

## “A Special Defence”: A Psychiatric Approach to Formalising Euthanasia

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Domestic and world opinion is gradually changing towards the idea of tolerating or even legalising active euthanasia. The implications of this are examined using Foulke's concept of the 'levels' in group discussions. Psychiatrists have a unique experience in using the statutory mental health legislation, in addition to the ordinary law, to regulate medical care. A new 'special defence' is suggested, to be enacted by Parliament, intended to justify, but also designed to control, deliberate acts of medical euthanasia.

The modern debate on euthanasia began in the UK in the 1930s (*Lancet*, 1931; Roberts, 1936; Hunterian Society, 1936), with the founding of the Voluntary Euthanasia Society in 1935 (*Lancet*, 1935; Oliver, 1991), followed in 1936 by the unsuccessful introduction of the Voluntary Euthanasia (Legalisation) Bill in the House of Lords. Although there were several further attempts to reform the law over the next 50 years, doctors remained predominantly antagonistic towards the “termination of life” (*British Medical Journal*, 1971) and were restrained or repulsed by the Nazi exterminations. In 1988 the British Medical Association reiterated its view that “the deliberate taking of a human life should remain a crime”. However, its report was met with reservation by some (Higgs, 1988; Byrne, 1990), and by outright rejection from others (Nowell-Smith, 1989).

Dying and terminal care, championed by the hospice movement since the opening of St Christopher's Hospice in Sydenham in 1967 (Saunders & Baines, 1989), has long been a subject of ethical controversy (Kohl, 1974; Glover, 1977; Pabst Battin, 1982; Rachels, 1986; Kuhse, 1987; Gillon, 1988; Wennberg, 1989). The Appleton International Conference guidelines on treatment abatement procedures (Stanley, 1989, 1992) and the editorial in the *British Medical Journal* calling for a Royal Commission (Smith, 1992) have further stimulated interest. The publicity surrounding the conviction of Dr Nigel Cox for the attempted murder of a dying patient (Dyer, 1992), and the decision of the courts to give permission to allow Tony Bland, a young man in a persistent vegetative state, to die (Jennett, 1992), have both increased public awareness (Helme & Padfield, 1993).

Changing practice abroad, especially in the US and in the Netherlands (Rigter *et al*, 1988; Leenan, 1990;

Jennett, 1991), has also exerted an influence. A Dutch study, “Euthanasia and other medical decisions concerning the end of life” (van der Maas *et al*, 1991), concluded that “these decisions are common medical practice and should get more attention in research, teaching, and public debate”. This study specifically excluded the views of paediatricians and psychiatrists on the grounds that “the average number of hospital deaths per clinician would be too small”. This was regrettable, as the care of the dying and bereaved has greatly benefited from the contributions of psychiatrists such as Hinton (1967) and Parkes (1972). Death is common, and often protracted, in psychogeriatric practice. There is also concern about the manner of dying and the quality of terminal care received by psychogeriatric patients (Baker, 1976; Black & Jolley, 1990, 1991). In theoretical discussions about euthanasia, psychiatric opinions are frequently cited in determining legal competence (e.g. Brody, 1988), partly because a wish to die is often the result of mental illness (Barraclough *et al*, 1974). A psychiatric perspective is therefore relevant.

In considering the legal context in which medicine has to be practised, Lord Devlin, in his summing up of the Bodkin Adams case in 1952, stated that a doctor is “entitled to do all that is proper and necessary to relieve pain and suffering, even if the measures he takes may incidentally shorten life” (Devlin, 1985). However, “no doctor, nor any man, no more in the case of the dying than the healthy, has the right deliberately to cut the thread of life.” There is, he said, under present law, no “special defence for medical men”.

This paper will argue that, if euthanasia is to be manageable, there will need to be just such a “special defence”, enacted by statute, in order to regulate the practice of medical men and women. First it will be

shown that opinion appears to be shifting towards favouring its acceptance. Secondly, using a framework derived from group analysis, an attempt will be made to clarify some of the dangers and difficulties which can be anticipated if euthanasia comes to be tolerated, or even to be expected, as part of established medical practice. Thirdly, since active euthanasia by definition involves an act of deliberate homicide, procedural boundaries need to be established and agreed. Parallels can be drawn with the mental health legislation which similarly involves a 'special defence', in that case in order to permit doctors to detain and to treat mentally disordered patients without valid consent. It may be reasonable to extrapolate from psychiatric experience to offer tentative suggestions as to how a least unacceptable option for euthanasia legislation might be approached.

### **Evidence for a change in opinion on euthanasia**

#### **Direct measurement of public attitudes**

Attempts have been made to measure public attitudes directly (Seguin, 1990; Leenan, 1990). These need to be interpreted with care, as the wording of the questions asked can appear nebulous, introducing the possibility of substantial systematic bias if interviews are conducted by those with particular or partisan expectations. However, polls have been carried out as part of larger surveys conducted by professional research organisations, putting the same questions to comparable population samples over long periods of time (Helme, 1992). The results of these surveys demonstrate a definite trend in public attitudes in several countries, support rising from about 50% in polls taken in the 1960s to 75% today. In Britain, National Opinion Polls Market Research Ltd (NOP) asked the question

"Some people say that the law should allow adults to receive medical help to an immediate peaceful death if they suffer from an incurable physical illness that is intolerable to them, provided that they have previously requested such help in writing. Please tell me whether you agree or disagree with this."

They found that the proportion giving a positive response had risen from 69% (of 2125) in 1976, through 72% (of 1709) in 1985, to 75% (of 1960) in 1989.

#### **Direct measurement of medical attitudes**

A telephone survey of a representative sample of British general practitioners (GPs) was conducted in

1987 by NOP. Of the 744 names selected, only 301 consented to be interviewed. Of those who did respond, only 30% stated that they agreed with the suggestion above, which contrasted markedly with the 75% support of the general population.

Such opposition to euthanasia is not typical of doctors around the world. In 1988 in Australia, of 869 of the 2000 doctors selected from Victoria who replied to a written questionnaire, 62% answered affirmatively to the question: "Do you think it is sometimes right for a doctor to take active steps to bring about the death of a patient who has requested the doctor to do this?" (Kuhse & Singer, 1988). Similar percentages favoured a change in the law and the introduction of a system such as that which now exists in the Netherlands. In the USA, a poll of 1743 members of the San Francisco Medical Society in 1988, although it also achieved only a 38.8% response rate, revealed a 70% positive response to: "Do you feel that patients should have the option of requesting active euthanasia when faced with incurable terminal illness?" (Heilig, 1988). In 1991, a telephone poll sponsored by the American Board of Family Practice was reported as finding that 91% of the 300 doctors interviewed believed that a terminally ill patient should have the right to choose to die (American Board of Family Practice, 1991).

Although such polls are only of small samples, have low response rates, and are not strictly mutually comparable, they offer the best available data on current medical attitudes.

#### **Professional opinion in the academic literature**

There has been a minority view expressed in favour of euthanasia for many decades. Glanville Williams, Rouse Ball Professor of English Law in the University of Cambridge, clarified the arguments for euthanasia in terms of the prevention of cruelty and the protection of liberty (1958*a,b*). However, it is only recently that the subject has been debated at length in the medical literature (Brewin, 1986; Stehbins, 1986), particularly in a spate of articles from North America following an anonymous paper, "It's over, Debbie" (*Journal of the American Medical Association*, 1988; Gaylin *et al*, 1988; Vaux, 1988; Lundberg, 1988; Pence, 1988; Angell, 1988; Reichel & Dyck, 1989; Wanzer *et al*, 1989; Orentlicher, 1989; Singer & Siegler, 1990; Cassel & Meier, 1990). The traditional reticence therefore seems to have been abandoned, and a few examples illustrating the changing attitudes can be offered.

In 1988, in their report *The Living Will*, the Age Concern Institute of Gerontology and the Centre of Medical Law and Ethics at King's College, London, chaired by Ian Kennedy, co-author of the standard

English textbook on medical law (Kennedy & Grubb, 1989), stated that: "To change the law would appear to be in keeping with the logic of respect for autonomy reflected in this report" (Age Concern, 1988).

In 1990, the Institute of Medical Ethics Working Party on the Ethics of Prolonging Life and Assisting Death concluded as its majority view that: "A doctor, acting in good conscience, is ethically justified in assisting death if the need to relieve intense and unceasing pain or distress caused by an incurable illness greatly outweighs the benefit to the patient of further prolonging his life" (Drain, 1990).

In America in 1990 an article by Sprung in the *Journal of the American Medical Association*, supported by an editorial (Carton, 1990), summarised that: "Active euthanasia programs in the United States are likely in the near future", to be followed the next year by an editorial in *Nature*, responding to a book by Derek Humphry mentioned below, proposing that: "The 'ethic' of using technology to prolong life when life is ebbing should give way to the ethic of individual choice, including the right of physicians to choose to assist the dying" (*Nature*, 1991).

By 1992, the editor of the *British Medical Journal* could write that "the tide seems to be running for euthanasia" (Smith, 1992). He quoted the Appleton International Conference's *Developing Guidelines for Decisions to Forgo Life-Prolonging Medical Treatment* (Stanley, 1992), which contained the advice that "requests for active termination of life by a medical act which directly and intentionally causes death may be justifiable and should be given serious consideration", although it also included a dissenting view that "requests for euthanasia by competent patients severely and irremediably suffering as a result of incurable disease may be understandable, but are not morally justified".

#### Political events and activity

The Netherlands is at the forefront of actual political change (De Wachter, 1989). Although euthanasia remains illegal there, guidelines have been in existence for a number of years which, if followed, provide a doctor with protection from prosecution (Brahams, 1990; Keown, 1992). In 1990 a commission was set up under the chairmanship of the Attorney-General of the Dutch Supreme Court to review medical practices (Rommelink, 1991), and the paper by van der Maas *et al* (1991) was a preliminary submission to their enquiry.

Euthanasia in other countries was recently reviewed in a series of articles in the *British Medical*

*Journal* (1992). In the USA, Washington State's euthanasia referendum on Initiative 119 (Misbin, 1991) was narrowly defeated (Breo, 1991), as was Proposition 161 in California (Rhein, 1992). The Patient Self Determination Act was passed clarifying patients' rights to refuse medical care and to execute advance directives as 'living wills' (Hope, 1992). In the UK, an all-party parliamentary group has now been set up, but the most significant development has been the appointment of a Select Committee of the House of Lords on Medical Ethics, under the chairmanship of Lord Walton of Detchant.

#### Lay and media coverage

The importance of popular coverage should not be underestimated, although it sometimes tends to focus on the sensational, such as the case of Jack Kevorkian, Michigan's 'Dr Death', and his suicide machine or 'mercytron'. A book by Derek Humphry (1986) of the American Hemlock Society, *Final Exit – The Practicalities of Self-deliverance and Assisted Suicide for the Dying*, although not initially available in the UK, became an international best-seller. In the UK, precedence probably goes to Ludovic Kennedy's trenchant pamphlet *Euthanasia – The Good Death* (1990). His views have by no means gone unchallenged, and have been vigorously discussed in the lay press.

#### Anticipated dangers and difficulties

Since public support for euthanasia is demonstrably on the increase, how should the medical profession respond? The question is a pragmatic one, on whether there is a need to formalise legal procedures, as much as an ethical one as to whether mercy-killing, or socialised suicide, is ever to be deemed to be morally commendable. The arguments used to debate the wisdom or otherwise of legalising it can be examined and described at various levels, in the sense originally introduced by Foulkes to elucidate discussions in therapeutic groups (Foulkes, 1964).

#### The current level

By current level, Foulkes meant the discussion of present reality on a factual, task-orientated basis.

At face value, advocates of euthanasia would hope to relieve the burden of human suffering. As Mr Justice Branson stated at the Chester Assizes in 1927, when describing the mercy-killing of a child: "It is a matter which gives food for thought that, had this

poor child been an animal instead of a human being, so far from there being anything blameworthy in the man's action in putting an end to its suffering, he would actually have been liable to punishment if he had not done so" (*Lancet*, 1927).

However, it has been claimed that any system designed to allow euthanasia would be dangerously open to abuse (Nelson, 1990). Economic considerations (Bliss, 1990, 1991), such as demographic concerns over a "rising tide" of dementia (Health Advisory Service, 1982; Ineichen, 1987), underline the need to ensure that budgetary responsibilities and personal financial interests do not distort clinical decision-making. However, it is difficult to see how attempts to formalise the procedure could do anything other than add to the safeguards and help to restrain impulses towards 'do-it-yourself' suicide, or mercy-killing by relatives. Many would accept that the process would need to be relatively time consuming, so that it could not be used precipitately, but only after a 'pause' for due consideration (Gillett, 1988). The opposite view, that legislation might become so cumbersome that it would be futile, unworkable or counterproductive, "creating far more problems than would be solved" (Wilkes, 1991), was eloquently stated by Lord Dawson in his speech in the 1936 debate, when he said that formally legalising euthanasia "would deter those who are, as I think, carrying out their mission of mercy" (Dawson, 1936). However, even if this was safe, it may well have been more feasible for doctors practising in isolation than for those working as part of integrated teams.

**The transference level**

In groups, at transference level, the discussion becomes distorted by the application of previous experience of relatively mature, or whole-body, object relations from one situation to another.

An individual act of euthanasia might be commendable in itself, but still need to be rejected because of possible repercussions. The transference, or precedent, argument against legalisation is therefore that, if the law was to be changed, the balance of opinion would alter so that what would be intended as an extension of the rights of some, and possibly only a small minority, might result in the transference of an obligation to others. Once a legal precedent had been established, social endorsement of euthanasia might place undue pressure on patients to class themselves as a burden to others, and to submit to it rather than to defend their individual interests. Simone de Beauvoir (1970)

described cultures enforcing compulsory 'senicide' (Post, 1990) as an expression of what Durkheim described as an obligatory altruistic suicide (Durkheim, 1897; Berrios & Mohanna, 1990). Thus, although some would accept the analogy with Article 5 of the United Nations Universal Declaration of Human Rights that: "No one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment", and most would accept that the "warehousing" (Miller & Gwynne, 1972) of the elderly for long periods of "pre-death" (Isaacs *et al*, 1971) may raise "considerable doubt whether this extension is in any sense beneficial to the patient" (Baker, 1976), others consider that any condonation of a philosophy of 'assisting death', with or without formalising the procedure, should be proscribed as "crossing the Rubicon" (Twycross, 1990).

However, the transference argument involves overruling a patient's interests in pursuit of a hypothetical public good, and has to be used with care. It should be balanced with another group of patients who would enter their final illnesses reassured by the knowledge that euthanasia could be available to them, but who in practice would never request it. Moreover, Twycross's fear that a statute designed to do "one limited thing" might lead to "an unlimited result", rather than merely to a shift in the balance of competing principles, suggests the next, or projective, level.

Another consideration at this level, in that it also concerns the consideration of ulterior ends, is that if patients were to be given a licence to make speciously plausible requests for euthanasia 'in bad faith', this would create the opportunity for them to play manipulative games, to threaten and to exploit over-conscientious carers. In some situations this might have a useful effect in 'empowering' the otherwise neglected and resourceless, but it is not difficult to envisage instances of 'para-euthanasia' similar to those of parasuicide (Kreitman, 1977). There is therefore a strong argument for restricting euthanasia legislation to a 'liberty to apply' rather than a 'right to demand', allowing doctors an additional and voluntary power or privilege rather than imposing on them an obligation to kill.

**The projective level**

At projective level, the debate begins to become dissociated into part-object relationships, so that boundaries between people become confused and qualities or emotions may be disowned and attributed inappropriately from one person to others.

Intense projection and projective identification may mean that it is difficult to be sure who is feeling

the pain and who needs to endure it or to be relieved of it (Weddington, 1981). Patients may be used as part-object care objects for defensive, narcissistic or even perverse purposes by relatives or staff. Their suffering may be exacerbated and prolonged by "compulsive care-giving" (Bowlby, 1979) from those with "the helping profession syndrome" (Malan, 1979). Alternatively, inappropriate appeals for 'mercy' may be made on behalf of patients, when it is only the relations and staff who are actually suffering (Goodwin, 1991).

Emotive language in the euthanasia debate is often indicative of projective processes. Doctors then risk being left in the unenviable position of having to contain persecutory accusations of being torturers on the one hand and murderers on the other, at an intensity which goes far beyond clinical realities. Rather than attempting to maintain what in Kleinian terms can be seen as an ambivalence between contradictory principles characteristic of a depressive position (Hinshelwood, 1989), the debate splits at this level into conflicting paranoid-schizoid stances: pro-life, pro-choice and pro-mercy, each corresponding to one of the duties to protect life, to defend liberty and to prevent cruelty, while at the same time dismissing the stances of their opponents. Thus when Keown (1992) talks of the protection of life taking priority "over the autonomy of the individual or the alleviation of suffering", he criticises the Dutch courts for having "inverted (without any show of juridically sufficient reason) [this] ordering of values", and suggests that the Dutch experience lends support to the 'slippery slope' argument.

Warnings of such slippery slopes (Fenigsen, 1988; Pollard, 1991) are perhaps sometimes exaggerated to the point of deliberate misinformation (Jennett, 1991; Borst-Eilers *et al*, 1991), but Alexander's (1949) warning about the dangers which faced the profession under conditions of political dictatorship should be borne in mind before embarking on legal change. Nevertheless, it is interesting that the Netherlands is the country whose doctors opposed the Nazis most courageously in the past (Alexander, 1949). It should also be remembered that the Nazi exterminations (Sereny, 1974; Müller-Hill, 1988) took place without any change in the law (*British Medical Journal*, 1992) and could perhaps have been prevented, or at least partially obstructed, had the Nazis been obliged by law to follow a more open and formalised procedure.

Keown's advocacy of the pro-life stance is not without its usefulness. He has demonstrated beyond doubt, what is also admitted by van der Maas *et al* (1991), that Dutch euthanasia includes the

non-voluntary variety as well as the voluntary. He has also shown that its practice is predominantly clandestine, and hence legally uncontrolled. His challenge that those propounding legislation must "explain *how* legislation would provide more effective safeguards against abuse" is well made and argues for a mechanism that is distinct from the ordinary law and ensures that the intent to kill is notified before the act itself, in order that it cannot then be denied after the event.

Thinking in psychiatric rather than in psychodynamic terms at this level, the clinical assessment might often revolve around considering the confounding influence of treatable mental illness, and particularly depressive illness, in requests to have life terminated (Potts, 1991). The suggestible, and particularly the mentally ill or disturbed, might have great difficulty in distinguishing and communicating their genuine wishes. Acute depressive illness requires vigorous treatment, including if necessary compulsory electroconvulsive therapy, and not euthanasia. But what of chronic resistant depression, and what if the depressive syndrome is consequent on severe physical illness and realistically consistent with it? Also, illness and health are on a continuum, whereas legal competence or non-competence has to be attributed dichotomously. One argument for drafting a restrictive non-voluntary euthanasia mechanism, as well as a less strict voluntary one, would therefore be that it would allow the evaluation of competence to assume a less absolute importance, and thus would limit the burden placed on the psychiatric assessment.

### The primordial level

Finally, at the primordial level, individual boundaries allegedly disintegrate to an extent that the world was considered by Foulkes to be experienced at a transpersonal level "according to the concepts of Freud and those particularly formulated by Jung concerning the existence of a collective unconscious". This is perhaps the level of ritual (Usandivaras, 1986), and may also be that of absolute religious beliefs.

According to some, there is an absolute need to defend the principle of the sanctity of life (Nelson, 1990). As an absolute belief, this is not amenable to argument any more on euthanasia than on, say, abortion. Perhaps, however, there are parallels with the debate on divorce, another example of a voluntary separation, where Stone states that by the time of the passage of the Divorce Reform Act 1969 in the UK, the "erosion of the old religious and political beliefs by the advancing tide of secularism

and individualism” had occurred to such an extent that “no speaker so much as mentioned the old theological arguments about the sanctity of marriage” (Stone, 1990). A tolerant attitude towards absolute religious beliefs must be maintained whenever possible in a pluralistic society, but these can no longer be imposed on those who do not choose such positions. Conversely, those who do choose such positions, and find euthanasia personally unacceptable for religious reasons, need to know that their views will be respected (Church Information Office, 1975; Sacred Congregation, 1980). However, many people whose strong religious beliefs stress responsibility rather than obedience appear to find the idea of euthanasia unexceptionable (Purcell, 1985).

#### Checks, balances and principles

If a satisfactory mechanism for the regulation of euthanasia is to be designed, these considerations need to find balanced expression.

(a) The system needs to be sufficiently open and legalistic to prevent abuse, but not so time consuming as to be impracticable, or so public as to be distastefully invasive of privacy. Should euthanasia be legalised, or should ‘the deliberate taking of a human life remain a crime’, or should it become a crime provided with a ‘special defence’ under statute law?

(b) Should the legal principle of a patient having a liberty to seek death, as acknowledged by the Suicide Act 1961, be conserved or converted into a ‘Right to Die’ (Humphry & Wickett, 1986)? This distinction between a liberty and a right implies a recognition of limits on personal autonomy, and an acceptance of restrictions on what may be demanded of others as obligations.

(c) Since a request for euthanasia would imply suicidal intent, but might reflect a distressed, and at times a confused, communication to others as much as an unambiguous determination to escape life, how should any legislation be integrated within the usual provision of both voluntary and compulsory psychiatric care?

(d) The potential strain on the practitioners involved should not be underestimated. They would need the reassurance and support of a sufficient ‘ritual’, the extent of which would depend on the anxieties provoked. Since the boundaries of euthanasia need to be defined in moral and legal terms, rather than in medical or technical ones, how should clinical discretion be made subject to a sensitive process of social review, ‘sanction’, or restraint?

#### Proposals for a statutory solution

How such principles should be translated into practice is clearly open to differences of ethical taste and judgement. Psychiatrists will presumably vary in their personal views as much as any other group, and would be unable to come to a unanimous decision. However, as Lord Horder said in 1936, “the public will look to the medical profession for certain facts, perhaps for guidance, but not I hope for a decision” (Horder, 1936). Psychiatrists, in view of their unique experience of implementing the statutes of the Mental Health Act, are particularly well placed within the profession to contribute to a clarification of the various legal options.

The present proposal, slightly different from ones previously offered (Helme, 1991a,b), is that in line with the above, a Euthanasia and Terminal Care Bill should be presented before Parliament involving two alternative but complementary mechanisms, both providing a statutory ‘special defence’ which a doctor would be entitled to plead in justification of an act of euthanasia. The first mechanism could be a formal Euthanasia Notification, along lines similar to that used for arranging admission under Section 2 of the Mental Health Act 1983. The second, a system of Euthanasia Tribunals, could be instituted to provide support and to establish boundaries so as to define the limits of acceptability. Under neither mechanism would the doctors be *entitled* to commit the act of euthanasia – they would merely be provided with the opportunity for a statutory defence. Defences against charges of homicide are divided into excuses and justifications (Leng, 1990), and a Euthanasia and Terminal Care Act would provide a potential justification that would be open to doctors in addition to those available under present law. An advantage of proposing a system based on the current procedures of the Mental Health Act is that these are already well described (Bluglass, 1983). It would be more easily understood than any more novel suggestion, and therefore likely to be inherently safer.

One function of many medical procedures is to contain anxiety, but this is not without a cost (Menzies Lyth, 1988). Under the first mechanism, designed for routine situations involving relatively little anxiety, medical confidentiality would be maximised. It would involve slightly more paperwork, but not much more inconvenience than an ordinary consultation, and is similar to the present Dutch guidelines. Under the second, inevitably the procedure would become more intrusive and expensive, but, being more formal and legalistic, should be capable of dealing with more difficult

cases. Both procedures would require a doctor to declare his/her intent before committing the act, in order to be covered by the statutory defence, which is where they differ from the Dutch guidelines. Both procedures would separate the responsibilities for the application, the medical recommendations and the legal review. However, in the first the legal review would operate entirely retrospectively, whereas in the second it would largely function prospectively.

The procedures might be as follows. Equivalent sections of the Mental Health Act 1983 are indicated in parentheses for comparison.

Euthanasia would need to be defined (1 (2)), as perhaps would some other "medical decisions concerning the end of life" (van der Maas *et al*, 1991) which would, or would not, be covered by the proposed legislation (1 (3)). The statutory provisions would not affect normal medical practice under existing law (131 (1)).

### **Euthanasia notification**

#### *Application*

An application for euthanasia (2 (1)) could be initiated (11 (1)) by the patient, or the nearest relative, or guardian.

(a) *The patient himself, being legally competent.* This is voluntary euthanasia, and in this case the doctor would merely need to demonstrate that there were adequate grounds (2 (2)) to believe that the patient was making the application in good faith while of sound mind, and that his/her continued existence unavoidably involved 'severe distress'. The term 'severe distress' would not be defined any more specifically than the terms 'mental disorder', 'mental impairment' or 'psychopathic disorder' (1 (2)). The nearest relative (26 (3)) would have the right to be informed and to be consulted (11 (3)), and would be entitled to object (11 (4)) by requiring a tribunal hearing if he/she so wished.

(b) *The nearest relative (26 (3)), the patient not being legally competent.* This is non-voluntary euthanasia and, because of a hypothetical increased risk of abuse due to conflicts of interest, the doctor might have to demonstrate that the patient would inevitably have to endure 'extraordinary suffering' (1 (2)) if euthanasia were to be refused. If the patient, previously and while still competent, had signed a 'living will' (Age Concern, 1988) setting out his/her attitudes and wishes, this might have the effect of reducing the criterion to 'severe distress'.

(c) *A guardian ad litem (13 (1)), the patient not being legally competent and the nearest relative being unavailable or also incompetent.* In exceptional

circumstances it would be possible to arrange for a guardian ad litem (29), perhaps another relative appointed by a county court or by the Court of Protection, to act as the applicant, in which case the 'extraordinary suffering' criterion would again apply as above. The latter would represent an increase in the responsibilities of the Court of Protection, which is presently only concerned with matters of property, but such an increase was envisaged by the Law Commission (1991) report on mentally incapacitated adults.

#### *Consultation*

After receiving the application, the doctor intending to carry out the euthanasia would be obliged to examine the patient and consult the nearest relative. He/she might have to inform several relatives as under Schedule 1 of the Enduring Powers of Attorney Act 1985. He/she would then request a second medical opinion (12 (1)). The second medical opinion might need to be of an approved status (12 (2)), such as that of a consultant, or perhaps merely be a member of any medical Royal College, who might have to discuss the case with others (58 (4)).

#### *Registration*

Both doctors would then submit their medical recommendations to an appropriate official (11 (2)) working in conjunction with and responsible to the coroner. Only once the application and recommendations had been received and registered by the coroner's official would an act of medical euthanasia be covered by the proposed statute. The notification would then be valid for a limited period of, say, 28 days (2 (4)).

#### *Certification*

Once the euthanasia had been carried out, the doctor would write this on the death certificate and retain adequate clinical documentation.

#### *Scrutiny*

The coroner would then decide retrospectively whether he/she was satisfied that the euthanasia had met the appropriate criteria within the meaning of the Act, and whether or not to hold an inquest. If he/she did so, the doctors concerned would be potentially liable to prosecution, and if subsequently charged with homicide would risk having to convince a jury that their actions had been reasonable and justifiable. The number of notifications each practitioner registered could be routinely recorded and audited.

### **Euthanasia tribunals**

#### *Referral*

There would be circumstances when the doctors would not feel confident to make the recommendations, not because they personally wanted to refuse the application, but perhaps because they considered that the case was uncertain and they feared there was therefore a significant risk of subsequent prosecution. Under these circumstances it should be possible to refer the application to a tribunal (65) for guidance as to whether to carry out the euthanasia. Doctors would presumably be more likely to refer the case if the applicant was not the patient him/herself, and indeed it could reasonably be argued that this ought to be made mandatory, as it would be if the nearest relative objected.

#### *Membership*

The membership of a tribunal might be rather larger than that of a mental health review tribunal (65 (2)) in view of the finality of the decision being considered. It might consist of:

- (a) a president, with a suitable legal qualification and experience
- (b) a medical practitioner, with an expert knowledge of the illness from which the patient suffers
- (c) a psychiatrist, to exclude treatable mental illness
- (d) a social worker, to examine the social and especially the financial implications of the death being contemplated, in order to minimise the possibility of duress
- (e) a lay person, to provide a balancing and general perspective.

#### *Role and powers*

The role of the tribunals (72) would merely be to make recommendations. This would perhaps usually be on the basis of the previous recommendation(s) by the patient's medical practitioner(s), as well as by the medical and the social work members who would have examined the patient and interviewed the relatives. It would be open to the tribunal to require, in addition, a psychiatric examination, or to seek further social information or medical opinions. The medical members of the tribunals would gain substantial experience in the working of the Act, and might under some circumstances provide independent recommendations without recourse to a full hearing (78 (2)(d)), in the manner of a Mental Health Act Commission second opinion (121 (2)).

#### *Formal hearing*

At the hearing, the patient could be legally represented if he/she wished (and receive legal aid), as could be the nearest relative. The tribunal would then provide, or decline to give, a recommendation to the doctor intending the euthanasia. It could presumably refer the case on to the High Court (78 (8)). The tribunal's recommendation could still merely constitute a second opinion, and confer a defence rather than a right. If, for instance, the doctor was found to have deliberately withheld or falsified information submitted to the tribunal, he/she might still be subsequently charged with an offence (126 (4)), even of murder. There are circumstances when it is conceivable that a coroner might even take the view that the tribunal itself had been plainly wrong. However, a tribunal's recommendation would certainly provide strong evidence in defence or mitigation of the doctor's actions.

#### *After the recommendation*

Discussion in the Netherlands is currently centred on "whether euthanasia should be legalised, or should be tolerated as culpable homicide that is not prosecuted provided that the conditions have been met" (Jennett, 1991). Even under the tribunal system outlined, the latter would still obtain. The ordinary legal presumption in favour of protecting life would remain, and doctors would not be given an automatic 'right to kill', although they could usually expect to be safe from prosecution after receiving a tribunal's recommendation. The primary clinical significance of the proposed change in the law is that the provision of a statutory justification would deflect attention from the less than pertinent distinction between active and passive euthanasia (Williams, 1969; Rachels, 1975), and focus it on whether or not it would be appropriate intentionally to allow a patient's death.

Finally, it is appropriate to recall the conviction of Dr Alexander Bonnyman for the manslaughter of his wife, not because he had done anything active to kill her, but merely because he had neglected to treat her when he should have done so (Court of Criminal Appeal, 27 & 28 April 1942).

### **Conclusion**

Medical attitudes concerning the care of the terminally ill are not immutable, and indeed it has been stated that "there is nothing more ephemeral than ethics in general and bioethics in particular" (Rapin, 1987). For instance, a study demonstrated



that it was the policy of 88% of doctors not to tell patients if they had cancer (Oken, 1961). When the same questionnaire was used in a replication study, Novack *et al* showed a complete reversal in medical opinion and practice, with 97% indicating a preference for 'telling' the patient (Novack *et al*, 1979). An editorial in the *Lancet*, eschewing ephemerality, commented that: "The change in attitude is here to stay and we should start to train our students so that they will be able to help their patients without some of the anxieties still experienced by an older generation of doctors" (*Lancet*, 1980).

If the same is now true of euthanasia, what is needed is a conceptual and forensic structure capable of containing these anxieties. Psychiatry should play a role in creating such a structure.

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