

# South Australian Voluntary Euthanasia Society Inc. (SAVES)

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6/9/02

To all Members of the South Australian Parliament

Dear Member,

## VOLUNTARY EUTHANASIA AND THE LAW

The view of voluntary euthanasia that governs our present law hinges on the principle of “double effect”. This says, briefly, that a doctor who terminates the life of a patient while using treatment to relieve pain and symptoms commits a crime if the death of the patient was his “primary intention” but not if it was only a “secondary effect”.

The attached extract from a lecture to the Royal Society by Professor Ian Kennedy points out that this is:

- irrational .opening paragraphs
- ambiguous .para. (1)
- hypocritical .para. (2)
- against the interests of patients .para. (3)
- harmful to doctors .para. (4) and
- brings the law into disrepute .para (5)

I hope you will find time to read it.

In the context of the Dignity In Dying Bill 2001 the following comment by Lord Mustill in his judgement on an appeal to the House of Lords in the landmark case of Tony Bland (1993) is appropriate:

***“It is important, particularly in the area of criminal law which governs conduct, that society’s notions of what is law and what is right should coincide. One role of the legislators is to detect any disparity between these notions and to take appropriate action to close the gap.”***

If there is any more information you would like on this, or any other aspect of voluntary euthanasia, please let me know:

Yours sincerely,

**Frances Coombe**

**President.**

# THE UPJOHN LECTURE

A brief extract from the lecture to the Royal Society on 25 April 94 under the title ‘The Quality of Mercy: Patients, Doctors and Dying’ by Ian Kennedy, Professor of Law and Ethics, King’s College, London.

## The Law is Unsatisfactory

Let me begin by explaining why the law is currently unsatisfactory. Dr A and Dr B are in all respects similar. They are caring, respected doctors with impeccable backgrounds. Dr A’s patient, Mr X, is suffering from a fatal illness which is now in its final stages. He is near to death and in great pain. He can also see the pain his suffering is causing to his family who maintain a vigil at his bedside. He asks Dr A to put him out of his misery. Dr A explains that he cannot do so, but that he will steadily increase the amount of pain relieving drugs which Mr X receives. The effect of this, Dr A explains, will be that over a period of time, perhaps a few days, the dose prescribed will be such that Mr X will in fact die, albeit, he adds, as a consequence of the attempt to relieve pain. Two days later Mr X dies. Meanwhile Dr B’s patient, Mrs Z, is virtually in the same situation. In response to her entreaties Dr B says he will give her something which will bring her the relief and release she seeks. Dr B injects Mrs Z with potassium chloride. She dies within minutes, a rapid end to her pain and suffering.

What characterises the two courses of conduct taken by the doctors is that the doctors’ intentions were the same — to ease pain and bring about a peaceful death; their motives were the same — to be as caring as they can be for their stricken patients; their conduct was the same — the active administration of injections; the result was the same — the death of their patients, though in Mr X’s case it took considerably longer to achieve. What further distinguishes Dr A from Dr B is that before Dr A began the course of injections intended to bring about Mr X’s death, he specifically disavowed any such intention. Furthermore, he used a drug which is acknowledged to be a pain reliever though it is also recognised as capable of causing death. Dr B used a much more effective pain reliever, but pain relief is not an indicated use for the drug. The only other thing that differentiates them is that the law regards Dr A as a perfectly reasonable doctor while it regards Dr B as a murderer.

Is this not rather odd, you may say. Dr A goes home to his family. Dr B gets a mandatory life sentence. The legal rationale which is offered is that doctors may bring about the death of such patients as Mr X and Mrs Z, always provided their first and primary intention in embarking on the course of conduct that ends in death is to relieve pain. They can know that death results, but as long as they claim otherwise — that “this is for your pain” — they are entirely within the law. If on the other hand they do something designed specifically to end the patient’s life, they break the law.

*(Professor Kennedy goes on to develop the theme of “oddness” — that the law appears to decide whether or not a doctor is a murderer on the basis of the drug used and how that drug is primarily classified.)*

## Why the Law is Unsatisfactory

I repeat however that this is not satisfactory. Here are some of the reasons.

(1) First the law should always strive to be clear and unambiguous. Nowhere is this more so than when life and death are in the balance and a charge of murder is the consequence of breaking the rule. In the treatment of a patient whose life has become an intolerable burden, however, the legal rule offered is far from clear. It relies, first of all, on there being an agreed list of pharmacological agents or medical interventions which are universally accepted as having a single function. But all drugs have multiple functions and are

appropriate in some circumstances and inappropriate in others. Further, it is well known that doctors will advocate a particular drug for one purpose while other doctors will decry such use as reckless or unproven. It is part of the history of medicine that drugs designed for one reason become used for another. What is to stop a doctor claiming that he intended to relieve pain albeit through an unconventional means? This alerts us to the second problem in the pursuit of clarity. Everything turns on what the doctor claims he was trying to achieve. As long as he uses the right verbal formula and records it in the patient's notes and to be on the safe side does not use too unusual a drug, he will stay within the law. Knowing how to play the game becomes the crucial determinant of criminal liability, rather than what objectively is done or what results. When the crime is murder, this can hardly be satisfactory.

(2) The second reason follows on from this. The current state of the law endorses, indeed entrenches, hypocrisy. "We all know what you are doing, but use the magic words, "I'm doing this to relieve your pain" and all will be well". Alternatively, the law encourages casuistry, as those who are anxious to do right by their patients, as they see it, feel compelled to resort to subterfuge. Out of fear of prosecution. Fear of prosecution is, of course, eminently desirable when designed to deter what is accepted as wrong. But when it is neither the means nor the end that which is regarded as wrong but rather the absence of the attendant rhetoric or ritual, such fear becomes itself wrong.

(3)-The law works against the interests of the patient in a number of ways. It will be said, of course, that the crucial feature of the existing law is that it protects patients who might otherwise be abused by their doctors, and by abuse here we mean killing patients. But does it? Obviously those patients who fall into the hands of a murderous doctor appear to be protected. Mercifully there are not too many such doctors around! And, of course, when such a rarity crops up the current law would not prevent him from carrying out his murderous intent, provided he remembered to use the "right" drugs and make the right noises. But we can forget such doctors. They are so rare. Certainly, what such a doctor might or might not do should not serve to determine the shape of the law. Instead, we should concern ourselves with the everyday conscientious doctor. How does the law fail to serve the interests of the patient by preventing the doctor from serving him as he might wish? The answer lies in the examples considered earlier. Fearful of the law, not really understanding it, he responds to his patient's wish for a peaceful end by embarking on a process of increasing dosage until the desired objective is reached. This may, as we have seen, take some time. During this time the patient is required to continue to suffer, physically and mentally, so that the proper form may be observed. Furthermore, the patient may fall into that relatively small but no less real group of patients whose pain is beyond the reach of drugs. Such a patient must continue to suffer until the proper legal courtesies have been observed and the final dose can bring the intended death. In fact, the law specifically asks him to suffer so as to protect others. The irony will not be lost on you or him. If these others are anything like him, it is precisely this "protection" which they do not want.

(4) The law is also unsatisfactory in that it can harm doctors in their ability to maintain a relationship of trust and support when their patients most need it. If, out of fear of the law or uncertainty about what they may properly do, the doctor rejects his patient's entreaties, it would be no surprise if the patient felt abandoned. The patient's trust in his doctor, so critical as death approaches, is lost and suffering is compounded. The doctor, for his part, is forced to deny his training. If he is to satisfy his patient's request, he must engage in subterfuge. Alternatively, he must fail his patient by not providing the means to end the patient's pain.

(5) Finally, the current law is unsatisfactory in that, far from serving the public interest, it can, in fact, undermine it. The hypocrisy it engenders brings it into disrepute. The care and support a patient receives is made to depend on how alert the doctor may be to ways of manipulating the law.

