

The Doctor's Defense

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Abstract

The paper takes as its point of departure a relatively recent case which attracted publicity in Britain, concerning a doctor charged with (but acquitted of) the murder of his terminally ill patient, and critically examines the criminal law of England and Wales relating to homicide in the context of medical practice. While similar issues obviously arise in many other countries, no comparative study is attempted in the paper. However, the arguments which have been presented are of more than local interest. From an analysis of this case and others, it appears that there is in common law something which can be called "the doctor's defense." It holds that a doctor may, when caring for a patient who is suffering great pain, lawfully administer pain-killing drugs, despite the fact that, as the doctor well knows, one certain or highly probable consequence will be to shorten the patient's life.

Current justifications for this defense are either incoherent or too weak. Some require that different conceptions of "intention" be deployed, depending on whether the agent is a doctor or not. Others rely on the philosophically controversial doctrine of double effect. Still others invoke an implausible notion of minimal causation. All these justifications apply readily enough to morally and factually easy cases, but fail in hard cases where the need for some justification is most pressing. These justifications seem incapable of providing adequate guidance to prosecutors or trial judges. Absent principled and transparent justification, the English criminal justice system exhibits different outcomes on what appear to be broadly similar facts. It is disturbing that the law is uncertain and incapable of giving adequate guidance. A doctor, compelled by conscience to intervene to end a person's life, should certainly be ready and willing to face rigorous legal scrutiny, but the law applied should not be arbitrary and random, nor should the outcome turn solely or chiefly on prosecutorial discretion or the predilections of the trial judge. The hope is to find a better rationale for the doctor's defense through an analysis of professional ethics and the concept of a recourse role.

Key Words: Law, cause of death, murder, euthanasia, professional ethics.

Introduction

"The frequently expressed view that we all know that doctors help people to die and it's all right provided they do not speak about it, is unsatisfactory." (1)

I LOOK ONLY AT THE CRIMINAL LAW of England and Wales as it pertains to murder and medical practice. I am, of course, aware that similar legal controversies and intellectual issues arise in other legal systems (2, 3), but I have not attempted a comparative study of practices in other jurisdictions. I take as my point of departure a relatively recent case which attracted publicity in Britain. From an analysis of that

case and commentary on it (4), I conclude that there is in common law something which can be called "the doctor's defense." In view of the ambiguities in the definition of "intention"(5), and the limitations inherent in the concept of causation, my hope is to find a better rationale for the doctor's defense than those current, and to find it in professional ethics. I shall deal with these three issues in the following order: (a) causation, (b) intention, and (c) professional ethics. First, I turn to the relevant details of the case.

Dr. David Moor, a general practitioner, who apparently admitted helping up to 300 people to die (6), was charged with murdering a patient by administering a large dose of diamorphine. The murder trial commenced on April 4, 1999 and concluded with the defendant's acquittal on May 11, 1999. The jury took only 65 minutes to reach its decision.

George Liddell was a widower of 85 who had been diagnosed as suffering cancer of the bowel. He had been hospitalized, and part of his bowel had been surgically removed. This

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surgery was successful, though there was some remaining cancerous invasion of adjacent fatty tissue and also, to a very small degree, of the liver. Rightly or wrongly, the hospital concluded that the patient was sufficiently recovered and mobile to leave and live with his daughter, who was already one of Dr. Moor's patients. Mr. Liddell was treated at home by Dr. Moor and a team of experienced nurses. The patient quickly became immobile and depressed, and appeared to have considerable pain. At first it was thought that the pain was caused by severe bedsores which had developed in the hospital, but as these healed, the relatives, nurses, and Dr. Moor concluded that the pain was internal and resulted from a failure to remove all the cancer. Dr. Moor prescribed 5 mg of diamorphine to be taken at intervals, and later this dosage was doubled when the pain resurfaced. Mr. Liddell was now very emaciated and appeared to be failing rapidly, though he was still taking food and water. The nurses thought him "terminally ill." He himself thought that his time had come and said that he did not want to go on. The relatives were very caring and there was no suggestion at all that they wanted to hasten death. On one occasion, when the relatives tried to move him, Mr. Liddell cried out in pain. This was reported to Dr. Moor by a nurse, who suggested that Mr. Liddell should be admitted to a local hospice for pain assessment. Dr. Moor agreed. With the consent of Mr. Liddell's relatives an application form was completed for admission to the hospice.

At this stage Dr. Moor prescribed diamorphine at the rate of 30 mg over a 24-hour period by way of a syringe driver, and that was set up later in the day. By evening Mr. Liddell was sleeping peacefully, although Dr. Moor thought that he was near death. When he telephoned the next morning, Dr. Moor was told that Mr. Liddell was still alive but making loud retching noises in his throat. Dr. Moor administered chlorpromazine and waited to see the effect. A nurse arrived and she thought that Mr. Liddell might be in a coma, but that was not confirmed by any rigorous tests. In any event, Mr. Liddell was breathing in a manner characteristic of one close to death. The nurse left, intending to return. Dr. Moor waited with his patient, who made more retching noises. By this time the syringe driver had run out. Believing Mr. Liddell was now very close to death, Dr. Moor decided not to renew the diamorphine in the driver but gave an injection of diamorphine and chlorpromazine. His stated purpose was to ensure that

the patient suffered no break-through pain. He told the relatives that Mr. Liddell had not long to live, and within about twenty minutes Mr. Liddell was dead.

Soon thereafter national newspapers reported about another doctor, who claimed to have helped patients die by means of large doses of diamorphine and also to have assisted suicide. A local journalist sought Dr. Moor's views on this, and he responded that he supported the other doctor's stance, though not on assisted suicides. That journalist reported that Dr. Moor had said that he had given many of his patients large overdoses of diamorphine to help them die a pain-free death. Mr. Liddell's case was not mentioned by name but it was referred to, and later Dr. Moor repeated his views on television, once again stressing that his actions were in the context of relieving pain. All this attracted considerable media attention; one tabloid newspaper branded Dr. Moor "Britain's greatest serial killer" and referred to him as "Doctor Death" (although there are as many differences from as similarities to Dr. Kevorkian). Inevitably, the Regional Health Authority became involved and sought a detailed account of Dr. Moor's treatment of Mr. Liddell. Frightened by the adverse publicity and the interpretations put upon his conduct, Dr. Moor neglected to mention the final injection which he had administered after the syringe driver had run dry. Similarly, in a prepared statement for the police, Dr. Moor again did not mention the final injection, although he corrected that statement some months later.

The evidence of the Crown toxicologists was that samples of Mr. Liddell's blood revealed postmortem levels indicative of an in-life injection of diamorphine up to six times greater than Dr. Moor admitted even in his final, corrected, statement. Fortunately for Dr. Moor, that damning evidence did not survive defense challenge as seriously unreliable. The trial judge directed the jurors not to rely on the Crown witnesses' evidence as to the amount of morphine which had been administered in life. This ruling significantly weakened the prosecution case, which proceeded on the basis that Dr. Moor had administered no more diamorphine than he admitted to, that is, 30 mg in the syringe driver and the additional final injection of 60 mg.

The Crown pathologist stated that Mr. Liddell was not terminally ill from cancer or any other cause, and that there was nothing physical found at postmortem which could have caused

him serious physical pain. Defense experts agreed that Mr. Liddell was not terminally ill from cancer, but argued that the cancer which had been left could have been responsible for his acute pain. In addition, defense experts stated that Mr. Liddell had a serious heart condition which had been missed by the hospital and by the Crown pathologist, but which might have caused death at any moment from arrhythmia, and that this simply could not be ruled out as the cause of death. This heart condition was almost certainly responsible for Mr. Liddell's very sick, indeed terminal, appearance to eye-witnesses, including experienced nurses. In light of this defense evidence, together with the discrepancy between the Crown pathologist's finding of reasonable health and the eyewitnesses' account of Mr. Liddell's acute condition, the trial judge directed the jury not to rely on the Crown pathologist's evidence. This ruling further weakened the prosecution case. Although the prosecution sought to counter the suggestion that the heart condition was the cause of death by inviting the judge to leave the question of attempted murder to the jury, the judge declined to do so, although this had been allowed in other cases (7). That, too, was not helpful to the prosecution. Finally, it might be added that in English law the question would not ordinarily be whether or not objectively the patient was terminally ill, but whether or not the doctor subjectively believed this to be so. Accordingly, the prosecution did not seek to dispute Dr. Moor's assertion that he believed Mr. Liddell to be terminally ill and *in extremis*.

Shorn of any evidence that Mr. Liddell had received a massive overdose and that, objectively, he was neither in pain nor close to death, the remaining prosecution case did not amount to much, other than Dr. Moor's statements to the press, the untruths which he had told to the Regional Health Authority and to the police, his administration of the final dose, and some answers given to the judge, which come close to an admission of intent to kill.

Judge: You said in evidence that when you gave the final injection you intended to put Mr. Liddell to sleep. Did you think he would wake from that sleep?

Dr. Moor: No.

Judge: Death was therefore virtually certain?

Dr. Moor: Highly probable.

Judge: If he had wakened, would you have given a further similar injection and put him to sleep again?

Dr. Moor: Yes.

Judge: If he was sleeping he would not have been eating or drinking?

Dr. Moor: No.

Judge: And death would have been inevitable?

Dr. Moor: Yes.

Judge: But you only did this in the belief he was *in extremis*?

Dr. Moor: Yes.

Although substantially weakened by the judge's several rulings, the prosecution still had a tolerably strong case, because in order to convict anyone of murder, the prosecution had to prove beyond reasonable doubt only that the accused caused the death of the victim and that the accused did so with intent to cause death or grievous bodily harm (8). Beyond that, the prosecution had to negate any applicable defense. There are only three routes by which an accused can escape conviction in a murder case: one can cast sufficient doubt on causation, effectively question intention, or deploy an applicable defense.

Causation

Murder is an archetypal "result" crime: the accused must therefore actually cause the prohibited outcome. Juries are frequently told that this is a matter of common sense. Indeed as the trial judge, Patrick (later Lord) Devlin put it in his seminal direction in *Adams* (9):

'Cause' means nothing philosophical or technical or scientific. It means what you twelve men and women sitting as a jury would regard in a commonsense way as the cause. Manifestly there must be cases in hospitals that are going on day after day in which what a doctor does by way of giving certain treatment prolongs or shortens life by hours or even longer. The doctor who decides to administer or not to administer a drug is not, of course, thinking in terms of hours or minutes of life. He could not do his job properly if he were. If, for example, because a doctor had done something or has omitted to do something, death occurs at eleven o'clock instead of twelve o'clock, or even Monday instead of Tuesday, no people of common sense would say 'Oh, the doctor caused her death.' They would say

that the cause of death was the illness or the injury, or whatever it was, which brought her into the hospital, and the proper medical treatment that is administered and that has an incidental effect on determining the exact moment of death is not the cause of death in any sensible use of the term.

Although this is wholly consistent with the general common law approach that normal medical treatment, even if inept and ineffective, does not break the causal chain from the original injury to the resultant death (10), it has the obvious defect of fudging questions of fact and questions of value, in that there is an implicit invitation to the jury to deploy the notion of "cause" functionally and morally for the attribution of responsibility and guilt and not analytically or scientifically as a finding of fact (11).

The point of departure in any discussion of causation and murder in the criminal law of England and Wales, especially in the context of medical treatment, is the trial of Dr. John Bodkin Adams. In 1956, Dr. Adams was arrested and charged with the murder of Mrs. Morrell, an 81-year-old patient who had died six years earlier. At the committal stage, evidence was shown that Dr. Adams had prescribed and administered such large doses of drugs, including morphine, that he must have known they would cause death. Even if the use of such drugs in quite large doses might be medically justified in cases where the patient was in severe pain, or restless, or otherwise *in extremis*, the prosecution claimed that Mrs. Morrell was not in any such condition. At the trial, the Crown provided new evidence that Dr. Adams was a beneficiary under Mrs. Morrell's will and knew that he was, but he had falsely affirmed in his cremation certificate that he was not a beneficiary.

A Crown medical expert testified that in his opinion the dosages of morphine given to the deceased shortly prior to her death must have been intended to kill her. Another Crown medical expert said the deceased could not have survived the quantity of drugs prescribed by Dr. Adams in the last few days of her life, although under cross-examination he conceded that he could not rule out the possibility that death was the result of natural causes, for example, a further cerebral hemorrhage. These Crown experts opposed the use of narcotic drugs for patients in Mrs. Morrell's condition. However, a defense medical expert did not condemn the use of such

narcotics in such cases. His opinion was that death was not caused by morphine, and he did not regard the doses as excessive. Indeed, he went so far as to conclude that the dosage contributed neither directly nor indirectly to Mrs. Morrell's death. Helpful as this testimony undoubtedly was to the defense, other highly significant evidence was introduced by the defense at the trial. First, by introducing the notes made by nurses attending Mrs. Morrell at the time of her last illness, the defense effectively demonstrated that their testimony was unreliable to such a degree that the trial judge told the jury that two of the nurses "had lied in giving their testimony." Secondly, by introducing hospital records, the defense demonstrated that a different doctor had considered it right and proper to prescribe morphine for Mrs. Morrell before she was a patient of Dr. Adams.

The trial judge pointed out anomalies in the Crown case, criticized the evidence of motive, and questioned the suggestion that Dr. Adams sought to inherit Mrs. Morrell's estate. The direction to the jury included the following significant passages:

Murder is an act or series of acts done by the prisoner which were intended to kill and did in fact kill the dead woman. It does not matter for this purpose that her death was inevitable and her days were numbered. If her life was cut short by weeks or months, it is just as much murder as if it was cut short by years.

We have heard a good deal of discussion ... about the circumstances in which doctors might be justified in administering drugs which would shorten life. Cases of severe pain have been suggested and generally approved by the witnesses ... and also there have been suggested cases of helpless misery. It is my duty to tell you that the law knows of no special defense of this character. But that does not mean that a doctor who is aiding the sick and dying has to calculate in minutes or even hours, and perhaps not in days or weeks, the effect on a patient's life of the medicines which he administers or else be in peril of a charge of murder. If the first purpose of medicine, the restoration of health, can no longer be achieved, there is still much for a doctor to do, and he is

entitled to [do] all that is proper and necessary to relieve pain and suffering even if measures he takes may incidentally shorten life.

That is not because there is any special defense for medical men; it is not because doctors are put into any different category from other citizens for this purpose. The law is the same for all and what I have said rests simply upon this, which is part of the definition of murder that I gave you: no act is murder which does not cause death....

But it remains the fact, members of the jury, and it remains the law, that no doctor, nor any man, no more in the case of the dying than the healthy, has the right to deliberately cut the thread of life ... [but if] the treatment that was given by Dr Adams was treatment that was designed to promote comfort and if it be the right and proper treatment in the case, the fact — if it be the fact — that incidentally it shortens her life does not give any grounds for convicting him of murder.

It was a pity perhaps that the word 'justified' was ever brought into it [the case]. 'Justified' suggests to the lawyer some legal justification and it suggests to you when we are talking of matters of life and death some moral justification. There is no legal justification and there is no moral justification that you have to consider in this case. The word 'justified,' as I understand it, was used in a purely medical sense, in this way. If a doctor is going to prescribe the course of drugs that was prescribed in this case, we have heard the sort of dangers that may result: the patient may become semi-comatose; the effect on the patient who is semi-comatose may be that there are complications — pulmonary congestion and so forth — and it may lead to death, and therefore the doctor who is going to prescribe this course of treatment has to consider that, and he has to ask himself whether he is justified in a medical way in running that risk, there being in the case of a woman who is dying, always, I suppose, the risk to run that the treatment may not be the right

one. And 'justified,' as I understand it, in the medical evidence is used purely in that way.

The jury acquitted Dr. Adams after 42 minutes' deliberation. The Attorney General, who prosecuted the case, entered a *nolle prosequi* in respect of a second indictment against Dr. Adams, for the murder of a Mrs. Hullett, and Dr. Adams was discharged.

Intention

With respect to the question of intent, the basic idea is that the medication is administered to kill the pain, not the patient. In Dr. Moor's case the judge instructed the jury, "Has the prosecution satisfied you so that you are sure that Dr. Moor's purpose in giving the intramuscular injection was not to give treatment which he believed in the circumstances (as he understood them) to be proper treatment to relieve George Liddell's pain and suffering?" If the answer is "No," the jury should acquit, but if the answer is "Yes," the jury is to resolve the final question: "Has the prosecution satisfied you so that you are sure that the defendant when he gave the intramuscular injection intended to kill George Liddell"? If the answer is "No," the jury should acquit, but if "Yes" then the jury should convict.

These questions only arise where the jury has already determined that the doctor has caused death, so that the only question which then remains is one of intention. What is sometimes called direct intention involves purpose, objective, want, or desire. The directly intended consequence is one which the agent wants or desires, and would account the project a failure if that consequence did not occur (12). What is sometimes called oblique or indirect intention refers to consequences which are not desired or wanted and which are not part of the agent's purposes or objectives but which the agent foresees as probable, highly probable, or virtually certain to occur. There are two closely related but distinct questions about this: (a) is such a state of mind properly referred to as "intention" at all, when it is obviously not intention but foresight? and (b) should agents be held legally or morally responsible both for directly intended consequences and for consequences not directly intended but foreseen as probable, highly probable, or virtually certain?

The criminal law of England and Wales has vacillated on the first of these questions but has

settled on a clear distinction between intention and foresight, while holding that a jury is entitled to find a defendant intended a consequence if it was actually foreseen as virtually certain to occur (13). It therefore follows that a jury is entitled to find that a doctor whose direct intention was to kill the pain, not the patient, also intended that patient's death if the doctor foresaw it as probable in a sufficiently high degree. But being entitled is not the same as being bound, and it is therefore also open to a jury not to find intention even in the presence of foresight of death as a virtual certainty (14). This means that when a jury is persuaded that a doctor acted to kill pain, not the patient, no matter how likely death was to result, and is also persuaded that the means used fall within the range of proper treatment to relieve pain, it is entitled not to find the requisite intention and can properly acquit on a charge of murder for want of proof of the requisite intention. But useful though this obviously is to lawyers defending doctors on such charges, it is not uniquely a "doctor's defense," because it is in principle available to a conscientious jury in any case where an agent knowingly brought about death, directly intending some beneficial result. For example, where a member of a bomb disposal team drives a car booby-trapped with a time-bomb away from a very crowded location at high speed in the few minutes before timed detonation, at and over innocent pedestrians. The principle of double effect is plainly not limited to cases involving medical treatment of the terminally ill.

Criminal law in England and Wales holds that, in general, agents should be held legally responsible both for directly intended consequences and for consequences not directly intended but foreseen as probable, highly probable, or virtually certain. The principle of double effect, however, asserts that there is a morally relevant distinction between directly intended consequences and foreseen but unintended consequences. Thus, under this principle it is sometimes permissible foreseeably to bring about a result which it is never permissible to intend, but the principle requires that the bad effect be unintended, not disproportionate to the intended good effect, and unavoidable (15). Given that for some "... the patient's good does not include death" (16), it is perhaps counterintuitive that death can ever be proportionate to the intended good effect, even where the pain and hopelessness of the patient is extreme.

If a doctor injects a severely ill patient with a powerful painkiller in the certain knowledge

that the drug will cause death within a matter of minutes, it is at best a transparent legal fiction to say that he or she intended to relieve the pain but did not intend to kill. It would be at least as true to say that the doctor intentionally killed the patient in order to prevent further suffering (17). But two distinguishable cases are conflated here, and their untangling reveals that the principle of double effect is also arbitrary. Are doctors morally and perhaps legally prohibited from acting in cases where there appears to be the greatest need to relieve pain? It is an unhappy conclusion that the point comes where the doctor must cease treatment of pain on liability for murder. Of course, distinguishing the two categories of case hypothesized above will not be at all easy in practice, and there is an obvious temptation to interpret cases of the second type as falling into the first category and therefore apt cases for continued treatment.

There are cases in which there is sufficient evidence of intention but genuine doubt as to causation. For example, the deceased may have died from causes other than the medication, such as the heart condition suggested by the defense in Dr. Moor's case. In such cases the common law court may proceed on the basis of attempted murder (7). This is because purpose is not required for criminal attempt: "The bounds are presently set requiring proof of specific intent, a decision to bring about, in so far as it lies within the accused's power, the commission of the offense which it is alleged the accused attempted to commit, no matter whether the accused desired that consequence of his act or not" (18). This understanding of the nature of "intention" required for criminal attempt has seemed to some an arbitrary and unprincipled "extension" (19) and it is perhaps unpersuasive to treat one who foresees an undesired or unwanted outcome as virtually certain, as "attempting" to bring about that outcome. If, however, "purpose" were to be a requirement for criminal attempt, then it would be very difficult to substitute a charge of attempted murder for one of murder in cases of the type under consideration.

Dr. Nigel Leigh Cox, a consultant rheumatologist at the Royal Hampshire County Hospital, was indicted on a charge of attempted murder of his patient Lillian Boyes, on August 16, 1991. The patient was dying and in great pain. A short time before her death the accused intravenously administered to her an undiluted injection of two ampules of potassium chloride. The prosecution provided evidence that, in-

jected in that manner and that quantity, the drug had no therapeutic property and that the accused's intention in so administering it was to end the life of his patient. The defense argued that the primary purpose had been to relieve the pain of the dying patient and that therefore there was no intention to kill Lillian Boyes. The prosecution conceded that, with regard to Mrs. Boyes's condition on the morning of the fatal day, they could not exclude the possibility that, in fact, she died of natural causes between the actual injection of potassium chloride and her death. For that reason the charge was not one of murder but of attempted murder. It is possible that this did a disservice to the accused, because it is easier even in so "sad and testing" a case for a jury to convict of the attempt rather than the full crime, knowing that there is no mandatory sentence for the former.

In the course of his direction to the jury, the trial judge paid tribute both to the "indomitable" and "resourceful" character of the deceased and the "exemplary character" of the accused. He mentioned the very special regard in which Dr. Cox was held and the very close bond which had developed between doctor and patient over 13 years. The judge explained that there is an "absolute prohibition on a doctor purposely taking life" and that Dr. Cox would be guilty "if he injected her with potassium chloride for the primary purpose of killing her, or hastening her death." The judge also stressed that "if a doctor genuinely believes that a certain course is beneficial to his patient either therapeutically or analgesically, then even though he recognizes that that course carries with it a risk to life, he is fully entitled, nonetheless, to pursue it. If in these circumstances the patient dies, nobody could possibly suggest that in that situation the doctor was guilty of murder or attempted murder." Dr. Cox's duty to do all that he could for his patient was recognized, but "what can never be lawful is the use of drugs with the primary purpose of hastening death." Further, "it matters not by how much or by how little her death was hastened or intended to be hastened." There was evidence that Mrs. Boyes was at best hours or possibly only minutes away from death when she received the injection. Even so, "no doctor can lawfully take any steps deliberately to hasten that death by however short a period of time."

It is relevant to note that Mrs. Boyes had "signed her own death warrant" on August 11 by declining (as she was wholly entitled to) any

further active medical treatment and specifying that she should receive only painkillers. The following day Dr. Cox reported to Mrs. Boyes's sons that she had asked to be given something to hasten death and that he had told her that he could not do that, but that he would certainly make her comfortable. By this time Mrs. Boyes was in great pain and the cessation of her steroid treatment must have exacerbated this pain. She was receiving diamorphine at the rate of 60 mg per hour (which rather puts Dr. Moor's prescription and injection into perspective), having started at less than 1 mg. Dr. Cox was very distressed by Mrs. Boyes's suffering. In that state he injected neat potassium chloride. It was common ground at the trial that in such a case this drug had no curative or analgesic properties, or clinical use, and, as "any doctor would know," injected neat, one ampule, let alone two, would certainly kill. In addition, there was expert testimony that since this drug was not a therapeutic option to alleviate pain from a purely physiological perspective, there could be no other purpose in its administration than the hastening of death. But that testimony also acknowledged that the probable effect of the injection was indeed to alleviate suffering only by bringing her life to an end. What we have here, therefore, is a case of death as a means of alleviating pain, rather than an instance of death as an effect only incidental to the alleviation of pain. There was indeed testimony that, with regard to the patient's uniquely grave condition, there was no other way of controlling the pain, and although the deliberate shortening of life to alleviate pain is "not proper," the expert hoped that if he was confronted with such circumstances he "would have the courage to do what Dr. Cox did." This confusion is understandable, given the state of the law, but it is intriguing that what appears to be morally proper is not perceived as medically proper.

Although Dr. Cox did not testify on his own behalf in court, defense counsel argued passionately for his client. He suggested that, faced with a terminally ill patient in severe pain, there is an air of unreality, even absurdity, in asking what the doctor's primary purpose was, because the line to be drawn between alleviating pain by means which incidentally cause death and causing death in order to alleviate pain for however short a period is so fine and subtle as to be incapable of sensible application by any doctor confronted with this particular situation. As Counsel put it, "Five minutes of peace is not

very much but it was all Dr. Cox could give, and he gave it." Counsel also elaborated on the use by Dr. Cox of other quite slow acting drugs and on his openness in recording the use of the potassium. What Counsel sought to persuade the jury was that all this was a way, albeit unorthodox, of relieving pain and suffering. Notwithstanding this passionate plea, the jury convicted Dr. Cox, who was sentenced to one year's imprisonment, which was then suspended. However, there were limits to the judge's compassion; whereas he acknowledged that what could not be excused could be explained, he responded to Counsel's plea for an unconditional discharge in view of the exceptional facts, "that deliberate conduct by a doctor aimed at bringing about the death of a patient required, as a matter of principle, to be marked by a term of imprisonment" (20). That plainly entails criminal liability and the sanction of imprisonment in all cases of mercy killing: "Since euthanasia will relieve the patient's suffering only by killing the patient, the physician cannot reasonably intend that the patient not die" (3).

Under the predictable heading "Hard cases make bad law," the *New Law Journal* (21) editorialized on a conviction which on the facts was "probably inevitable" but "we are not clear how the conviction of Dr Cox has helped anyone." Given that it genuinely could not be said that the injection killed the patient, because she was so near to death that she might in any event have died from natural causes, the editor wanted to know how it could be in the public interest to prosecute. This alone is enough to call into question the peculiar "extension" in the meaning of intention which legitimates charges of criminal attempt in such circumstances. Of course, "absolute horror" would have been rightly expressed had a mandatory life sentence been visited on Dr. Cox. As to what the General Medical Council should do about the matter, the editor helpfully suggested "that a suspension of 24 hours would be more than adequate," noting that "an expert medical witness at the subsequent General Medical Council hearing said that Dr. Cox's mistake was to give potassium chloride; [whereas] a large dose of sedative causing [Mrs. Boyes] to lapse into a coma would have fallen on the right side of the law" (4). Apparently Dr. Cox could then have credibly said or plausibly claimed that his purpose was to alleviate pain and not to cause death, although the effect on the patient would have been precisely the same in all material respects and it has seemed to some that "terminal

sedation is a method of death that is ethically inferior to assisted suicide" (3). This illustrates the moral limits of the principle of double effect and the shortcomings of the criminal law of England and Wales as it is currently understood. Regrettably, it requires hypocrisy, evasion, and untruth within what is a relationship of trust. And, what is far worse, it results in an extended, miserable and undignified death.

The reasoning and outcome of Dr. Cox's case compares unfavorably with the little known and rarely discussed case of Dr. Thomas Lodwig (22), a former senior house officer at Battle Hospital, Reading. In 1989 Dr. Lodwig was committed for trial by the Reading magistrates, charged with the murder of Roy Spratley, a 48-year-old male patient who was in the terminal stages of incurable cancer of the pancreas, which had been diagnosed in June 1987. Although he had been given six months to live, he died on September 29, 1988. In the days before his death the patient was no longer lucid and suffered terrible and uncontrollable pain. His family pressed Dr. Lodwig to do something further to relieve it. Shortly before Mr. Spratley died, Dr. Lodwig asked a nurse to fetch an ampule of potassium chloride and some lignocaine, which he infused. The patient died peacefully a few minutes later, although the precise time of death was not recorded; nor was the administration of potassium chloride and lignocaine (unlike what happened in Dr. Cox's case). Following concerns expressed by nurses and administrators, the police treated the death as suspicious, and a forensic pathologist retained by the prosecution, who performed a postmortem on Mr. Spratley, entered the cause of death as acute potassium poisoning.

For many months before his death (which was expected within hours, days or weeks), Mr. Spratley had been receiving regular injections of heroin in increasing dosages for the purposes of pain relief. This was no longer effective in the days before his death, notwithstanding that the postmortem examinations revealed morphine levels of 5.4 mg/L, said by the toxicologist to be the highest levels that he had seen. Accordingly, Mr. Spratley could have died from heroin at any time, or from his tumor, and in addition he had significant narrowing of the coronary arteries. On Dr. Lodwig's behalf, it was said that it was his intention to kill the pain and not the patient. In addition it was reported that experiments had been conducted using potassium chloride with painkillers to accelerate their painkilling effect, and the results from an-

imal and clinical trials had been “encouraging,” but as yet none of these have been published. There is a further suggestion that this research may have been conducted at St Bartholomew’s Hospital, London, where Dr. Lodwig had finished his training about three years before he was charged (22). On March 15, 1990, Dr. Lodwig was acquitted by direction at the Old Bailey after the prosecution decided to offer no evidence at his trial and admitted that it was no longer convinced that Mr. Spratley had died from a potassium overdose.

It is very troubling that these two very similar cases had such different outcomes, and one wonders why the prosecution pressed on relentlessly with a count of attempted murder, in Dr. Cox’s case but not in Dr. Lodwig’s, and why the potential of potassium chloride to facilitate the operation of painkillers, which might have gone some way towards blunting some of the prosecution’s sharper points, was not part of the defense in the later case. Perhaps the research was never written up and published, and perhaps it did not amount to anything very impressive at the end of the day. But it remains disturbing that the criminal justice system could exhibit two such different outcomes on what appear to be broadly similar facts. Unfortunately, much seems to turn upon prosecutorial discretion and the predilections of the trial judge. Above all, the law is uncertain and incapable of giving adequate guidance.

It is one thing to agree with the BMA’s Euthanasia Report that “Any doctor, compelled by conscience to intervene to end a person’s life, will do so prepared to face the closest scrutiny of this action that the law might wish to make” (22) and quite another to conclude that this scrutiny is arbitrary and random, rather than principled and transparent. A distinguished commentator on Dr. Moor’s case recalled that “Sybille Bedford called her account of the trial of Dr. Bodkin Adams ‘The Best We Can Do’” and added, “Perhaps this is still the best we can do” (4), but surely this is not the best we can do almost half a century on from Dr. Adams’s case. In Britain we need a euthanasia and terminal care act and we need it now. However, a House of Lords Select Committee on Medical Ethics, which reported in 1994, was against any change in the law to permit euthanasia, because this would “weaken society’s prohibition of intentional killing.”

Professional Ethics

If there is a doctor’s defense, it is a defense based on professional ethics and not on minimal

causation or the doctrine of double effect. I argue that a virtue ethics (23) approach is more inclusive and less doctrinaire than the principle of double effect. So any commonsense distinction between accelerating and causing will not prove helpful beyond such cases where the medical treatment so slightly accelerates death as to be virtually no cause. However, because a doctor has a professional duty to relieve a patient’s suffering, “it is permissible for him, when the patient is doomed to die shortly, to administer painkilling drugs with his consent even if they shorten life ... it does not follow that it would be permissible, as opposed to understandable, for someone without such a duty to do the same” (24). But this has “abandoned the lack-of-causation defense and to have embraced a special doctor’s defense instead ... we cannot distinguish between a doctor and a layman doing the same act on grounds of causation, but only on the ground that what is permissible for the one is not permissible for the other” (4).

All moral agents have duties, and it might plausibly be suggested that there is moral virtue in anyone reducing human pain and suffering, but it is also plausible that this is a virtue specific to doctors in a high degree: “Our society broadly recognizes the necessity and appropriateness of allowing doctors to do what others are forbidden from doing” (25). For example, doctors are permitted to look at and even touch our naked bodies in ways which would be morally impermissible for others.

Some are unhappy about distinguishing between doctors and non-doctors, and think that it is unacceptable that there should be different judicial directions (on *mens rea*) in criminal trials “depending on the identity of the defendant” (5). In response, it should be noted, first, that it is not so much the “identity” but rather the professional status and role of the defendant which is relevant. However, if one recognizes that doctors have ethical duties which differentiate them from non-doctors, one may seek to have these differences recognized by the criminal law. This is controversial, in that what ethical duties are implicit in the doctor’s role is itself contested. One distinguished view of the ethics of medical practice is that “physicians, under no circumstances, should be parties in assisting patients in ending their lives” (16). Another “conception of physician duty [is that] under certain circumstances physicians have a moral responsibility to assist a patient in hastening death” (25).

In my own view there can be no general ethical duty of doctors to assist suicide as that is

conventionally understood; quite the reverse. Doctors, one might think above all others, ordinarily should discourage suicide and even heroically strive to save the life of an attempted suicide (25), and in my experience they do, and rightly so. In similar vein the judge in Dr. Cox's case observed, that "patients, however gravely ill, often confound the doctor's prognosis and make a recovery that defies all expert expectations. That is, no doubt, one of many reasons that leads [sic] to the absolute prohibition on a doctor purposefully taking life, as opposed to saving it" (26).

But I distinguish suicide in general from treatment of the terminally ill, where different moral considerations apply. Ideally, deaths occurring in the context of medical treatment of the terminally ill should be taken outside the ambit of the general criminal law and dealt with on a separate statutory basis. And any statute should take account of the moral mission of the medical professions, so that where motivated by proper medical concern to relieve suffering and to respect patient autonomy, a death would no more result in a charge of murder than surgery would provoke a charge of unlawful wounding (25). And, failing legislation, common law courts should develop the law so as to accommodate professional ethics, mindful of the distinction between doctors and non-doctors.

The distinction between doctors and non-doctors is warranted, if at all, only by reference to the special moral duties incumbent on doctors by virtue of their being doctors, and that is a professional ethics argument which invokes virtue ethics and does not hold to the artificial distinction between knowing and intending. In arguing, as I think persuasively, that there is "no moral difference between killing and letting die" (25), Rosamond Rhodes deploys what I shall call "the transitivity argument," moving from the conventional moral acceptability of "letting die" to the proposed moral acceptability of "causing (or hastening) death." In this paper I deploy a similar transitivity argument, moving from the conventional moral (and legal) acceptability of prescribing painkilling drugs which incidentally hasten death to the proposed moral (and legal) acceptability of causing (or hastening) death as a means of or for the purpose of alleviating pain. On the basis that the law should aspire to be moral in general and should, in particular, respect professional ethics, the argument for legal acceptability is contingent on winning the moral argument, both with doctors and with the public.

The conclusion that a doctor may prescribe and administer painkilling drugs even if that has the incidental effect of causing death, without being exposed to a murder charge, flows from the doctor's ethical duty to alleviate pain and suffering. It is not a defense based on the absence of causation or of intention. It is an exception or override based upon the doctor's moral mission. There is widespread reluctance to recognize that the doctor's duty is the true basis of the doctor's defense, because, as currently recognized by the criminal law of England and Wales, the doctor's defense is an unhappily truncated affair and full recognition would call for fuller implementation of the doctor's defense. Given that a doctor (such as Dr. Moor) can (morally and legally) prescribe death-accelerating drugs where death is incidental and foreseen but not intended, nor a causally necessary means to alleviating pain, why cannot a doctor (such as Dr. Cox) simply prescribe (morally or legally) the same or different drugs where death is intended as the only means to alleviate human suffering? The doctrine of double effect and the "bishop's argument" that "there is a proper and fundamental ethical distinction which cannot be ignored between that which is intended and that which is foreseen but unintended" (27) prevents that extension. But the suggestion that had Dr. Cox only used a sedative, there would have been nothing wrong simply misses the moral mission of medicine in the presence of someone like Lillian Boyes: "there are some dying patients who experience suffering that is intolerable and that cannot be relieved by traditional medical care" (3).

It is probable that some, perhaps many, doctors and other health care workers placed in Dr. Cox's position would have acted in a similar way: "surely many a nurse has engaged both in involuntary as well as voluntary euthanasia, and one can be sure that many would readily volunteer" (16), although it may be that this author meant to distinguish what is ethically proper for *doctors* from that which is ethically permissible for other health care workers, including *nurses*. The Voluntary Euthanasia Society, albeit hardly an impartial observer, believes that in the United Kingdom up to 100,000 patients a year are quietly helped to die (28). Dr. Moor's prosecution was seen by many as an abuse of the criminal law, and even those who welcomed the prosecution were disappointed, even "appalled" by what they saw as a green light to "backdoor euthanasia," which is said by some reporters to

be favored by 60% of doctors (28). Although Dr. Moor's acquittal was hailed as a victory for euthanasia, plainly it was not, and Dr. Moor himself certainly did not see it as such. And it was not such a victory precisely because it maintained the distinction, however philosophically suspect, that there is a moral and a legal difference between prescribing painkilling drugs which may incidentally hasten death, and causing death as a means to alleviating pain. On the other hand, had Dr. Cox been acquitted, one might have been able to hail that as a victory for euthanasia. The reduction of the charge to attempted murder, the modest penalty, the condemnation of the prosecution, and the conviction all suggest that even 10 years ago the tide seemed to be running for euthanasia.

I want to revert, briefly, to some ideas developed in the context of medical ethics and confidentiality, and in particular to the concept of a "recourse role" (29). By a recourse role I mean a role that enables the agent to take action in situations where the role's prescribed ends conflict among themselves or with its prescribed means. Thus, "alleviating pain" may sometimes conflict with "preserving life." Recourse roles provide for such situations by establishing conditions under which the agent may be justified in undertaking actions that depart from the primary role requirements. Recourse roles extend a liberty in handling role obligations. This imposes a moral burden, because the choice between conflicting obligations is left to the agent as a moral responsibility of the role. I have argued that "the role of the health care worker may be a recourse role, in that it is embedded in the legal system in a particular way which allows good faith judgment in the resolution of the dilemmas of the role even where the resolution may appear to conflict with primary legal rules. Simply because answers cannot be prepared in advance, decisions have to be made and respected in the context of the role. In so far as the legal system respects, or at least reveals a tendency to respect, these decisions, they are, at least in part, both role defining and law-making, or law-shaping" (29). However, this is normally not a solitary but a collective venture: "decisions to cooperate with hastening patients' deaths are discussed in the semipublic arena of team decision-making and unit-conferences, thereby giving physicians the opportunity to reexamine cases, to justify their decisions to their peers, to raise additional considerations, and to voice objections. This ongoing practice has allowed

doctors and their institutions to accumulate substantial experience in managing life-ending decisions. And because of the generally satisfactory results, our society has come to trust doctors to cooperate with patient decisions" (25). Doctors who, like Dr. Cox and perhaps Dr. Moor, make the hard decisions at the limits of recognized proper practice are moral pioneers whose risk-taking may make it easier for other doctors to honor their professional duties without exposure to criminal prosecution.

On the view of medical ethics which I favor, doctors "have a greater obligation than others to provide help in hastening death" (25). I agree with Phillipa Foot that, for some, life is no longer a basic good but has become an evil, that there is no conceptual connection between "life" and "good," and that "to save or prolong a man's life is not always to do him a service" (30). I also agree with Rosamond Rhodes that "a doctor's commitment to acting for patients' good creates a clear obligation to help a patient avoid an agonizing, protracted death" (25). Quoting Dr. Smalhout, an anesthetist then practicing in Utrecht and translated from the Dutch *Een Monument van onmacht en lafheid* (A Monument to Incompetence and Cowardice), published in the general press (*NRC Handelsblad*) on January 15, 1990, Diana Brahams reports that such a "death is dreadful to watch. The skin and the muscosa dry out; the blood thickens; the kidneys no longer produce urine and gradually die. The eyes become damaged for the lack of tears; the mouth is infested by fungal infections because the natural cleaning by saliva is lost. The body is gradually poisoned by the breakdown of products which can no longer be excreted. In the airways crusts of dried mucus develop which makes breathing steadily more difficult and so the unconscious patient fades away under the eyes of doctors, nurses and family. It can well take ten days or more before death arrives and in dying the patient becomes a monument to medical and judicial cowardice and hypocrisy" (22). Is this really "the best we can do"? Or is a good death a moral and legal option?

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References

1. Arlidge A. The trial of Dr. David Moor. *Criminal Law Review* 2000; 31–40.
2. *Washington v Glucksberg* 521 U.S. 702 and *Vacco v Quill* 521 U.S. 793.
3. Orentlicher D. The Supreme Court and terminal sedation. In: Battin MP, Rhodes R, Silvers A, editors. *Physician assisted suicide: expanding the debate*. New York: Routledge; 1998. pp. 301–311.
4. Smith JC. A comment on Moor’s Case. *Criminal Law Review* 2000; 41–44.
5. Cooper S. Summing up intention. *New Law Journal* (Aug 18) 2000; 150:1258.
6. Wilkinson P. GP attracted loyal support and police attention. *The [London] Times* 1999 May 12 (newspaper items are accessible electronically to subscribers, for example, at <http://web.lexis-nexis.com/executive/>).
7. *R v Arthur* 12 BMLR 1 (Crown Court at Leicester, November 5, 1981); *R v Cox* 12 BMLR 38 (Crown Court at Winchester, September 19, 1992).
8. *R v Cunningham* [1982] AC 566 and *R v Powell & Daniels* [1999] 1 AC 1, 15 (Lord Steyn).
9. [1957] *Criminal Law Review* 365 (Central Criminal Court April 9, 1957).
10. *R v Jordan* (1956) 40 *Criminal Appeal Reports* 152.
11. Williams G. *Textbook of criminal law*. 2nd ed. London: Stevens; 1983. p 385.
12. Duff RA. *Intention, agency and criminal liability*. Oxford (UK): Blackwell; 1990. Chapters 3–5.
13. *R v Woollin* [1999] AC 82; *R v Nedrick* [1986] 3 All ER 1.
14. Mirfield P. Intention and foresight of virtual certainty. *Criminal Law Review* 1999; 246.
15. Uniacke S. The doctrine of double effect. *The Thomist* 1984; 48(2):188–218.
16. Baumrin B. Physician, Stay thy hand! In: Battin MP, Rhodes R, Silvers A, editors. *Physician assisted suicide: expanding the debate*. New York: Routledge; 1998. pp. 177–181.
17. Davies M. *Textbook of medical law*. Oxford (UK): Blackstone Press; 1996. pp. 311–314.
18. *R v Mohan* [1976] QB 1, 11 (James LJ).
19. Duff RA. *Criminal attempts*. Oxford (UK): Oxford University Press; 1996. pp. 17–21.
20. Mahendra B. Taking liberties with life. *New Law Journal* (Oct 10) 1997; 147:1461.
21. Hard cases make bad law [editorial]. *New Law Journal* (Sep 25) 1992; 142:1293.
22. Brahams D. The reluctant survivor. *New Law Journal* (Apr 27) 1990; 140:586.
23. Hursthouse R. On virtue ethics. Oxford (UK): Oxford University Press; 1999.
24. Hart HLA, Honoré T. *Causation in the law*. 2nd ed. Oxford (UK): Oxford University Press; 1985. p. 344.
25. Rhodes R. Physicians, assisted suicide, and the right to live or die. In: Battin MP, Rhodes R, Silvers A, editors. *Physician assisted suicide: expanding the debate*. New York: Routledge; 1998. pp. 165–176.
26. 12 BMLR 28 (Ognall J, Sep 19, 1992).
27. Helme T, Padfield N. Lord Walton’s sandcastle. *New Law Journal* (Nov 4) 1994; 144:1521.
28. Hornell M. Profession awaits guidelines for treating terminally ill patients. *The [London] Times* 1999 May 12 (newspaper items are accessible electronically to subscribers, for example, at <http://web.lexis-nexis.com/executive/>).
29. Tur RHS. Medical confidentiality and disclosure: moral conscience and legal constraints. *Journal of Applied Philosophy* 1998; 15:15–28.
30. Foot P. Euthanasia. *Philosophy and Public Affairs* 1977; 6:85–112.