

September 1998

# That Which Does Not Kill Us, Does It Makes Us Stronger? Legal Aspects of Pain Management in Great Britain

Wendy E. Smith

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### Recommended Citation

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# COMMENT

## THAT WHICH DOES NOT KILL US, DOES IT MAKE US STRONGER? *LEGAL ASPECTS OF PAIN MANAGEMENT IN GREAT BRITAIN*

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“When life is so burdensome, death has become for man a sought-after refuge.”

—Herodotus (c. 485–c. 425 B.C.)<sup>1</sup>

“[M]ere living is not as good, but living well. Accordingly, the wise man will live as long as he ought, not as long as he can. He will mark in what place, with whom, and how he is to conduct his existence, and not the quantity, of his life. . . . It is not a question of dying earlier or later, but of dying well or ill. And dying well means escape from the danger of living ill.”

—Seneca, *Epistula Morales*.<sup>2</sup>

“To kill oneself to escape from poverty or love or anything else that is distressing is not courageous but rather the act of a coward, because it shows weakness of character to run away from hardships, and the suicide endures death not because it is a fine thing to do but in order to escape from suffering.”

—Aristotle, *Ethics*.<sup>3</sup>

“God has reserved to Himself the right to determine the end of life, because He alone knows the goal to which it is His will to lead it. It is for Him alone to justify a life or cast it away.”

—Dietrich Bonhoeffer, *Ethics*.<sup>4</sup>

“I’m not afraid to die but I am afraid of this illness, what it’s doing to me. I’m not better. I’m worse. There’s never any relief from it now. Nothing but nausea and this pain. . . . Who does it benefit if I die slowly? . . . I’m stuck—stuck in life. I don’t want to be here anymore. I don’t see why I can’t get out.”

—B. Rollin, *Last Wish*.<sup>5</sup>

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<sup>1</sup> D. HUMPHRY & A. WICKETT, *THE RIGHT TO DIE: AN HISTORICAL AND LEGAL PERSPECTIVE OF EUTHANASIA*, Dedication page (1986).

<sup>2</sup> SENECA, *EPISTULA MORALES* (‘On Suicide’), quoted in George P. Smith, II, *All’s Well That Ends Well: Toward a Policy of Assisted Suicide or Merely Enlightened Self-Determination?*, 22 U.C. DAVIS L. REV. 275 (1989).

<sup>3</sup> ARISTOTLE, *ETHICS* 130, quoted in Daniel M. Crone, *Historical Attitudes Toward Suicide*, 35 DUQ. L. REV. 7, 14 (1996).

<sup>4</sup> DIETRICH BONHOEFFER, *ETHICS* 168.

<sup>5</sup> B. ROLLIN, *LAST WISH*, 149, 150, 170 (1985).

## I. INTRODUCTION

The cancer [Jack's tumor] had metastasized beyond control. At the prescribed hour, a nurse would give Jack a shot of the synthetic analgesic, and this would control the pain for perhaps two hours or a bit more . . . . Then he would begin to howl, like a dog. When this happened either he or I would ring for the nurse, and ask for a pain killer. She would give him some codeine or the like by mouth, but it never did any real good. [I]t affected him no more than half an aspirin might affect a man who had just broken his arm . . . . The third night of this routine a terrible thought occurred to me. "If Jack were a dog, I thought, what would be done to him?" The answer was obvious, the pound, and chloroform. No human being with a spark of pity could let a living thing suffer so, to good end.<sup>6</sup>

Jack's case graphically illustrates the inhumane suffering endured by patients around the world. One would think the way to improve the management of debilitating<sup>7</sup> pain<sup>8</sup> is to invest in pharmacological and medical research that tediously analyzes data from animal and human studies of various new drugs and treatments. Such research would greatly contribute to developing better means of treating a patient's intractable pain. But according to a project completed in 1996, sponsored by the American Society of Law, Medicine, & Ethics ("ASLME"), the next frontier for treating pain may not involve new drugs, but rather new law and regulatory policies.<sup>9</sup>

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<sup>6</sup> Lori D. Pritchard Clark, *Rx: Dosage of Legislative Reform to Accommodate Legalized Physician-Assisted Suicide*, 23 CAP. U. L. REV. 689, 689 (1994).

<sup>7</sup> The term "debilitating" is used to describe pain which impairs the strength of the individual, to weaken as in to reduce in intensity or effectiveness. WEBSTER'S NEW COLLEGIATE DICTIONARY 328 (9th ed. 1986).

<sup>8</sup> See AMERICAN COLLEGE OF LEGAL MEDICINE, LEGAL MEDICINE THIRD EDITION 536 (3d ed. 1995). "Pain", defined by Dr. John Bonica, is "an unpleasant sensory and emotional experience associated with actual or potential tissue damage or described in terms of such damage." *Id.*

<sup>9</sup> American Society of Law, Medicine & Ethics, *The Project on Legal Constraints on Access to Effective Pain Relief Findings*, Boston, MA (1997). The Project is funded by the Mayday Fund and the Emily Davie and Joseph S. Kornfield Foundation. See *id.* The principal investigators on the project were leading scholars in the fields of law, bioethics and medicine including: Robert Levine, Professor of Medicine and Lecturer in Pharmacology, Yale University School of Medicine; Nancy Dubler, Director, Division of Bioethics, Montefiore Medical Center; and Sandra H. Johnson, Professor of Law, Center for Health Law Studies, St. Louis University Schools of Law, Medicine and Public Health. See *id.*

ASLME established the Project on Legal Constraints to Access to Effective Pain Relief (the "Project") in response to the recognized problem of health care providers' failure to adequately treat pain experienced by patients.<sup>10</sup> The Project produced a model Pain Relief Act<sup>11</sup> giving providers who prescribe pain treatment a defense if disciplinary or criminal action is initiated against them by state medical boards or prosecutors, unless clinical expert testimony establishes that the health care provider did not substantially comply with accepted practice or care-giving guidelines for pain management.<sup>12</sup>

The project was timely, given the current national policy debate surrounding the legalization of physician-assisted suicide and the emerging role of pain management.<sup>13</sup> The parameters of this debate not only include the legal aspects—civil, criminal and disciplinary—but also a discussion of the most efficacious remedies for pain and an exploration of how health care providers, payers and the legal system should respond to the problem of under-treatment. Numerous articles have been written dissecting the multitude of decisions handed down by all levels of state and federal courts on the issue of physician assisted suicide ("PAS").<sup>14</sup> However, few of these decisions,

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<sup>10</sup> *See id.*

<sup>11</sup> The full text of the Act follows at Appendix A.

<sup>12</sup> *See id.*

<sup>13</sup> AMERICAN COLLEGE OF LEGAL MEDICINE, *supra* note 8, at 534. "Pain management", a new specialty in the field of medicine, developed like so many treatments do, out of patient need. *See id.* Acute pain sufferers, often accused of dependence on pain medicine, eventually convinced the establishment of their plight. *See id.* As reward for their diligence, guidelines eventually evolved to help direct the medical community in treating this unfortunate occurrence. *See id.* Unfortunately, many patients before and still today suffer due to "inadequate [prescription of] analgesic medications." *See id.*

\* These guidelines were promulgated in U.S. DEPT. OF HEALTH AND HUMAN SERVICES, ACUTE PAIN MANAGEMENT: OPERATIVE OR MEDICAL PROCEDURES IN TRAUMA (1992).

<sup>14</sup> *See, e.g.*, Ronald Scott Kuniak, *European Perspectives Towards Euthanasia and Physician-Assisted Suicide*, 9 N. Y. INT'L. L. REV. 85 (1996); John Hodgson, *Comparative Health Law: Rights of the Terminally Ill Patient*, 5 ANN. HEALTH L. 169 (1996); Stephanie Graboyes-Russo, *Too Costly To Live: The Moral Hazards of a Decision in Washington v. Glucksberg and Vacco v. Quill*, 51 U. MIAMI L. REV. 907 (1997); C. Ann Potter, Esq., *Will the "Right to Die" Become a License to Kill? The Growth of Euthanasia in America*, 19 J. LEGIS. 31 (1993); George J. Annas, *The "Right to Die" in America: Sloganeering From Quinlan and Cruzan to Quill and Kevorkian*, 34 DUQ. L. REV. 875 (1996).

most of which disallow the practice of PAS, address the patient's right to proper treatment for intractable pain<sup>15</sup> given that they cannot legally end their lives. Furthermore, courts give the medical community little direction on how to best administer palliative care<sup>16</sup> without crossing the ambiguous lines drawn in the controlled substance legislation and regulations.

While buzz words such as "palliative care", "pain management", and "intractable pain" float around legislative chambers, policy think tanks, and medical association ethics committees, many patients are suffering horrible pain with no relief in sight.<sup>17</sup> This is not because medicine has not advanced to the point where it can alleviate such pain, but rather because the law has not so advanced. In failing to find resolution in the American legal system as of yet, individuals find themselves turning elsewhere for answers.

Section I of this looks at the British system of law regarding the regulation of controlled substances used in the treatment of intractable pain and the role these substances play in the ongoing debate over physician assisted suicide and the right to live and die in comfort. Section II sketches the American background against which the reader should examine the British legal and philosophical approaches to this problem. The reader must appreciate that while the debate over the right to

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<sup>15</sup> Statutes and case law fail to succinctly define the condition referred to throughout this article as "intractable pain." While definitions for "acute" and "chronic" pain are available, the medical community has yet to put into words this subjective and personal experience. See AMERICAN COLLEGE OF LEGAL MEDICINE, *supra* note 8, at 536, 537. See also *Compassion in Dying v. Washington*, 79 F.3d. 790 (9th Cir. 1996) (the court in several instances refers to the pain as protracted, undignified and extreme). See, e.g., VETERANS ADMINISTRATION POLICY GUIDELINES, Nov. 18, 1991, M-2, pt. I, ch. 31, para. 31.02, at 31-2. Some policies, as exemplified in guidelines for Veterans Administration hospitals have such great elasticity that even individuals whose conditions are solely related to arthritis or mental illness could fall within the category of terminally ill. This would allow removal of life sustaining treatments such as food and fluids, under certain circumstances. Veterans Administration Hospital Guidelines have defined "terminal illness" to include "chronic debilitating conditions from which there is no reasonable hope of recovery." *Id.*

<sup>16</sup> Palliative care is medical treatment, of various kinds, which serves to reduce the violence of or to moderate the intensity of the pain suffered by a patient. See WEBSTER'S NEW COLLEGIATE DICTIONARY 848 (9th ed. 1986).

<sup>17</sup> Annas, *supra* note 14, at 888. Ninety percent of Americans would choose not to continue medical treatment if in a Persistent Vegetative State ("PSV"). See *id.* See also Pritchard, *supra* note 6.

die or to live is not a new one, it is an evolving one. The recent decisions rendered by the Supreme Court, the continuing technological and medical advancements and renewed popularity of religion have propelled this issue back into the forefront of debate.

Section III addresses how and why individuals with intractable pain find themselves following what they feel is the only path to relief, death. The anguish and distress endured by such individuals, whom the reader will meet in Section III, help enlighten the reader about suffering most of us, God willing, will never experience. Section IV examines how this suffering is formally addressed through Health Care Systems.

Section V discusses the British legal system regarding the treatment of intractable pain. Specifically, this section looks at the criminalization of prescribing controlled substances by licensed professionals to treat debilitating pain. This section examines the premise and history for such laws and the effect on the patients of the medical practitioners reigned in by them. Concluding is examination of the significance of these criminal laws on individuals suffering from under-treated or completely un-treated debilitating pain. Partly because of this restrictive prescription system, medical practitioners are forced to choose between under-treating their patients and breaking the law. Patients are left with even more daunting decisions, continue to suffer or look for another way out. The author intends that by broadly examining the British system, this article offers guidance and direction to those bearing the weighty responsibility of balancing an individual's right to be free from pain with the state's interest in protecting the public.

## II. A CONSTITUTIONAL RIGHT TO RELIEF: THE AMERICAN BACKDROP

Inside the space of a month, two United States Courts of Appeal struck down long-standing state laws in Washington and New York. An eight to three majority of the United States Court of Appeals for the Ninth Circuit,<sup>18</sup> and a three judge panel in the United States Court of Appeals for the Second Cir-

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<sup>18</sup> See *Compassion in Dying*, 79 F.3d at 838.

cuit,<sup>19</sup> found state laws forbidding physicians to aid or abet their patient in acts of suicide<sup>20</sup> unconstitutional. Within a virtual blink of an eye, a seemingly unshakable consensus supporting criminalization of PAS within the medical profession, the judiciary, the bioethics community, and the general public had been unceremoniously overturned. The United States Supreme Court restored this consensus in June of 1997 in two equally controversial holdings.<sup>21</sup>

#### A. Compassion in Dying: *The Ninth Circuit's View*

Judge Stephen Reinhardt, writing for a majority of an en banc decision of the Ninth Circuit,<sup>22</sup> held that competent, terminally ill patients have a powerful "liberty interest," what used to be called a Constitutional right, to enlist the aid of their physician in hastening death via prescriptions for lethal drugs.<sup>23</sup> He reasoned that just as the right to privacy guarantees women the right to choose an abortion, this liberty interest protects the right to choose the time and manner of one's death.<sup>24</sup>

Judge Reinhardt, in response to warnings against the expansion of this right to broader categories of patients (for example, to the mentally incapacitated) and against the great likelihood of mistake and abuse, permitted the regulation of PAS to avoid such evils. However, he pointedly ruled out any and all blanket prohibitions.<sup>25</sup> Judge Reinhardt, responding to the traditional objections that allowing PAS would subvert the state's interests in preventing suicide and maintaining the integrity of the medical profession, contended that our society al-

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<sup>19</sup> *Quill v. Vacco*, 80 F.3d 716, 731 (2d Cir. 1996).

<sup>20</sup> *See id.* *See also* Clark, *supra* note 6, at 701. The American Medical Association ("AMA") has taken the position that mercy killing, or the intentional termination of the life of one human being by another is prohibited. *See id.* Interestingly, the AMA also condones the cessation of life-sustaining treatment as morally justifiable. *See id.*

<sup>21</sup> *Vacco v. Quill*, 117 S.Ct. 2293 (1997); *Washington v. Glucksberg*, 117 S.Ct. 2258 (1997).

<sup>22</sup> *See Compassion in Dying*, 79 F.3d. at 790.

<sup>23</sup> *See id.* at 816.

<sup>24</sup> *See id.* at 813-14. *See also* *Roe v. Wade*, 410 U.S. 113 (1973); *Planned Parenthood of Southeastern Pennsylvania v. Casey*, 505 U.S. 833 (1992) (Court protects a constitutional right to abortion under certain circumstances enunciated, and subsequently revised by the court).

<sup>25</sup> *See Compassion in Dying*, at 816-32, 836-37 (reviewing state interests and illustrating the application of the balancing test and holding).



ready has effectively erased the distinction between merely allowing patients to die and killing them.<sup>26</sup> Reinhardt claimed that by allowing patients or their surrogates to forgo life-sustaining medical treatments, including artificially administered nutrition and hydration, and by sanctioning the administration of pain-killing drugs that might also hasten death, our society already permits a variety of “death inducing” practices.<sup>27</sup> Thus, the social risks of allowing PAS are only different in degree, not in kind, from risks that we already countenance.

### B. *Second Circuit Uses Quill and Ink in Support of PAS*

Writing for the Second Circuit and striking down a similar New York statute, Judge Roger J. Miner explicitly rejected the claim of the Second Circuit majority that a “substantive due process” right of PAS exists in the Constitution.<sup>28</sup> He conceded that the Supreme Court is unlikely to extend the boundaries of the so-called right to privacy, but found nevertheless that the statute violated the equal protection clause of the Constitution.<sup>29</sup> Echoing Judge Reinhardt’s opinion in *Compassion in Dying*, Judge Miner observed that New York’s law<sup>30</sup> allowed some people relief from the ravages of terminal illness (i.e., those connected to some form of removable life-support) but denied relief to those not so connected, for whom PAS was the only remaining exit.<sup>31</sup> Concurring with Judge Reinhardt’s assertion that the social risks of PAS are identical to those of our more socially approved “death inducing” practices, Judge Miner concluded that this kind of differential treatment serves no legitimate state purpose.<sup>32</sup> Thus, he held that the New York law was unconstitutional even in the absence of a new fundamental right to PAS.<sup>33</sup>

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<sup>26</sup> See *id.* at 822-23.

<sup>27</sup> *Compassion id.*, at 804. See generally Clark, *supra* note 6, at 705-09 for a concise overview of the laws of PAS.

<sup>28</sup> See *Quill*, 80 F.3d at 724-25.

<sup>29</sup> See *id.*

<sup>30</sup> See *id.* at 727-29. See also NY Penal Law §§ 120.30 and 125.25, subd. 3 (McKinney’s 1986) (the sections of the penal law defining manslaughter and suicide in New York State).

<sup>31</sup> See *Quill*, 80 F.3d. at 716.

<sup>32</sup> See *id.* at 726.

<sup>33</sup> See *id.* at 727.

### C. States' Rights Reign Supreme

In June of 1997, however, the Supreme Court reversed the *Washington v. Glucksberg* and *Vacco v. Quill* decisions and upheld the statutes criminalizing PAS.<sup>34</sup> It ruled that individuals have no constitutional right to assistance in committing suicide.<sup>35</sup> The court disposed of the due process<sup>36</sup> and equal protection<sup>37</sup> analysis proffered in support of such a right but did not foreclose legalization of PAS as a matter of state law.<sup>38</sup> Moreover, the court expressed two somewhat divergent ideas: "That there is no constitutional right to physician assistance to hasten one's death, and that the resolution may ultimately lie in changing medical policies toward treating pain in the terminally ill."<sup>39</sup>

This unexpected finding of a constitutional right to palliative care will have a wide impact on the treatment of not only the terminally ill but also those suffering from chronic intractable pain. Legal authorities<sup>40</sup> are relying on the Justices' suggestion that palliative care may be a constitutional right.<sup>41</sup> Justices Breyer, Ginsburg and O'Connor stated "judicial intervention would be necessary 'were state law to prevent the provision of palliative care, including the administration of drugs as needed to avoid pain at the end of life.'"<sup>42</sup> Justice Breyer further stated that "[t]he laws before us . . . do not prohibit doctors from providing patients with drugs sufficient to control pain despite the risk that those drugs themselves will kill . . . [W]ere state laws to prevent the provision of palliative care, . . . the

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<sup>34</sup> See *Vacco*, 117 S.Ct. at 2293; *Washington*, 117 S.Ct. at 2258.

<sup>35</sup> See *Vacco*, 117 S.Ct. at 2297; *Washington*, 117 S.Ct. at 2269-71.

<sup>36</sup> See *Washington*, 117 S.Ct. at 2267.

<sup>37</sup> See *Vacco*, 117 S.Ct. at 2297.

<sup>38</sup> See *Vacco*, 117 S.Ct. at 2302; *Washington*, 117 S.Ct. at 2258, 2272-75.

<sup>39</sup> Alexandra Dylan Lowe, *Facing the Final Exit*, ABA JOURNAL, Sept. 1997 at 48, 50-51.

<sup>40</sup> Robert Burt, Op. Ed. Article, NEW ENGLAND JOURNAL OF MEDICINE (Sept. 1997). Robert Burt, Yale Law Professor and member of the Project on Death in America's advisory board, stated that "[t]he court has, in effect, said that the states are not authorized to impede the access of terminally ill persons to pain relief." *Id.* See generally Diane M. Gianelli, *A Constitutional right to Pain Control? Ruling on Assisted Suicide May Have Wider Impact*, AMERICAN MEDICAL NEWS 3 (November 10, 1997).

<sup>41</sup> See Gianelli, *supra* note 40.

<sup>42</sup> See *id.*

court might have to revisit its conclusions in these cases.”<sup>43</sup> Finally, Justice Souter added that “[s]tates that refuse to address obstructive elements in their law are guilty of ‘legislative foot dragging.’”<sup>44</sup>

The effects of the holdings in *Vacco v. Quill* and *Washington v. Glucksberg* have yet to be felt. For the purposes of this article it is important to remember this new “fundamental right” to palliative care in grasping the different approaches to pain management around the world. An underlying reverence for human life exists in both the state and federal jurisdictions this article addresses.<sup>45</sup> However each society faces unique challenges from religious, economic, social and even tribal fronts and all must be addressed by the one system of law—the ultimate authority in each jurisdiction.

### III. DEATH: THE ONLY PATH TO RELIEF

In Great Britain and in the United States, patient testimonials have proven time and again that patients suffering from intractable pain from terminal illness and chronic conditions see death as the only path to relief. Strong evidence of this theory is found in the popularity of doctors in the United States, such as Dr. Kevorkian, who have helped individuals commit suicide at the patient’s request.<sup>46</sup> The trend in Great Britain is no different. One of the many moving stories brought before legislative bodies here and abroad is the struggle of Ms. Annie Lindsell.<sup>47</sup> Ms. Lindsell, a British citizen, suffered from motor neuron disease (“MND”), a degenerative neurological condi-

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<sup>43</sup> See *id.*

<sup>44</sup> See *id.*

<sup>45</sup> Each jurisdiction’s criminal laws grew out of Christian doctrines venerating human life.\* For example, the release of Pope John Paul II’s encyclical on human life, in which the Pope “restate[d] in the strongest terms the [C]hurch’s opposition to abortion and euthanasia, urged conscientious objection to laws that permit them, and issued a ringing rejection of the death penalty.” Bob Keeler, *Papal Creed: Restating Opposition to Abortion, Death Penalty and Euthanasia*, NEWS-DAY, Mar. 31, 1995, at A5.

\* See generally Crone, *supra* note 3; Herbert Hendin, *The Slippery Slope: The Dutch Example*, 35 DUQ. L. REV. 427 (1996).

<sup>46</sup> *No Legal Action is Anticipated as Kevorkian Suicides Multiply*, WASH. POST, Aug. 24, 1996, at A2.

<sup>47</sup> See UNITED KINGDOM HOUSE OF LORDS, ANSWERS TO WRITTEN QUESTIONS, HOME DEPARTMENT, Tuesday, July 22, 1997.

tion.<sup>48</sup> The most inhumane manifestation of this disease occurs when the body, while maintaining the ability to feel pain, slowly loses its motor control. Many late stage MND patients suffer the indescribable fate of choking on their own mucus while trying to eat.<sup>49</sup> Ms. Lindsell feared the same agonizing death for herself, having become quite close to many such patients through treatment and support groups.<sup>50</sup>

These philosophical reflections can be understood in light of a more clinical perspective addressing to the motivational factors behind many requests to die. Many people advocate legalization of PAS because they fear a loss of control at the end of their lives. They fear falling victim to the technological imperative; they fear dying in chronic and uncontrolled pain; they fear the psychological suffering attendant upon the relentless disintegration of the self; they fear, in short, a bad death. All of these fears, it so happens, are eminently justified. Statistics show physicians routinely ignore the documented wishes of patients and all too often allow patients to die in uncontrolled pain.<sup>51</sup> Furthermore, many researchers have found that uncontrolled pain, particularly when accompanied by feelings of hopelessness and untreated depression, is a significant contributing factor for suicide and suicidal ideation.<sup>52</sup>

#### IV. HEALTH CARE SYSTEMS

Both the British and American health care systems incorporate the safeguard requirement that a physician, prior to providing life-terminating assistance, inform the patient of the

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<sup>48</sup> See *id.*

<sup>49</sup> See *id.*

<sup>50</sup> See generally Clark, *supra* note 6. See also United Kingdom House of Lords, *Answers to Written Questions*, *supra* note 47. The House of Lords discussed at length the government's approach to palliative care. See *id.* The Lords discussed such policy in light of the case of Annie Lindsell. See *id.* Ms. Lindsell attempted to get the court's permission to commit physician-assisted suicide. See *id.* Her request was denied. See *id.*

<sup>51</sup> See *A Controlled Trial to Improve Care for Seriously Ill Hospitalized Patients: The Study to Understand Prognoses and Preferences for Outcomes and Risks of Treatments (SUPPORT)*, 274 JAMA 1591, 1591-92 (Nov. 22, 1995).

<sup>52</sup> See *id.* at xiv.

availability of health care alternatives.<sup>53</sup> They also require that a patient receive psychiatric care, when found necessary, prior to qualification for euthanasia assistance.<sup>54</sup> Although all the systems express concern that the patient be informed of the availability of health care options and require utilization of some alternative health care services, no system coordinates a guarantee that information on availability of other health care alternatives ensures geographic and financial access to health care alternatives.

#### A. *Access to Health Care*

Health care systems in Great Britain and the United States vary. Most notably, Britain has universal access to health care.<sup>55</sup> In contrast, the United States is one of the few remaining industrialized countries without universal access to health care.<sup>56</sup> Universal coverage does not guarantee immediate access but does guarantee eventual access.<sup>57</sup>

By contrast, the United States generally guarantees immediate access only for emergency care and only limited access for uninsured routine care when the patient lacks the resources to pay.<sup>58</sup> When access is gained, the uninsured are likely to receive a lower level of health care services.<sup>59</sup> Furthermore, uninsured patients have less access to preventative and non-emergency care that can often eliminate or shorten periods of pain and illness.<sup>60</sup> With increasing financial pressure being placed on hospitals and physicians, access and level of health care service for the uninsured face increasing compromise.<sup>61</sup>

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<sup>53</sup> See Roger S. Magnusson, *The Sanctity of Life and the Right to Die: Social and Jurisprudential Aspects of the Euthanasia Debate in Australia and the United States*, 6 PAC. RIM L. & POL'Y J. 1 (1997).

<sup>54</sup> See *id.*

<sup>55</sup> See P.D.G. SKEGG, *LAW, ETHICS, AND MEDICINE: STUDIES IN MEDICAL LAW* 144 (1984).

<sup>56</sup> See EDWARD M. MENDOZA & BRYN J. HENDERSON, *INTERNATIONAL HEALTH CARE: A FRAMEWORK FOR COMPARING NATIONAL HEALTH CARE SYSTEMS* 7-8 (1995).

<sup>57</sup> See *id.* at 8.

<sup>58</sup> See *id.* at 8-9.

<sup>59</sup> See Tom Stacy, *The Courts, The Constitution, and a Just Distribution of Health Care*, 3 KAN. J. L. & PUB. POL'Y 77, 79 (1994).

<sup>60</sup> See *id.*

<sup>61</sup> See *id.*

When a system permitting euthanasia requires that the physician inform the patient of other health care alternatives, of what benefit is the information if access to the other alternatives is not available? In the United States, an estimated thirty-seven million people are uninsured.<sup>62</sup> "Although those greater than 65 years of age and the very poor have access to good coverage, there are increasing numbers of working poor without coverage. Access difficulty is increasing for poor, black, Hispanic, or underinsured citizens."<sup>63</sup>

### B. *Access to Palliative Care*

Palliative care, as a health care alternative, is experiencing increased success in alleviating pain and providing comfort to patients with a limited life expectancy diagnosis.<sup>64</sup> A 1986 national hospice study of home-care, hospital-based hospices, and conventional care revealed that a respective ten, four, and eighteen percent of patients experienced persistent pain.<sup>65</sup> In contrast, a 1973 report indicated that seventy-three percent of patients experienced persistent pain.<sup>66</sup> Although palliative care is improving, there are several barriers to its increasing overall access: fifty countries do not have access to medicinal morphine, few medical schools offer palliative care in the curriculum, and physicians fear the legal ramifications of medicating for pain.<sup>67</sup>

The United States does not guarantee access to medical treatment.<sup>68</sup> Absent such access to alleviate pain, information about palliative care as a health care alternative is of little use to a patient who is enduring a painful illness. The British have

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<sup>62</sup> See THOMAS S. BODENHEIMER & KEVIN GRUMBACH, UNDERSTANDING HEALTH POLICY: A CLINICAL APPROACH 19 (1995).

<sup>63</sup> MENDOZA & HENDERSON, *supra* note 56, at 8.

<sup>64</sup> See Warren L. Wheeler, *Hospice Philosophy: An Alternative to Assisted Suicide*, 20 OHIO N. U. L. REV. 755, 757 (1994).

<sup>65</sup> See *id.*

<sup>66</sup> See *id.*

<sup>67</sup> See *id.* at 757-58.

<sup>68</sup> See JOHN A. ROBERTSON, THE RIGHTS OF THE CRITICALLY ILL 146-53. The area of costs and allocation of scarce resources in medical care is unclear. While doctors and hospitals do have some responsibility to treat patients regardless of their ability to pay, this treatment is generally mandatory in emergency situations only. See *id.* See generally GEORGE J. ANNAS, THE RIGHTS OF PATIENTS 218-221 (2d. ed. 1989).

established palliative care as a component of their national health care system.<sup>69</sup>

In contrast, the American system does not guarantee access to palliative care.<sup>70</sup> Palliative care is not, however, new to the health care continuum in the United States; since 1978, the National Hospice Organization has advocated the needs of the terminally ill.<sup>71</sup> "In the 1990s, annual growth in the number of hospice patients nationwide has averaged 13 percent."<sup>72</sup> However, Medicare and Medicaid public assistance programs, available only to select portions of the population, continue to pay for over seventy-five percent of all hospice care provided.<sup>73</sup> Access is further limited when a patient is a member of a minority race,<sup>74</sup> does not have a primary caregiver,<sup>75</sup> or requires "high tech" therapies.<sup>76</sup>

If the overriding purpose of a system of euthanasia is to provide the final alternative on a continuum of patient autonomy, how can it fulfill its purpose without providing access to other health care alternatives? How can information about alternative services provide comfort and dignity to a patient when those services are not available? Information alone does not permit a patient to effectively choose between enduring a deteriorating, painful, and perhaps slow death and a quick death that at a minimum ensures an end to an unknown future. A system that permits voluntary euthanasia cannot equally guar-

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<sup>69</sup> See UNITED KINGDOM HOUSE OF LORDS, *supra* note 47.

<sup>70</sup> See ROBERTSON, *supra* note 68, at 14-15, 146-53.

<sup>71</sup> See NATIONAL HOSPICE ORGANIZATION, HOSPICE FACT SHEET (1996) London, England. Hospice care is provided to a patient with a limited life expectancy of six months or less. *See id.*

<sup>72</sup> *Id.*

<sup>73</sup> *See id.* Sources of payment for hospice services are as follows: Medicare, 66.8%; private insurance, 14.6%; Medicaid, 9.1%; indigent (non-reimbursed) care, 6.3%; other, 3.2%. *See id.*

<sup>74</sup> *See* NATIONAL HOSPICE ORGANIZATION, HOSPICE FACT SHEET (1996). Consistent with other health care census statistics, 85% of hospice patients were white; 9% were African American; 3% were Hispanic; and 3% were identified as 'other'. *See id.*

<sup>75</sup> *See id.* Forty-five percent of hospices admit patients without primary caregivers; another 31% admit patients without caregivers on a case-by-case basis. *See id.*

<sup>76</sup> *See id.* Fifty-one percent of hospices admit individuals requiring 'high-tech' therapies; an additional 42% admit patients needing 'high-tech' services on a case-by-case basis. *See* NATIONAL HOSPICE ORGANIZATION, HOSPICE FACT SHEET (1996).

antee the right to live and the right to die without a guarantee of alternative health care.

V. *THERE OUGHT TO BE A LAW: LEGALITY OF PAIN MANAGEMENT IN GREAT BRITAIN*

A. *All in a Day's Work: The Doctor's Duty*

English law, in this author's view, is very similar to that of the United States. However, before setting out the law, it is important to delineate to what extent there exists any unifying principle or premise, which draws together the individual legal rules. Such a principle would not only add rational coherence to what would otherwise be a set of unrelated rules, but would also supply the reference point whereby novel dilemmas may be resolved. One such principle, often referred to in the United States, is that of contract—that the relationship between the doctor and the patient is regulated by agreement between the two parties.<sup>77</sup> This is not unifying for a number of reasons. First, in England there is not, as a matter of law, a contract between doctor and patient in the vast majority of all relationships, because health care is made available through the National Health Service.<sup>78</sup> Second, the notion of a contract carries the implication that medical care is a commodity to be bargained for in the market-place, and available only if the price is right, a notion specifically rejected in England.<sup>79</sup>

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<sup>77</sup> See AMERICAN COLLEGE OF LEGAL MEDICINE, *supra* note 8, at 62-63. Dr. John Bonica states "[t]he physician-patient relationship is based on a contract that creates a fiduciary relationship between the parties, and in which the physician impliedly promises the patient that he or she will exercise that degree of skill ordinarily possessed by his or her colleagues and practice according to accepted standards." *Id.*

<sup>78</sup> See JONATHAN MONTGOMERY, *HEALTH CARE LAW* 54-55 (Oxford, 1997). While central government has not articulated the specific goals of the National Health Service, they are primarily defined under the National Health Service Act of 1977. See *id.* "[Such act] obliges the Secretary of State to promote 'a comprehensive health service designed to secure improvement—(a) in the physical and mental health of the people of [England and Wales], and (b) in the prevention, diagnosis and treatment of illness.'" *Id.*

<sup>79</sup> See European Social Charter, 1961, Art. 13 and pt. I, rights 11 and 13. The United Kingdom, under human rights law, recognizes a right to health care. See *id.* Specifically, "everyone has the right to benefit from any measures enabling him to enjoy the highest standard of health attainable . . . [and] anyone without adequate resources has the right to social and medical assistance." *Id.*



Another unifying principle is said to be the concept of trust. Trust, it is said, is the key factor governing the doctor-patient relationship.<sup>80</sup> This analysis is equally flawed. First, to argue that each party must trust the other does not demonstrate in fact that each does. Indeed, oftentimes a doctor may expect trust without himself reciprocating. For example, the doctor will choose not to tell his patient certain facts, on the paternalistic premise that the patient is better off not knowing.<sup>81</sup> Second, trust presupposes a conscious and reasoned decision by the patient which, in fact, may be beyond many patients who, through pain or the effect of pain killing drugs, cannot make sound decisions.<sup>82</sup>

If there is a unifying premise guiding the law, it is the concept of duty. A doctor has expertise. More often than not, the patient lacks such expertise and, therefore, stands in a more vulnerable position. He can only rely on the doctor's skill and good faith. Given this reality, the law imposes duties upon the doctor existing independently of agreement. The patient may expect and ultimately demand that these duties be carried out.<sup>83</sup>

One of the many duties doctors owe to terminally ill patients and patients suffering from intractable pain is to make the patient comfortable, which includes pain management.<sup>84</sup>

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<sup>80</sup> See AMERICAN COLLEGE OF LEGAL MEDICINE, *supra* note 8, at 62-63, 119. The contract between the parties and the nature of the duty of care of the doctor to the patient are fiduciary in nature. *See id.*

<sup>81</sup> *See id.* at 278. The doctrines of informed consent and disclosure developed to help erode this paternalistic attitude of doctors toward patients as well as to help protect both parties from misunderstandings regarding diagnosis and treatment. *See id.*

<sup>82</sup> *See id.* at 282. Dr. John Bonica stated "[c]onsent must be given by a patient who is mentally and physically capable of comprehending the information provided by the physician . . . and capable of making a decision concerning the course of treatment. *The physical effects of pain and medication must not be so great as to diminish the patient's mental abilities to comprehend the consent process.*" [emphasis added]. *Id.* *See also* B. v. Croydon Health Authority [1995] 1 All E.R. 683; Secretary of State for the Home Department v. Robb [1995] 1 All E.R. 677; Aire-dale NHS Trust v. Bland [1993] 1 All E.R. 821.

<sup>83</sup> In tort actions at common law, a duty of doctor toward patient exists, i.e. medical malpractice. *See* AMERICAN COLLEGE OF LEGAL MEDICINE, *supra* note 8, at 129-39.

<sup>84</sup> Doctors swearing to uphold the Hippocratic Oath swear in part to ". . . follow that system of regimen which, according to my ability and judgment, [he/she] consider for the benefit of my patients, . . ." The Oath continues, "I will give no

There may arise circumstances in which a doctor may use a form of treatment for his or her patient's benefit, aware of the fact that it may have the secondary effect of accelerating (or run the risk of accelerating) the patient's death. This reflects the so-called doctrine of double effect,<sup>85</sup> incorporated in English law in one of the few cases that have been decided in this area, *R v. Bodkin Adams*.<sup>86</sup> The doctor is not in breach of his legal duty to his patient if, by adopting the particular form of treatment, his principal and primary intention is the alleviation of symptoms, which are discomforting and irremediable in any less drastic way.

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deadly medicine to anyone if asked, nor suggest any such counsel; . . . ." THE HIPPOCRATIC OATH *reprinted in* J.K. MASON AND R.A. MC CALL SMITH, LAW AND MEDICAL ETHICS, appendix A (Butterworth & Co. 1984). In circumstances such as those presented here, these two separate affirmations may very well directly contradict each other.

<sup>85</sup> See Rita L. Marker & Wesley J. Smith, *The Art of Verbal Engineering*, 35 DUQ. L. REV. 81. The "Principle of Double Effect" provides that it is permissible to perform an act that has both a good effect and a bad effect only if all of the following conditions are met:

The act to be done must be good in itself or at least indifferent;

The good effect must not be obtained by means of the bad effect;

The bad effect must not be intended for itself but only permitted; and

There must be a proportionately grave reason for permitting the bad effect.

*Id.* at 105, FN 113.

<sup>86</sup> *R. v. Bodkin Adams* [1957] Crim. L.R. 365. J. Devlin's analysis in this case seems to have two strands. *See id.* First, the doctor in administering drug therapy does not intend the patient's death. *See id.* But in knowing that such therapy may hasten the patient's death and that such death will probably follow, he/she intends the death although may not desire it. *See id.* Second, the analysis may be that the doctor does not cause the death at all; the patient dies from the underlying illness. *See id.*

Regardless, J. Devlin's analysis and charge to the jury resulted in the proposition that a doctor may lawfully commit an act whereby he intentionally causes the death of a patient in circumstances which the law (the courts, mind you, not Parliament) thinks permissible, as a matter of public policy. *Adams*, [1957] Crim. L.R. 365. The specific circumstances must be analogous to those here, where the life in question and the illness/condition ravaging the body with pain makes such a life intolerable. *See id.*

## B. *Underlying Legal Theories of Murder, Manslaughter and Assisted Suicide*

Doctors shoulder an additional burden, the duty to uphold the law.<sup>87</sup> If a doctor prescribes or administers a drug accelerating a patient's death, he potentially comes within the scope of the law of homicide.<sup>88</sup> But such conduct would not always amount to murder or manslaughter—or, for that matter, any other criminal offense.<sup>89</sup> In some circumstances the doctor's conduct might not be regarded as a legally recognized cause of death. Even if it were so regarded, the doctor would not usually have the fault element of murder or manslaughter.<sup>90</sup>

Murder and manslaughter have the same external elements; the difference between them lies in their different fault elements. The external elements of these offenses involve causing the death of a fully born human being.<sup>91</sup> Only acts "but for which" death would not have occurred when it did can be regarded as a cause of death for the purpose of the law of homicide. But, by no means, are all "but for" causes regarded as imputable causes. The act may be treated as simply part of the

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<sup>87</sup> As members of civilized society, doctors are obliged to be law abiding and honest. Furthermore, the Hippocratic Oath requires that doctors "[w]ith purity and holiness . . . will pass my life and practise my Art." THE HIPPOCRATIC OATH, *supra* note 84.

<sup>88</sup> See generally *Adams*, [1957] Crim. L.R., at 773; *R. v. Ludwig* Crim. L.R. —. Dr. Ludwig was tried and acquitted on the basis of the use of a cocktail of drugs including powerful painkillers and potassium chloride ("KCl"). It was accepted that there was a therapeutic effect overall, even though the KCl was simply a poison. *Id.* See also *R. v. Cox* [1992] 12 B.M.L.R. 38. Dr. Cox was convicted of attempted murder of a patient to whom he had administered a fatal dose of KCl. The doctor's patient of eleven years was suffering debilitating pain and asked the doctor for relief. The jury was deeply moved by the necessity of returning a guilty verdict and Justice Ognall validated those sentiments by imposing a suspended sentence. *Id.* See also Diana Brahams, *Criminality and Compassion*, LAW SOCIETY'S GAZETTE (London) Sept. 30, 1992 at 2 (subsequent decision of the General Medical Council to take no further disciplinary action against Dr. Cox other than its finding of professional misconduct also reflects the consensus view that the doctor acted without malice).

<sup>89</sup> For other offenses which sometimes apply to the prescription or administration of drugs hastening death see *Offenses Against the Person Act 1861*, § 18, 23, 24; *Suicide Act 1961*, § 2.

<sup>90</sup> See *Adams*, [1957] Crim. L.R. 365.

<sup>91</sup> See *Offenses Against the Person Act 1861*. See generally *R. v. Cook* [1898] 62 J.P. 712; *R. v. Instan* [1893] 1 Q. B. 450, 454; 4 William Blackstone 188-190. See also *R. v. Crook* [1859] 1 F. & F. 521, 523 (produced or accelerated).

history,<sup>92</sup> as a doctor's act would be if a patient were knocked down and killed when crossing a road, which the patient would not have been doing but for the doctor's request that he attend the surgery.

There is no need for the act to be the sole, or even the main cause of death. For the purpose of the law of homicide, it is sufficient if the act is a cause, provided it is a cause "outside the *de minimis* range, and effectively bearing upon the acceleration of the moment of the victim's death."<sup>93</sup> A person who intends to kill, or who has no substantial doubt that his act will kill, has the fault element for murder.<sup>94</sup> If a doctor gave an injection for the purpose of hastening death, or if he administered a drug knowing it would have this effect, he would therefore be guilty of murder if the patient died.

An intention to cause serious bodily harm is also, in most circumstances, a sufficient fault element for murder.<sup>95</sup> The possible exception is where it would be lawful intentionally to cause such harm. If a person intentionally causes serious bodily harm in the course of using reasonable force in self-defense, no problem would arise. If, in such instance, he were regarded as having the fault element of murder, a well-established justification would be available to him. But where a doctor intentionally causes serious bodily harm by performing an operation to which consent has been given, and for which there is a good reason, there could be difficulties if the doctor were regarded as having the fault element for murder. Rather than provide a separate justification, it might be convenient to say that as it was lawful for the doctor to intend to cause serious bodily harm in these circumstances, he is not to be regarded as having the fault element for murder.<sup>96</sup> However, where it is unlawful to intentionally cause serious bodily harm, which is usually the case, a person may be convicted of murder if he acts with this

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<sup>92</sup> See *R. v. Smith* [1959] 2 Q.B. 35, 43. See also *R. v. Blaue* [1975] 1 W.L.R. 1411, 1414-15; *R. v. Malcherek* [1981] 1 W.L.R. 690, 696.

<sup>93</sup> *R. v. Cato* [1976] 1 W.L.R. 110, 116. See also *Malcherek*, 1 W.L.R. at 696. *De minimis* derives from the Latin term *de minimis non curat lex* translated "the law is not concerned with trivial matters." BLACK'S LAW DICTIONARY 297 (6th ed. 1991).

<sup>94</sup> See *Adams*, [1957] Crim. L. R. 365.

<sup>95</sup> See *R. v. Cunningham* [1982] A.C. 566.

<sup>96</sup> See *R. v. Hyam* [1974] Q.B. 99, [1975] A.C. 55, 77D-79C.

intention, and thereby hastens death.<sup>97</sup> There is no need to prove that he knew that his act would endanger life.

In the leading case of *R. v. Hyam*, the trial judge directed the jury that a person could be convicted of murder if, when doing the act which led to the death, that person knew that it was "highly probable" that death or serious bodily harm would result.<sup>98</sup> Doctors rarely take action believing that it is highly probable that their act will hasten death. There are occasions, however, when doctors act believing it is highly probable that extremely serious bodily harm will follow, as well as other occasions when they believe death or extremely serious bodily harm is a probable or likely consequence.<sup>99</sup> If it is accepted that a doctor would not have the fault element of murder if he acted lawfully in intentionally causing really serious bodily harm, then it follows that he would not have the fault element of murder simply because he believed that really serious bodily harm was a probable, or highly probable, consequence of his otherwise lawful actions. But what of a case where a doctor intervenes, believing that it is probable that his conduct will hasten the patient's death?

If a patient had a very serious heart condition, doctors might consider it most unlikely that the patient would live for another year if he did not have a heart transplant. Moreover, the doctors might believe that if he had a transplant it is probable that he would die earlier than if he did not have one, but that there would be a significant possibility that the transplant would be a success. If it were a success, the patient would live a

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<sup>97</sup> See *id.* at 101.

<sup>98</sup> See *id.* The House of Lords dismissed the defendant's appeal, but in the course of doing so raised the possibility of a defendant being convicted of murder even though he did not desire that death or really serious bodily harm should ensue, and even though he did not believe that death or really serious bodily harm was 'highly probable'. See *id.* Lord Hailsham and Lord Cross both delivered speeches which indicated that in their opinion it was unnecessary for the trial judge to have inserted the word 'highly', before 'probable', in his direction to the jury. See *id.* See also *R. v. Moloney* [1985] 1 All E.R. 1025; *R. v. Hancock* [1986] 1 All E.R. 641; *R. v. Nedrick* [1986] 3 All E.R. 1 (people intend to kill or do serious harm if they foresee that this is virtually certain to be the result of their actions).

<sup>99</sup> See, e.g., *R. v. Larkin* [1943] K.B. 174; *R. v. Church* [1966] 1 Q.B. 59, D.P.P. v. *Newbury* [1977] A.C. 500 (terms 'likely', 'serious risk', and 'dangerous' used interchangeably in discussions of manslaughter). On foresight of probability and foresight of possibility see *La Fontaine v. R.* [1976] 136 C.L.R. 62, *R. v. Gush* [1980] 2 N.Z.L.R. 92.

fuller and longer life than if he did not have a transplant. If the patient consented to the operation under these circumstances and the doctors proceeded without any problems, aside from the fact that the patient does not survive the procedure, would they have the fault element of murder?<sup>100</sup> In Lord Hailsham's view, expressed in the *Hyam* opinion, a person would not be guilty of murder if he had a lawful excuse for exposing the deceased to the risk of death.<sup>101</sup> He even recognized that the transplant surgeon would not be liable even if he foresaw, as a high degree of probability, that he would hasten the patient's death.<sup>102</sup>

*R. v. Adams*,<sup>103</sup> decided in 1957, was the first case wherein the high court addressed these issues. Adams was a doctor accused of deliberately increasing the dosage of opiates used as pain relief in order to end patients lives.<sup>104</sup> The court summarized the law stating:

If the first purpose of medicine—the restoration of health—could no longer be achieved, there was still much for the doctor to do, and he was entitled to do all that was proper and necessary to relieve pain and suffering even if the measures he took might incidentally shorten life by hours or even longer.<sup>105</sup>

Given this summation in their charge, the jury acquitted the doctor.<sup>106</sup>

This direction was based on the argument that in such cases the doctor's actions would not cause death; death would result from the illness itself.<sup>107</sup> In addition, a second implicit argument was that the doctor would lack the relevant criminal

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<sup>100</sup> See *Hyam*, [1975] A.C. at 74E-F, 77 C, G. Lord Hailsham did discuss this example in his opinion. See *id.* He said that his own opinion corresponded with that of the Commissioners on the Criminal Law, when they said that it ought to make no difference in point of legal distinction whether death results from a direct intention to kill, or from willfully doing an act of which death is the probable consequence. See *id.*

<sup>101</sup> See *id.* at 79B-C.

<sup>102</sup> See *id.*

<sup>103</sup> *Adams*, [1957] Crim. L.R. 365.

<sup>104</sup> See P. DEVLIN, *EASING THE PASSING: TRIAL OF DR. JOHN BODKIN ADAMS* (London, 1986). Apparently, the patients Dr. Adams over-medicated had left the doctor money in their wills. See *id.*

<sup>105</sup> *Adams*, [1957] Crim. L.R. 373.

<sup>106</sup> See *id.*

<sup>107</sup> See *R. v. Bateman* [1925] 19 Cr. App. R. 8.

intent.<sup>108</sup> If the intention was to relieve suffering then there was a lawful excuse for the administration of the drugs despite the incidental effect of shortening the patient's life.<sup>109</sup> While this double effect principle may be criticized, it is unlikely that a future judge would depart from this approach.

As recently as 1992, the court considered these issues and employed the doctrine of double effect.<sup>110</sup> Dr. Cox was charged with attempted murder by administering a lethal dose of potassium chloride to a dying patient.<sup>111</sup> The court instructed the jury to consider the doctor's purpose for taking such actions.<sup>112</sup> Expert evidence, however, showed that the drug administered had no pain relieving properties and the dosage clearly would have been fatal.<sup>113</sup> Dr. Cox chose not to testify on his own behalf.<sup>114</sup> Given that the jury convicted the doctor, it is arguable that such expert evidence, when considered in relation to the doctor's intent, showed the doctor's primary purpose was not to relieve his patient's pain.

There is very little danger of a judge taking the view that a doctor would be guilty of murder whenever he performed an act hastening death, knowing that it was probable that it would have this effect. The doctor would not be guilty where there was a "lawful excuse" for exposing the patient to that risk.<sup>115</sup> Just as there is only one crime of murder, although it can be committed with one of several mens rea, so there is only one crime of manslaughter. It is, however, customary to speak of manslaughter according to the mens rea concerned. The two most important concepts to the issue here are "unlawful act"<sup>116</sup> and "negligent"<sup>117</sup> manslaughter.

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<sup>108</sup> See *id.*

<sup>109</sup> See *id.*

<sup>110</sup> See *Cox*, [1992] 12 B.M.L.R. 38.

<sup>111</sup> See *id.*

<sup>112</sup> See *id.*

<sup>113</sup> See *MONTGOMERY*, *supra* note 78, at 440.

<sup>114</sup> See *Cox*, [1992] 12 B.M.L.R. 38.

<sup>115</sup> See *Hyam*, [1975] A. C. 55, *supra* note 96 and accompanying text.

<sup>116</sup> See Offenses Against the Person Act 1861. See generally 4 William Blackstone 180-185.

<sup>117</sup> See *id.*

“Unlawful act” manslaughter encompasses those instances where death is caused by an unlawful act,<sup>118</sup> which any reasonable person would recognize as involving the danger of at least some harm.<sup>119</sup> For instance, if a doctor carried out a risky non-therapeutic experimental procedure, knowing that legally effective consent had not been given, he would have the fault element for unlawful act manslaughter. If his conduct resulted in the patient’s death the doctor would be guilty of unlawful act manslaughter, even though he did not believe that there was any risk of death, and even though he performed the procedure with the greatest care and competence.<sup>120</sup>

Negligent death happens when death occurs by defendant’s gross negligence.<sup>121</sup> A defendant can be convicted even though he was not aware that there was any risk to the deceased, but the negligence must be so serious that the jury must regard it as sufficient to warrant a conviction of manslaughter.<sup>122</sup> Where death resulted from a doctor’s extreme carelessness in prescribing a drug, the doctor could be regarded as guilty of negligent manslaughter.<sup>123</sup>

As seen in *Adams* and *Cox*, a doctor’s reason for acting sometimes affects his liability under the law of homicide.<sup>124</sup> If a patient died as a consequence of a very risky operation performed in the hope of saving the patient’s life, the heart transplant patient for example, the doctor would not normally be guilty of murder.<sup>125</sup> But, if death resulted from the doctor performing an identical operation on a healthy person, for the sake of an unnecessary research project, he would be liable. It is clear, however, that the intent to alleviate suffering will not provide a legal justification for a doctor who intentionally ad-

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<sup>118</sup> See *R. v. Lamb* [1967] 2 Q.B. 981 (an act must be unlawful for some reason other than that it is negligently performed).

<sup>119</sup> See *R. v. Church* [1966] 1 Q.B. 59, 70.

<sup>120</sup> See *Hyam*, [1975] A. C. 55.

<sup>121</sup> See *Bateman*, [1925] 19 Cr. App. R. 8 (case involving a doctor). *But see R. v. Stone* [1977] Q.B. 354.

<sup>122</sup> See *Andrews v. D.P.P.* [1937] A. C. 583. On principal, negligence as to death (or, at the very least, serious bodily harm) should be required as a prerequisite to conviction. *But see Stone*, [1977] Q. B. 354, 363.

<sup>123</sup> See *Andrews*, [1937] A. C. 583.

<sup>124</sup> See *Adams*, [1957] Crim. L.R. 365; *Cox*, [1992] 12 B.M.L.R. 38.

<sup>125</sup> See *Hyam*, [1975] A. C. 55, *supra* note 96 and accompanying text.



ministers what he knows to be a lethal dose of a drug.<sup>126</sup> In *R. v. Arthur*<sup>127</sup> the court accepted that the doctor had acted from the highest of motives, but directed the jury that "however noble his motives were . . . that is irrelevant to the question of your deciding what his intent was."<sup>128</sup> If a doctor acts with the intention of bringing about the death of a patient, the fact that he was acting to alleviate suffering, or for some other exemplary motive, would not provide him with a defense to a charge of murder.<sup>129</sup>

In some circumstances, the fact that a person has particular medical qualifications will affect that person's liability for murder or manslaughter.<sup>130</sup> Further, the fact that one was medically qualified would make no difference if he administered a drug, or took any other action intending to hasten the death of a patient.<sup>131</sup> In the few cases where doctors were prosecuted for murder or attempted murder due to action taken in the course of treatment, trial judges have stressed that the law does not place doctors in any special position.<sup>132</sup>

Even if a doctor acts in compliance with statements on medical ethics propounded by the British Medical Association (BMA), or any other organization, this does not of itself provide a doctor with a defense to certain acts. If, for example, the doctor *administers* a drug, or does any other act, for the purpose of hastening the death of a patient,<sup>133</sup> such compliance is not itself a defense. Given this standard, a reasonable jury could find

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<sup>126</sup> See *R. v. Arthur* [1981] 283 Br. Med. J. 1340.

<sup>127</sup> See *id.*

<sup>128</sup> *Id.*

<sup>129</sup> See *Hyam*, [1975] A.C. at 73.

<sup>130</sup> See *Adams*, [1957] Crim. L.R. at 375. Justice Devlin said that the law was the same for all: there was not any special defense for medical men. See *id.*

<sup>131</sup> See *Arthur*, [1981] 283 Br. Med. J. 1340. Justice Farquharson stated there "is no special law . . . that places doctors in a separate category and gives them extra protection over the rest of us. . . . [they are] given no special power . . . to commit an act which causes death'. *Id.* at 1344.

<sup>132</sup> See *Adams*, [1957] Crim. L.R. 365; *Arthur*, [1981] 283 Br. Med. J. 1340.

<sup>133</sup> See *Arthur*, [1981] 283 Br. Med. J. 1340. Justice Farquharson stated that it was customary for professions to agree on rules of conduct for their members but warned the jury that "that does not mean that any profession can set out a code of ethics and say that the law must accept it and take notice of it." *Id.* Furthermore, "whatever a profession may evolve as a system of standards of ethics, cannot stand on its own, and cannot survive if it is in conflict with the law." *Id.*

that a doctor committed murder even if they believe he acted in accordance with the profession's ethical standards.

Beyond the crimes of murder and manslaughter, a doctor may find himself subject to prosecution for the crime of assisting suicide under the Suicide Act 1961.<sup>134</sup> As mentioned earlier, suicide has traditionally been held by the Christian tradition as sinful<sup>135</sup> and until 1961 was a common law crime in England.<sup>136</sup> Section 1 of the Act statutorily abolished the crime of suicide and in turn the crime of attempting suicide.<sup>137</sup> Considering prosecution of one successfully completing the crime was impossible and to prosecute someone for attempt did not serve the victims' obvious psychological needs, Parliament passed the Suicide Act.<sup>138</sup>

The removal of the common law crime was not intended to be a rubber stamp approval of suicide, and to further make that clear, section 2 of the Act creates the crime of assisting suicide.<sup>139</sup> The elements of assisting a suicide are fulfilled when, a person "aids, abets, counsels or procures the suicide of another, or an attempt by another to commit suicide."<sup>140</sup> Despite thirty-one convictions for assisting suicide made over a nine-year period ending in 1991,<sup>141</sup> there is still some confusion over what exactly is required to establish the offense.

In *A. G. v. Able*,<sup>142</sup> the attorney General sought a declaration that a booklet published by the Voluntary Euthanasia Society (VES) was illegal under the Suicide Act.<sup>143</sup> The court held

<sup>134</sup> See Suicide Act 1961, ch.60, § 2(1) (conviction of assisting suicide punishable by a maximum of fourteen years in prison).

<sup>135</sup> See Crone, *supra* note 3. Thomas Cranmer (1489-1556), Archbishop of Canterbury and the most influential man in shaping the Church of England, said that "self-murder was 'cursed of God, and damned forever.'" *Id.* at 23. See also Rev. Richard E. Coleson, *Contemporary Religious Viewpoints on Suicide, Physician-Assisted, and Voluntary Active Euthanasia*, 35 DUQ. L. REV. 7 (1996).

<sup>136</sup> See Suicide Act 1961.

<sup>137</sup> See *id.*

<sup>138</sup> See Hodgson, *supra* note 14, at 189. See also *Attorney General v. Able & Others* [1984] 1 All E. R. 277 (civil suit to determine the scope of the act).

<sup>139</sup> See Suicide Act 1961 § 2.

<sup>140</sup> See *id.* at § 2.

<sup>141</sup> See K.J.M. Smith, *Assisting Suicide—The Attorney-General and the Voluntary Euthanasia Society*, CRIM. L.R. 579 (1983).

<sup>142</sup> *Able*, [1984] 1 All E.R. 277.

<sup>143</sup> See *id.* The booklet at issue in this case began by indicating that the Society disapproved of hasty decisions about suicide, but went on to describe a number

that, in order to prove the allegation, three things had to be shown: (a) that the accused knew that suicide was contemplated, (b) that he or she approved or assented to it, and (c) that he or she encouraged the suicide attempt.<sup>144</sup> Here, publishing the booklet was not necessarily illegal because the third element was not established in relation to any specific death.<sup>145</sup> Consequently, giving someone pills and advising that they should be taken to end his or her life would be an offense,<sup>146</sup> as is directing someone to one who can help him or her commit suicide.<sup>147</sup> An offense under section 2 may be committed even if no actual attempt at suicide is made.<sup>148</sup> A person who attempts to encourage another to commit suicide can therefore be guilty of attempted assisted suicide, even if the victim is unsuccessful.<sup>149</sup>

It is evident from this analysis that a health professional who helps a patient to take his or her own life is likely to commit a criminal offense. Even explaining how it might be done will be illegal if the professional knows that it would encourage the patient to go ahead. Making drugs available knowing that the patient is likely to take a fatal overdose would also be a crime. The conclusion is that the condition of the patient, the doctor's high ethical motives, professional qualifications, or compliance with accepted ethical standards would provide any doctor with a defense when he/she prescribes or administers a drug which hastens the death of the patient.

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of ways in which "self-deliverance" might be achieved. *See id.* The Attorney General had evidence that the booklet was associated with at least fifteen cases of suicide within eighteen months of its publication. *See id.* The argument was made that the fact that the VES felt it necessary to discourage ill-considered suicides indicated that it must have been aware of the risk that people might use the information to commit suicide. *See id.* It was therefore contended that the VES was committing the offense of assisting suicide under section 2 of the 1961 Act. *See Able*, [1984] 1 All E. R. 277.

<sup>144</sup> *See id.*

<sup>145</sup> *See id.*

<sup>146</sup> *See R. v. McShane* [1977] 66 Cr. App. R. 97.

<sup>147</sup> *See R. v. Reed* [1982] Crim. LR 819, discussed in *Able*, [1983] 1 All E.R. at 286.

<sup>148</sup> *See Suicide Act of 1961.*

<sup>149</sup> *See McShane*, [1977] 66 Cr. App. R. 97.

C. *Choose Your Weapon: An Overview of Controlled Substance Regulations*

It is widely accepted that if there were no other way to assuage pain, a doctor would be morally justified in administering a pain-killing drug to a patient whose death was imminent, even if he believed that the drug might have the incidental effect of hastening death.<sup>150</sup> But, would the doctor be guilty of murder if the drug did hasten death? The question seems preposterous. Yet, this question arises from the possibility that any act hastening death may be regarded as a cause of death. Moreover, a person can be convicted of murder even though he did not desire to hasten death, and was not substantially certain that his conduct would have this effect.<sup>151</sup>

It is almost certain that a doctor will not be prosecuted as a result of his prescribing or administering a drug under these circumstances.<sup>152</sup> Were there to be a prosecution, there would be little danger of the jury convicting the doctor, whatever the content of the judge's concluding remarks. Indeed, there would be more than one way in which a judge could avoid directing the jury that a doctor would be guilty of murder or manslaughter if he administered a pain-killing drug to a patient whose death was imminent, in the belief that the drug might well hasten death.

Prior to examining these different possibilities, it is important to examine the drugs concerned and the other than criminal controls on their use currently in place. The development,

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<sup>150</sup> See Patricia C. Crowley, *No Pain, No Gain? The Agency for Health Care Policy & Research's Attempt to Change Inefficient Health Care Practice of Withholding Medication from Patients in Pain*, 10 J. CON. H. L. & POLICY 383 (1994). Crowley points out that "[t]he health care industry's current standard of care concerning acute pain is to treat the pain retroactively as needed, rather than with preventative measures. This practice has its foundation in two long-standing myths of western culture. First, is that enduring pain develops character making one a better, stronger and more moral person. Second, there is a fear that patients will become addicted to drugs administered for pain relief." *Id.* See also *Pain and the Doctors*, WASH. POST, Mar. 14, 1992 at A22 ("Stoicism is out the window").

<sup>151</sup> See *Hyam*, [1975] A.C. 55.

<sup>152</sup> Assuming that the patient was not opposed to the administration of the drug, a common law battery, and was not given a greater quantity of it than could reasonably be regarded as necessary to relieve pain. See generally *Cox*, [1992] 12 B.M.L.R. 38; *Arthur*, [1981] 283 BR. MED. J. 1340; *Adams*, [1957] Crim. L.R. 365; *Hyam*, [1975] A.C. 55.

manufacturing, distribution, and importation of medicines are regulated under the Medicines Act 1968.<sup>153</sup> Responsibility for licensing drugs under the Act formally lies with the Secretary of State for Health.<sup>154</sup> In practice, the Medicines Control Agency, part of the Department of Health exercises this authority.<sup>155</sup> As part of the statutory framework, advice is available from the Medicines Commission, whose members must have expertise in medicine, pharmacy, non-pharmaceutical chemistry, and the pharmaceutical industry.<sup>156</sup> There are also a number of statutory committees, including the Committee on Safety of Medicines. Powers to enforce the provisions of the Medicines Act 1968 lie with the Secretary of State, who has delegated them concurrently to the Royal Pharmaceutical Society.<sup>157</sup>

Various pieces of legislation introduce a number of provisions aimed to ensure that medicines are used safely and for licit purposes. The United Kingdom Central Council (UKCC) has usefully categorized four stages in the therapeutic use of medicines; prescription, dispensation, administration, and patient acceptance.<sup>158</sup> The last is primarily regulated by the law of consent.<sup>159</sup> Administration is generally regulated by malpractice law.<sup>160</sup> Certain controlled drugs may be administered by or under the direction of medical and dental practitioners only,<sup>161</sup> but the actual administration is not restricted to professionals.<sup>162</sup> The dispensation stage covers the process by which drugs are released for use, ceasing to be subject to any storage requirements that applied.<sup>163</sup>

Drugs are divided into a number of categories.<sup>164</sup> Under the Medicines Act 1968, there is a threefold distinction between

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<sup>153</sup> See generally Medicines Act 1968.

<sup>154</sup> See *id.*

<sup>155</sup> See *id.*

<sup>156</sup> See *id.*

<sup>157</sup> See generally G. APPLEBE & J. WINGFIELD, DALE AND APPLEBE'S PHARMACY LAW AND ETHICS 5TH ED. (London 1993).

<sup>158</sup> See UNITED KINGDOM CENTRAL COUNCIL FOR NURSING, MIDWIFERY AND HEALTH VISITING, *Administration of Medicines* (London: UKCC, 1986).

<sup>159</sup> See MONTGOMERY, *supra* note 78, at ch. 10.

<sup>160</sup> See *id.* at ch. 7.

<sup>161</sup> See Misuse of Drugs Regulations 1985, SI 1985 No 2066, r. 7.

<sup>162</sup> See *id.*

<sup>163</sup> Storage requirements depend on the class of drug in question.

<sup>164</sup> See Medicines Act 1968.

(a) prescription-only medicines, (b) medicines that can only be supplied by a pharmacist (but which can be dispensed without a prescription), and (c) general-list medicines (which need not be obtained through a pharmacist).<sup>165</sup> The Misuse of Drugs Act 1971, which is primarily concerned with control of illicit drug use, contains three categories of controlled drugs, known as classes A, B, and C.<sup>166</sup> More importantly, for the health context, controlled drugs are further classified by the Misuse of Drugs Regulations 1985, which places them into one of five schedules.<sup>167</sup> Schedule 1 drugs are not used for medicinal purposes.<sup>168</sup> Schedule 2 drugs include opiates and major stimulants, such as amphetamines.<sup>169</sup> Schedule 3 drugs include most barbiturates, and some minor stimulants.<sup>170</sup> Schedule 4 contains benzodiazepine tranquilizers.<sup>171</sup> Schedule 5 contains preparations of controlled drugs where there is minimal risk of abuse.<sup>172</sup>

Drugs from Schedules 2 and 3 can be dispensed only on prescription.<sup>173</sup> To be valid, a prescription has to be written in ink, or some other indelible material, dated, and signed by the prescriber.<sup>174</sup> The name and address of the person for whom it is prescribed must be set out together with the dosage to be taken.<sup>175</sup> If the patient is under 12 years of age, his or her age must also be recorded.<sup>176</sup> Where a controlled drug is prescribed, the prescription must be personally handwritten by the prescriber (otherwise it may be written by means of carbon paper).<sup>177</sup> Where a drug from Schedules 1, 2 or 3 of the Misuse of

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<sup>165</sup> See *id.*

<sup>166</sup> See Misuse of Drugs Act 1971.

<sup>167</sup> See Misuse of Drugs Regulations 1985.

<sup>168</sup> See APPLEBE & WINGFIELD, *supra* note 157, at 172-75.

<sup>169</sup> See *id.*

<sup>170</sup> See *id.*

<sup>171</sup> See *id.*

<sup>172</sup> See *id.*

<sup>173</sup> See Medicines Order (Products other than Veterinary Drugs)(Prescription Only) 1983, SI 1983 No 1212, as amended.

<sup>174</sup> See *id.*

<sup>175</sup> See *id.*

<sup>176</sup> See *id.*

<sup>177</sup> See *id.*

Drugs Regulations 1985 is prescribed, the dosage must be written in both figures and words to avoid errors.<sup>178</sup>

There are also requirements as to the storage of controlled drugs and record keeping.<sup>179</sup> There must be a special register, in the form of a bound book for controlled drugs in Schedules 1 and 2 of the 1985 regulations.<sup>180</sup> An entry must be made every time such a drug is obtained or supplied, recording the person from whom it was obtained or to whom it was supplied, the quantity involved, and the form in which the drug was transferred.<sup>181</sup> Regulations on the safe custody of controlled drugs apply to those in Schedules 1, 2, and 3.<sup>182</sup> Such drugs must be kept under lock and key.<sup>183</sup>

Regulation of the use of drugs centers on the legal power to prescribe. The use of prescription-only drugs is not regulated beyond the licensing system, which deals with the availability of drugs on a general basis. Prescription-only medicines are restricted to those patients that a health professional has identified as an appropriate recipient.<sup>184</sup> Such medicines may be dispensed only under a prescription, usually given only by a medical doctor or dentist.<sup>185</sup> Limited provision has also been made for nurses and practice nurses.<sup>186</sup> Midwives may possess and use specified controlled drugs under a "midwives supply order," which must be signed by a doctor or by the supervisor of midwives.<sup>187</sup> Occupational health nurses may use prescription-only medicines without immediate directions provided that they do so only in circumstances specified in writing by a medical practitioner.<sup>188</sup> Certain district nurses and health visitors, whose registration with the UKCC is annotated to show that

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<sup>178</sup> See Medicines Order (Products other than Veterinary Drugs)(Prescription Only) 1983, SI 1983 No. 1212, as amended.

<sup>179</sup> See Misuse of Drugs Regulations (Safe Custody) 1973, SI 1973 No.798, as amended, Sch.12.

<sup>180</sup> See *id.*

<sup>181</sup> See *id.*

<sup>182</sup> See *id.*

<sup>183</sup> See *id.*

<sup>184</sup> See Misuse of Drugs Regulations (Safe Custody) 1973, SI 1983 No 1212, as amended.

<sup>185</sup> See *id.*

<sup>186</sup> See Medicines Act 1968, §58 and regulations promulgated thereunder.

<sup>187</sup> See Medicines Order (Products other than Veterinary Drugs)(Prescription Only) 1983, Sch. 3, Pts. I and III.

<sup>188</sup> See *id.* at art. 9 and Sch.3, Pt. III, para. 5.

they are qualified to do so, may prescribe drugs under a limited formulary.<sup>189</sup> Ambulance paramedics are also able to use certain prescription-only medicines.<sup>190</sup> Special restrictions exist on the prescription of medicines to drug addicts.<sup>191</sup>

Finally, mention must be made of the use of unlicensed products by doctors for individual patients. Under section 9 of the Medicines Act, the usual licensing requirements are waived where a doctor or dentist uses a drug specially prepared or imported for a particular patient.<sup>192</sup> This is usually known as use on a "named patient basis."<sup>193</sup> This enables the practitioner to use drugs that have not yet been licensed, or to use licensed drugs in a way that is not within the scope of the product license.<sup>194</sup> This may mean use in a different form, dosage, or by a different mode of administration. It may mean using the drug for the patient falling outside the group for which the drug is licensed (for example using the drug for children or pregnant women when the drug has been licensed for non-pregnant adults only).<sup>195</sup>

#### D. *The Proverbial Salt in the Wound: When Pain Relief is Criminal*

After examining the drugs concerned and the controls on their use, it is possible to explore the ways a judge could avoid directing the jury that a doctor would be guilty of murder or manslaughter if he administered a pain-killing drug to a patient whose death was imminent, in the belief that the drug might well hasten death. If a doctor prescribed a pain-killing drug for the purpose of hastening the death of the patient, he would have the fault element for murder. The dichotomy arises where he simply believed that such treatment might well have this effect.

The speeches in the House of Lords in *R. v. Hyam* raised the possibility of someone being guilty of murder because he

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<sup>189</sup> See *id.* at art. 2, Sch. 1A.

<sup>190</sup> See *id.* at Amendment No. 2 Order 1992.

<sup>191</sup> See Misuse of Drugs Regulations (Notification of and Supply to Addicts) 1973, SI 1973 No. 799.

<sup>192</sup> See Medicines Act 1968, § 9.

<sup>193</sup> See *id.*

<sup>194</sup> See *id.*

<sup>195</sup> See *id.*



knew that it was 'probable' or 'likely' (rather than highly probable, or substantially certain) that his act would hasten death.<sup>196</sup> Given the facts of that case, there was no need for their Lordships to consider risk-taking in medical practice.<sup>197</sup> But, as previously mentioned, Lord Hailsham did discuss the hypothetical heart transplant surgeon, arguing there was a high degree of probability that such surgeon's actions would hasten death and that such surgeon knew so at the time.<sup>198</sup> Lord Hailsham stated that the surgeon would not be liable when there was a lawful excuse for the conduct.<sup>199</sup> If the court gives the same effect to the statements made in *Hyam* supporting a very broad fault element for murder, one can expect it to accept that the general statements must be qualified in some way.

In the surgeon hypothetical, the court recognized that surgery was the best or only means of securing the patient's survival. Even if length of life were the sole relevant consideration, it could be argued that doctors would sometimes be justified in prescribing or administering pain-killing drugs that may hasten death. Such drugs can have the effect of prolonging life, by improving the patient's capacity to sleep and eat.<sup>200</sup> However, there is no reason to believe that length of life is the sole consideration. A slight risk of death is inherent in many operations, which are performed to remedy conditions not themselves endangering life. Where death is imminent, much greater risks are justifiable to control pain.

There is not the least doubt it would be accepted that, if there was no other clearly preferable way of relieving the pain of a terminally ill patient, a doctor could properly prescribe or administer a drug for that purpose. This is so even though the doctor believed the drug might hasten death.<sup>201</sup> As such risk-taking would be regarded as justifiable, it would come within the "lawful excuse" exception of Lord Hailsham's formulation of

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<sup>196</sup> See *Hyam*, [1975] A. C. 55, 74 E-F.

<sup>197</sup> See *id.* See also *Hyam*, [1975] A. C. 55, *supra* note 96 and accompanying text.

<sup>198</sup> See *id.*

<sup>199</sup> See *id.*

<sup>200</sup> See AMERICAN COLLEGE OF LAW MEDICINE, *supra* note 8, at ch. 38.

<sup>201</sup> This is assuming the patient is not known to be opposed to such treatment. See ANNAS, *supra* note 14, at 218.

the fault element for murder. Even if it were highly probable that the drug would hasten death, the doctor should not be regarded as having a fault element sufficient for a conviction for murder.

Manslaughter is more straightforward than murder. Unless the doctor acted in a way in which no reasonable doctor would act,<sup>202</sup> he would not have the fault element for negligent manslaughter. Further, if the doctor did not commit some other offense, he would not meet the requirements for the fault element of 'unlawful act' manslaughter.

In terms of actual cause, it would often be extremely difficult to prove that a painkilling drug did hasten death. Sometimes such drugs will prolong life, by reducing debilitating effects of severe pain. On the other hand, patients can die of pneumonia whether or not they were given drugs that could lead to respiratory complications. In other words, without more, evidence of the use of such drugs is not dispositive of the cause of death.

Even if it were apparent that the administration of the pain-killing drug did accelerate death there is a strong possibility that the doctor's conduct would not be regarded as a cause of death, for the purposes of the law of homicide. In relation to most deaths there are innumerable acts "but for" which death would not have occurred. The issue of whether a particular "but for" cause is also an "imputable" cause, is often left to the jury as a matter of common sense.<sup>203</sup> But sometimes judges propound principles which lead to the conclusion that particular conduct should, or should not, be regarded as a "cause" in the eyes of the law.<sup>204</sup> Both approaches played a part in Justice Devlin's summation in *Adams*.<sup>205</sup> Several years following the holding in *Adams*, Justice Devlin repeated portions of the jury charge<sup>206</sup> in a lecture before the Medical Society of London.<sup>207</sup> He further stated "[that] proper medical treatment consequent upon illness or injury plays no part in legal causation [and that]

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<sup>202</sup> See AMERICAN COLLEGE OF LAW MEDICINE, *supra* note 8, at 119.

<sup>203</sup> See H. Palmer, 'Dr. Adams' Trial for Murder [1957] CRIM. L.R. 365-77.

<sup>204</sup> See *id.*

<sup>205</sup> See *id.*

<sup>206</sup> See *Adams*, [1957] Crim. L.R. 365. Specifically, Justice Devlin repeated the language found herein at page 24, note 106. See *id.*

<sup>207</sup> See P.D.G. SKEGG, LAW, ETHICS, AND MEDICINE 135 (Oxford, 1984).

to relieve the pains of death is undoubtedly proper medical treatment."<sup>208</sup>

Justice Farquharson, in *R. v. Arthur*, stated that there comes a point when "the amount of those doses are such that in themselves they will kill off the patient, but he is driven to it on medical grounds."<sup>209</sup> In such case, he feels, that a jury would undoubtedly say "that could never be murder. That was a proper practice of medicine."<sup>210</sup> Such a principle would lead to a satisfactory result in relation to the administration of pain-killing drugs to a dying patient. Although the courts would have the last word on the propriety of treatment, there could be no doubt that their view would be similar to that summed up by Justice Farquharson above.

There are objections to the adoption of a general principle whereby nothing which could be described as proper medical treatment could be regarded as a "cause" for legal purposes. But in view of the lead given by Justice Devlin in *R. v. Adams*, it is likely, in any future case involving the prescription or administration of a drug to relieve the pains of death, a judge would be prepared to manipulate the concept of causation to avoid the conclusion that the doctor's act was the legal cause of death.

## VI. CONCLUSION

Across the board, governments face unique challenges in balancing the rights of an individual to be free from pain against the state's right to protect individuals from harm, such as the slippery slope we saw in the Netherlands experiment. In looking to the standards adopted by Great Britain, the development and implementation of common law and statutory schemes including criminalization and regulation, the interested parties in the United States may recognize a blue print to follow. While the criminal law is merely one lens through which to view this problem, to the health practitioners subject to those prosecutions, it is the most consequential. Not only must we recognize that, if convicted and sentenced to prison, a

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<sup>208</sup> *See id.*

<sup>209</sup> *Arthur*, [1981] 283 BR. MED. J. 1340.

<sup>210</sup> LAW REFORM COMMISSION OF CANADA, EUTHANASIA, AIDING SUICIDE AND CESSATION OF TREATMENT 70 (1982).

doctor's license, reputation—livelihood—is at stake in these matters. Indeed, a doctor's very freedom is at stake.

The issues of pain management and PAS implicate the law in numerous and diverse ways. For example, in countries, such as Great Britain, supporting nationalized health care systems, the regulation of controlled substances not only includes the protection and sanctity of human life, but also the more base issue of economics. Even in countries where health care is "free," so to speak, there must be limits on these expensive and limited treatments. The government must determine who is to get what benefit and at what point in their treatment. Furthermore, constituents demand appropriations for preventive or palliative care in addition to demands for everyday treatment.<sup>211</sup> Insurance law and medical practice acts must weigh these financial concerns in trying to balance the substantial interests on both sides.

The principles of British criminal law considered herein indicate that the administration of drugs that hasten death would be lawful providing that three tests are satisfied. First, the patient must be terminally ill. It is unclear how close to death the patient need be, and this is not always known with any certainty. However, the patient must already be dying if it is to be argued that the illness, not the drugs was the cause of death. Second, prescribing the drugs must be "the right and proper treatment." This appears to mean that it must be treatment accepted as proper by a responsible body of the profession. In 1990, a prosecution against a doctor was dropped when it became apparent that some doctors supported the use of the drugs administered, despite the fact that the predominant opinion was that they were inappropriate.<sup>212</sup> Third, the motivation for

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<sup>211</sup> See *First Ever Hospice/Palliative Care Summit in Canada*, CANADA NEWS WIRE, Monday, Nov. 10, 1997. "Demand for hospice and palliative care is growing rapidly," says Linda Lysne, Executive Director, Canadian Palliative Care Association. "We want and need to see hospice and palliative care gain more prominence in our healthcare system." *Id.* See also *Taking Better Care of the Dying*, ABA JOURNAL, Sept. 1997 at 51.

<sup>212</sup> See *Doctor is Cleared of Murdering Patient*, THE INDEPENDENT Mar. 16, 1990. See also PHYSICIAN ASSISTED SUICIDE, at <[Http://www.netlink.co.uk/users/vess/mclean.html](http://www.netlink.co.uk/users/vess/mclean.html)> (visited, Oct. 4, 1997). A survey performed by Sheila McLean, Professor of Law & Ethics in Medicine at Glasgow University on a grant from the Voluntary Euthanasia Society of Scotland, revealed that a majority of doctors in Britain believed they should be allowed to help suffering patients die. See *id.* The

prescribing the drugs must be to relieve suffering. Otherwise the shortening of the patient's life would not be "incidental" to the prescription, but its primary purpose.

Wendy E. Smith†

#### APPENDIX A

The Act states:

#### MODEL STATUTE ON IMMUNITY FOR EFFECTIVE PAIN RELIEF

##### Short Title

§ 1. This Act may be cited as the Pain Relief Act.

##### Definitions

§ 2. For the purposes of this Act:

1. "Board" means [insert the appropriate list of state licensure boards that govern doctors, nurses, physician assistants and pharmacists].
2. "Physician" means a licensee of the [insert the name of the board or boards licensing M.D.s and D.O.s].
3. "Nurse" means a licensee of the [insert the name of the state board of nursing].
4. "Pharmacist" means a licensee of the [insert the name of the state board of pharmacy].
5. "Physician Assistant" means a licensee of the [insert the name of the state board regulating physician assistants].

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survey, released on May 23, 1997 was the first of its kind in Britain. *See id.* The results are as follows: 54% of doctors responding would support a change in the law which would allow them to help patients die. *See id.* Of those, 16% said they would help in terminal cases, 11% in cases of physical suffering, and 7% simply if the patient wished. *See id.* Notably, of those admitting that patients have asked for such help, 3% have complied with the patient's request. *See id.*

† 1999 J.D./M.P.A. Candidate, Pace University School of Law and the Dyson College of Arts and Sciences. The author would like to thank Joseph Ryan, Ph.D. for his encouragement and invaluable comments on this article and Joseph Deer for his constant love and support.

6. "Intractable pain" is a state of pain, even if temporary, in which reasonable efforts to remove or remedy the cause of the pain have failed or have proven inadequate.
7. "Clinical expert" is one who by reason of specialized education or relevant experience has knowledge regarding current standards and guidelines for pain management.
8. "Accepted practice/care guidelines for pain management" are guidelines for pain management developed by nationally recognized clinical or professional associations; specialty societies or government-sponsored agencies that have actively researched pain management and thus developed practice/care guidelines. In the absence of current accepted practice/care guidelines, rules or policies issued by the Bard may serve the function of such guidelines as described in § 3 of this Act. Guidelines established for the purposes of coverage, payment or reimbursement do not qualify as "accepted practice/care guidelines for pain management: when offered to limit treatment options otherwise covered within this Act.
9. "Therapeutic purpose" is the use of pharmaceutical and non-pharmaceutical medical treatments that conforms to accepted practice/care guidelines for pain management.
10. "Disciplinary action" includes formal, informal, remedial or punitive actions taken by a board against a health care provider.
11. "Health care provider" is a licensed physician, nurse, physician assistant or pharmacist as defined in subsections 2,3,4 and 5 of this section.

### § 3

1. A physician, nurse, physician assistant or pharmacist who prescribes, dispenses or administers medical treatment for the therapeutic purpose of relieving intractable pain shall be immune from criminal prosecution and disciplinary action unless it can be established by clinical expert testimony that the health care provider did not substantially comply with accepted practice/care guidelines for pain management.

2. The provisions of subsection 1 of this section shall apply to physicians, nurses, physician assistants and pharmacists in the treatment of all patients for intractable pain regardless of the patient's prior or current chemical dependency. The Board may develop and issue rules, policies or guidelines establishing standards and procedures for the application of this Act to the care and treatment of chemically dependent individuals, consistent with the provisions of this Section of the Act.
3. Nothing in this section shall deny the authority of the Board to discipline a health care provider who:
  - a. fails to maintain complete, accurate and current medical records documenting the physical examination and medical history of the patient, the basis for the diagnosis of the patient and the treatment plan for the patient;
  - b. writes false or fictitious prescriptions for controlled substances scheduled in the Federal Comprehensive Drug Abuse Prevention and Control Act of 1970, 21 U.S.C. 801 et seq. [or related statute];
  - c. prescribes or administers or dispenses pharmaceuticals in violation of the provisions of the Federal Comprehensive Drug Abuse Prevention and Control Act of 1970, 21 U.S.C 801 et seq. [or related statute];
  - d. or who self-prescribes or self-administers pharmaceuticals in violation of current professional standards.