from people whose mental capacity has permanently ceased (such as in cases of persistent vegetative state). The decision of the Law Lords in the case of Anthony Bland provided a helpful clarification of the position. The Department would want to look very carefully at the suggestion that further legislation is required and looks forward to the views of the Committee on this issue.

Persistent Vegetative State and Brain Death

23. The first of the circumstances described in the Termination of Medical Treatment Bill (see paragraph 20) will often be associated with the so-called "persistent vegetative state" (PVS). In this condition—which is commonly due to head injury or other trauma—there is no evidence of cognitive functioning ("thinking") but lower biological functions, such as breathing, eye movement, heart function etc are intact, and the patient will exhibit "primitive" responses to external stimulation. Unlike someone in a coma, a PVS patient will be wakeful and often maintaining a cyclical sleep pattern. "Persistent" implies "permanent and irreversible" and hence a period of time of perhaps 12 months is often required to make the diagnosis of PVS with certainty. Anthony Bland was diagnosed as being in PVS. There are no official figures collected on the numbers of PVS cases, but the Department is aware of independent estimates that there are between 300 and 600 new cases—due to head injury or other acute cause—in the United Kingdom each year. (The figure will largely be balanced by deaths of pre-existing PVS cases.)

24. A patient in PVS must also be distinguished from one who has suffered "Cerebral (or Brain) Death", in whom essential biological functions, in particular, breathing, will cease if not artificially maintained.

25. The British Medical Association have issued a consultative paper on PVS. The approach suggested is helpful, but the Department believes the issues involved need much wider discussion by lay and professional bodies.

Departmental Guidance

26. The treatment of individual patients is, of course, for the clinical judgment of the doctor. The Department does not itself draw up guidance for doctors on how to treat particular kinds of patients, or when to stop treating them. Such guidance is primarily a matter for the profession, including the General

Medical Council, the British Medical Association and the Royal Colleges and Faculties. The Department has on occasion circulated and commended the use of particular guidelines drawn up by professional bodies.[1]

27. Administrative control or regulation by the Department is not the appropriate method of approach. It is better that doctors should make the necessary judgments in the light of legal principles laid down by the Courts and in accordance with professional guidance.

Other Countries

28. The Department is aware of initiatives in other countries in the area of advance directives and withdrawal of treatment, and has concluded on the evidence so far that there is nothing which suggests that the United Kingdom should depart from its current approach. However, we will be interested to see the Committee's assessment.

Conclusion

29. The Department of Health:

— rejects euthanasia;

— acknowledges doctors' responsibility to exercise their clinical judgment on whether and when to discontinue medical treatment (in some cases it may be necessary to obtain the opinion of a Court);

— has no objection to advance directives, which are in keeping with the Patient's Charter right of consent to treatment—but would want to look very carefully at any suggestion that there should be legislation in this area;

— believes it essential that there are proper safeguards for withdrawal of treatment from a person whose mental capacity has permanently ceased, but would want to look very carefully at any suggestion that further legislation is required.

30. The Department awaits with interest the Committee's conclusions, and will of course respond to the Committee's report, when published.

HOSPICES AND PALLIATIVE CARE

Background

1. The hospice movement provides specialised palliative care and support for the terminally ill and their families. Services provided, mainly to patients with cancer, include in-patient care, day care, home care, and counselling.

2. Most in-patient hospices are in the private and voluntary sector. Out of 199 hospices operating in 1992–93 with a total of 2,979 beds, just under 500 beds are provided by 38 NHS patient units. There are also 185 day units with 1,857 places, 355 home care teams and 98 hospital support teams.

3. A hospice is a registered nursing home, usually managed by a voluntary organisation, which provides specialist palliative in-patient care for terminally ill people. Terminally ill people are those with an active and progressive disease for which curative treatment is not possible or not appropriate, and whose death can reasonably be expected within 12 months or less.

Government Support

4. In December 1989, Virginia Bottomley, then Minister for Health, announced that £8 million was being allocated to health authorities in England in 1990–91 to enable them to increase the support they gave to hospices and similar organisations. £17 million was allocated in 1991–92, £31.7 million in 1992–93, and £32.326 million has been allocated for 1993–94.

Future Funding

5. From 1994–95, the funding regime will change. The money will be allocated on a recurrent basis and built into health authorities' general allocations. Health authorities will be required to agree service contracts with palliative care providers including the voluntary hospice sector. Funding will follow those contracts.

Supply of Drugs to Hospices

6. In 1991–92 a scheme was introduced to enable hospices to obtain drugs for their in-patients free of charge. Health authorities were allocated £3.2 million to cover the cost of drugs. A further £5.5 million was allocated in 1992–93, when the scheme was extended to cover the free supply of dressings and appliances. The scheme has been generally well received and has been extended for a third year with an allocation of £5.6 million. The scheme will be reviewed during 1993–94.

[1]Criteria on which to base a diagnosis of brain death have been established by the Royal Colleges, and were accepted by a Working party set up by the United Kingdom Health Departments. The Working party published a Code of Practice in February 1983.

Children's Hospices

7. These tend to provide respite care for children with life-threatening conditions rather than palliative care for the terminally ill. A £5 million programme (£1 million a year for five years) to support the development of innovative projects for children with life-threatening conditions was launched in January 1992.

The National Council for Hospices and Specialist Palliative Care Services

8. The National Council for Hospices and Specialist Palliative Care Services was set up in December 1991 to act as a voice for the hospice movement in England, Wales and Northern Ireland (Scotland has its own organisation). The Department of Health sends an observer to Council meetings. The Council has representatives from the main cancer charities, professional associations and regions. British Gas provides most of the Council's funding, and the Chairman of British Gas chairs the Council.

"The Principles and Provision of Palliative Care"

9. A Joint Standing Medical and Standing Nursing and Midwifery Advisory Committee working group on palliative care has produced a report: "The Principles and Provision of Palliative Care", which was published in March 1993.

10. The report:

— commends the patient-centred approach developed by hospices;

— recommends that the principles and good practice which have been stimulated by the voluntary sector should be incorporated at all levels in the NHS;

— endorses the need for partnership and joint planning between NHS purchasers and the voluntary sector; and

— emphasises that the basis of improvement in palliative care and its extension to other service areas is education, including continuing education for nurses and doctors.

11. The NHS Management Executive has asked health authorities to take the report's recommendations into account in commissioning services and developing palliative care strategies for people who are terminally ill, but emphasised that achieving these aims within available resources would be a gradual process.

Education

12. In the past decade, palliative care and pain relief have emerged as specialties in their own right. Post-graduate training is available for doctors intending to practise in these specialties. As palliative medicine is a relatively new medical specialty there are few academic posts and some of these are funded by charities.

13. Most hospices provide education for professionals on palliative care; some community nurse training placements, for instance, are in hospices. Project 2000 (the nurse education scheme) has a number of diploma courses in palliative care and care of the dying. Charities provide education and training for professionals; chiefly the Cancer Relief Macmillan Fund whose specialist nurses provide training and support for community and some hospital nurses, and Marie Curie Cancer Care who run a number of very well-respected courses.

Examination of witnesses

Dr J S Metters, Deputy Chief Medical Officer, Mr P Gibbons, Principal Nursing Officer, Mr P K J Thompson, Solicitor, Miss R D B Pease, Under Secretary Policy Division, and Mr P G Smith, Principal Policy Division, Department of Health, called in and examined.

Chairman

1. Good afternoon, and thank you for coming. If, at the end of the afternoon, there are items which relate to your written evidence which you feel may not have been covered in the questions or discussion, please feel free to write in with any supplementary comments, if you should wish to do so. Could I ask you to introduce yourselves briefly, say what you do, what your responsibilities are, and then if you wish to make a brief opening statement relating to your written evidence.

(Dr Metters) Thank you, my Lord Chairman. The Department are very grateful for this opportunity to discuss this important subject with your Committee. If I may introduce the Department's team. Mr Peter Thompson, on my right, is the Solicitor for the Department of Health and also for the Department of Social Security; on my left is Miss Dora Pease, the Under Secretary of the Health Care Division, with responsibility, among other things, for ethical matters; on my extreme right is Mr Paul Gibbons, Principal Nursing Officer with responsibility for hospital nursing policy and ethical matters; and, on my extreme left, Mr Peter Smith, the Principal responsible for this particular area; and I am Dr Jeremy Metters, Deputy Chief Medical Officer, and I have ethical matters among other responsibilities. You

[Chairman *Contd*]

asked if we might introduce the paper. A brief introduction only, because it does follow through fairly logically. The focus is very much on the circumstances in which life-prolonging treatment might be withheld or discontinued. That is to be found in paragraph 4 of the paper. Our concerns centre on three points, which come out in the paper: firstly, the protection of the interests of patients; secondly, safeguarding the patient's right to withhold consent to treatment, exemplified in the Patient's Charter (and that is at point 5); and, thirdly, the proper protection of people who are in no position to look after their own interests. We believe these three issues are quite fundamental, and that they are not compatible with euthanasia. The rest of our paper follows on from the three concerns I have mentioned.

2. You say, of course, that a patient is entitled to decline treatment, even where such a decision appears irrational. Of course, the advice that is now given to members of the medical profession is that the days of "doctor's orders" are long past, and that the present situation is one of partnership between the doctor and patient, where the doctor may advise but it is up to the patient to decide whether to accept that advice. What safeguard is there against such a decision being regarded as a sign of unsoundness of mind, and therefore incompetence to decide?

(Dr Metters) In the Department's view the patient's express wishes must be determinative, and should not be overridden. Clearly, there are powers of compulsory treatment under the Mental Health Act but those are in relation to treatment for mental disorders, and not for treatment of physical disorders. While the patient may, to the doctors and other members of the health care team, appear to be taking a perverse decision against his own best interests, and they may feel that he has a mental disorder which has led him to the position that they may seek powers under the Mental Health Act for the treatment of mental disorder, that does not give them the right or the justification to proceed to any form of treatment for the physical disorder.

Lord Mishcon

3. Might I pursue this a little further, because of course there is a situation that can easily develop where the patient, whilst not certifiable (if I can use that shorthand expression) under the Mental Health Act, is obviously confused and unable really to make a correct decision but keeps on mumbling, "No, doctor, don't touch me". What is the doctor's power or duty in a case of that kind, which would be very common especially amongst people who are very, very ill?

(Dr Metters) I think, my Lord, the doctor's duty is to act in the best interests of his patient as he perceives it. If he believes that the patient does not understand or comprehend what is being proposed for him the first action must be to seek a second opinion of another doctor and see whether he would agree with the first doctor that the patient is confused and does not understand the nature of what is being proposed. If they then agree that the patient should probably be following some form of treatment that he is refusing, then we are into the case of dealing with a patient who is unable to think or speak for themselves. At that point all members of the care team—doctors, nurses, and particularly the relatives—must be brought into the discussion, and at the end there must be a conclusion as to what a reasonable multidisciplinary team, including the patient's relatives, believe is in the best interest of the patient. One is dealing with a situation where the patient is unable to speak coherently for themselves, but a decision has to be taken whether they fully understand or they do not fully understand. I do not know whether Mr Thompson would wish to join in.

(Mr Thompson) I would only add that I am sure Lord Mishcon would be aware of similar problems when clients want to have a will made, or they have made a will and want to change it, and there are difficulties in deciding whether there is sufficient competence or capacity to rely on those instructions, or whether there is not. It seems to me it is analogous here with the position of the doctor who is not getting straight, coherent instructions from the patient and has, therefore, to make some kind of value judgment of his own as to how to proceed.

Baroness Warnock

4. The answer to the Chairman's question, which was what safeguard is there against such an irrational decision being regarded as unsoundness of mind, is really the obligation to get a second opinion, is that correct?

(Dr Metters) I think if there is any doubt the doctor must seek a second opinion. He must also take advice from those who know the patient and know the patient well because, after all, the patient may have said exactly the same thing years ago when they were entirely in control of their faculties and repeating what is a long standing view in which case a different outcome may result from the patient who has given no previous advice.

Lord Mishcon] I am most grateful for the clarification. I did feel the first answer to the question, which was very courteously given, should not be limited to when the position is resolved by the Mental Health Act or there is no other answer. We now know where we stand.

Chairman

5. You acknowledge that euthanasia, as the term is generally understood, and the withholding of life-prolonging treatment raise similar moral and ethical questions but you emphasise the distinction between the two. On what grounds do you base that distinction? I think it would be important just to clarify what you mean in your evidence by euthanasia.

(Mr Thompson) Oh dear, I thought the question was going to be rather different. Well, it is the taking of life.

6. Yes.

(Mr Thompson) And the contrast that we see is

[Chairman *Contd*]

between the taking of life and the withdrawal of treatment. The law relating to this distinction has been well explored recently in the case of Tony Bland and we feel, in the Department, that the position has been greatly clarified by the judgments in that case. Firstly in the narrow situation of a patient in a persistent vegetative state for whom no therapeutic treatment can be devised in which the law is now clearly stated that there is no duty to continue that treatment and indeed it may be that it would be wrong to continue that treatment. Then the other area which of course was not directly for decision in the *Bland* case which my colleague, Dr Metters, will address, which is the very much more difficult case where therapeutic treatment is available but there is a difficult balancing exercise to be performed in weighing what is in the best interests of the patient where treatment and non treatment have to be weighed against each other.

7. Before Dr Metters follows that up, may I ask you for clarification on two points? First, may I assume from what you said relating to the *Bland* case that you in the Department accept that under certain circumstances tube feeding, for example, is to be construed as medical treatment? The second question is whether you see a difference in law between the withdrawal of treatment once having been started and the withholding of treatment not having been begun?

(Mr Thompson) I think in the PVS context we stand with the decision in that case that there is no distinction between feeding, tube feeding or any other kind of invasive procedure. The question is whether one is entitled to continue with an invasive procedure which does not have any therapeutic effect or value. Therefore, whether the treatment has begun and must be stopped or whether the question is whether it should be begun, the answer is the same: if, as their Lordships there held, there is not a duty to provide or continue such treatment then it should not be provided.

Lord Mustill] Lord Chairman, if I might just press on question one a little, not in terms of what the law is because one of the matters for the Committee is whether it should be different or we should advise Parliament it should be different. I do not think anybody thinks the law is very satisfactory. Let me press the ethical issue: take a situation of a patient who is incapable of making a reasoned decision and everyone else concerned—medically, and the family—agreed it is for the best a patient should die sooner rather than later—and I put "for the best" in quotation marks because there is an enormous number of questions involved in that—let us assume that is a decision honestly made. They conclude on a course of action which is intended to produce the result that he or she does die sooner rather than later and they engage on that course of action and the patient does die sooner rather than later. It is the intention that death should be brought about and it is brought about. What I so far cannot grasp is the ethical distinction between the case where the course of action involved doing something and the case where the course of action involved stopping doing something. I concede there is a number of distinctions but it is the ethical distinction I am concerned with for the moment.

Baroness Warnock

8. My difficulty with paragraphs six and seven in the paper you have prepared for us was there seemed to be an assumption lying behind that that there is a difference between cause of death which seems to be doing something and allowing a patient to die by withdrawing something. I simply cannot grasp the moral distinction between these two things. This is really what I find very puzzling.

(Mr Thompson) I would prefer to look at it purely on the legal ground and this avoids the issue.

9. If I may, the legal question must also have an ethical background, it seems to me. We are here to consider whether the law needs changing in any respect and if it does need changing it does so partly because of its present obscurity and partly because the moral issues are not really addressed by the present laws. That is what I understand our duties to be. I do not think it is possible to say we had better start with the law.

(Dr Metters) If one goes back to the most ancient text on this subject it includes the phrase—roughly interpreted—"above all do no harm". If one moves from that point to the situation the noble Lord describes, clearly if one is continuing a treatment which is going to prolong life in circumstances and where all involved in the care of the patient, including relatives, believe it is not in the patient's interest then one is doing harm. So, the ethical consequence should be that the treatment is stopped if it is doing harm.

Lord Mustill

10. May I take that up. I think one has to be blunt about it. Let us get away from Anthony Bland. The removal of nutrition and hydration is not always the most pleasant way to die, there are means of palliating it. If you conclude harm is being done by continuing the treatment and keeping the patient alive then the least harmful thing you can do is to administer a lethal injection.

(Dr Metters) That has logic to it.

Chairman

11. The withdrawal of treatment which no longer serves any therapeutic purpose may result in a situation where allowing death to take place is less quick and humane than taking action to bring death about. Some might suggest that the latter course would be preferable. Would you like to amplify what the view of the Department might be?

(Dr Metters) I think Mr Thompson has already made plain what the legal position is.

12. Yes.

(Dr Metters) The primary aim must be that treatment should prevent pain and distress. The doctor will not withdraw treatment if he is going to cause

[Chairman *Contd*]

extreme pain and distress. To take positive action conflicts with the principle that I referred to from the Hippocratic oath "above all do no harm". The logic stemming from the Hippocratic oath is if, by whatever action, you are continuing a course of treatment that does harm, ethically this is not in accord with the basic principle which is more than 2,000 years old. That is not at the moment compatible with the legal position regarding the deliberate ending of life.

Baroness Flather] I am struggling. It seems to me that actually doing something positive to end someone's life may be doing less harm, even in your terms, at a given moment rather than doing nothing. That, I think, is what has been pursued in a way, that if it is just omission of something which will take time to have effect and during that time, whilst it is taking effect, the patient is not in a particularly happy state then doing something—although it is a positive act which is not allowed by law—may be doing less harm.

Chairman] I can see the problem very clearly. I am sure that one of the things we shall be struggling with at the end of the day is an attempt to try to equate the moral dimension on the one hand with legal requirements on the other.

Lord Rawlinson of Ewell

13. You can kill someone just as much by starving them as shooting them, it would still be murder. Leaving aside the medical circumstances, it would still be murder. What I would like to know is, when you say you accept the *Bland* decision, what do you understand by it? Has this been a problem which has arisen prior to the last few months that has caused the Department considerable anxiety, or not?

(Mr Thompson) As to the first point, what we understand *Bland* to have decided is that the doctor or the hospital, or whoever has care of the patient, is not under a duty to continue with treatment, indeed it would be unlawful to continue with the treatment, because the treatment is not what the patient requires. It has no therapeutic effect, and there is no consent to the continuing of that treatment.

14. They can do that on their own decision?

(Mr Thompson) The courts have said that these are difficult cases which the courts should give a ruling on.

Chairman

15. Every individual case in a similar situation, as the law stands, would have to be referred to the court for a decision?

(Mr Thompson) I think the precedent indicated that as soon as the Courts had seen the full measure of these kinds of cases and felt sufficiently confident, they would say that they did not wish to have cases that were on all fours with *Bland* brought before them; but, naturally, cases at the margins, or where there were particular difficulties, they would expect to be brought. That seems to be a way forward which would be helpful to the public and to the medical profession.

(Dr Metters) I think the answer to the noble Lord's question is that the persistent vegetative state has not been a major issue for the Department. There was some years ago much greater concern about cases of cerebral or brain death, on which guidance was issued. At that time there was no great interest in the much more difficult condition of the persistent vegetative state.

16. You, as a Department, would stand by the guidance given by the Joint Committee of the Royal Colleges about the definition of brain death, which effectively in law is death?

(Dr Metters) Absolutely.

Lord Mishcon

17. Could I revert to the distinction between the lethal injection and the withholding of treatment, both of them causing death, with the lethal injection possibly being the kindlier thing to the patient as the doctor might think. Is not the distinction that in the case of the lethal injection you are deliberately taking life, albeit for the benefit, as you think, of the patient, and the withdrawal of treatment is not that allowing life to be taken away but not by you as the principal actor? Is there not that distinction?

(Mr Thompson) There is, but I do not know whether Baroness Warnock is going to say that that is conclusive of the matter. To me it would not be the distinction I as a lawyer would put the weight on. I would put the weight on whether there is a duty on the doctor or the hospital to abstain from, in one case, continuing treatment and, in the other case, administering a lethal dose.

Lord Mishcon] I am sorry, I possibly did not make myself clear. I thought the question we were trying to solve was this: if everything is for the benefit of the patient, what really is the ethical distinction—is there one—between administering a lethal injection, namely, a deliberate act, or the omission of treatment which is an omission which causes the same end but possibly leads to a lingering death instead of an immediate one? I thought we were trying to address the ethical and moral distinction, if there is one, between the two. I suggested that there may be the distinction that in one case you, as an individual human being, albeit with the benefit of a second opinion or a third opinion, are actually causing a death with intent to do so; and in the other case you are allowing death to occur, however you are doing it, in the best possible sense. Is there not that distinction?

Baroness Warnock] Just to make that clear, I personally believe that people do make that distinction. It is a bit of harmful mythology and should not be made. If you take an example of a crime where the intention is bad I personally cannot see the difference between administering a quick death, maybe poison or stabbing but you do something to take away the life of a person and, on the other hand, withdrawing some substance, some drug, without

which they cannot live. You would know in both cases they are going to come to the same conclusion and would intend to murder your victim. In one case you murder by stabbing or strangulation and in the other you murder him by withdrawing his supportive and sole supportive drug. In each case I think your motive would be the same—the outcome would be the same—and I cannot for the life of me see any moral difference between stabbing him and not allowing him to have the drug without which his life ebbs away.

Chairman] I think that was the point I was trying to make about the incompatibility between the moral dimension, where the intent is the same but the method is different, on the one hand, and the legal position on the other, where there is a clear distinction between the positive act and the withholding.

Lord Colwyn

18. I think my question follows on from that. From your paragraph 6 it is very clear that you say euthanasia cannot be accepted, and you require that an essential distinction is made between euthanasia and the withholding or withdrawing of treatment, but are you clear when palliative treatment for such a patient could possibly become euthanasia? Is that distinction clear to you, because it is not clear to me? I wondered if this was something that generally goes on in general practice and in hospital. I would also like to hear from the nursing officer on this, whether that is a problem on his side—where palliative treatment can become euthanasia, and how one makes the distinction between the two?

(Dr Metters) No, my Lord, it is not a clear distinction at all. In effect, the giving of some powerful pain relieving drugs may have the dual effect of relieving the pain that is absolutely necessary for the patient's condition and also hastening the patient's end. That is well recognised and something the doctor would want to talk to other members of the care team about also with the patient's relatives and with the patient if the patient so wishes and is able to understand. There is a dual effect here. Whether the giving of large quantities of opiates would be regarded as euthanasia I think is open to interpretation but you cannot say that there is a nice white and black dividing line, there is a very large area of grey in which doctors and nurses sadly have to operate very frequently. I am sure Mr Gibbons will want to say something about this.

(Mr Gibbons) I think Dr Metters is absolutely right, we are working in a very grey area here but I think there are so many developments of late in palliative care and pain control that with adequate titration of those powerful drugs against the pain level of the individual it is possible to administer sufficient of the drug to relieve the pain without any of the other side effects.

Chairman] It seems to be clear that in law as it stands, even though it may not have been precisely defined, that if you give to a patient, as happened in a recent notable case, a substance intravenously which could have no other effect than to terminate life that is murder, or attempted murder as was found in that case. If, however, you give a dose of an analgesic drug such as an opiate intended to relieve the pain and that has the secondary effect of terminating life, it may have the same effect in the end but the intention is different. That appears in law to be an important distinction, though it may not be as clear a moral distinction as was mentioned earlier by Baroness Warnock.

Lord McColl of Dulwich

19. Going back to this distinction between not treating a naturally occurring lethal complication and the other actively killing off the patient, do you think we should consider the feelings of the one million health care workers, especially the nurses, who are presented with this problem and presented with the problem of giving them a lethal injection? Do you think from the ethical, moral, legal point of view that their views and feelings should be considered?

(Mr Gibbons) I think they must be very carefully considered. I think where good team working is in place this happens and is dealt with very satisfactorily. I think in areas where team working is not of the standard we would all wish to see there can be problems but overall they are in the minority and I think it is important when we do consider these questions the whole of the care team are involved along with the patient's relatives and others who are close to that patient.

20. That is an answer to a question I have not asked actually. I agree with you entirely that is what we should do, what I was asking was if you introduce legislation which brings in euthanasia—that is what we are talking about—are the views of the nurses not rather important as they are the people who are going to have to administer the lethal dose?

(Mr Gibbons) Absolutely critical and yes those views are taken on board.

(Dr Metters) If I may, Chairman, I think it would clearly be for decision as to who should have to administer the lethal dose but I believe a fundamental principle—and I agree entirely with Mr Gibbons—that with well ordered wards there is no difference between what the doctor advises and the nurse administers. Whatever treatment is given, this is particularly relevant to large doses of pain relief, the doctor must be prepared to give what he has prescribed rather than leave it to the nurse, the more so if the nurse or anyone else is concerned that the dual effect might result in the patient's death rather than relief of the pain. It is entirely wrong for the doctor to abrogate that responsibility to anybody else.

Chairman] We are taking evidence from people with a very wide range of views and will eventually come to conclusions. We should note here one thing which has come over very loud and clear which is that all decisions of this nature must be the subject of the most extensive consultation by all members

of the health care team including the patient, if competent, and also the patient's family.

Archbishop of York] I want to express a concern and then ask a question which will take us off in a different direction. I was concerned that, when asked what you meant by euthanasia you went straight to the *Bland* case as having clarified some of the issues whereas I thought precisely the issue there was it was not to be interpreted as euthanasia at all and that indeed there is a whole range of other questions when you are with PVS, not least the question about the nature of death. I wondered whether you would be prepared to reconsider your answer about the definition of euthanasia? I then want to take you off in a different direction, this is about the resources for palliative care and what gap you see between the resources now and the resources that ought to be available and what sort of timescale you envisage before appropriate palliative care is available to all who need it?

Chairman

21. You gave us in your document some helpful statistical information about financial support for the hospice movement. The question which follows from what has been said is how fully does the present hospice movement meet the demands and how far do you see there being a need for additional resources and additional hospice beds to be provided?

(Miss Pease) Hospices have a most important part to play. Although palliative care has always been part of medical and nursing treatment in the recent years we have seen what you might call specialised palliative care. We have referred to this in paragraph 12 of our written evidence and in the annex and you can see, as you have said my Lord, the increase in the money that has been given to the hospice movement from 1991 through to 1993/1994 together with money for the supply of drugs and dressings, money for research and innovative action. From next year it will be channelled through health authorities in the purchaser-provider contracts. Health authorities will have to agree contracts for palliative care for their population. It is the duty of health authorities to assess the health needs of their population and to make provision accordingly. The question about how great is the need is essentially a local one. The hospice movement is, I understand, patchy geographically. What the feeling in my colleagues who deal with this is, is that the development that one now wants most to see is in home care, outreach care rather than hospice beds themselves and a spread of this.

Chairman] I regret that it is necessary—and I hope you will forgive us—to adjourn the meeting temporarily.

The Committee suspended from 4.59 p.m. to 5.07 p.m. for a division in the House.

Chairman

22. I am terribly sorry, you were in mid-sentence. We heard you say that the hospice movement is rather unevenly distributed throughout the country. Clearly, there are efforts being made to correct this all the time by voluntary organisations, no doubt in collaboration with the Department. What are you doing to encourage the extension of the movement more widely?

(Miss Pease) I was explaining that, concentrating on the numbers of in-patient beds, we have gone beyond that stage. The movement and the needs of the patients for palliative care have gone beyond that. What we are wanting to develop now much more is out-reach, people receiving palliative care in their own homes. This is something we are very keen indeed to develop. The other aspect that we would wish to develop is for generalist staff, particularly in the acute hospital sector, to be aware of what is possible with palliative care, and for GPs to be more aware of what can be done with palliative care and how it can be applied. We think that there are enough consultants and doctors coming up through the junior grades who are specialists in palliative care. What is now needed much more, and something we would like to pay more attention to is the development of a general awareness of what can be done among colleagues in the profession. We referred in the Department's written evidence to the joint report of the Standing Medical Advisory Committee and the Standing Nursing and Midwifery Advisory Committee on the principles and provision of palliative care which was published a few weeks ago. These are groups which were serviced by the Department and people in the NHS, and my colleague assures me that we could let the Committee have copies if this is what the Committee would like.

23. We would be very grateful.

(Miss Pease) It sets out the latest thinking on this topic. It has been commended and sent out to all health authorities by the NHS Management Executive who have made it a priority for health authorities to agree service contracts for specialised palliative care services for 1994/95 and beyond.

Archbishop of York

24. Could I just press this and ask, what are the resource implications of this policy?

(Miss Pease) For educating staff in the fact there is such a thing as palliative care, and that palliative care services are available. That is, I think, a minimal education resource. The sort of money that we have been giving in this financial year, which I think is something like £32m, we would envisage being continued, but it is not specifically ring-fenced. We shall certainly monitor what has happened to hospice beds; what has happened to out-reach teams which are set up; what has happened to GP teams; and take back to ministers what we have found in monitoring what is going on.

Lord Mustill] In the information about hospice treatment and the funds being made available, it is most interesting and helpful. I wonder if one could look at the costs of treating people, say, in a persistent vegetative stage. Tony Bland was being nursed in a general hospital and if the figures we were

given during that case are at all right (and there is no reason to doubt them) the cost of doing that for all the PVS patients (and they are only one category of the sort of people the Committee is looking at) dwarfs the figures that you have put in as being made available to hospices. It is an unpleasant fact but it has to be faced that for every patient who is being nursed in those circumstances somebody else is not. That was a speech, not a question, but could I turn it into a question by inviting a comment.

Baroness McFarlane of Llandaff

25. This means that, of course, the PVS patient is being treated, by and large, in a high-tech situation?

(Dr Metters) No.

(Miss Pease) If I can make the general point that, in our view and in the Department's view, resource allocation has no part to play in decisions affecting the stopping of life-prolonging treatment, because they have to be jointly agreed by the patient, if able to discuss, by those close to the patient, the care team and the doctor. There is no question of withholding effective treatment for financial reasons. If I can go to the *Bland* case, I am afraid I am not quite certain what figures you have seen. The figures we have got are that for the type of PVS case such as Tony Bland it would be in the order of £25,000 a year for care. It is relatively low-tech, and is not in fact high-tech, but feeding, nursing care, the handling of pressure sores, excrement and that sort of thing.

Lord Mustill

26. What I really had in mind was not so much that you should think, "This is an expensive business, so let the patient die", but the fact is that there is only so much to go round. What I have to ask is this: are the strategical implications of the rapidly improving methods of life support under consideration?

(Miss Pease) Yes, we keep them under consideration, but they are not something that we think should affect the decision at the moment. If one takes it that there are something like a thousand or 1,200 patients in PVS, that amounts to only £30m a year, which is 0.1 per cent. of the budget. I think one would be much more worried about the rightness of continuing treatment which was not needed and which was, therefore, questionably wrong.

Lord Meston

27. I am not quite clear what you envisage happening in the future in practical terms if things stay as they are, if the law remains as it is, clarified as it has been by the *Bland* case and no doubt enhanced by further and better guidelines? I got the impression you were suggesting future cases would not have to go before the courts on a case by case basis. I wonder whether in fact that is correct bearing in mind, as was said in the *Bland* case, that was an extreme case and there may well be—inevitably will be—less extreme cases. Is it not inevitable these cases will one by one have to go before the courts if decisions are to be made to end life if only for the protection of the medical and nursing team involved?

(Mr Thompson) You may be right, my Lord. We take the view offered by the President and the Master of the Rolls that as public understanding of the factual and medical issues came to be improved then it would not necessitate a full dress hearing, and appeal up to the House of Lords, and matters would be disposed of more expeditiously; the President would in due course indicate that in these kinds of cases it would not be necessary to come to the court because the law had been sufficiently discussed, ventilated, analysed and made clear to the world so that there was not an issue to bring back to the court. Maybe that was over-optimistic and we await, of course, the report of this Committee and other contributions to the public debate but when I indicated that we hoped to move to a time not every case was brought to the court, it was on the basis that the view of the judges in the *Bland* case was that there would come a time when not every such case was brought.

28. I can see streamlined procedures evolving. I think that happens in sterilisation cases and they would not always go all the way to the House of Lords. Is it not inevitable though that doctors and nurses would want protection, at least a declaration at first instance?

(Mr Thompson) I may be wrong but the narrow basis of the decision in the *Bland* case was quite simply that if the only treatment which can be offered has no therapeutic purpose, it is therapeutically futile, then as a matter of law there is no duty to provide it. That was laid down as a general legal principle and it was, it seemed to me, open to the courts to leave it there and let the doctors get on with the business of applying it. They did indicate, however, because it was an area of such public concern that it would be appropriate for such cases to be brought before the courts as a matter of reassuring the public as well as educating the medical profession.

Chairman

29. Yet the question as to whether the law is in need of change or modification is one of the reasons why this Committee is in existence.

(Dr Metters) Indeed.

Baroness Llewelyn-Davies of Hastoe

30. Mine is not a question of great principle, it is a practical one. Everybody I think on the Committee wants to see the hospice movement spreading and being more used but I worry about the home care side, if the Minister's policy is very much "put it out into the home". I do not understand the practicality of that. Who is going to look after the patient? We all know how busy district nurses are and equally how GPs really cannot fit in their home visits. Who is going to be with the patient, monitoring them, how will they administer that?

(Dr Metters) I think there may be a misunderstanding here. We were not suggesting cases of persistent vegetative state——

[Baroness Llewelyn-Davies of Hastoe *Contd*]

31. I am not talking about that.

(Dr Metters) There are far greater numbers of patients with terminal cancer who do need care at home. They can be cared for at home. If I may respond to the question about resources which the Archbishop raised, there is a resource issue regarding the education of doctors and nurses in modern methods of palliative care. Those emerging from medical school know of modern techniques which were not available when I was at medical school. There is a large number of doctors practising of my age who need to be updated about what is now possible. Your point about this requiring skilled care is very well taken, it is not something which can be done by sending district nurses in once a day, it requires a lot of careful planning and above all the principle of keeping the patient comfortable because above all if you keep pain away there are far fewer problems than if pain occurs and you have to increase the dose of the analgesic. There is a major issue to be resolved there.

Chairman] We could obviously have gone on talking for a long time. May I ask you to look at our questions after today's hearing and to let us know any points we have not covered, in particular in relation to decision-making processes, proxy decision makers, etc., upon which you may wish to elaborate at a later stage. We look forward to hearing further from you and we thank you for coming along and answering our questions.

Supplementary Memorandum by the Department of Health

1. *You acknowledge that euthanasia and the withholding of life-prolonging treatment raise similar moral and ethical questions, but emphasise the distiction between the two (paragraphs 6 and 7). On what grounds do you base the distinction?*

No ethical framework can tell one where to draw the line, only help one to judge where it should be drawn. The intentional taking of life is murder, even if there is a merciful motive. But it is entirely legitimate to withdraw treatment that is having no beneficial effect for a patient. Indeed, it would be unethical to persevere with any treatment that is clearly not doing good. The *Bland* decision helped to clarify the circumstances in which life-prolonging treatment might be withdrawn.

2. *You say that a doctor's duty to a patient "does not include an obligation to seek to preserve the patient's life in all conceivable circumstances" (paragraph 8). Yet anecdotal evidence suggests that doctors sometimes continue their attempts to prolong life beyond the point at which common sense might dictate that efforts be ceased, and many people fear that hospital procedures actually prolong dying. How might this be prevented?*

Doctors do not have an *obligation* to preserve life in all circumstances. The right action in individual cases must be a matter for clinical judgment. This cannot be governed by blanket rules.

The Patient's Charter emphasises a patient's right to information, and promotes greater openness between NHS staff and patients. This should help to remove any fears people may have about their treatment towards the end of life.

The BMA and the Royal Colleges are also developing general guidelines in this particular area. For example, BMA guidelines on persistent vegetative state cover diagnosis and treatment of PVS, as well as advising on when treatment can be discontinued.

3. *Would you elaborate on the way in which decisions should be made to withhold or withdraw treatment from patients who are unable to take part in the decision-making process (paragraph 11)? Would the appointment of a proxy decision-maker, perhaps by extension of the principle of enduring power of attorney, be of assistance?*

Decisions to withhold or withdraw treatment from patients who are unable to take part in the decision-making process are only taken following full discussion with the whole multi-disciplinary care team, including nursing staff, and the patient's relative/friends as appropriate. The consultant in charge may also seek a second opinion from another doctor. The care team must have regard to any wishes expressed by the patient in the past though these may need to be interpreted cautiously, as not all circumstances can be anticipated.

Proxy decision-making, such as that of a parent for a child, could be extended, by law, to other situations: but any such development would need careful consideration, particularly as regards undue influence and abuse.

4. *You say that a patient is entitled to decline treatment, even where such a decision appears irrational (paragraph 9). What safeguard is there against such a decision being regarded as a sign of unsoundness of mind and, therefore, incompetence to decide?*

The Department's guidance[1] emphasises a patient's right under common law to give or withhold consent to treatment. This guidance was agreed with the medical profession, and the general principle is reaffirmed in the Patient's Charter.

A patient's decision to refuse treatment, even if it seems to be against his/her best interests, is not in itself evidence of mental disorder. The patient's expressed wishes regarding treatment for a physical condition are normally determinative. However, before acting upon a patient's request that treatment be withdrawn or withheld, a clinician must be satisfied that the patient's decision to refuse treatment is genuine, made with a full understanding of the consequences, and not influenced by others or clouded by mental disorder. The doctor will seek a second opinion from another doctor in cases of doubt. He will also want to discuss the patient's decision with other members of the care team, and with the patient's relatives/friends as appropriate. He will want to know whether the patient is repeating a wish stated previously, whether in an advance directive or not. If necessary, the relevant health service body could seek a decision from the Courts.

5. *You say that application to the Courts for guidance may be necessary in certain cases (paragraph 10). What is your view of the drawbacks of such a course (for example the lack of general applicability of case law; the length of time taken)?*

The main drawbacks of going to the Courts for guidance are cost, delay and publicity, which can be very distressing for the family concerned. Advantages are that a fully considered decision is taken and the patient's interests are protected. A Court decision also removes any lingering doubt there may be about the legality of the action proposed in a particular case.

However, it would not be realistic for all cases to go to Court. In most instances the legality of the decision to provide or withdraw treatment is clear-cut. Only in cases where there is some doubt (eg Tony Bland) is a Court ruling sought. As a body of case law builds up, there will increasingly be less need to go to Court on individual cases.

6. *You repeatedly emphasise the role of doctors in making decisions and formulating guidance for the withholding of treatment (paragraphs 10, 26 and 27). Others suggest that such ethical questions are too important to be left to doctors alone, and indeed that they are a responsibility that doctors alone should not be expected to carry. How best can a balance be achieved between allowing doctors sufficient professional latitude and providing guidance to them as to what society as a whole finds acceptable?*

The individual decision has to be a matter between the doctor and the patient if the patient is competent, and those who have a reasonable interest in the matter where the patient is not competent. It is for society to set the framework in which that interchange takes place but it is not for society, except in cases before a Court, to determine the outcome of an interchange, which can only be considered in the light of individual circumstances.

Decisions on life-prolonging treatment should only be taken after all relevant factors, including diagnosis and prognosis, have been fully discussed with the patient (if competent), members of the care team (eg nurses) and the patient's relatives/friends as appropriate. The doctor in charge of the patient's care must take ultimate repsonsibility for the decision, but it is arrived at only after full discussion.

The medical and nursing professional bodies support health care staff in these decisions through the issue of professional advice and guidance.

7. *It is sometimes suggested that adequate availability of proper palliative care, as in a hospice, would remove the demand for euthanasia from those who fear dying in pain and indignity. What level of resources, and how many additional hospice beds, would be required in order fully to meet demands for such care?*

While most palliative care is currently provided by the voluntary hospice sector, terminally ill people also receive palliative care services in NHS hospice units, in hospitals, in nursing homes, or through day care, respite care and care at home. For example, the Cancer Relief Macmillan Fund and Marie Curie Cancer Care provide specialist nurses to provide and co-ordinate specialist care for terminally ill people in their own homes. Other local voluntary groups provide "hospice at home" schemes.

In a recent report "The Principles and Provision of Palliative Care" the Standing Medical Advisory Committee and the Standing Nursing and Midwifery Advisory Committee recommended that all patients needing palliative care services should have access to them, and that the principles and good practice of palliative care which have been stimulated by the voluntary sector should be incorporated at all levels in

[1] "A guide to consent for examination and treatment"—NHS Management Executive, Department of Health, August 1990.

the NHS. The Department of Health has asked the NHS management to take the report's recommendations into account in developing strategies for palliative care.

The challenge is, therefore, not so much to increase the number of hospice beds as to ensure that the principles of good palliative care (patient-centred, concentrating on the physical, emotional and spiritual needs of the dying individual) should spread more widely through the NHS so that terminally ill people can be assured of sensitive care and relief from pain and other distressing symptoms. We believe that this is becoming increasingly widespread through the NHS and will continue to encourage this development.

The Department is determined to ensure that the support provided by the NHS to voluntary hospices is put on an ever more secure footing. That is why, from 1994–95, we will build funding into HAs' general allocations to enable them to purchase palliative care services to meet the needs of their populations.

It is the responsibility of DHAs to assess the health needs of their populations and commission services to meet these needs. Palliative care for terminally ill people should not be seen as separate from this over-riding responsibility. We are making it a priority for the NHS in 1994–95 to ensure the agreement of service contracts for palliative care services to meet the needs of terminally ill people.

8. *Although actions intended to hasten the death of a patient are unlawful, actions intended to relieve pain which may as a consequence hasten death are not. How does this distinction operate in practice? Does it create uncertainties for doctors and patients alike?*

This distinction is regarded as important, both in law and as a matter of medical ethics.

A doctor's job, where he cannot effect a cure, is to control a patient's symptoms. With all medical treatment, there can be side-effects. A side-effect of controlling terminal pain may be that a patient's life is shortened.

The distinction between actions intended to hasten the death of a patient and actions intended to relieve pain operates very well in practice. Doctors understand the distinction between using opiates and other drugs that are intended to relieve pain and may as a side-effect hasten death, and the consequences of injecting other drugs which hasten death but have no pain relieving effect. Doctors have an ethical duty to ensure that they have the appropriate skills and competences to treat the patients within their care. On occasions it may be appropriate for an individual consultant to seek the advice of an expert in the management of pain in order to help discharge that responsibility.

9. *The withdrawal of treatment which no longer serves any therapeutic purpose may result in a situation where allowing death to take place is less quick and humane than taking action to bring death about. Some might suggest that the latter course would be preferable. What is your view?*

A primary aim of treatment is to prevent pain and distress. No doctor will withdraw treatment if to do so will cause pain or distress. When "curative" treatment has no effect, the doctor's purpose will be to try to relieve or control pain and other distressing symptoms.

We do not agree that positive action should ever be taken in order to cause death. That is murder, and must remain so to protect vulnerable individuals. It is also fundamentally at odds with the Hippocratic oath ("above all, do no harm") and professional codes of ethics.

10. *What part do questions of resource allocation play in consideration of all these matters? What part* should *such questions play?*

The NHS seeks to provide the most cost-effective treatment to meet patients' needs. Resource allocation has no part to play in decisions concerning the withdrawal of an individual's life-prolonging treatment. The doctor is obliged to do the best he can for the patient under his care.

Resources for the NHS have increased year on year in real terms. Average annual real terms increase since 1978–79 is 3.3 per cent; 3.6 per cent since 1986–87.

Memorandum by the Home Office and the Scottish Office

I. The Responsibilities of the Home Secretary and the Secretary of State for Scotland

It may help the Committee if this evidence begins by describing the Home Secretary's specific responsibilities in relation to the issues that it is considering. These responsibilities relate almost entirely to the criminal law. The Secretary of State for Scotland has equivalent responsibilities in Scotland, and references to the Scottish position are included where necessary. They are that the law should identify clearly actions that should properly be deemed criminal together with any defences that can reduce or remove an individual's culpability, and that there should be adequate powers for the courts to convict and punish offenders. The product of an adequate legal framework should be public confidence that the law protects both life and property. Any uncertainty about the scope of the law's protection produces public anxiety and fear. There can be no more important area in which the law's protection should be complete and transparent than where individuals' lives are at stake.

2. This evidence does not therefore seek to deal with the issues surrounding decisions to withhold or discontinue treatment at the request of a dying person, or where, as in the Bland case, such treatment serves no therapeutic purpose. The criminal law's concern is with acts or omissions that have as their intention another's death, and this will be the focus of what follows.

II. What Should the Criminal Law Have to Say in This Area?

The Law as it Stands

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

The Sanctity of Life as Against the Right to Personal Autonomy

4. Until 1961, the criminal law held that it was illegal for a person to take, or attempt to take, their own life. In law, the sanctity of life was the utterly dominant principle. The Suicide Act of that year abolished that rule, but it continues to be an offence, punishable by up to 14 years' imprisonment to aid, abet or procure another's suicide. Again, the victim's wishes provide no defence.

5. The Suicide Act 1961 provides a clear exposition of how the criminal law resolves the potential conflict between the sanctity of life as a guiding principle and the right to personal autonomy. Compassion dictated that attempted suicides themselves should not be made to suffer under a law that was widely considered to have become out-dated. But the State's interest in preserving absolutely, and under pain of severe penalty, the prohibition against acts calculated to destroy the life of *another* person, even with their agreement, was unequivocally re-stated. In effect, the Act prohibits acts by one person on behalf of another that are designed to end that other person's life in circumstances where, for whatever reason, they could not take their own life. Similarly, whilst a doctor may not, except in the most limited of circumstances, treat against a person's wishes, even though he knows that death will result, where there is doubt about the patient's wishes, the law puts the duty of care first, and the risk of an assault upon the patient's autonomy second. That principle was clearly established in *In re T* (Adult: Refusal of Treatment) [1992] 3 WLR 782.

6. Although the Suicide Act 1961 does not extend to Scotland, the effect of Scots criminal law is similar. Thus, while suicide is not a criminal offence, the aiding and abetting of a suicide may constitute the offence of recklessly endangering life, culpable homicide or murder, depending on the circumstances of the case.

Acts and Omissions

7. It has been argued that there is no logic or moral justification in allowing omissions (the withholding of treatment) that lead to death but forbidding active interventions that could bring about a swifter, less painful and more dignified death. In his opinion in the case of *Airedale NHS Trust* v. *Bland*, Lord Browne-Wilkinson acknowledged that the *law* was entirely clear on the matter, but admitted that it might nevertheless seem irrational to permit Mr Bland's slow death through the withdrawal of treatment but to deny his family the relief of a quicker end to their ordeal. Lord Browne-Wilkinson said that he "found it difficult to find a moral answer to that question".

8. In Scotland, there has been no case similar to the *Bland* case but there is no reason to believe that a Scottish court would not apply similar principles.

9. The Government's view remains that the distinction between positive interventions to end life and

the withholding of treatment (providing always that the latter is consistent with any duty of care that the relationship with the patient creates) is of critical importance and must be maintained. That view is based partly on an appreciation of the difficulty of devising an adequate system of safeguards to protect the public if the law were to be altered. These are explored in part IV below. But the Government is also concerned about the moral or ethical foundation for any alternative.

10. In practice, any system that allowed active interventions designed to end life whether at the victim's request or in the "best interests" of an incompetent patient, would require the intimate involvement and support of the medical profession. That profession deals daily with matters of life and death, and its considered views clearly carry a particular weight. The 1988 Report of the British Medical Association Working Party on Euthanasia (see in particular paragraph 92 of that Report), concluded that the distinction between an act and an omission *was* legitimate and should be maintained. Briefly, the Working Party's arguments were that:

— there is an irreconcilable gulf between a doctor's primary duty to preserve and restore life on the one hand and any policy aimed at its deliberate destruction on the other;

— experience, for instance in hospices, suggests that euthanasia requests often represent something other than a request to be killed. They may often be a "veiled enquiry as to whether people ... can be bothered about them (the patient) any more";

— a decision to terminate life allows no respite for re-evaluation and, almost by definition, cannot be fully informed. Very few people who have been saved from a serious suicide attempt subsequently kill themselves, suggesting that people's real attitudes may only be formed when death is an imminent rather than a hypothetical reality;

— patients will often acquiesce to treatment simply because the necessary arrangements have been made. For the elderly and lonely, in particular, the courage required to "back out" of a process once it has been started may be more than they can bring to the situation. This could very well prove true even in situations where the "treatment" amounted to euthanasia;

— any system of active intervention to end life would "make one of the most profound features of our humanity radically subject to human choice".

11. The unspoken assumption of the last of these arguments is that our capacity to regulate and control the proper exercise of choice over this "profound feature" of our humanity is lacking. In a matter of such enormous complexity, where every individual's dilemma will be a unique product of an infinite range of experience and sentiment, there may be no adequate moral or philosophical basis for so grave an intervention in the natural order of things. Where there is doubt, it might be thought, the only safe course is to maintain the *status quo*.

12. On the other hand, proponents of voluntary euthanasia point to the immense suffering of both patients and relatives in situations in which physical pain cannot be relieved, or physical or mental deterioration alleviated, and a person's life is ending slowly and without peace or dignity as a result. They point to cases in which death seems to offer the *only* possible end to intense suffering and query the morality of not intervening to end such an ordeal. More radically, we have heard it argued that the law's fundamental assumption that personal autonomy does not extend to the right to insist on one's own death in circumstances where the means to take it oneself do not exist is outdated and wrong, rooted in a religious philosophy which an increasingly secular society has inherited but does not own.

Pain Relief that Accelerates Death

13. It is largely uncontroversial that doctors will from time to time administer pain-relieving treatment to a terminally ill patient that may also have the effect of accelerating the patient's death. But such an act *may* be criminal. Whether it is or not will depend both on the doctor's intention and on whether the doctor's actions can be said to have caused the patient's death. The law is no stranger to these matters and it may be thought that there is no need to interfere with the way it has developed and is applied in this difficult area.

The Extent of a Duty of Care

14. As already noted in paragraph 9, the criminal law considers a failure to observe a duty of care in the same light as a positive intervention. The extent of that duty of care is not a matter in which the Home Office has any particular locus. But it seems far from certain that the criminal law would profit by any attempt to define the extent of the duty in statute, given the continual advance of medical knowledge and expertise. It may be thought that the BMA's work in this field provides a secure source of guidance for both practitioners and, where necessary, the courts.

III. Culpability and the Penalty for Murder

15. There is a long history of support for the proposition that active intervention to end life should not be excused on the grounds either of motive or the victim's consent. There have, however, been proposals

to reduce the degree of culpability for "mercy killings". For example, the Criminal Law Revision Committee proposed in the consultation process that preceded its 14th Report in 1980 that murder should be reduced to manslaughter where certain conditions concerning the victim's condition and wishes were satisfied.[1] The Law Commission, in its evidence to the House of Lords' Select Committee on Murder and Life Imprisonment built on the CLRC's proposal by adding an additional condition that the *accused* should have been suffering "severe emotional distress", (thus bringing the defence more clearly into line with other defences that go to the state of mind of the accused and the inferences that can be drawn about his intention as a result).

16. The CLRC proposal attracted little support, in part because it was seen as relying on the external circumstances of the case to provide a defence (albeit partial) to the most serious of crimes. It did not appear as a recommendation in the Committee's final Report. It may be thought that the Law Commission proposal is also flawed in that it is expressly designed to cater only for the narrow category of case in which a *non*-medical person takes the life of a suffering relative or loved one. It may be doubted whether the courts would find that "severe emotional distress" could readily be identified as a state of mind distinct from diminished responsibility, or, in the light of the statistics in the table below, even that it would be helpful for such a distinction to be made. Juries might be expected to look for some objective justification or measure for the level of stress. This would be difficult to establish. It may also be thought that it would be wrong for the law to assume that doctors and nurses are in all cases themselves immune from emotional distress. Juries might well not think so.

17. Proposals to reduce the culpability (as recognised by law) of certain types of "mercy-killing" are not of course seeking to address the central concerns of those who would want to see the "right to die" acknowledged by the criminal law. They may, as a result, seem to fall between two stools, raising anxieties amongst those opposed to euthanasia but equally unwelcome to those who support it.

18. Other reformers would be prepared to leave the criminal law as it is, provided that the penalty for "murder" could be more flexible. Many think that the continued existence of the mandatory penalty for murder can no longer be justified given the range of circumstances in which "murder" can be committed. The Select Committee chaired by Lord Nathan concluded its examination of this area by arguing that the abolition of the mandatory life sentence would allow judges to reflect the particular circumstances of every case in the sentence passed, while maintaining the criminal law's abhorrence of deliberate killing.

19. The Government acknowledges the force of that argument, but has not yet been persuaded that it would be right to abandon the mandatory life sentence. It has pointed out that the period of time spent in custody varies greatly from case to case and that in practice the system is flexible enough to ensure that custody is not unjustifiably prolonged where the requirements of retribution, public safety and public confidence do not demand it.

20. Figures for England and Wales show that in practice, prosecutions for murder in which the issue of "mercy killing" arises, and for offences under the Suicide Act 1961, are extremely rare (see Table below). The statistics show that convictions for murder in "mercy killing" cases are very rare indeed. On the basis of those cases which come to the attention of the courts, it would appear that mercy killing of adults tends to be carried out by relatives without resort to any medical expertise or assistance. In these cases, courts frequently find diminished responsibility and in consequence a life sentence is seldom imposed. Indeed, most convicted "mercy-killers" are not imprisoned at all. It should be noted, however, that these statistics rely on the identification of cases as "mercy killings" by police forces and that they may not, therefore, be complete.

21. The extent to which euthanasia may be practised undetected is not something on which the Home Office would venture an opinion.

The Position of the Non-Medical Individual Caring for the Terminally Ill

22. As the statistics show, the criminal justice system rarely finds that it is doctors with whom it is dealing when euthanasia may be an issue. The Committee's terms of reference point towards the problems faced in hospitals and by the medical profession; and recent cases that have attracted public attention have had a similar focus. But the law as it stands makes no distinction between the qualified and the unqualified person. As indicated in paragraph 16 above, there might be considerable difficulties in principle and in practice in making such a distinction in law. The Committee will also no doubt wish to bear in mind that the implications of any change that sought to "regulate" in some way the practice of euthanasia would be likely to be different in a domestic as opposed to clinical settings. What might seem sensible and defensible in one situation might be inapplicable in another.

IV. Public Confidence

23. Euthanasia is a subject which arouses strong and fervently held views. No one is likely to consider it wholly in isolation from their own experience of bereavement or from their personal attitudes to their

[1]For clarification see QQ 63 and 64.

Offences Currently Recorded as Homicide where Circumstance was Coded as "Mercy Killing"[1]

Year	*Relation to victim*	*Method*	*Age of victim*	*Age of suspect*	*Final outcome*	*Sentence*
1982	Husband	Stabbed	73	73	Sec. 2 manslaughter	3 years probation
1983	Husband	Suffocated	48	55	Sec. 2 manslaughter	2 years probation
1984	Mother	Suffocated	17	47	No proceedings	—
1984	Husband	Strangled	73	74	Manslaughter	2 years imprisonment (suspended)
1984	Father	Suffocated	22	51	Sec. 2 manslaughter	2 years probation
1984	Son	Suffocated	76	48	Sec. 2 manslaughter	12 months conditional
1985	Husband	Suffocated	72	74	Sec. 2 manslaughter	4 months imprisonment
1985	Daughter	Strangled	74	47	Sec. 2 manslaughter	3 years probation
1985	Acquaintance male	Suffocated	25	37	Sec. 2 manslaughter	2 years imprisonment (suspended)
1985	Mother	Suffocated	0	24	Infanticide	2 years probation
1985	Husband	Strangled	71	70	Suspect died	—
1986	Husband	Strangled	59	60	Sec. 2 manslaughter	18 months imprisonment
1987	Husband	Poisoned	53	73	No proceedings	—
1988	Husband	Suffocated	74	76	Sec. 2 manslaughter	2 years probation
1988	Acquaintance male	Suffocated	50	16	Murder	Life
1988	Son	Strangled	92	66	Sec. 2 manslaughter	3 years probation
1988	Other family	Suffocated	84	76	Sec. 2 manslaughter	2 years probation
1989	Mother	Drowned	2	37	Sec. 2 manslaughter	3 years probation
1989	Husband	Suffocated	80	80	Sec. 2 manslaughter	2 years probation
1989	Husband	Strangled	43	55	Sec. 2 manslaughter	3 years probation
1991	Mother	Suffocated	36	57	No proceedings	—
1991	Mother	Poisoned	0	26	Manslaughter	12 months probation

Suicide Act 1961.

Convictions Under S2 (Aiding, Abetting, Counselling or Procuring the Suicide of Another)

1982	*1983*	*1984*	*1985*	*1986*	*1987*	*1988*	*1989*	*1990*	*1991*
1	3	1	0	0	2	2	5	5	2

Note:
(1) For further clarification of this data see Supplementary Memorandum.

own death. It is an issue that may stir deep anxieties within many who are nearing the end of their life, whether by reason of old age or illness. For some, the fear will be of a painful, possibly undignified death, whilst for others the fear may be of becoming a burden and, perhaps, of falling victim to the unscrupulous nature or simple impatience of those caring for them.

24. Others, however, may approach the topic with a profound ambivalence, uncertain of how they might react in certain circumstances and reluctant to contemplate those circumstances. Their views may be coloured by a broader concern about the social implications of change. Some people, for example, worry about the effect of an apparently inexorable increase in the pressure on resources for the National Health Service against a background of an ageing population. But others fear that medical science might develop to a point at which it could be possible to prolong life beyond what they would see as either natural or desirable.

25. Although it is inconceivable that any United Kingdom Government would ever contemplate the legalisation of euthanasia for "social engineering" purposes, some people worry about change from the perspective of what a change in the law *might* allow, regardless of what the actual (and limited) intention of any change might be. Although there would appear to be no significant support for the suggestion that euthanasia might be allowed without the strictest of safeguards, there is a real question about whether adequate safeguards *could* be devised, if the general principle that the law should be changed were to be accepted. Proponents of euthanasia must address this crucial practical question. This concern also applies to proposals for greater regulation within the law as it stands, for instance in relation to the withholding of treatment from incompetent patients. In that context, there is clearly a difficult balance to be struck between translating the accumulated learning of successive judgments into guidance that is widely available on the one hand, without encouraging a belief that whole categories of case might be decided in isolation, at too junior a level or with too little thought for the legal and ethical implications of the particular circumstances.

Safeguards for "Voluntary" Euthanasia, were it to be made Legal

26. The Committee will be aware that a system of safeguards exists in the Netherlands in a procedure that protects doctors from prosecution if they have killed a dying patient at the patient's request. The doctor is protected if the public prosecutor is satisfied that:

— the patient was terminally ill, in unbearable pain and had repeatedly asked to die;

— a second medical opinion was sought;

— the doctor reported his action to the coroner.

27. This practice has been followed in the Netherlands since November 1990, and has recently been put on a statutory basis. 590 reports were filed in 1991 and over 1,300 in 1992, but there are allegations that the number of patients given lethal injections is actually higher. Critics of the Dutch system allege that the system creates a climate in which involuntary euthanasia is commonplace, in which the "consent" of patients to euthanasia is often far from unequivocal, and in which the development of alternatives (such as advanced pain relief and hospice care) is neglected.

28. We have no information on which to assess the truth of such allegations. But the *fear* of such developments has often been cited in this country as good reason not to seek to allow and regulate deliberate killing. Inevitably, those most at risk from abuse of any regulation would be the most vulnerable members of society, often afflicted by the emotional distress of impending death. There is also a risk that the defences to what would be very serious charges of failing to observe the regulations could be very difficult for juries to interpret fairly. Evidence that a person who was in fact motivated by compassion also stood to benefit materially from the patient's death could, for example, produce an unjust conviction. The greater risk, perhaps, would be that, faced with such imponderables, juries would tend to acquit more often than the truth of the matter deserved.

Safeguards for the Regulation of Treatment of Incompetent Patients

29. The Government's view is that an active intervention to end the life of an incompetent person raises the same central issues as an active intervention to end the life of a competent patient who requests it. An active intervention intended to cause death will create a liability for murder, even if it is carried out in accordance with the previously expressed wishes of the patient. The arguments against active intervention to end the life of an incompetent person are as strong as those against any other active intervention to end life.

30. However, there are circumstances in which the previously expressed wishes of an incompetent patient are clearly of very great significance. Proponents of advance directives or "Living Wills" argue that these can provide an invaluable aid to doctors facing the dilemma of how and whether to treat patients who cannot give their view. Although it is accepted that such directives may be helpful in some circumstances, a number of concerns remain.

31. The first concern is that an advance directive should not be legally binding. It may well be that the document, whether by describing an anticipated wish or appointing a proxy, should be accepted as an important factor (perhaps the most important factor) in influencing the decision that has to be made about treatment; but the Government's view is that the law should not exclude a judgment by the doctor caring for the incompetent patient that the advance directive should not be followed. It may often be, for example, that the circumstances anticipated by the directive are not precisely in line with the circumstances that have now arisen; or that the proxy decision-maker appears to be recommending a course of action that is clearly not in the patient's best interests (taking into account the criteria that the courts have described for such decisions).

32. Secondly, there is a strong interest in ensuring that any statutory system of advance directives should take full account of the potential for abuse that such a system might contain. In the worst cases, an advance directive written under false pretences or improper pressure might be evidence of an intention to murder. The potential for abuse and the practical capacity of regulation to prevent it are both important factors which need to be borne in mind in considering this particular issue. Proponents of change must address these questions and assess whether secure practical proposals for safeguards *can* be devised. The Government would therefore wish to examine the detail of any proposals to put advance directives on a statutory basis with great care. The Committee will no doubt be aware of the fears of some that a statutory arrangement for advance directives might seem to pave the way for even more radical change in the law.

Examination of witnesses

Mr AUSTIN WILSON, Criminal Policy, Mr PETER DAWSON, Criminal Law and Procedure, Mr RICHARD HEATON, Legal Adviser, Home Office, Mr MICHAEL LUGTON, Criminal Division and Mr M SINCLAIR, Scottish Office.

Chairman

32. Would you like to introduce your group, Mr Wilson?

(Mr Wilson) Thank you, my Lord. I think the first thing I have to say is your current witnesses represent two Government Departments: the Home Office and the Scottish Office. My name is Austin Wilson and I am an Assistant Under Secretary of State in charge of the criminal policy department of the Home Office. Sitting on my right is Peter Dawson, a principal in C4 division, the criminal law division of the Home Office and on his right, Richard Heaton, a member of the Home Office legal advisers branch. Sitting on my immediate left is my colleague from the Scottish Office, Michael Lugton, head of the criminal justice division there and on his left is Mr Murray Sinclair, a legal adviser in the Scottish Office.

33. We are very grateful to you for submitting your written evidence which we have all read with interest and I take it that this expresses the joint opinion of the Home Secretary and the Secretary of State for Scotland?

(Mr Wilson) Yes, my Lord.

34. Would you care then to make any introductory comments upon your paper before we go on to the questions.

(Mr Wilson) Well, my Lord, I am grateful for that opportunity. I do not think I need do more really than perhaps refer you to the very first paragraph of our memorandum where we do in fact attempt to set out what we regard as the *locus* of the Home Office in relation to the matters before the Committee. Broadly what we are saying there is no more than that we regard the responsibility of the two Secretaries of State as being to ensure the criminal law in this area is clear, for example, that it should clearly identify action which is criminal and, of course, indicate what defences there might be to that action and, looking at the question more broadly, that the law should be defensible and command public support. It is the continuing view of both Departments (and I say "continuing" because it has been a view long held) that the criminal law should proscribe, make unlawful, actions which have as their intentions another person's death. I think, as you read our paper, you will recognise that theme running through it.

35. Thank you. You have heard, I think, some of the questions we posed to our witnesses from the Health Department. Would you care to elaborate on the legal position of a doctor who administers pain-relieving treatment with the intent of relieving pain with, however, the consequence that it may accelerate death?

(Mr Wilson) My Lord Chairman, I think if the preceding hour has taught us anything (and we found it most interesting) it has showed that that is perhaps one of the most difficult questions that your Committee, and the rest of us concerned with this, have had to grapple with. We would I think (and I now speak from the point of view of English law) start with the late Lord Devlin's remarks to the jury in the *Bodkin Adams* case which has been regarded, since that time, as being a starting point—not necessarily as the law, because the context in which those remarks were made were not such as literally to create law, but that is a starting point. From that starting point it would appear that there should be no question of a doctor being at risk from the criminal law if his patient dies after he has properly (and by that we mean in accordance with his duty of care to his patient) administered pain-relieving drugs. By saying that, I obviously include the situation which is the one you have described, i.e. that he is aware both of the pain-relieving quality of his drug and of its possible effect in terms of shortening the life of his patient. In practice, again as it appears to the Home Office, a sensible view seems to have been taken since that case that doctors must be allowed to exercise some judgment in these matters. Having said that, I would like to go on to emphasise, the fact rather than the view, that the law does require that treatment given should be necessary to the relief of pain. The taking of action that has no pain-relieving qualities, and simply accelerates death, is not lawful, and reference has already been made to the conviction of Dr Cox, which I think substantiates exactly that position. This is and will remain a difficult area, but the Home Office view at present is that the existing law is, by and large, producing the right outcomes and not causing problems.

36. Would there not, however, be a difference in the case of Dr Cox because the substance he administered, potassium chloride, is not an analgesic but is, in fact, a substance which, in the dose given, and if given in that way, could only cause death?

(Mr Wilson) Exactly, my Lord. I think that was the point I was trying to make. Action by a doctor which has and could have no therapeutic effect but would only cause death, is unlawful and, in the Home Office view, it must remain unlawful.

Lord McColl of Dulwich

37. When you say that analgesics can be given only to relieve pain, by "pain" presumably you include distress without pain; because there are, for instance, many patients who die in respiratory failure who are extremely distressed and have no pain. Presumably you would include that kind of respiratory distress under the heading of pain, would you?

(Mr Wilson) I would. The decision, of course,

[Lord McColl of Dulwich *Contd*]

would be the decision of the doctor. The answer to your question is certainly, yes. When I used the word "pain" I certainly meant to imply the inclusion of distress as well.

Chairman

38. Distress and suffering?

(Mr Wilson) Yes. I am sorry, I was perhaps using shorthand. Pain, suffering and distress could, I think, be taken together.

39. Would your colleagues from Scotland take a similar view?

(Mr Lugton) Yes, indeed, my Lord Chairman. Although Mr Wilson has been speaking in relation to the situation in England and on behalf of the Home Office, I think on the issues of principle here there is no real distinction between the situation in Scotland and the situation in England.

Lord Mustill

40. Speaking for myself, I have no difficulty in accepting that the doctor is the person to decide whether the patient is suffering, full stop, in one way and another and, if so, what the degree of suffering is. What preoccupies me a little is why it seems to be assumed, and seems to be assumed by the courts to some extent, that when you get the ethical problem—is it better that he should die, and what the word "better" means—that that should be a decision left to the doctor. May I say straight away it is a question of wondering whether the doctors are qualified to take that kind of decision. I am suggesting not that the judges are better qualified for this. There was a Justice of the American Supreme Court who said, in a very similar case, that he thought the Justices of the Supreme Court were no better qualified to make those decisions than any nine names drawn at random from the city council telephone directory, and I actually share that view. Does your Department take the view that the question, that it is best that he should go, is one that should be taken by the medical profession, the carers?

(Mr Wilson) I think, looking at the position you describe realistically, perhaps it cannot be other than the doctor, advised by colleagues, by members of a caring team, and after taking account of known wishes of individuals or family, to decide what kind of or what level of treatment or action it would be proper for him to take. Doctors are not without some guidance. They do have, and have had over the years, advice from the British Medical Association. I think from the Home Office point of view I am rather worried about the corollary of what you were saying, Lord Mustill,—if you were suggesting that, if it is not the doctor perhaps it ought to be, if not the courts, then the criminal law. I think what worries me is the thought that it might be regarded as proper, or "safe" is perhaps a better word, for the criminal law to seek to establish conditions in which it would be, as it were, lawful for one person to take another person's life. We think that the dangers of attempting to legislate in that way are very great.

41. I think this is probably not a question you could answer off the cuff, but the judges so far have had to take the law as they have found it. It is not, I think, good enough. That is my personal view. One of the things that is not very good is that the phrase "best interest" has been put into play without any description of what it means. This, I think, actually increases the difficulties for the doctors rather than helps to solve them. What is at the back of my mind is whether perhaps Parliament could give some more specific definition of a) what are the relevant factors when deciding whether it is in the patient's best interest to die, and b) how they are to be weighted. I do not really think this is a question for half past five in the afternoon, but is it something which the Department would contemplate as a possibility?

(Mr Wilson) The short answer is, of course, it would be contemplated because one of the things we will certainly do is to look very carefully at what the findings of this Committee may be and this Committee will be looking at that issue. But I think I repeat myself when I say we are concerned about the dangers and difficulties of attempting to write into law the sort of factors to which Lord Mustill has referred. We do not say it is not possible to do that, we would only say it is very difficult and so far it has defeated quite a lot of effort.

Lord Mishcon

42. If I may refer to the opening part of your paper, you remind us that the responsibilities of the Home Office are almost entirely in this context criminal law.

(Mr Wilson) Yes.

43. I was just wondering how you really felt about the state of criminal law at the moment which as you very correctly said is this, that if Dr Cox had in fact produced the death of his patient instead of that death, as it was found, being caused by other matters than the injection he gave, he would have been guilty of murder although the public, the man on the Clapham Omnibus, would have called it mercy killing. Do you think it is a satisfactory state of our law that in a case such as I have mentioned the verdict must be that of murder with the resultant effect of the judge being left with no alternative open to him other than a mandatory life sentence? In advising us upon the state of the criminal law in this context, would you say you would welcome something being done about this so juries are not faced with what they would regard as a very, very difficult job in finding that murder has been committed, knowing apart from the greatness of that crime—if I may put it that way—that they leave the judge with no alternative but to say life sentence. Would you not want to amend the law there?

(Mr Wilson) There are, I think, my Lord Chairman, two questions there. The first, put simply, if I may repeat it to the noble Lord to make sure I am not misunderstanding him, is the question "is the Home Office satisfied with the situation in which someone acting as Dr Cox acted—and we would all accept that was from the best of motives and in accordance with the wishes of the patient—

[Lord Mishcon *Contd*]

should be guilty of murder?" Here I am afraid, and this will sound hard, that on our current state of thinking of this issue, the answer is "yes", because we believe that the law should recognise and condemn the deliberate act of killing. So far the criminal law has not taken notice of motive, it has taken notice of intention but not of motive. The Home Office view is once you take motive into account, which is something which is open always to a good deal of argument, it is capable of being argued over, then you might be on a very slippery slope. In the particular case of Dr Cox, who rightly felt he owed a duty of care to his patient, I would not wish to put myself directly in his position and say what he should have done, but I would remark that, as an experienced doctor he must have been aware that there was other action which he could have taken which would have had the effect of at least to some extent—and I know there were particularly difficult circumstances in this case— alleviating the pain and distress of his patient without taking a deliberate action to end life.

Lord Mishcon] I hope I am not rudely interrupting you, I am not suggesting a crime was not committed. What I am suggesting is that the crime of murder seems to be inapplicable in the circumstances we are talking about. I repeat with the sequel of necessity that there has to be, at the moment, a mandatory life sentence. Would you not have thought another crime might be nominated?

Chairman

44. Could I ask the lawyers present and yourself: is there a difference in some other countries between unlawful killing and murder?

(Mr Wilson) I would like perhaps some assistance from lawyers and not only around me but I have lawyers in front of me. It is certainly the case, as I understand it, that different kinds of homicide are not defined in exactly the same way in all countries. The law in England and Wales is reasonably clear as to what is murder and what is not murder and I think that clarity has in the past served the country well and we would be concerned about the danger of changing it. On the question of mandatory life, this is an issue which your Lordships have discussed more than once and I think have come to a near unanimous view but I can only say to you, speaking as a representative of my Minister, that he has not yet been persuaded—and I use that phrase deliberately "not yet been persuaded"—that it would be right to move from that situation. It is an open secret that he is considering a number of possible changes to the criminal law as most Home Secretaries do most of the time. I think if Mr Clarke was sitting in my place here he would not want to say he has a closed mind on this.

Lord Rawlinson of Ewell

45. I just make the comment that the English law has a good balance between that and manslaughter which is affected practically. To go back to your difference between motive and intention, motive can be dealt with by a mandatory sentence by the Home Office and where it was not, a mandatory sentence by the judge in sentencing so he would take motive into account in that way.

(Mr Wilson) Yes. May I take it that is a defence of mandatory life?

46. Yes.

(Mr Wilson) Thank you.

47. To go back to your statistics on mercy killings, they show there were only 21 cases in ten years.

(Mr Wilson) For prosecution, yes.

48. If my arithmetic is right, who have been dealt with and all of them have been dealt with if we look at the sentence with probation or suspended imprisonment. I think one had 18 months' imprisonment——

(Mr Wilson) Yes.

49. —— for strangling a husband. Basically looking at it purely practically this has not been a problem in the criminal law over the past few years and has not been one which has had to exercise the Home Office as something which needs urgent attention.

(Mr Wilson) No, you are substantially correct.

Baroness Llewelyn-Davies of Hastoe

50. We have been asked by the most prominent and respected legal people to contemplate an Act of Parliament changing the law and there is a feeling it is going to be too difficult to do that because of the attitude of the Departments. The Department of Health has said it has no intention of changing the law and in your own paper in paragraph 13 you say: "The law is no stranger to these matters and it may be thought that there is no need to interfere with the way it has developed ...", in other words, it hands the baby straight back to the doctor and puts it all on the doctors, which I do not think is fair.

(Mr Wilson) What we are, I think, saying in paragraph 13, to which you draw attention, is that under the current law it is largely uncontroversial that doctors, when they are treating terminally ill patients who are suffering from pain or who are in distress, may with the support of society at large provide palliative treatment, provide therapeutic treatment even, to that patient in circumstances in which the principal aim and objective of giving that treatment is the relief of pain, but in the knowledge that the doing of those acts or the giving of that treatment may have the effect of bringing forward something which is going to happen anyway. I think we would be happy enough with that position.

Lord Hampton

51. In paragraph 25 you raise the question of voluntary euthanasia and the need for adequate safeguards. My question is: are these really possible? Is it not true that in Holland euthanasia is often involuntary? A number of people have suggested to me that the "thin end of the wedge" and the "slippery slope" principles are a great danger. Are you prepared to give an opinion on this?

[Lord Hampton *Contd*]

(Mr Wilson) The answer I give, I think, would be to support the line of thought that you have just offered to me. We do indeed have grave doubts, that it would be possible to write into the law safeguards which were wholly adequate.

52. You have doubts?

(Mr Wilson) We have doubts. Although we have no direct experience of the law in the Netherlands, our understanding of the way it is operated is, I think, rather similar to your own. That is to say, that it is operated in a way which has had the effect of allowing more people to die, if I may put it that way, than might otherwise have been the case had their law not been in operation. There is a significant body of opinion in the Netherlands (I do not say the majority of people) which is concerned that the effect of that law may have been to unduly hasten the deaths of some persons affected by it. In a word, we are concerned because we doubt whether it would be possible to write effective safeguards into a law which was in effect authorising what has been called euthanasia.

Lord Hampton] It seems significant that there is no hospice movement in the Netherlands.

Chairman

53. Your view would be, that even the requirement that an independent doctor should be required, say, from a different place or different speciality, to confirm the decision—would not prevent the possibility of collusion?

(Mr Wilson) It would not, I think, be enough for us and, I suspect, for a number of other people who would be concerned about it. We would be concerned that safeguards might not always identify a wish to die that might have been expressed under unfair pressure or in some ignorance. We can perhaps elaborate on our concern about safeguards when we respond, as you suggest, in writing.

Archbishop of York

54. I want to take you to paragraph 12 where you talk about ... "the law's fundamental assumption that personal autonomy does not extend to the right to insist on one's own death ...", and there are other references in the paper to patient autonomy and so on. This is a rather new concept, which I think has crept into this country from America. I am wondering what legal basis there is for the notion of patient autonomy or personal autonomy, or what legal basis there is for limits on it, and indeed, what ethical basis there is for it? I am puzzled the way this phrase keeps coming into these discussions. We have no background to it.

(Mr Wilson) I hope I might be helped by one or other of my lawyer colleagues on this one. The phrase has, I think, come in, as perhaps one of my colleagues at the Department of Health suggested, because of increasing concern about, and the desire to create, patient's rights. I think that is where it starts from. We believe that the law should not give anybody an absolute right in effect to require someone else to take action, even in relation to the person making the request, which action is also unlawful. That is, I think, the fundamental stopping point for the Home Office. I am conscious that I am not fully answering your question.

55. I want to know who decides what patient's rights are?

(Mr Wilson) I am concerned with what they are not. I think that is where the Home Office comes in, so I am not the best person to answer your question who decides what they are. I think my colleagues in Health might have been the better recipients of that question.

Lord Mustill

56. There is a very interesting article in an American law journal about advance directives, which the Chairman is going to take us to. It is suggested there that the reason for the development of this idea of patient autonomy stems from the early decades of the century and the times of heroic surgery and the fear on the part of the patients of the doctors. This was a reaction against what was seen as overweening arrogance on the part of the medical profession at that time, not now. It is not surprising that it comes from the United States because the instinct of anybody in the United States is to think in terms of constitutional rights and we do not have that. It has been taken for granted that the patient has a right to determine his or her fate without examination. I do not know whether you want to take that any further?

(Mr Heaton) It may be, my Lord Chairman, that the label of personal autonomy is a new one but merely gives expression to the age old principle in law that a person may not be assaulted by someone without that person's consent without fear of criminal sanctions, and it is a criminal offence to assault somebody. That may not have been recognised by medical practice before recently.

Chairman

57. It is not widely recognised in this country that there is no restriction on the practice of medicine to members of the medical profession, and anyone may practise medicine; all they must not do in law is to say they are a registered practitioner when they are not. The question of rights and a possible question of assault then arises; any medical procedure carried out by an individual, whether medically qualified or not, must be done with the patient's consent. That is where personal autonomy rests in this setting. Is that a reasonable conclusion?

(Mr Heaton) I think that is right, my Lord Chairman.

Chairman] We have no Bill of Rights, so that personal autonomy is not legally defined in the United Kingdom; here I turn to my lawyer colleagues.

Lord Rawlinson of Ewell] I do not know what it means.

Lord Mishcon] You are master of your own destiny.

Chairman] Exactly. Nevertheless, the law of consent is rather clearer, but that is common law, is it not?

Lord Mishcon] I would have thought that was right.

Chairman

58. We are getting into rather muddy waters but, having done so, we shall take you out of the mire and ask you to comment upon advance directives. You will probably have seen that Lord Allen of Abbeydale has drafted a Bill which has had its first reading, and it has been referred to us for comment. This is a Bill which would simply (and I use shorthand here) define the right of an individual to be able to give advice to his or her doctor as to the circumstances under which certain treatment should or should not be given or should be withdrawn. It does not require (and I know the medical profession in the United Kingdom would oppose it) that the advance Directive should or could be legally binding upon the doctor. What are your views about this particular Bill?

(Mr Wilson) The first thing I would like to say is we associate ourselves with the remark that has just been attributed elsewhere that advance directives should not be legally binding. We think that attempting to make it so would give rise to considerable difficulties. We believe that advance directives properly made, by which I mean without pressure and by people who are fully aware of what they are doing, may indeed have a real value to a doctor who finds himself at a subsequent time faced with what has been called a moral dilemma. We would not wish there to be created a situation in which even if the doctor were not to regard the directive as legally binding he should even regard it as morally binding because we think it almost impossible that we could be certain that the situation envisaged by the patient when he gave the advance directive would be exactly replicated by the situation in which the doctor and that patient subsequently found themselves. We think that there should always be a margin of appreciation and of course a necessity for a doctor contemplating action to have regard not only to his own ethical considerations but also to those that might have been advised to him by the BMA for example, and also very much—I emphasise this—to the criminal law. So we are broadly neutral on the issue of advance directives. We do think they have a part to play but we are not absolutely convinced that were they in existence the situation would be a great deal better than it is now.

59. Thank you. Could I just follow that up by saying that it has been suggested in certain quarters that while advance directives if entered into should not be legally binding, if a doctor did not wish to comply with such directives, for personal, religious or other reasons, it might be then right for that doctor to refer the patient to another medical colleague. What is your view about that?

(Mr Wilson) I think it would be proper for a doctor to do that.

60. Yes.

(Mr Wilson) It would then place his colleague in a situation of having to make the decision he did not wish to make.

61. Thank you.

(Mr Wilson) I see nothing intrinsically difficult in that doctor asking another doctor.

62. What about the incompetent patient, not in any way competent in law to make decisions about their medical treatment, and the question of enduring powers of attorney. Do you have any comments to make about that?

(Mr Wilson) Again, although I apologise for saying this, I think it is probably rather more a matter for the Department of Health than for us. I think our own view would be that giving someone what is in effect power of life and death over another person is something to which we think the law should move only with caution if at all.

63. Would you like to comment upon your remark in your document about the Criminal Law Revision Committee on "mercy killings" and the reasons why they rejected the assumption?

(Mr Wilson) Well, I am grateful for that question, my Lord Chairman, because I must now apologise and apologise very sincerely to this Committee for the fact that in our written evidence we inadvertently but nevertheless actually misrepresented what the Criminal Law Revision Committee had recommended because we told you in the memorandum that they had recommended a new defence to the charge of murder whereas in fact they had recommended the institution of a new offence other than murder.

64. Thank you.

(Mr Wilson) That is a mistake for which there is no proper excuse other than I think the fact that in the end the paper was put together in a hurry.

65. Thank you very much indeed for clarifying that point. Are there any other questions the Members of the Committee would wish to pose to our visitors? Are there any additional comments then any of your colleagues would wish to make in relation to the discussion we have had this afternoon?

(Mr Wilson) It appears not.

Archbishop of York

66. Can I come in with one more question: in paragraphs 10 to 12 you are very even handed in setting out arguments, pro and con, if you were not being even handed where would the Department end up in relation to these two comments?

(Mr Wilson) I think I am going to need reminding

[Archbishop of York *Contd*]

of the two contrasts unless I can read very quickly through 10 to 12.

67. In paragraph 10 you summarise the BMA evidence.

(Mr Wilson) Yes.

68. You then come to paragraph 11 and, as it were, try and put in a nutshell what you see as a fundamental reason why the medical profession should not interfere with this sphere. You then go on in paragraph 12 to put the arguments for euthanasia. You turn the page and think where are they going to come out and they did not come out anywhere.

(Mr Wilson) We come out strongly against euthanasia and we believe the BMA's Working Party's arguments were strong and sound when they were first put forward and still are.

Chairman

69. We shall be seeing them in a couple of weeks from now and they will no doubt wish to elaborate. We can only thank you again for coming and say if you have any afterthoughts after today's meeting which you would like to add to or any elaborations you would like to give in relation to the questions you have answered please do not hesitate to write to us. Again our sincere thanks to you.

(Mr Wilson) Thank you. We are grateful for the invitation.

Supplementary Memorandum by the Home Office

The Committee requested clarification of the statistics contained in our original memorandum. The Committee particularly asked about the three cases in which the relevant table shows the outcome as "no proceedings". In the first of these cases, a decision to discontinue proceedings was taken after the defendant was taken into hospital. In the second, proceedings for murder were discontinued after a decision was taken to issue a caution on a charge of aiding and abetting a suicide. In the third case, proceedings were discontinued following an assessment of the defendant's mental condition and re-assessment of the public interest in a prosecution.

In addition, the Committee may wish to know that, during the same period (1982–91), there were two prosecutions for murder in "mercy killing" cases which resulted in acquittals, both in 1989.

The Committee also asked if the charge was murder in all of the cases contained in the table. The original charge was murder in every case except the one in which infanticide was the charge. In the two cases in which the verdict is recorded simply as "manslaughter" the original charge of murder was reduced to one of manslaughter before trial.

Finally, the Committee asked if we could supply information of a similar kind on attempted "mercy killings". Unfortunately, such information is not recorded centrally.

We apologise for the room for confusion allowed by the original table.

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