**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 25 May 1993

**SIR STEPHEN BROWN**

**MR LUDOVIC KENNEDY**

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TUESDAY 25 MAY 1993

Present:

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

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**Examination of witness**

Sir STEPHEN BROWN, President of the Family Division, High Court of Justice, called in and examined.

*Chairman*

285. Sir Stephen, we are grateful to you for agreeing to come and meet the Committee and to look at some of these extremely difficult and sensitive issues which have been set out in our terms of reference. Could I start by asking you first, what do you see as being the implications for the Family Division of the requirement that application should be made to the court in any case where it is proposed that treatment and nutrition should be withdrawn from a patient in a persistent vegetative state?

*(Sir Stephen Brown)* As you know, it was Lord Brandon who indicated, in cases where a declaration was appropriate in medical cases, that it would be appropriate to make the application by an originating summons in the Family Division in the absence of any laid down procedure. That was in a sterilisation case, you will appreciate. Accordingly, a number of cases in different fields have come to the Family Division, for example sterilisation, where there is a mental incapacity and matters of that kind. That is, I suppose, why the originating summons in the *Bland* case was issued in the Family Division. The implications are that the Family Division would feel capable of considering these cases. There are suggested figures as to how many cases there are, but I think those are speculative, quite frankly, and the case of *Bland* was an extreme case. It would seem appropriate, in the absence of any legal framework specifically laid down by Parliament, that such cases ought to be examined carefully, in public if possible, with the Official Solicitor representing the interests of the unfortunate patient so that the matter can be examined on its facts. I feel the Family Division would be able to deal with these matters. Clearly we have no idea as to the extra weight of business it might engender, but so far we have not had any further cases. I expect we will have cases in the future and we shall have to do our best to cope with them when they come if this is the procedure which is to be continued.

286. There seem to be on the face of it, and I speak not as a lawyer, two possible ways in which the situation might in the future be modified. One would be to change the law so that it was in some way capable of dealing specifically with situations of this nature and, of course, the consultation document produced by the Law Commission makes suggestions which may be relevant. The second might be to wait until, in the words of Lord Keith, "a body of experience and practice has been built up which might obviate the need for application in every case". Would you wish to comment on which of those alternatives you might see as being preferable?

A. I would think Lord Keith's view is a very relevant and appropriate view. I think one would have to gain experience. Interestingly enough, I was talking to an Australian family judge this morning and they had this "conflict" in their discussions in the Family Court of Australia. I think they have come to the majority view at the moment that cases should be examined case by case for the present time.

287. Just one other point before, no doubt, other members of the Committee would wish to ask questions. Do you see any case for the restoration of the *parens patriae* jurisdiction in respect of patients who do not have the capacity to participate in decision-making about their medical treatment?

A. I think the case can be made for it, but I think it would be difficult to bring it about at this stage. No doubt Parliament could legislate accordingly, but I would think from a practical point of view (and I do view this from my position, of course, as a practical problem) I would have thought that the present procedure could be developed.

288. Did it lapse as a deliberate act of commission or do you think it was an act of omission?

A. The disappearance of the *parens patriae*—I think that this has lapsed. Indeed, as one sees with the passing of the Children Act, there are legislative barriers which have been erected in certain fields. I think those of us who exercise, have exercised, and still in the private field exercise the wardship jurisdiction, which is in effect *parens patriae*, are very conscious of its advantages. The flexibility which it gives to the courts is very wide.

*Lord Rawlinson of Ewell*

289. I find it difficult to take on board the concept of the civil court taking over, as it were, jurisdiction over a matter which basically is that of the criminal court, namely, whether a person was guilty of a crime

[Lord Rawlinson of Ewell *Contd*]
or not by doing, failing or omitting to do something. Is there any way the route could go, assuming the law was enacted, so that no prosecution could be brought save with the leave of the Attorney General and the Director being directed to deal with any private prosecutions? It does seem odd that the Family Division are, in a way, coming into the jurisdiction of the criminal courts.

A. When this matter came to me the Official Solicitor came to see me and said that he would like me, if possible, to hear this application. The originating summons did, in fact, seek certain relief which was framed as a declaration that no criminal offence had been committed. Because of that I telephoned the Attorney General and I said that this troubled me in the civil court and would he wish to be a party to the proceedings? After consideration he told me that he would rather instruct counsel as *amicus curiae* and so I held a directions hearing when, in fact, the Attorney General did instruct counsel, as you know, as *amicus* and that is how his interests were represented but at the end of the hearing I did not grant declaration in those terms because I do not believe a civil court has the power or jurisdiction, or should have the power, to say categorically that no criminal offence has been committed.

290. Is it not rather strange in a sense that the Attorney General has constitutional responsibility? *Amicus curiae* is rather different from the duties of the Attorney General.

A. Well, that was his decision.

*Lord Mishcon*

291. Following on from what Lord Rawlinson asked, is not the difficulty, if I may say so, in regard to a saving clause in any Bill that there will not be a prosecution unless the Attorney General issues a fiat and the Director of Public Prosecutions is consulted? Is the weakness there that nobody knows whether, in fact, he is going to be prosecuted until that decision has been made and the act has already been committed?

A. I think that is absolutely true, if I may say so.

292. Yes and if I may ask this question in regard to the Family Division because it is so pleasant, if I may say so, to have the benefit of your being here so one can ask it: is the present state of business in the Family Division together with the number of judges available such that an application of this kind that we were envisaging could be made and dealt with promptly?

A. We should certainly do that. We are very heavily pressed and we have not got any extra judges. In fact we are two down on what has been regarded as our establishment. One was taken away from us in February and we are still two down. One of our number has been for five and a half years President of the Employment Appeal Tribunal, for example, but these are problems which we have to face and I am continually having to face this. The amount of business is quite enormous but we do pride ourselves on being able to deal with the really urgent cases very speedily.

293. May I ask this question: do you regard it as being adequately prompt for a case of this kind from when it is initiated to have a decision made within a period of, say, three months at the outside?

A. Oh yes, certainly and in this case from the time the application was made it moved ahead very speedily and, of course, it went eventually through all its stages to your Lordship's House as well which was very salutary with such an important matter.

*Lord Mustill*

294. Sir Stephen, I felt some difficulty in working out exactly what was happening in the *Bland* case—and that is not a criticism at all because as far as I can see there is no other mechanism which could have got an answer to the question that needed answering. The fact is that that case started with the uncertainty of the doctors, the proper uncertainty which they properly referred, I think, to the coroner to get proper advice as it seems to me and from the start the criminal law was not in the background but in the foreground and one of the prime reasons (although not necessarily the only reason) why the doctors did not do what they and the family wished was because of the fear of criminal consequences which was perfectly proper. Now as a result of the relief granted in the Family Division and upheld on appeal, the doctors in a sense were free to do what they wanted to do, their anxieties had been dispelled, but at the same time the declaration was not a declaration of non-criminality in theory and yet that is what it really was in practice. My first question is do you regard this as a framework within which it is very easy to work and the second is, given a free hand, would you be able to design some other framework which Parliament might contemplate legislating? I am not talking about substantive law at all; I am not talking about euthanasia or anything like that, just is there a better way of getting these things decided?

A. I do not know at the moment. I must say I shall welcome help about that but, of course, the position of the court is that the court is faced with an application and the declaratory jurisdiction has been developed, particularly in relation to the medical profession, progressively in recent years—and I mentioned the sterilisation cases. I had over a lunch time one day a very urgent case which involved a caesarian operation where minutes were ticking by and I think the whole thing from actually coming to the notice of the court to my giving judgement was under 50 minutes. I managed to get assistance from the Official Solicitor in that time and that was a declaratory remedy which enabled the doctors to do something in an endeavour to save life and which did, in fact, save life.

295. If the Lord Chairman would permit me, I would like to follow this up just a little. I get the impression that this extremely valuable jurisdiction was enlarged very greatly, it seems to me, by *Re: F* and that is the law. There might be two views about that but that is the law which has up to now been preoccupied in ascertaining the right of those concerned. If one looks at *Re: F*—which for the benefit of any of the Members of the Committee who do not know, was the compulsory sterilisation of a mentally

[Lord Mustill *Contd*]

disordered girl "in her best interests" and that is where the best interests' doctrine comes from—almost all the discussion there was in the terms of can the doctors do this without this being a civil wrong, without this being a tort, an assault, a wrongful infringement of her dignity and things like that. In those cases the criminality of the act was very much in the background—I am sorry, I seem to be giving more evidence than you do but I am trying to make a point. For a case where all you are worried about is is it legitimate from a civil law and civil rights' point of view to sterilise a girl without asking her whether she wants to be sterilised, I think declaratory relief and the intervention of the courts is extremely valuable. *Bland* seems to move to a different dimension. What was really being asked was "Can we do this without murdering Tony Bland?" I wonder what your views were on the suitability——

A. I must say I think the use of the word "murder" is somewhat emotive. I realise that it was used but I think it is emotive in this instance because here we have experienced doctors faced with a real human position, with a "being" who is quite insensate, all ordinary life has disappeared and the framework of the body is being kept functioning—and I need not go into the details; the evidence was given formally in very graphic detail—and one had the feeling that here were doctors who were very anxious to do what they believed was in accordance with good medical practice and in accordance with their Hippocratic oath and who wanted to do the best for their patient, with the support of all those who were most closely involved and that was a really practical problem and the doctor, if I may say so, was at his wits' end to know what to do and the only way that he could achieve, as it were, some reassurance was to go to some authority and the court was the only authority and that is really how the declaratory relief has developed. It is a very real difficulty, is it not; as one has said, the poor patients being the prisoners of medical technology as it has advanced. I think it was the United States Supreme Court who used that phrase, and one is grappling with a very difficult problem indeed.

296. I am sorry, I think you misunderstand my question completely. I was not addressing the ethical question at all, or the question of whether the decision that you and the court reached was correct. I was on a rather different point. One of the things which had exercised this House was, what was the difference in law, not in morals, between what was being proposed in Tony Bland and the requirements of the law on murder. That is what exercised the coroner. What I was raising with you was not at all intending to question the motivation of everybody concerned, but to say, "Is this a good vehicle for deciding whether, just as what Dr Cox did for the best of motives was undoubtedly criminal, this was not", and we concluded that it was not. What I was asking was whether this was a good vehicle for getting the answer to that question of criminal law or whether there might not be a better one.

A. At the moment I am not aware of a better one, and I think that is the difficulty. I do see the juridical problems which were raised, and they were very clearly raised, but how do we develop answers to really practical problems which beset us with the so-called advance of civilisation?

*Chairman*

297. It was argued before us last week that it is a regular matter for doctors seeing a patient approaching the end of life to decide that the patient's condition is so terminal and that death is so inevitable that they would not under those circumstances, for example, prescribe antibiotics in order to prolong life and prolong suffering unnecessarily. That is never regarded as being a criminal act. The question upon which we would wish to know your view is whether, in your opinion, the actual withdrawal or withholding of artificial feeding, as in the *Bland* case, was significantly different from that decision that doctors regularly make?

A. I do not think it is, if the facts of the case are sufficiently strong and extreme. "One should not strive officiously to keep alive" I think is the phrase we sometimes hear.

*Baroness Warnock*

298. I am not sure my question has not been overtaken, but I will ask it all the same. Is it the presumption that if somebody—the Official Solicitor or whoever it is—represents the best interests of the patient that that must always be in the interests of prolonging his life? Is it the assumption that it must always be in the patient's interest to be kept alive?

A. I think the Official Solicitor really is here putting almost, one might say, the devil's advocate standpoint. He is raising all the points in order to see that the right result is achieved.

299. If it continues to be the case that application should be made to the courts in every case there would always be somebody raising the question of the so-called best interests of the patient. I am just wondering whether that would always be the presumption, that prolonging his life was representing his best interests?

A. I think for the time being that life is so precious and so important that one has to examine the facts very carefully indeed.

300. A great deal of the evidence concerned with voluntary euthanasia (which I know is a completely different question) is that it is not just life that is precious but the particular quality of life or the sort of life that one lives, rather than just a spark of life.

A. Poor Anthony Bland did not have anything at all.

301. This is really why I raise the question of whether it must always be represented as in his best interests; that the spark of life should be what is preserved, rather than the life he has to lead?

A. Yes, I think that is a very real point, if I may say so.

*Lord McColl of Dulwich*

302. Are you saying, Sir Stephen, that in fact there was no need to apply for this decision through

[Lord McColl of Dulwich *Contd*]
the court, because all they had to do was withdraw antibiotics, as indeed we do and have done for a very long time? In fact, if he had gone into a hospice at six months he would not have survived for more than two weeks.

A. I believe in Scotland they have never thought it necessary to make such an application, so I am told anecdotally. I think there is very little difference actually. Here was a doctor who was warned by the coroner who was dealing with the Hillsborough victims as a group, "Look here, if you do this you run the risk of facing criminal proceedings".

303. In so giving that advice are you saying that that was incorrect advice?

A. I am not saying it was incorrect; it was very wise, practical advice, because otherwise the position would never have been examined in detail. This is a very emotive area, of course. I think that there is a very good case for doctors who say, "We have examined this clinically, and in our ethical committee at the BMA. We have looked at the practice throughout the world. If we, the doctors, are satisfied that all meaningful life has disappeared [if one may use that phrase] then the time has come not to continue to feed". It is such a sensitive area that I think the public generally would wish it to be examined carefully.

304. I do understand. I understand the question of the withdrawal of feeding and I think that is rather different. What I was really going back to was withdrawing antibiotics and ordinary treatment, because that in fact is what has been going on for a very long time?

A. Yes, I think that is certainly the case.

Baroness Jay of Paddington] One of the practical ways out of some of these practical issues that you have been talking about for finding other solutions, as has been suggested, is giving some kind of legal force to the concept of the advance directive. Obviously that would probably not have been a practical solution in the *Bland* case, because he was a very young man and so on. What do you think the arguments are about the possibility of giving some kind of statutory status to an advance directive? Would that get around some of these problems?

Chairman] Before you answer, may I interject. I was going to follow up that point by saying, the BMA and the nurses seem to be opposed to legislation in relation to advance directives, and yet those who favour advance directives say that one of their objectives is to produce a means in statute to protect professionals from being, as it were, accused. What is your view on that?

*Baroness Jay of Paddington*

305. Possibly serving the best interests of both the patient and the person looking after them.

A. The problem is, with the advance directive, how long before? Conditions change and somebody who gives a directive at the age of 40 may not feel quite the same at the age of 60, and may find that life is really quite enjoyable.

306. There is a rather similar argument about a will. People may make a will when they are 40 and then want to revise it, but that does not mean the final will, or the intervening one, does not have the force of law even if they decided the day after that they would not give all their money to Aunt Agatha.

A. Yes, from the court's point of view, very helpful if I may say so, but I am not sure it is the final answer, particularly if the doctors do not want this at all. It is helpful for the courts because there is a legal situation which is presented to the court—a statute has its authority.

*Chairman*

307. You would agree, would you, that if they were enshrined in legislation, they could not be made binding on a health care professional because of the possibility of conscience preventing them from taking that action?

A. Yes, I would.

*Lord Rawlinson of Ewell*

308. Can I go back to the first point. Despite what Lord Mustill says, the application has always got to be made before the event and I just wanted to get into my mind that it is right, is it, to go to your court? In other words are you, first of all, the right court and, secondly, is it right to go to the court or is it not right to go to *the* authority which says, "If you do this there will be no prosecution"?

A. Are we the right court? That is hardly, in a sense, for me to say. Lord Brandon thought we were and I think probably our judges are fairly experienced in dealing with human conditions and emotive situations.

309. Not to the Lord Chief Justice of the criminal court?

A. Oh it certainly could do. We do not have a monopoly of jurisdiction, as you know.

310. I am just getting in my mind what is the best way in these cases.

A. I must say I do not see any reason to dissent from what Lord Brandon said in *Re: F*. We are certainly willing to accept the jurisdiction.

*Baroness Llewelyn-Davies of Hastoe*

311. Do you think there would be any danger of the practice growing up that it would be inevitable that it came to your court properly and then there would be a lot of delay and appalling expense for the people who want to bring it? Do you think it would automatically become practice that cases had to go to you?

A. I think it is a developing situation. I think the point has been made, as Lord Keith indicated, that one would have to see how it develops. It is difficult to forecast in advance but when one thinks of it, if the medical evidence is very clear, the evidence of the doctors would be available and could be assimilated quite quickly. I do not see why there should be delay to any great extent when the facts are clear. If there is a dispute, of course, then that is another matter.

Chairman] I fear that several Members of the Committee will wish to go and vote in the division now called but before they do Lord Mishcon will pose a short question to you.

*Lord Mishcon*

312. Sir Stephen you said, rightly in my view, that the term "murder" was emotive and did not seem very appropriate for the case that you quoted in regard to a doctor exercising his conscience to the best of his ability. Would you as a very experienced judge, if I may say so, regard it as useful if the law provided for different degrees of killing, one of them being mercy killing and not the word "murder"?

A. Yes.

*The Committee suspended from 4.58 pm to 5.07 pm for a division in the House.*

*Chairman*

313. There are just two things that I would like to take up with you and which other Members of the Committee may want to amplify. The first is that the BMA made a suggestion to us which is not dissimilar from that which is being made by the Law Commission in its consultation document, to the effect that there might be some kind of local community mechanism whereby the health care team could in the case of an individual who was incompetent, whether by virtue of a physical or mental disease, have authority to take decisions about very minor matters such as dressing an abrasion or suturing a small cut. However, they also suggested that there should be established a local committee with medical, nursing, lay and legal representation which could take decisions in some of the more important or difficult cases. Finally in the most sensitive cases, such as the issue of sterilisation as in *Re: F* (to which you referred) there should be the opportunity of a more powerful judicial type of forum with, of course, the reservation that if there were disagreement the case must still be referred to the High Court. Do you see advantages in that kind of three-tiered local network?

A. Yes, I do. I think from a practical point of view that has a lot to recommend it.

314. Thank you. The final question which has been pointed out to us that it seems curious that if you push a person into a river and he or she drowns that is murder but if you see somebody drowning and do nothing to go to their aid that is not an offence.

A. You are under no duty.

315. That is right.

A. The problem with a doctor is he has a duty to care for his patient.

316. Yes, I realise that. It did not strike us in the beginning that "easy rescue" as it is called fell within our terms of reference; but it has been pointed out to us that it could do. We are not talking about the duties of a doctor. Do you feel from what you know of our terms of reference this is something we should look at or leave aside?

A. I think, if I may respectfully say so, you should leave it aside.

Chairman] Thank you very much. We are very grateful to you and if you have any afterthoughts please do not hesitate to write to us.

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**Examination of witness**

Mr Ludovic Kennedy, called in and examined.

*Chairman*

317. Mr Kennedy, thank you very much for coming and being willing to talk to us. We, of course, have all seen what you call "Counterblast",[1] or at least what your publishers call "Counterblast", and I read it with interest. It seems perhaps an unfortunate title for a book which I thought was written in a very dispassionate and thoughtful way. Having said that, may I take it, as you make clear in the volume, you are not wishing to come and talk on the issue of the incompetent patient? You say that is not within the terms in which you are writing; you are looking simply at the issue of voluntary euthanasia?

*(Mr Kennedy)* Yes, that is right, my Lord Chairman. If you want to ask me any questions about anything vaguely related to this subject, of course, I would be very happy to answer it. I just have to say one thing before I start, and that is I am very deaf and I did not hear all that was said to Sir Stephen just then or very much of what he said so I would be very grateful if people could speak up.

318. We will do our best.

A. I have prepared a brief opening statement. I do not know if you want to hear it or not.

319. We shall be very happy to hear it. Thank you.

A. As you say, the "Counterblast" booklet has been distributed to Members of the Committee and I would be happy to answer any questions relating to it. All I want to add is this: since I wrote that pamphlet some years ago the voluntary euthanasia movement has grown apace, not only in this country but throughout the western world. The World Right to Die Federation which did not exist 13 years ago, now has more than 30 branches in 20 countries. The position in Holland where voluntary euthanasia has been permitted, although not legalised, since 1981 has been confirmed with the Dutch courts. In two American states recently referenda in favour of voluntary euthanasia were narrowly defeated, largely because of the seemingly unlimited funds for

[1] *Euthanasia: The Good Death*, Counterblast No. 13, published by Chatto and Windus, 1990.

[Chairman *Contd*]
advertising available to the chief opponents of the proposal, the Roman Catholic Church. In this country membership of the VES has increased dramatically in recent months. I get requests for their address almost every day. The most recent of their public opinion polls, I think you know, embracing members of all religious affiliations and of none, showed 79 per cent of those interviewed to be in favour. There have been similar findings in other countries and I had personal experience of this trend when I covered for the *Daily Telegraph* the trial and conviction of attempted murder of Dr Nigel Cox. Of the 80 or so letters I received in response to my article, all but four expressed the hope that if ever they found themselves suffering in the way that Dr Cox's patient had suffered, that another Dr Cox would be at hand to help them on their way. I have no doubt at all—and nor, I am sure, do you my Lord Chairman—that if the Cox case had come about twenty, perhaps even ten, years ago, the GMC would have had little hesitation in striking him off the register and had the charge against him been murder instead of attempted murder, as it might have been, then the judge would have had no option but to sentence him to life imprisonment. The *Cox* case, the *Bland* case and the other facts I have given you are clear indications of the strength and speed of the growth of a movement which affirms that there are, and indeed must be, exceptions to the generally held belief about the preservation of human life—a view which the Law Lords recognised and, indeed, endorsed in their judgment on the *Bland* case. For what people have increasingly come to realise is that what really matters—and this is the heart of it—is not the length of life but the quality of it. The reason for this change of attitude, I submit, is that while in the past the great fear of euthanasia was of our being snuffed out accidentally or deliberately before our time, the dominant fear today is of being denied release from a prolonged period of painful, distressing and undignified dying. When I spoke on this subject to the Cambridge University Union I expected the hall to be a quarter full, most members there being under the age of 25. In fact, it was full to overflowing; and when I asked the president the reason, he said that many of those present either had a terminally ill relative or knew a friend who had a terminally ill relative whose life, because of modern medical techniques, was being unnecessarily lengthened. What so many people fail to realise is that while the life force is strong in most of us, the wish of many terminally ill people to die—"to cease upon the midnight with no pain" as Keats put it—is no less strong. It was my mother's wish, which could not be granted, it may be my wish—though I hope not just yet—and in time the bell may also toll for you.

320. One journalist recently wrote about the work of this Committee, that the House of Lords, she thought, was better at looking at issues of death than the House of Commons, perhaps because most members of this House were somewhat closer to it than members of the other place!

A. It has been estimated by the year 2030, Dr Admiraal told me this, that half the population of Europe will be over sixty. So the problem is not going to go away; indeed the demand for release from intolerable suffering is going to increase year by year. The Roman Catholic Church remains implacably opposed to it, as it was also opposed, and still is, to contraception and abortion. The British Medical Association, equally reactionary and lacking in both courage and perception, has decided to walk away from it. I trust that this Committee will not do the same.

321. Thank you, Mr Kennedy. May I just ask you at the outset, it has been suggested to us by the medical and nursing organisations in particular that the methods of treatment of terminal illness and palliative care have now improved so much that there should be no need for anyone to have a terminal illness characterised by intense suffering which cannot be relieved. Secondly, it has been suggested to us that in the case of Dr Cox, to which you have referred, if he had given, in order to relieve his patient's pain and suffering, very high doses of sedatives and analgesic drugs, rather than by giving an injection which could have only one effect, namely that of terminating life, that the issue would not have come before the court. What is your view about those comments?

A. My view, my Lord Chairman, about palliative care, it is quite true, it has improved enormously according to the information that I have been given. I do not think that this alters the fact that terminal patients sometimes, perhaps often, get to a stage where they simply do not want to go on. It is not only a question of pain—pain, I understand, can be relieved to a great degree but not as much perhaps as the BMA and Cicely Saunders would think it can, I think they exaggerate there, and Dr Morley of the Liverpool Pain Research Institute thinks they exaggerate—but it is also the side effects of what an illness can do. I am talking about things like double incontinence, about oedema, about bed sores and about discomfort which lasts all day and perhaps all night. Okay, you can keep the patient sedated; you can keep them so that they do not suffer very much, but this is not what they want. They want to go. My contention is that they should be allowed to go and should be given help to go. As far as Dr Cox is concerned, I think myself that he got in a panic, and I do not blame him. This woman had asked him a week earlier if he would help her to ease her on her way and he said he could not, it was against the law. Then he had this extraordinary thing, that she was given this rather large dose of diamorphine and, I am told, (and you would know far more about this than I would) that owing to the metabolism of Mrs Boyce this had the opposite effect of what was intended. It did not help to ease her pain, in fact it made it worse. Here again, the Pain Research Institute have got something to say on that subject. I think he lost his head. Yes, of course, if he had stopped to think about it he should have got hold of somebody in the palliative unit and he should have given her some kind of other drug. Here was this woman screaming, as one of the nurses said, like a wounded dog, so whenever she was touched it was agony to her and he just thought, "I can't stand this any more, and I'm going to do what I think the right thing is". I think

[Chairman *Contd*]

there was one case some time ago, and I cannot remember where I read it now of a doctor saying that in this situation "the law does not allow you to do to a patient in that state what the law would blame you for not doing if it was a question of a dog".

322. May I follow that point up by going on to some of the arguments that have been proposed against the legalisation of euthanasia. First of all, in Holland it seems to be a rather curious situation that, although you say the position has not been fully enshrined in law, doctors are now able to give an injection in order to terminate life and are only then required to report the case to the coroner, who must then decide whether or not a prosecution is appropriate. The second point is the argument that is continually advanced is that if doctors were allowed legally, even with the advice and consent of an independent colleague, to give an injection to terminate life, how could one exclude the possibility of coercion or collusion? In other words, what do you advance against the slippery slope argument?

A. The first point, of course, refers to the Remmelink Report. The anti-euthanasia lobby has lit on a section in the Remmelink Report which, of course, concerned a confidential questionnaire sent to a great many doctors (I think most of the doctors in Holland) about what their practices were. In that questionnaire they were asked if they had ever given involuntary euthanasia to terminal patients, and I think this was in 1991 and something like 1,030 doctors said, yes, they had. The anti-euthanasia people here said, "Look, this is what happened in Holland. You have voluntary euthanasia and it leads, of course, to involuntary euthanasia", but, my Lord Chairman, this happens in this country all the time. I am not telling you something you do not know. In the last two or three years, in my researches for this pamphlet and also for a lecture I am going to give later on next month, I have talked to many, many doctors, from GPs, to specialists, to one or two presidents of medical institutions, and I have absolutely no doubt in my own mind that every day of the year hundreds of doctors are helping patients who are in a terminal state and have days to live, perhaps only hours, or perhaps weeks to live, but are helping them on their way. I think it is very wrong and dishonest of people to bring out this Remmelink Report as though this happened in Holland because of them bringing in their very liberal laws. The slippery slope argument is one I think they have met with in Holland, but when we talk about Holland, my Lord Chairman, could we talk about the principle of the thing. I happen to believe that in criminal justice the inquisitorial system has got something to recommend it, but all the people here who are wedded to our own system say, "Look what the French are doing. They're making the most awful mess of it. If we had that here we'd make the same mess of it". I do not think it would—but it is the same thing here, people say, "Look at Holland, it all goes wrong there." Well I do not think that it does go wrong there and I think that the safeguards that they have brought to bear are probably adequate. Safeguards can always be improved on but I think that you know as well as I do that the doctor concerned must consult another doctor he does not know either socially or professionally. The request for voluntary euthanasia must be in writing, it must be witnessed and it can be withdrawn at any time in the same way that an advance directive can be withdrawn at any time, the next of kin must be informed but cannot have a decision on the matter and things of that nature and maybe more can be found but those to my mind are the most important defences against the "slippery slope" argument.

323. How can you be satisfied that patients making a request towards the end of life for euthanasia are not doing so for fear of being burdensome to family or friends or because of depression or anxiety or some other mental disturbance which might lead them to have become tired of life; such a condition could be eminently treatable. Admittedly, of course, this should be recognised by their medical attendants but what safeguards could possibly avoid that kind of problem?

A. Well, I think you really do have to trust the medical profession. I think this matter is entirely a medical matter. I do not think any doctor or two or more doctors, which would have to be the case in determining a case, are going to be fooled by that sort of thing. A relative can put pressure upon a patient but the doctor, if he is any good at all, will be aware of this and will be in close touch with his patient. I think the doctor can decide whether a request for euthanasia from a patient is genuine or not. What I think people who are against euthanasia will not accept is that for a lot of these people life really has lost its value. The life force is tremendously strong in healthy ordinary people; it is tremendously strong, it is the strongest motivation we have, to keep alive. Therefore I think it unlikely that if somebody really does have a life force, even if they are in a late stage of illness that they are going to succumb to a relative saying, "Come on, it is time you moved on; we want your bed," and that kind of thing. I do not think that is very likely to happen and, as you all know, people get very depressed and say, "I want to end my life and all that kind of thing," but here again a doctor who is any good will be able to diagnose that. You see in Holland the demand for euthanasia really does have to be sustained. I could not tell you exactly what the time period is but certainly it is days, probably weeks, if weeks exist. So I think that that problem is taken care of.

324. You will appreciate that some of the counter arguments that we are putting to you are not views that are necessarily held by members of this Committee but are views that have been put to us by other bodies. There is a danger there—I hope you will not mind me saying so—of a circular argument where it is being suggested by you that the doctors must be trusted but others have said that one of the dangers of legalising voluntary euthanasia might be that this would destroy trust between doctors and patients because patients might come to the conclusion that the doctors would terminate their lives at a time when they did not wish that to happen.

A. Could you just say that again, Chairman, I just missed that.

[Chairman *Contd*]

325. The point I was making was that for instance the BMA, and not just the BMA but the nurses too, have suggested that if euthanasia were to be legalised this might impair or even damage the trust between members of the health care team on the one hand and the patient on the other, some of whom might feel that there was a risk that their lives might be terminated when they did not really wish it.

A. Let me say I have shifted my ground on this point since I wrote this pamphlet. I have agonized in my own mind for a long time as to the merits of having voluntary euthanasia legalised or not. I have now come—although I may change again; we all do—to the conclusion that it should not be legalised but some kind of arrangement as they have in Holland should apply here and the reason I say that is because I think if it was legalised it would frighten too many people. The fact that it would be there on the statute book would frighten too many people and for that reason I would not want to see it. It may come to that eventually if it operates in a satisfactory way for 10, 20 or 30 years when people may feel that it is time for it to be formalised but I do not think so at the moment. Now the question about the trust, I take the opposite view. I think far from destroying the trust between a doctor and a patient, it will do the opposite; I think it will enhance the trust. Dr Admiraal told me when I saw him in Holland that it gives many patients release and relief to be told as a last option for them euthanasia is available. The interesting and paradoxical thing about that, he told me, is that, having told them that, they are enormously pleased and gratified to know that their suffering can stop if they want it to, but many of them do not take advantage of it.

*Lord Mishcon*

326. Mr Kennedy, as I understand it, you have now come to the conclusion—it may be a temporary one—that voluntary euthanasia should not be legalised. Have you any advice to give us as to the procedures then that should be adopted if doctors agree that euthanasia is the correct end of this life and the patient expresses a wish? What procedure have you got in mind for that to be a non-criminal matter?

A. Well, now, Lord Mishcon, we are getting into medical affairs, are we not? You are asking me what kind of drugs——

327. I am so sorry; I think you did not hear me. I am saying if it is not legalised and the doctors agree that euthanasia is a proper course ethically and medically from their point of view and the patient has, in fact, requested it, what procedure to safeguard the doctors have you got in mind, if we have not got it on the statute book but where they are acting legally.

A. I think we have to have something similar to what they have in Holland, that is to say that the Supreme Court in Holland said that if doctors follow certain procedures and safeguards, as are listed in that book, they will not be prosecuted and this, of course, means being absolutely clear and open about it and making a report to the coroner, which is what I would advocate here. In that way, as long as they follow those guidelines they will not be prosecuted. I do not see why we cannot do something similar here. I think it is a nice point as to whether you are going to legalise it or not and I personally think it is too early for that but I do not think it is too early for permitting it in the way that they do in Holland.

328. Mr Kennedy, you do of course realise that the procedure in Holland is literally a *post mortem* procedure, namely it takes place after death has occurred and the coroner should receive some sort of registration of particulars. Therefore to some extent the doctors concerned do not know where they stand. Would you not think it proper that there should be a procedure before the death takes place by way of an application to somebody, be it the court or some other body?

A. I do not know about that. Perhaps you are right. I do not know if you agree with what I said and submitted a little while ago, and that is that euthanasia is going on here every day of the year. Doctors are helping patients on their way. I have talked to them. I could give you a list of 15 or 20 doctors I have talked to who have done this in the past and who are doing it now. You know this dilemma that they have. As long as they give a drug which is ostensibly to relieve pain they can do it without fear of prosecution. Who is to say for what reason they are giving it? I know perfectly well that a great many of them are giving it in order to bring that person's life to an end and it seems to me a most compassionate thing to be doing. But who is to say? It is a very difficult problem, I quite agree with you, but I think in view of the fact this is done so frequently that it is a small step really to formalise it.

*Baroness Jay of Paddington*

329. Could I ask you two questions about formalising this, which is not going as far as you say you no longer wish to do, legalising voluntary euthanasia. Do you think it would be helpful, as Lord Mishcon asked Sir Stephen Brown, if there was a legal concept of mercy killing which would, as it were, lower the whole procedure? Secondly, what do you feel about the advance directive, if that was given some kind of legal status? Would that be another prop in making the whole situation clearer from your perspective?

A. I think mercy killing is one of the most difficult areas there is. If there is any one group of people for whom voluntary euthanasia were permitted, either legally or some other way, it is them. Every month you read in the papers of some appalling case of a patient who is at home and in pain and suffering greatly who says to a near relative, "Please, please, help me on my way. Please, please please", and they say, "No, we can't, it's against the law", and then finally in many cases of this kind they succeed and they do. They are honest about what they have done and they admit it and they are taken off to court and charged with murder. 20, 30 or 40 years ago they would have been sentenced to a term of imprisonment and now what happens is that they have to endure the trauma of a trial, when they have helped to end the life of somebody they deeply love, and

[Baroness Jay of Paddington *Contd*]

the whole thing is a tragedy and a farce. Half the court is in tears and the judge mostly discharges the person absolutely, or gives them a lesser sentence in some way, and everybody goes home and that is the end of that. That, I think is awful. What I would like to see, and this is one of the reasons I am so keen about voluntary euthanasia, if a patient at home felt they did not want to go on, they did not have to turn to a relative; they would be able to ring up or send for their local GP and say, "Look, I've had enough. I want this to end".

330. I really meant, could you not adapt that principle of mercy killing to the concept of voluntary euthanasia more systematically applied by the medical profession, and not the anguished relative you have described? Would that get round one of your difficulties of a halfway house which is not having voluntary euthanasia fully legalised but making the situation more comfortable in your terms for those undertaking it?

A. Yes, I see what you mean. Who would decide whether it was a mercy killing—the doctor?

331. That is back to the point which Lord Mishcon was raising.

A. Yes, that is right. I certainly would not want it to be done by one doctor, but if you had two or three doctors I think that would be in order. There are so many people in these terminal stages who are unhappy, I think the idea that you have to go to some kind of tribunal or make an application to somebody beforehand would not be right. I do agree absolutely in the *Bland* case for people in the future in a persistent vegetative state that that should go to the courts in the first instance, but then I think that is another matter. Your second point about the advance directive, the Master of the Rolls (correct me if I am wrong) said in the appeal of the *Bland* case that if he had made an advance directive and the doctors who were looking after him did not obey it and did not follow it through, even if it resulted in the patient's death, that would be an unlawful act on their part. It would be perfectly lawful if they were to do what he had asked them to do. I am saying, for the sake of argument, if he had developed into a persistent vegetative state and said that if he did in his advance directive that they would be obliged not to give him any more sustenance. That, I think, was endorsed by the Law Lords, was it not?

*Chairman*

332. I think Lord Mustill will speak in a moment or two. One of the points which has been made to us by many people who favour advance directives is that they are concerned about them being enshrined in law and they certainly would not wish them to be binding upon members of the health care team perhaps on the grounds of conscience. Your argument clearly favours the proposal that the advance directive might have the force of law?

A. Yes, I am sure Lord Mustill will straighten that out for me, but that is what I understood it to be and that the Law Lords had more or less said the same thing. That is a very dangerous area. Professor Dworkin, who you are going to see later on, brought out a case of somebody who had Alzheimers Disease, not the kind of Alzheimers Disease where somebody was totally incompetent but where they were being fed and watered and seemed quite happy gazing out of the window, and had made an advance directive that if they got into a persistent vegetative state they did not want to be resuscitated. It would be terribly hard and it would be unthinkable to start saying to people like that you have got to withdraw food and drink. There are degrees of this thing which have got to be considered.

*Lord Mustill*

333. I would like to go back to two linked questions which we looked at before. The first was calling up the Dutch experience. I think there is a slight difficulty here because there are very different signals coming out of Holland. Could I just concentrate on the procedure which you mentioned, which essentially involves the decision by the state prosecuting authorities not to prosecute and an assurance to the doctor that that will happen in an individual case. I find it rather difficult to see the difference between that procedure, which you advocate, and legalising what has been done. If you are not going to be prosecuted for it and told officially that you are not going to be prosecuted, *de facto* it is being legalised or at least decriminalised, which is the same thing. I am not picking on you but am a little puzzled by the distinction.

A. I think it is simply this distinction—I have appeared in a lot of discussions and debates and television and radio programmes and things in the papers in the last year or two and there is no doubt in my mind that some people are really terrified that if this becomes law they will be in jeopardy. It is as simple as that. You may think this is compromising and you may think it is cowardly not to go the whole way, and you may well be right, but that has been my experience. I think it is too sudden a shift from one state to another.

334. It is such a difficult area I do not think anybody is going to criticise anybody for holding views or for saying they are not always logical, because life is not logical. Could I then go to another area linked with this which I find a little bit difficult. The idea of it somehow or another recognising the area of mercy killing is one that is often put forward, to which I believe you subscribe if I understood what you said earlier this afternoon. There are two ways you can deal with mercy killing—one of them is to identify situations which will rank as mercy killings, and you define them by statute and then you decriminalise them. You provide by statute that if thus and thus characteristics are satisfied that there is no crime. The other which I have heard put forward is that you should have a new crime called "mercy killing". The advantages of this are said to be, first, that you get rid of the nasty overtones of the word "murder", which people do not like associated with doctors who are doing their best; and, secondly, you get rid of the mandatory life sentence, which is another matter. Those are two entirely different propositions. If you have a crime of mercy killing it

[Lord Mustill *Contd*]
involves, first, that it must be wrong because otherwise it would not be a crime and, secondly, that you have got to punish it. Which of these two proposals do you advocate, because the first is really the same as decriminalising certain kinds of euthanasia?

A. You are saying if you make mercy killing a crime you put it in a different category to other forms of murder.

*The Committee suspended from 5.46 pm to 5.52 pm for a division in the House.*

*Chairman*

335. My apologies for that interruption.

A. Could I just say in reply to Lord Mustill's question about mercy killing, that until I came into this room today I had never heard the suggestion before. I do not know if it has been given wide publicity or not but I think it is interesting and with your permission I would like to think about it and perhaps at a later stage I could make a submission on my views on that.

*Lord McColl of Dulwich*

336. When you say that euthanasia is practised every day and is going on all the time, do you mean what is going on in the hospice movement, and in the domiciliary movement and in every hospital in the country of relieving people not only of pain but also distress because it is not just pain that we relieve. If somebody has a cancer of the lung, they may not have any pain but they certainly may have a great deal of respiratory distress and it is our intention and we do in fact relieve that stress at all costs by giving them the appropriate drug but we do not give them drugs that have no therapeutic value like, for instance, intravenous potassium. Could you clarify what you meant?

A. Would I be right in thinking—and I am not an expert on drugs by any means—that a painkiller of sorts (and it may not be relevant in the case you are mentioning) like diamorphine is able to be given with a sedative of some kind. Now it is hard for me to say because I do not have the clinical experience of what exactly is being given for what but my understanding over a great many interviews is that a great many doctors will help a patient who is in distress, who is in some degree of pain too, on their way with a drug of some kind. That is my understanding.

337. I just wonder whether the understanding is correct because what we are doing is relieving pain at all costs and in fact initially when we give regular pain relief in this way the patient may become more conscious at first because we have removed the pain totally if you give it regularly every four hours but if, as we go on continuing to relieve their pain, we depress their respiration and they die, that is a perfectly acceptable thing.

A. Yes. I just want to get this right myself. You say it is a "perfectly acceptable thing" because the doctor has not given a lethal drug.

338. He has given a lethal drug but not with the intent to kill the patient there and then but only to relieve their pain.

A. Not there and then, that is right, but it has a double effect, does it not? You give this thing and you know that over a certain dose this will result in death.

339. No, we do not, you see because we can go on giving more and more and you never know and one is often surprised when it happens. Could I also deal with the question of not being able to relieve pain in some cases. If somebody is in such distress you can give them a general anaesthetic, no problem. So it is not really true to say that you cannot relieve pain; you can and it is our job to. But it is not only pain, it is distress of all kinds.

A. That is right. You can put them under, can you not, and keep them under but is that really better in the end than giving them a quick dose of something that is going to kill them?

340. Well, there is another side to this and that is that those who are looking after the patient, the nurses, I think their views have to be taken into account and for them suddenly to change their role of nursing and looking after the patient to deliberately terminating life is a very very stressful thing for those of us who work in the health care set up and I think that has not been mentioned enough.

A. I am absolutely sure that is true but let us face it this whole subject is a very radical revolutionary thing we are talking about. We are talking about something not just for the nurses, but certainly for them particularly because they are on the spot as it were, but for society as a whole; this is a very big step.

341. But the point I am making is that it is not a step that has just been taken. We have been doing this for over one hundred years; it is not a new thing.

A. I am sorry, what have you been doing for over a hundred years.

342. Relieving pain and distress at all costs.

A. Yes, which can often result in death.

*Chairman*

343. You see, Mr Kennedy, the medical witnesses we have seen have distinguished between on the one hand a deliberate act of terminating life by a method which can have no other consequence and which is still murder within the terms of the law, while on the other hand they have recognised there are many circumstances when they have to give treatment, as Lord McColl has said, to relieve pain and suffering which has the secondary effect of shortening life. The distinction may not be a moral one but they believe that in practice there is a distinction between the two.

A. Yes, I understand that but again I have talked to Dr Admiraal about this quite a lot and he said that the difficulty about giving a drug which does not have the deliberate effect of killing somebody but does relieve the pain as a means of helping them towards an end is extremely unreliable because the metabolism of different people varies very considerably.

344. We accept that.

A. And what they want is a quick and dignified

[Chairman *Contd*]

death and this can only be met by some kind of drug like potassium chloride or curare or something of that nature.

Chairman] We understand your point of view on this issue. Archbishop of York?

*Archbishop of York*

345. Forgive me, Mr Kennedy, if you dealt with what I am saying in your earlier submission, which I missed. From what I did hear of you, you were giving very moving examples of individuals suffering distress. I think all of us in the face of individual cases feel the kind of compassion that you were expressing. What I have not heard and have not seen in your book is any recognition of the wider social consequences of the change of perception towards the process of dying, and the kind of pressure which that changed social consciousness then puts on people who might not otherwise have thought that euthanasia was for them. I was wondering how you would yourself understand that change of perception, whether you would welcome it or whether you would deplore it? Just to give an example of what I think is a changed perception in your own book, I was somewhat startled to read on page 24 that the argument about life being sacred is nonsense. You then go on to justify this on the grounds that in many cases the principle of the sacredness of life is violated. I am wondering whether you are saying that the idea about life being sacred ought to be regarded as nonsense, or is in practice regarded as not absolute?

A. I am not a religious person and therefore the words "sacred" and "sanctity of life" are the wrong words.

346. "Respect for life"?

A. "Respect for life" or "preservation of life", whatever you like, I would not use that particular language.

347. Would you hold to that view as something which ought to be so, namely that you ought not to regard "respect for life" as a key value?

A. No, I certainly do not think that. Generally we all believe in having a respect for life. What I was going to say was, I think I am right in saying that the Law Lords made this very point in their judgments in the *Bland* case. I think they said that everybody generally subscribes to the belief in the sanctity of life, but there are exceptions. It is not absolute, I think they said. I have the report here, but you will know better than me. It said something to that effect, that it is not absolute and can be rebuttable. That is my view there. As far as the change of perception is concerned, I imagine we are talking of a patient, and if he or she felt that voluntary euthanasia was available to them, where this was a thought which had not crossed their mind before and what about it.

348. That is it but also as part of that the kind of social pressures that people feel when they say, "Is this something that I want, but is this something that I ought to have in order to save money on the National Health in order to relieve my relatives and so on?" You develop a euthanasia-mindedness, in much the same way as much of society has developed an abortion-mindedness?

A. Yes, that is true. As I said earlier on, I do believe the life force is very, very strong in all of us who are well and healthy. In old people, and even dying people, it can be. We are only talking here about a minority of people. Most people keep their—I do not say "enjoyment"—awareness and stake some sort of pleasure in life right up until the end. We are only talking about a minority of people who do not. We have this argument about what the relatives and what the next of kin might say, "It's time you moved on", and so on and so forth, but I do not think if you have got a strong desire to live that this would have any effect; what is more, I think a good doctor will see this happening and take the patient into his confidence and talk to him about it. I have to add this: we are moving into an age now when more and more old people are going to be supported by more and more younger people and resources are finite. I think it is possible that in the years to come—I do not say now, but 15 or 20 years from now—when there may be pressures on people to accept death perhaps earlier than they would have done. I think there could be but I do not think that if we have voluntary euthanasia that is going to be the slippery slope that is going to lead to that. I think that is another matter.

*Lord Rawlinson of Ewell*

349. Mr Kennedy, on page 13 of your pamphlet you quote the 72 per cent figure in 1985. Was that 72 per cent figure in favour, was that the answer to the question which was "Some people say that the law should allow adults to receive medical help to a peaceful death if they suffer from an incurable physical illness that is intolerable to them, provided that they have previously requested such help in writing?"

A. I could not tell you exactly what the wording was because I have not studied it but I think it was the same wording—and the VES will tell you—as appeared in the most recent one.

350. They told us in their paper that that was the question that was posed and some Members of the Committee were asking would you not expect 72 per cent to answer in favour if the question is posed in those terms?

A. Yes. Are you saying it should have been phrased in some different way?

351. "Some people say that the law should allow adults to receive medical help to a peaceful death"—do you think that accurately and fairly presents the person being questioned as a statement as to whether they are in favour of voluntary euthanasia or not?

A. In a broad sense I think it does.

*Lord Colwyn*

352. Forgive me if I have not understood what you said earlier but I just want to clarify the point—when you said you had interviewed lots of doctors and, indeed, prospective patients perhaps—when you say that euthanasia is very commonly practised

[Lord Colwyn *Contd*]
although we do not necessarily hear about it, are these doctors actually giving injections which terminate life prematurely or are you referring to opiates and drugs in the home? Are you aware of doctors who are actually terminating life with drugs such as potassium chloride?

A. The trouble with answering this question is that naturally doctors are very very discreet about what they say because they know that what they have done is to break the law and therefore they simply are not completely, I do not say honest, but are not detailed about what they have done. As I understand it I think that many doctors have given more doses of something like diamorphine than the patient's condition would warrant and there have been others I have met, and the head of quite an important medical institution in this country has told me that he believes not only that but they have given them what Dr Cox gave Mrs Boyce as well and this surprised me very much but it was from a man for whom I have enormous respect.

Chairman] Thank you very much, Mr Kennedy. Does any other Member of the Committee wish to raise any other points? We are very grateful to you for coming along and if you have any afterthoughts or wish to submit any supplementary evidence we would be very happy indeed to see it. Thank you very much.

**Memorandum by Ludovic Kennedy**

1. I would ask the Committee to be very careful in its employment of the phrase "sanctity of human life". I notice that the phrase was used in a question to the representatives of the Voluntary Euthanasia Society. The word *sanctity*, like sanctify, sanctum, sacred etc., has a specifically religious connotation in that it posits that the sanctifying is being done by God. Professor Dworkin makes the same mistake when he talks of the *sacredness* of life. He also uses the word "religious" about people's attitudes when what he actually means is "moral". I trust the Committee no longer subscribe to the view current in my younger days that a sense of morality can only come from a belief in God.

Human beings everywhere share an instinctive revulsion against the needless destruction of human life, an equally strong predisposition to preserving it. But we live in an increasingly secular age, and I would submit that in future this thought should be expressed by the Committee in other than religious terms.

2. I was asked what I thought about a suggestion of creating a new criminal offence called *mercy killing*. I am against it. I cannot see what sort of situation it might encompass that is not already encompassed by the offence of manslaughter. I am also against the "kill" or "killing" forming any part of a new statutory offence in relation to voluntary euthanasia. It is a loaded word which the BMA and the Roman Catholic Church do not hesitate to use pejoratively. I have always regarded it as positing a situation where the victim's consent to his own death has not been obtained—the very opposite to the whole concept of voluntary euthanasia. After all, when we have a pet in terminal decline, we do not ask the vet to "kill it", rather to put it to sleep or end its sufferings. Even more do we need that sort of language when it comes to human beings.

3. At Q.333 Lord Mustill asked me what the difference was between what they do in Holland where voluntary euthanasia is permitted but not legalised, which I also advocate and having it legalised. I replied that to legalise it here, as it were in one fell swoop, might unnecessarily arouse some people's fears. All the doctors I spoke to in Holland were in favour of retaining their system, and when the Committee visit Holland, as I understand they will do, this is a matter they might like to pursue further.

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