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## MERCIFUL ACTS AND CRUEL OMISSIONS

COLLEEN DAVIS\*

*Criminal law draws a clear distinction between positive acts that cause death, and omissions to do acts that would prevent death. Judges have relied on the differentiation between acts and omissions to determine whether a medical killing is unlawful. However, this act-omission distinction is not an appropriate criterion for determining the lawfulness of the actions of doctors who assist patients who want to die, particularly in cases where competent patients suffer from a medical condition that prevents them from actively killing themselves. This inconsistent application of the act-omission distinction is evident in cases of adult conjoined twins and patients who suffer from locked-in syndrome. Instead, the law should give effect to the rhetoric of respect for patient autonomy and dignity, and regard the consent of a patient of full capacity, in conjunction with the defence of necessity as a complete defence for doctors who help these patients to die a dignified and painless death.*

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## I INTRODUCTION

In the 1993 case of *Airedale NHS Trust v Bland*, the House of Lords emphasised that the criminal law draws a clear distinction between positive acts that cause death, and omissions to do acts that would prevent death.<sup>1</sup> Since then, judges have relied on the differentiation between acts and omissions to determine whether a medical killing is unlawful. A doctor who withdraws or withholds treatment — an omission to act in the eyes of the law — is not criminally responsible for the resulting death of the patient, provided it is not in the best interests of the patient to be treated and provided the doctor is no longer under a duty to maintain the patient’s life.<sup>2</sup> However, a doctor who ends the life of a patient by a lethal injection — a positive act — even if this is done at the request of the patient whose life has become intolerable, may be guilty of murder.<sup>3</sup>

This paper argues that the act-omission distinction is not an appropriate criterion for determining the lawfulness of the actions of doctors who assist patients who want to die, particularly in cases where competent patients suffer from a medical condition that

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<sup>1</sup> *Airedale NHS Trust v Bland* [1993] 1 All ER 821, 862 (Lord Keith), 867 (Lord Goff), 880 (Lord Browne-Wilkinson), 885 (Lord Mustill).

<sup>2</sup> *Ibid* 862 (Lord Keith), 867 (Lord Goff), 877 (Lord Lowry), 880 (Lord Browne-Wilkinson), 890 (Lord Mustill).

<sup>3</sup> *Ibid* 867 (Lord Goff).

prevents them from actively killing themselves. The two examples that will be used to illustrate the inconsistent application of the act-omission distinction are adult conjoined twins and patients who suffer from locked-in syndrome. Instead of perpetuating the artificiality of the act-omission dichotomy, this paper argues that the law should give effect to the rhetoric of respect for patient autonomy and dignity, and regard the consent of a patient of full capacity, in conjunction with the defence of necessity as a complete defence for doctors who help these patients to die a dignified and painless death.<sup>4</sup>

The first part of this paper discusses four cases that illustrate the inconsistencies in the law when judges try to circumvent the blanket prohibition on positive acts that kill when these acts are performed by doctors. These cases – *Airedale NHS Trust v Bland*,<sup>5</sup> *Re A (Children) (conjoined twins surgical separation)*,<sup>6</sup> *Nicklinson v Ministry of Justice*,<sup>7</sup> and *Aarushi Dhasmana v Union of India*,<sup>8</sup> — demonstrate judicial willingness to depart from the settled principle in some cases in order to justify the perceived desired outcome. The decisions in these cases are difficult to reconcile, and they show that Lord Mustill’s concern that the artificial distinction between positive acts and omissions would emphasise ‘distortions of a legal structure which is already both morally and intellectually misshapen’<sup>9</sup> have indeed come to pass.

The second part of the paper focuses on the principles of sanctity of life and autonomy. It will argue that, in cases where people are physically unable to commit suicide but are fully informed and consent to and request that doctors euthanase them, the principle of autonomy should be given priority over sanctity of life. The method of killing in these cases — be it by means of an omission or a positive act — is immaterial. The paper will

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<sup>4</sup> Necessity in this paper refers to the lesser-evils version of the defence outlined by Brooke LJ in *Re A (Children)* [2000] 4 All ER 961, 1052. There are comparable defences in Australian common law jurisdictions, but not in code jurisdictions. It may be possible to bring euthanasia or assisted suicide of locked-in patients within s 282 *Criminal Code 1899* (Qld), which provides that a person is not criminally responsible for performing or providing, in good faith and with reasonable care and skill, medical treatment of a person for the patient’s benefit if performing the operation or providing the medical treatment is reasonable, having regard to the patient’s state at the time and to all the circumstances of the case. In *Queensland v Nolan* [2002] 1 Qd R 454, Chesterman J relied on this section to find that the doctors would not be criminally responsible for the death of an infant conjoined twin during sacrificial separation surgery. However, the section has not been used to date to exculpate doctors in a case involving a mercy killing by means of a positive act. Voluntary euthanasia in all Australian states and territories is unlawful.

<sup>5</sup> [1993] 1 All ER 821.

<sup>6</sup> [2000] 4 All ER 961. There was a similar case in Queensland two years later: *Queensland v Nolan* [2002] 1 Qd R 454.

<sup>7</sup> [2012] EWHC 2381.

<sup>8</sup> (10 April 2013) Writ Petition (civil) No 232 of 2012.

<sup>9</sup> *Airedale NHS Trust v Bland* [1993] 1 All ER 821, 885.

conclude by showing that, although judges are reluctant to authorise the positive act of killing a consenting adult and have repeatedly called for legislative intervention, the current state of the law, as applied in conjoined twin cases, is such that the judges do have the means to declare voluntary euthanasia lawful in locked-in syndrome cases and thereby allow these patients to die quickly, painlessly and with dignity.<sup>10</sup> This paper does not advocate a legal approach that makes all active killings lawful, even if the killing is with the consent of the person killed, but argues instead that in exceptional cases where people are unable to kill themselves, the law should not criminalise the conduct of doctors who help these patients to die.<sup>11</sup>

## II BACK AND FORTH ACROSS THE RUBICON

In the first of the four cases, *Airedale NHS Trust v Bland*, the House of Lords declared it would be lawful to withdraw food and hydration from a patient in a persistent vegetative state with no hope of recovery, in accordance with the wishes of his parents and hospital staff.<sup>12</sup> This is the only one of the four cases which involved a medical 'omission', and this conclusion was itself based on the fiction that the act of turning off a ventilator or removing a nasogastric tube was not an act at all, but an omission. Having made it clear that doctors who cause the death of a patient by means of a positive act, as opposed to an omission to perform acts that would prevent death, would cross the Rubicon between lawful killing and euthanasia,<sup>13</sup> the Law Lords had to contrive the artificiality of categorising a positive act of withdrawing a nasogastric tube as an omission and not as an act, and also had to find a way of circumventing the legal duty imposed on a doctor to treat a patient. Lord Goff resolved the latter by holding that a

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<sup>10</sup> MedicineNet.com <<http://www.medterms.com/script/main/art.asp?articlekey=11024>> defines locked in syndrome as a neurological disorder characterised by complete paralysis of voluntary muscles in all parts of the body except for those that control eye movement. The locked-in syndrome is usually a complication of a cerebrovascular accident in the base of the pons in the brainstem. The patient is alert and fully conscious but cannot move. Only vertical movements of the eyes and blinking are possible.

<sup>11</sup> Herring, 'Escaping the Shackles of Law at the End of Life: *Nicklinson v Ministry of Justice* [2012] EWHC 2381 (Admin)' (2013) (18 April) *Medical Law Review* 1, 9, puts forward the same argument.

<sup>12</sup> [1993] 1 All ER 821.

<sup>13</sup> Crossing the Rubicon means 'to commit oneself irrevocably to some course of action': see G A Wilkes and W A Krebs, *Collins English Dictionary* (HarperCollins, 3rd ed, 1992). The saying alludes to the crossing of the River Rubicon by Julius Caesar with his army. In so doing, Caesar broke the law that a general might not lead an army out of the province to which he was posted and so committed himself to a civil war in 49 B.C. Lord Goff in *Airedale NHS Trust v Bland* [1993] 1 All ER 821, 867 uses the analogy to distinguish between a doctor withholding or withdrawing treatment, which is lawful, and actively administer a drug to his patient to bring about his death, a mercy killing. Performing the latter 'is to cross the Rubicon which runs between on the one hand the care of the living patient and on the other hand euthanasia-actively causing his death to avoid or to end his suffering'.

doctor is no longer under a duty to treat a patient where medical treatment that prolongs life would be futile and not in the patient's best interests.<sup>14</sup> As far as the former is concerned, Lord Goff and Lord Browne-Wilkinson conceded that removing a tube or turning off a ventilator are both positive acts.<sup>15</sup> However, Lord Goff said discontinuing life support is no different from not initiating life support in the first place.<sup>16</sup> Lord Lowry expressed a similar view.<sup>17</sup> Lord Browne-Wilkinson makes the point that, if the tube was left in place but no further nutrients were provided to a patient, this would be an omission.<sup>18</sup> For these reasons, withdrawing life support is regarded in law as an omission.

While these arguments have merit, the fact is that doctors who turn off life support or withdraw a tube are performing a positive act rather than omitting to act. Furthermore, it is equally implausible to regard the same act as an omission if performed by a doctor but as a positive act if carried out by a non-medical person such as a family member.<sup>19</sup> It is not surprising that, as Robert Walker LJ pointed out in *Re A (Children)*, '[m]any of the judges who considered *Bland's case* were understandably anxious about the intellectual robustness of the distinction between death brought about by an omission, on one hand, and death caused by a positive act, on the other hand'.<sup>20</sup>

Seven years after *Airedale NHS Trust v Bland*,<sup>21</sup> the intellectual robustness of the act-omission distinction was put to the test in *Re A (Children)*,<sup>22</sup> a case in which doctors sought a declaration that it would be lawful to sacrifice one infant conjoined twin during separation surgery to save the other. In the High Court, Johnson J drew on the decision in *Airedale NHS Trust v Bland* to find that the sacrificed twin's death would be caused by the 'withdrawal of the supply of blood which she receives' from her twin.<sup>23</sup> 'Here the analogy is with the situation in which the court authorises the withholding of food and hydration. That, the case is made clear, is not a positive act and is lawful.'<sup>24</sup> However, in

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<sup>14</sup> *Airedale NHS Trust v Bland* [1993] 1 All ER 821, 869 -70 (Lord Goff).

<sup>15</sup> *Ibid* 867 (Lord Goff), 881 (Lord Browne-Wilkinson).

<sup>16</sup> *Ibid* 867 (Lord Goff).

<sup>17</sup> *Airedale NHS Trust v Bland* [1993] 1 All ER 821, 875.

<sup>18</sup> *Ibid* 881.

<sup>19</sup> *Ibid* 868 (Lord Goff).

<sup>20</sup> [2000] 4 All ER 961, 1058.

<sup>21</sup> [1993] 1 All ER 821.

<sup>22</sup> [2000] 4 All ER 961.

<sup>23</sup> [1993] 1 All ER 821; *Re A (Children)* [2000] 4 All ER 961, 989 (Ward LJ).

<sup>24</sup> *Re A (Children)* [2000] 4 All ER 961, 989 (Ward LJ).



the Court of Appeal, the Lords Justice held that separation surgery was clearly a positive act,<sup>25</sup> with Ward LJ saying it would be ‘utterly fanciful to classify this invasive treatment as an omission in contra-distinction to an act’.<sup>26</sup> The Lords Justice therefore had to rely on defences to conclude it would be lawful for doctors to perform the surgery,<sup>27</sup> knowing that the infant with virtually no functioning lung tissue and a very poorly developed primitive brain, could not survive the procedure but that the other could be saved. Both infants would have died had they remained joined.

*Re A (Children)*<sup>28</sup> is a landmark case, for several reasons. Of key importance in the context of this paper is that it was the first time that the Court had sanctioned a positive act of killing by a doctor, and also the first time that judges were prepared to make necessity available as a defence to murder.<sup>29</sup>

Neither of these two points was lost on counsel for a locked-in syndrome patient in *Nicklinson v Ministry of Justice*.<sup>30</sup> He submitted that the Rubicon between positive acts and omissions, referred to by Lord Goff in *Airedale NHS Trust v Bland*,<sup>31</sup> was crossed in *Re A (Children)*<sup>32</sup> and that this indicated the court is ‘able to fashion means of permitting doctors to act in a way which accords with the demands of humanity’.<sup>33</sup> Nicklinson had suffered a catastrophic stroke that left him paralysed below the neck and unable to speak. He communicated by blinking or by using a special computer. He described his life as ‘dull, miserable, demeaning, undignified and intolerable’<sup>34</sup> and told the court he had wanted to end his life since 2007 and that his wish was ‘not a passing whim. I know consent makes no difference but the doctor has it anyway. Legal arguments are fine but they should not forget that a life is affected by the decision they come to. A decision

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<sup>25</sup> Ibid 1003 (Ward LJ), 1027 (Brooke LJ), 1061 (Robert Walker LJ).

<sup>26</sup> Ibid 1003 (Ward LJ).

<sup>27</sup> Ward LJ relied on defence of others, Brooke LJ on necessity and Robert Walker LJ on the doctrine of double effect and duress of circumstances.

<sup>28</sup> [2000] 4 All ER 961.

<sup>29</sup> In *R v Dudley and Stephens* [1881–5] All ER Rep 61, Lord Coleridge CJ refused to allow necessity as a justification for murder. Lord Hailsham confirmed this principle in *R v Howe* [1987] 1 All ER 771, 777. These cases are discussed by Brooke LJ in *Re A (Children)* [2000] 4 All ER 961, 1034–9, 1051–2. Brooke LJ held that necessity requires that (i) the act is needed to avoid inevitable and irreparable evil; (ii) no more should be done than is reasonably necessary for the purpose to be achieved; and (iii) the evil inflicted must not be disproportionate to the evil avoided.

<sup>30</sup> [2012] EWHC 2381.

<sup>31</sup> [1993] 1 All ER 821.

<sup>32</sup> [2000] 4 All ER 961.

<sup>33</sup> *Nicklinson v Ministry of Justice* [2012] EWHC 2381, [63].

<sup>34</sup> Ibid 13.

going against me condemns me to a life of increasing misery'.<sup>35</sup> He therefore sought a court declaration that it would not be unlawful for a doctor to help him end his life.

Counsel argued that a humane application of the doctrine of necessity — as applied in *Re A (Children)* — would make the defence available to a doctor who agreed to end Nicklinson's life, at his request.<sup>36</sup> However, Toulson LJ reiterated the well-established distinction between omissions and positive acts that kill, and said 'it would be wrong for the court to depart from the long established position that voluntary euthanasia is murder, however understandable the motives may be'.<sup>37</sup> All three judges refused the application and made it clear that any change in the law was the domain of Parliament.<sup>38</sup> Toulson LJ referred to the guidelines set out by Lord Lowry in *C (A Minor) v DPP* that advocate judicial caution rather than activism in cases where the law is uncertain.<sup>39</sup> Interestingly, none of the judges in *Re A (Children)*<sup>40</sup> referred to these guidelines. Instead, according to Ward LJ, judges have 'a duty to decide what parties with a proper interest ask us to decide ... Deciding disputed matters of life and death is surely and pre-eminently a matter for a court of law to judge. That is what courts are here for'.<sup>41</sup>

In view of the fact that the English Court of Appeal in *Re A (Children)*<sup>42</sup> sanctioned a positive act that resulted in a death, and that the Lords Justice were prepared to overturn decades of settled law in allowing necessity to be used as a defence to murder, it is difficult to understand why the judges in *Nicklinson v Ministry of Justice* were not prepared to do the same.<sup>43</sup> They could quite easily have applied Brooke LJ's interpretation of necessity, and could have restricted their decision to facts where a person who wants to die cannot take his own life, just as Ward LJ in *Re A (Children)*

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<sup>35</sup> Ibid 14.

<sup>36</sup> *Nicklinson v Ministry of Justice* [2012] EWHC 2381, [72].

<sup>37</sup> Ibid [87].

<sup>38</sup> Ibid [150] (Toulson LJ), [151] (Royce J), [152] (Macur J).

<sup>39</sup> [1996] 1 AC 1; The guidelines as set out by Lord Lowry at 28 are: 'one can find in the authorities some aids to navigation across an uncertainly charted sea. (1) If the solution is doubtful, the judges should beware of imposing their own remedy. (2) Caution should prevail if Parliament has rejected opportunities of clearing up a known difficulty or has legislated, while the leaving the difficulty untouched. (3) Disputed matters of social policy are less suitable areas for judicial intervention than purely legal problems. (4) Fundamental legal doctrines should not be lightly set aside. (5) Judges should not make a change unless they can achieve finality and certainty.'

<sup>40</sup> [2000] 4 All ER 961.

<sup>41</sup> *Re A (Children)* [2000] 4 All ER 961, 987 (Ward LJ).

<sup>42</sup> [2000] 4 All ER 961.

<sup>43</sup> [2012] EWHC 2381.

restricted his decision to conjoined twins.<sup>44</sup> One explanation for the reluctance of the judges in *Nicklinson v Ministry of Justice* to grant the appeal might be the difference in the facts of the two cases.<sup>45</sup> Toulson LJ indicated that *Re A (Children)* is ‘as a case of highly exceptional facts’ whereas Mr Nicklinson’s condition ‘is tragic but sadly not unfamiliar’.<sup>46</sup> However, a converse argument is plausible. While conjoined twins are rare, and cases of sacrificing one to save the other are even more rare, it could be argued that there is nothing unusual about the restricted lifespan of children born with disabilities. In this respect, conjoined twins are no different from other infants born with medical problems that doom them to an early death. On the other hand, it is uncommon for people to be put in a situation where they are physically unable to take their own lives. Therefore, this reason for not allowing necessity, as applied in *Re A (Children)*, to be relied on by doctors in the case at hand, is hard to support.

Another difference between the two cases is that in *Nicklinson v Ministry of Justice*,<sup>47</sup> although the patient was an adult and able to make his own decisions about medical care, the court would not accede to his wish to be killed and declare it lawful for a doctor to terminate his life. In *Re A (Children)*,<sup>48</sup> the person killed was an infant. The court overrode the parents’ opposition to the intentional killing of one of their babies — they wished instead to leave the twins’ fate in God’s hands — and authorised the sacrifice of one baby.<sup>49</sup> Given that the infant twins were unable to make their own decisions about health care, and were in the protection of the court, one might have expected judges to have been even more reluctant to authorise the sacrifice of a baby than to sanction the euthanasia of a consenting adult. If, as Ward LJ pointed out, ‘there could not have been the slightest criticism’ if the hospital had decided to follow the parents’ wishes,<sup>50</sup> this may have been the preferable course, and one that would have accorded with the law as it stood at the time.

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<sup>44</sup> *Re A (Children)* [2000] 4 All ER 961, 1018 (Ward LJ).

<sup>45</sup> [2012] EWHC 2381.

<sup>46</sup> *Nicklinson v Ministry of Justice* [2012] EWHC 2381, [74].

<sup>47</sup> [2012] EWHC 2381.

<sup>48</sup> [2000] 4 All ER 961.

<sup>49</sup> *Re A (Children)* [2000] 4 All ER 961, 969 (Ward LJ).

<sup>50</sup> *Ibid* 988.

A third point of difference between *Re A (Children)*<sup>51</sup> and *Nicklinson v Ministry of Justice* is that the death of one twin was necessary if the other was to have a chance at life.<sup>52</sup> There was, at first glance, no corresponding benefit to another person in *Nicklinson's case*. The court's preoccupation with saving the life of at least one conjoined twin is hard to understand if one considers that the law condones the deaths – causally related to omissions to treat — of defective or disabled neonates in paediatric intensive care units. Further, if saving one life was indeed the crucial concern, it is difficult to distinguish between the conjoined twins' situation and Thomson's hypothetical about five patients in need of transplants who could all be saved if one healthy person is killed for his organs.<sup>53</sup> Furthermore, the money spent on medical care of the conjoined twins, and indeed the litigation, could have been diverted to other areas of health care and could possibly have saved countless lives, as opposed to just the one conjoined twin.<sup>54</sup>

The two cases are similar in that both Mr Nicklinson and the sacrificed twin suffered from disabilities that had a negative effect on their then current and future quality of life. It is ironic that the decision of the Court of Appeal in *Re A (Children)* appears to have been facilitated by the fact that the future life of the twin to be sacrificed would hold nothing 'except possible pain and discomfort'.<sup>55</sup> Nicklinson was facing a life that was equally 'distressing and intolerable'<sup>56</sup> and this was precisely the reason that he wanted to die but the court viewed his explicit wish as irrelevant.

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<sup>51</sup> [2000] 4 All ER 961.

<sup>52</sup> [2012] EWHC 2381.

<sup>53</sup> Judith Jarvis Thomson, 'The Trolley Problem' (1985) 94(6) *Yale Law Journal* 1395, 1396.

<sup>54</sup> The cost associated with the sacrificial separation surgery of the Lakeberg twins in 1993 was the subject of considerable discussion in the media at the time. The controversy related to the wisdom of spending limited resources on what seemed to be a futile operation, at a time when many other people could not access the health care system for life-saving treatment. According to David C Thomasma et al, 'The Ethics of Caring for Conjoined Twins, The Lakeberg Twins' (1996) 26(4) (July-August) *Hastings Center Report* 4, 7, the cost of caring for the surviving twin in intensive care until she died nine months after the operation was reported to be more than \$1.2 billion. Stephen E Lammers, 'Tragedies and medical choices' (1993) 110(25) (September 8 1993) *The Christian Century* 845, 856 pointed out that it was 'grimly ironic' and indefensible that the Lakeberg surgery proceeded at a time when the infant mortality rate in the United States was one of the highest in the industrialised world. Charles L Dougherty, 'Joining in Life and Death: On Separating the Lakeberg Twins' (1995) 11(1) *Bioethics Forum* 9, 15 expressed similar views, saying that the Lakeberg case represented a serious dysfunction in the American health care system and highlighted America's 'collective unwillingness to set health care priorities that serve individuals while also honouring a commitment to the common good'.

<sup>55</sup> *Re A (Children)* [2000] 4 All ER 961, 1070 (Robert Walker LJ).

<sup>56</sup> *Nicklinson v Ministry of Justice* [2012] EWHC 2381, [7].

In *Re A (Children)*, all three Lords Justice referred to the right to life (a right not to be killed intentionally) and had no difficulty in concluding that each twin had an equal right to life.<sup>57</sup> The right to life, enshrined in Article 21 of the *Constitution of India*, underpins comments by the two judges in the recent Supreme Court of India case of *Aarushi Dhasmana v Union of India* that they would be prepared to sanction sacrificial separation surgery of teenage conjoined twins,<sup>58</sup> Farah and Saba Shakeel. According to K.S. Radhakrishnan and Dipak Misra JJ, in a situation where both twins might die if not separated but one would survive the surgery, the right to life creates a duty on the Court to save at least one.<sup>59</sup> In this case, a petition was brought as a Public Interest Litigation by a law student, who asked the court to set up a 'high-level committee of medical experts for the purpose of examining the possibility of separating the twins'.<sup>60</sup> The judges indicated they would be prepared to override the wishes of the parents, who were opposed to surgery on the 15-year-old craniopagus conjoined twins because of the risk that one or both might die during the procedure.<sup>61</sup> There is no mention in this case of *Re A (Children)*<sup>62</sup> or *Airedale NHS Trust v Bland*,<sup>63</sup> or indeed of the distinction between omissions and positive acts, or of lawful killings and euthanasia in a medical context. Of even greater concern is that the wishes of the twins themselves were not considered. Media reports suggest the girls do not want to be separated.<sup>64</sup> It was only because the girls' parents refused to allow doctors to carry out the necessary tests and evaluations, again because of the risks involved,<sup>65</sup> that the Supreme Court did not have the medical information it needed to decide whether or not to order separation surgery. The two judges did refer to *Gillick v West Norfolk and Wisbech Area Health Authority* to support

<sup>57</sup> *Re A (Children)* [2000] 4 All ER 961, 1016 (Ward LJ), 1026 (Brooke LJ), 1070 (Robert Walker LJ).

<sup>58</sup> *Aarushi Dhasmana v Union of India* (10 April 2013) Writ Petition (civil) No 232 of 2012, [11].

<sup>59</sup> *Ibid.*

<sup>60</sup> 'SC pushes for surgical separation of conjoined sisters', *Daily News* (online), 16 July 2012 <<http://india.nydailynews.com/business/a6d9ab34fe508d6da0926926aa307205/sc-pushes-for-surgical-separation-of-conjoined-sisters>>.

<sup>61</sup> Craniopagus means joined at the head; *Aarushi Dhasmana v Union of India* (10 April 2013) Writ Petition (civil) No 232 of 2012 [7].

<sup>62</sup> [2000] 4 All ER 961.

<sup>63</sup> [1993] 1 All ER 821.

<sup>64</sup> Giridhar Jha, 'Bihar's conjoined twins welcome SC decision of ruling out surgical separation', *Mail Today* (online), 10 April 2013 <<http://indiatoday.intoday.in/story/conjoined-twins-supreme-court-surgery-saba-farah-patna-aiims/1/261609.html>>.

<sup>65</sup> In 2005, the girls' parents had refused an offer by a leading American neurosurgeon, experienced in separated conjoined twins, to perform separation surgery, funded by the Crown Prince of Abu Dhabi, because of the risk that one or both twins might die. See 'SC directs to bring conjoint twins Saba, Farah to AIIMS for treatment', *Post* (online), 30 July 2012 <<http://post.jagran.com/SC-directs-to-bring-conjoint-twins-Saba-Farah-to-AIIMS-for-treatment-1343633163>>.

their argument that the court could override the wishes of the parents but they did not mention the possibility that the girls,<sup>66</sup> then aged 15, might be Gillick competent.<sup>67</sup> It seems perverse that judges could contemplate forcing one twin to die, against her will and by means of a positive act, but judges in *Nicklinson v Ministry of Justice* refused to countenance the positive act of killing a patient, with his consent and in accordance with his wishes.<sup>68</sup>

It also seems incongruous that the judges drew on the explicitly guaranteed right to life in the Constitution of India to suggest they would mandate the sacrifice of one twin ie that this constitutional right to life could authorise, or even compel, the active killing of one person to save the life of another. According to Vinod et al, Article 21 guarantees the protection of life 'and by no stretch of the imagination can extinction of life be read into it'.<sup>69</sup>

Further, the apparent readiness of the judges to sacrifice one twin is surprising in a country in which an Indian court indicated for the first time, only in 2011, that withdrawal of life support was permissible.<sup>70</sup> The patient in that case was a nurse who had been in a vegetative state since being brutally raped in 1973.<sup>71</sup> It may also be unlikely that courts would have acceded to a reported plea from the conjoined twins' father, also in 2011, that doctors be allowed to carry out a mercy killing to end the girls' suffering if no funding for their treatment was forthcoming.<sup>72</sup> The twins were reported at the time as suffering continuous headache and body pain. In July 2012, the Supreme Court ruled that the twins should be registered as severely disabled, and therefore

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<sup>66</sup> [1985] 3 All ER 402.

<sup>67</sup> Janet Loveless, *Criminal Law, Text, Cases, and Materials* (Oxford University Press, 3rd ed, 2012) 563 explains that the test of competence in children is not a question of age, but of 'maturity, understanding and intelligence'. The test comes from *Gillick v West Norfolk and Wisbech Area Health Authority* [1985] 3 All ER 402. It was argued in this case that girls under 16 lacked capacity to consent to medical treatment, but the House of Lords held that these factors were more important than age.

<sup>68</sup> [2012] EWHC 2381.

<sup>69</sup> Vinod Sinha, S Basu and S Sarhkel, 'Euthanasia: an Indian perspective' (2012) 54(2) *Indian Journal of Psychiatry* 177.

<sup>70</sup> *Shanbaug v Union of India* (7 March 2011) Writ Petition (crl) No 115 of 2009.

<sup>71</sup> 'India court rejects Aruna Shanbaug euthanasia plea', (online), 7 March 2011 <<http://www.bbc.co.uk/news/world-south-asia-12662124>>.

<sup>72</sup> Ted Thornhill, 'Let my little girls die,' pleads father of 15-year-old conjoined twins suffering from blinding headaches', *Mail Online* (online), 21 June 2011 <<http://www.dailymail.co.uk/news/article-2006085/Allow-die-The-heart-breaking-plea-Siamese-twins-father.html>>.

entitled to treatment and medicines,<sup>73</sup> and the parents' pleas turned from mercy killing to financial assistance for medication and treatment for the girls.

These four cases show that the act-omission distinction has not been applied consistently as a means of determining the lawfulness of killings in a medical context. In cases other than conjoined twins, judges have refused to declare active killings — in effect voluntary euthanasia — lawful, but have accepted that so-called omissions that result in patient deaths are lawful. In conjoined twin cases, judges have taken the view that it is better to save one twin than allow both to die even if the only means of achieving this is the sacrifice — by means of a positive act on the part of the doctors who perform separation surgery — of one twin. In *Nicklinson v Ministry of Justice*,<sup>74</sup> the court refused to declare lawful the act of any doctor who would help Mr Nicklinson to die. On the other hand, in *Aarushi Dhasmana v Union of India*,<sup>75</sup> the court indicated it was prepared to order the sacrifice of one teenage conjoined twin, and in this situation a doctor's positive act would apparently be lawful.

### III SANCTITY OF LIFE, AUTONOMY AND CONSENT

*Airedale NHS Trust v Bland* is the only one of the four cases in which judges concurred with the wishes of the patient or the persons making decisions on the patient's behalf.<sup>76</sup> In *Re A (Children)*,<sup>77</sup> the conjoined twins' parents refused to consent to sacrificial separation surgery, but judges decided otherwise. The parents of the Shakeel sisters were also opposed to separation surgery, yet the judges in that case indicated they would have ordered separation, in contravention of the parents' wishes (and apparently against the wishes of the twins themselves) if one twin could be saved. Tony Nicklinson, on the other hand, wanted to die, but judges refused to declare lawful the actions of any doctors who helped him to end his life. Nicklinson's case is perhaps the greater abrogation of the principle of autonomy because Mr Nicklinson was competent and capable of making his own decisions about medical treatment, whereas the other three cases involved persons not legally competent.

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<sup>73</sup> Giridhar Jha, 'Bihar government finally awards conjoined twins disability certificate', *India Today* (online), 31 July 2012 <<http://indiatoday.intoday.in/story/bihar-government-conjoined-twins-saba-and-farah-shakeel/1/211176.html>>.

<sup>74</sup> [2012] EWHC 2381.

<sup>75</sup> (10 April 2013) Writ Petition (civil) No 232 of 2012.

<sup>76</sup> [1993] 1 All ER 821.

<sup>77</sup> [2000] 4 All ER 961.

According to Singer, the principle of respect for autonomy allows 'rational agents to live their own lives according to their autonomous decisions, free from coercion or interference; but if rational agents should autonomously choose to die, then respect for autonomy will lead us to assist them to do as they choose'.<sup>78</sup> Judges in a number of cases have emphasised that the right of an adult of sound mind to determine what shall be done with his or her own body is fundamental in our society.<sup>79</sup> According to Butler-Sloss P, 'the concepts inherent in this right are the bedrock upon which the principles of self-determination and individual autonomy are based. Free individual choice in matters affecting this right should, in my opinion, be accorded very high priority'.<sup>80</sup>

Lord Goff's endorsement of this 'libertarian principle of self-determination' in *Airedale NHS Trust v Bland* was referred to by Ward LJ in *Re A (Children)*.<sup>81</sup> Lord Goff said the principle of self-determination requires that the wishes of an adult patient of sound mind must be respected where this patient refuses, even unreasonably, to consent to treatment that would prolong his life.<sup>82</sup> He said that here 'the principle of the sanctity of human life must yield to the principle of self-determination'.<sup>83</sup> However, in cases of active killings, 'the interest of the state in preserving life overrides the otherwise all powerful interest of patient autonomy'.<sup>84</sup> The consent of a patient to his or her own death does not relieve doctors from criminal responsibility for homicide.<sup>85</sup>

It could be argued that there are pressing and cogent reasons for making an exception to this principle, and for giving priority to autonomy over the preservation of life in cases where a competent patient wants to end his or her own life, but does not have the physical wherewithal to do this. The sanctity of life is not absolute — the law does not

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<sup>78</sup> P Singer, *Practical Ethics* (2nd ed, Cambridge University Press, 1993) 195, discussed in Julia Werrem, Necef Yuksel and Saxon Smith, 'Avoiding a fate worse than death: An argument for legalising voluntary physician-based euthanasia' (2012) 20 *Journal of Law and Medicine* 184, 190.

<sup>79</sup> See, eg, *Schloendorff v Society of New York Hospital* (1914) 211 NY 125, 126 (Cardozo J), *F v West Berkshire Health Authority* [1989] 2 All ER 545, *Airedale NHS Trust v Bland* [1993] 1 All ER 821, *Ms B v An NHS Hospital Trust* [2002] EWHC 429 (Fam). In Australia, the right of adults to decide what should happen to their own bodies is principle approved by the High Court in *Rogers v Whitaker* (1992) 175 CLR 479, 487.

<sup>80</sup> *Re T (Adult: Refusal of Treatment)* [1993] Fam. 95, 116-117 (Butler-Sloss P).

<sup>81</sup> [1993] 1 All ER 821; *Re A (Children)* [2000] 4 All ER 961, 990 (Ward LJ).

<sup>82</sup> *Airedale NHS Trust v Bland* [1993] 1 All ER 821, 866.

<sup>83</sup> *Ibid.*

<sup>84</sup> *Ibid* 890.

<sup>85</sup> Law Commission, 'Murder, Manslaughter, and Infanticide' (Report, Law Com No 304, London, 2006), 145. The position is the same in Australia: see s 284 *Criminal Code 1899* (Qld), s 53 *Criminal Code 1924* (Tas), s 26 *Criminal Code 1983* (NT), *Boughey v The Queen* (1989) 161 CLR 10.



require the preservation of life at all costs. As the discussion above illustrates, judges have not applied the act-omission distinction consistently. Further, there is no ethical or moral difference between withdrawing treatment and mercy killing in locked-in syndrome cases (and indeed the latter may well be the more moral and ethical option). If the reason for the act-omission distinction is based on policy considerations, *Nicklinson's case* highlights the need for a change in policy and the law.

#### *A Exceptions to the Principle of Sanctity of Life*

In *Airedale NHS Trust v Bland*, Lord Goff recognised that the principle of sanctity of life is not absolute and that the law recognises exceptions, such as the taking of a life in self-defence.<sup>86</sup> In *Re A (Children)*, judges created another exception in the defence of necessity. In *Airedale NHS Trust v Bland*, Lord Goff conceded that doctors are not always required to prolong a patient's life just because treatment is available.<sup>87</sup> It is not appropriate to prolong a patient's life where the treatment is futile because there is no prospect of improvement. The invasiveness of the treatment and the indignity involved should also be taken into account.<sup>88</sup> According to Smith, it is absurd to suggest that life must be sustained at all costs. Not only would this involve 'the committal of vast resources to heroic, technologically daunting attempts to eke out the process of dying' it would be 'an insult to human dignity — and to common sense'.<sup>89</sup> In the case of a locked-in patient such as Mr Nicklinson, who himself decided that life and further life-prolonging treatment would be futile and undignified, refusing him access to euthanasia seems as great an affront to dignity and common sense. Suicide is no longer a criminal offence,<sup>90</sup> but patients like Mr Nicklinson cannot end their own lives quickly and painlessly.

Another example of an exception to the sanctity of life principle is cases involving defective neonates. Judges have held it is lawful to withhold life-saving treatment from young children where it would be cruel to prolong life, or where the child's life would be

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<sup>86</sup> *Airedale NHS Trust v Bland* [1993] 1 All ER 821, 866.

<sup>87</sup> *Ibid.*

<sup>88</sup> *Ibid* 870.

<sup>89</sup> A McCall Smith, 'Euthanasia: the strengths of the middle ground' 7(2) (SUMMER) *Medical Law Review* 194, 200.

<sup>90</sup> Michael Freeman, 'Denying Death its Dominion: Thoughts on the Dianne Pretty Case' (2002) 10 (Autumn) *Medical Law Review* 245, 247. Suicide and attempted suicide are also no longer offences in Australia. See Simon Bronitt and Bernadette McSherry, *Principles of Criminal Law* (Lawbook Co, 3rd ed, 2010) 547.

so 'demonstrably awful' and could even be regarded as cruel.<sup>91</sup> According to McHaffie, it is accepted practice to withhold treatment from severely deformed or handicapped neonates.<sup>92</sup> Yet an adult with locked-in syndrome could likewise be described as severely handicapped, and Tony Nicklinson's description of his future resonates with this: 'what I have to look forward to is a wretched ending with uncertainty, pain and suffering whilst my family watch on helplessly ... If I were able-bodied I could put an end to my life when I want to. Why is life so cruel?'<sup>93</sup> It seems inconsistent to allow defective neonates to die but not to allow locked-in syndrome patients the same outcome, where the patient's present or future quality of life is similar in both cases and a determining factor in the former cases but irrelevant in the latter. As Freeman says, the law is morally obtuse in that it discriminates against the disabled and privileges the incompetent over the competent.<sup>94</sup> However, the perpetuation of the act-omission distinction means that withholding treatment from a defective neonate is lawful, but the positive act of mercy killing a locked-in syndrome patient is unlawful.

#### B *Merciful Acts, Cruel 'Omissions'*

In *Nicklinson v Ministry of Justice*, Toulson LJ referred to Lord Mustill's comment in *Airedale NHS v Bland* that there is no ethical difference between withholding treatment from a patient and taking active steps to end a patient's suffering.<sup>95</sup> While this was probably true in *Bland's case*, because Bland would have suffered no pain or distress as he starved to death,<sup>96</sup> the same cannot be said in a case where a patient is fully conscious and cognisant of his surroundings. Mr Nicklinson could have refused to be given food or water, and his wishes would have had to be respected by medical staff,<sup>97</sup>

<sup>91</sup> *Re B (a minor)* [1981] 1 WLR 1421, discussed in *Re A (Children)* [2000] 4 All ER 961, 999 (Ward LJ).

<sup>92</sup> Hazel E McHaffie et al, 'Withholding/withdrawing treatment from neonates: legislation and official guidelines across Europe' (1999) 25 *Journal of Medical Ethics* 440.

<sup>93</sup> Caroline Davies, 'Locked-in syndrome sufferer begins high court battle for right to die', *The Guardian* (online), 23 January 2012 <<http://www.guardian.co.uk/society/2012/jan/23/locked-in-syndrome-high-court>>.

<sup>94</sup> Freeman, above n 94, 270.

<sup>95</sup> *Nicklinson v Ministry of Justice* [2012] EWHC 2381, [62] (Toulson LJ) referring to *Airedale NHS Trust v Bland* [1993] 1 All ER 821, 885 (Lord Mustill).

<sup>96</sup> *Airedale NHS Trust v Bland* [1993] 1 All ER 821, 871 (Lord Goff).

<sup>97</sup> *Airedale NHS Trust v Bland* [1993] 1 All ER 821, 877 (Lord Goff). In *Ms B v An NHS Hospital Trust* [2002] EWHC 429 (Fam), [99] Butler-Sloss P granted a declaration that a tetraplegic woman, dependent on a ventilator to live but mentally competent, had been treated unlawfully by a hospital in contravention of her request that the ventilator be withdrawn. Nominal damages were awarded which recognised the tort of trespass to the person. In Australia, *Brightwater Care Group (Inc) v Rossiter* [2009] WASC 229, the West Australian Supreme Court held that a hospital may not lawfully continue administering nutrition and

but he would have died a slow and painful death, distressing to him as well as his family and nursing staff.<sup>98</sup> It is difficult in such a case to argue that there is no ethical difference between this course of action and taking active steps to end his life, quickly and painlessly. Indeed, a strong sense of ethics may demand the latter course of action.

*C People, Policy, Parliaments and the Law*

It is interesting that in *Airedale NHS Trust v Bland*, Lord Mustill said that, as far as he was aware, 'no satisfactory reason has ever been advanced for suggesting that it makes the least difference in law, as distinct from morals, if the patient consents to or indeed urges the ending of his life by active means'.<sup>99</sup> The only possible reason he could proffer for this distinction is the interest of the state in preserving life.<sup>100</sup> Likewise, Lord Goff in *Airedale NHS Trust v Bland* and Toulson LJ in *Nicklinson v Ministry of Justice* suggest that policy reasons underlie the law's refusal to countenance any suggestion that mercy killing by means of a positive act is lawful.<sup>101</sup>

In light of the unique plight of locked-in patients, it could be argued that there are strong policy reasons and a public interest in the law facilitating a just and humane outcome, in accordance with the patient's wish to die. Wicks suggests that, in order to protect a strong autonomy interest, it may be justifiable to allow doctor-assisted suicide in cases where there is unbearable suffering and the patient is unable to take his own life unaided.<sup>102</sup> However, although Toulson LJ accepted that law can adapt and develop principles of common law to keep up with the requirements of justice, he said major changes on a matter of controversial social policy are for Parliament, and not courts of law.<sup>103</sup> Toulson LJ's reluctance to follow the Lords Justice in *Re A (Children)* and further develop the common law to accommodate Mr Nicklinson's predicament is

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hydration in contravention of the express wishes of a competent quadriplegic patient. In each of these cases, the patient was not terminally ill, but wanted to die.

<sup>98</sup> This was the prospect that the patient in *Ms B v An NHS Hospital Trust* [2002] EWHC 429 (Fam) feared if she agreed to the doctors' suggestion that she be weaned off the ventilator gradually. The proposed weaning programme would not include any pain control, and death would be slow and painful. Doctors did not dispute this. Ms B was also concerned about the distress to her loved ones who would have to watch her die slowly over several weeks. Instead, she wanted to be sedated and then have the ventilator withdrawn.

<sup>99</sup> *Airedale NHS Trust v Bland* [1993] 1 All ER 821, 890.

<sup>100</sup> *Ibid.*

<sup>101</sup> [1993] 1 All ER 821, 868; [2012] EWHC 2381, [74]-[75].

<sup>102</sup> Elizabeth Wicks, 'Positive and Negative Obligations under the Right to Life in English Medical Law: Letting Patients Die' in Jon Yorke (ed), *The Right to Life and the Value of Life* (Ashgate, 2010) 311, 329.

<sup>103</sup> *Nicklinson v Ministry of Justice* [2012] EWHC 2381, [79].

understandable given the failure of numerous recent parliamentary attempts to legalise medically assisted suicide,<sup>104</sup> and voluntary euthanasia in cases where self-administration of lethal medication was not possible.<sup>105</sup> Many of these failed attempts have occurred since the Court of Appeal's decision in *Re A (Children)*.<sup>106</sup>

In *Airedale NHS Trust v Bland*, Lord Lowry made the point that, in the area of criminal law that governs conduct, 'society's notions of what is the law and of what is right should coincide. One role of the legislator is to detect any disparity between these notions and to take appropriate action to close the gap'.<sup>107</sup> Werrem et al report that, in a number of surveys conducted between 2002 and 2009, 78-80 per cent of respondents were in favour of legalising voluntary euthanasia. By restricting such legislation to physician-based euthanasia, many of the ethical and policy concerns raised previously would be largely addressed.<sup>108</sup> These surveys suggest that the current status of the law in this area is out of kilter with public opinion. If legislatures either refuse or are unable to change the law,<sup>109</sup> it might behove judges to follow the lead of the Lords Justice in *Re A (Children)* and extend the common law to cover the specific dilemma of patients with locked-in syndrome as well as conjoined twins to achieve a just and humane result.<sup>110</sup> Parliament would then be able to legislatively amend any perceived aberrations.

#### D Judicial Activism or Humane Justice

Lord Justice Toulson is not alone in saying that any change in the law on assisted dying and voluntary euthanasia must be made by Parliament.<sup>111</sup> However, as Herring points out, Toulson LJ fails to acknowledge the difficulties facing Parliament and that the complexity and sensitivity of the issues involved.<sup>112</sup> Further, according to Freeman, despite repeated judicial remarks that disputed matters of social and public policy must be addressed by parliamentary democracy, 'this has not stopped the judges legislating in

<sup>104</sup> *Re A (Children)* [2000] 4 All ER 961.

<sup>105</sup> In *Nicklinson v Ministry of Justice* [2012] EWHC 2381, [45] – [49], Toulson LJ outlines several parliamentary attempts to change the law.

<sup>106</sup> [2000] 4 All ER 961.

<sup>107</sup> *Airedale NHS Trust v Bland* [1993] 1 All ER 821, 877.

<sup>108</sup> Werrem, Yuksel and Smith, above n 81, 191.

<sup>109</sup> According to Herring, above n 11, 10 Toulson LJ makes a powerful case for the difficulties in the court intervening in this area, but he fails to acknowledge the difficulties facing Parliament too. The complexity of the issues and sensitivity of the messages sent mean a legislative response is not automatically suitable.

<sup>110</sup> [2000] 4 All ER 961.

<sup>111</sup> See, eg, *Pretty v DPP* [2002] 1 All ER 1; *C v DPP* [1995] 2 All ER 43, *Re F (in utero)* [1998] Fam 122.

<sup>112</sup> Herring, above n 11, 10.

sensitive, contentious, controversy-ridden areas of medical law. What else was the *Bland* decision?’<sup>113</sup>

However, it could be argued that there was no need for the judges in *Nicklinson v Ministry of Justice* to follow the judges in *Re A (Children)* down the path of perceived judicial activism.<sup>114</sup> The latter had already run a gauntlet of extensive public, legal and academic criticism in sanctioning an active killing for the first time, and in overturning decades of settled law by making the defence of necessity available to doctors to excuse a positive act that resulted in a foreseen death. It would have been a relatively small step by the judges in *Nicklinson v Ministry of Justice* to extend the law laid down in *Re A (Children)* to cover the facts at hand.<sup>115</sup> The defence of necessity set out by Brooke LJ in *Re A (Children)* requires a need to avoid an inevitable and irreparable evil, that no more should be done than is reasonably necessary for the purpose to be achieved; and that the evil inflicted must not be disproportionate to the evil avoided.<sup>116</sup> It could be argued that each of these elements is met in the predicament of locked-in syndrome patients as Tony Nicklinson.

The judges in *Nicklinson v Ministry of Justice* could have avoided criticism that they were usurping the role of Parliament by following Ward LJ in *Re A (Children)*, who limited the application of his judgment to specific facts.<sup>117</sup> By making it clear that the necessity only applies to cases involving competent and fully-informed patients who want to die but are unable to kill themselves, the courts would ‘not be legislating, but acknowledging that in a particular case the criminal law should not apply’.<sup>118</sup> As Herring points out, the inability of Parliament to legislate for a generalised response to the legal and social issues raised by the assisted dying debate does not mean a legal solution cannot be

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<sup>113</sup> Freeman, above n 94, 265.

<sup>114</sup> [2012] EWHC 2381; [2000] 4 All ER 961.

<sup>115</sup> [2012] EWHC 2381; [2000] 4 All ER 961.

<sup>116</sup> [2000] 4 All ER 961, 1052

<sup>117</sup> [2012] EWHC 2381; [2000] 4 All ER 961, 1018, Ward LJ said: ‘Lest it be thought that this decision could become authority for wider propositions, such as that a doctor, once he has determined that a patient cannot survive, can kill the patient, it is important to restate the unique circumstances for which this case is authority. They are that it must be impossible to preserve the life of X without bringing about the death of Y, that Y by his or her very continued existence will inevitably bring about the death of X within a short period of time, and that X is capable of living an independent life but Y is incapable under any circumstances (including all forms of medical intervention) of viable independent existence. As I said at the beginning of this judgment, this is a very unique case.’

<sup>118</sup> Herring, above n 11, 10.

found to an individual case.<sup>119</sup> Allowing necessity to operate as a defence for doctors, in cases where patients are unable to commit suicide, is 'not an argument in favour of a wholesale change in the law'<sup>120</sup> but rather an extension of the defence, as applied in *Re A (Children)*,<sup>121</sup> to cover this specific situation.

#### IV CONCLUSION

Although judges have repeatedly drawn a distinction in criminal law between deaths that result from doctors' omission to treat patients and positive acts that result in patient deaths, the four cases discussed above show that the judges have not applied this distinction consistently. However, reliance on this distinction in cases other than conjoined twin cases means that the only lawful way for patients who want to die but who are physically unable to commit suicide is to refuse food, hydration and medical treatment, and to then face a slow, painful and distressing death by starvation or infection.

This paper acknowledges concerns about 'normalising' euthanasia,<sup>122</sup> the potential for abuse,<sup>123</sup> the vulnerability of some people,<sup>124</sup> the 'slippery slope' argument,<sup>125</sup> and suggestions that safeguards built into a legislative response would address much of the potential for abuse, but not all.<sup>126</sup> The submission by counsel in *Nicklinson v Ministry of Justice* that it is time for the common law to give respect to a locked-in patient's right to autonomy and dignity by recognising that voluntary euthanasia can provide a defence to murder by way of the defence of necessity has much to commend it.<sup>127</sup> In cases where a patient's physical condition makes it impossible for him or her to commit suicide and provided the patient is competent, fully informed and consents to being killed, necessity should operate to exculpate doctors from criminal responsibility for homicide. Such an

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<sup>119</sup> Ibid.

<sup>120</sup> Ibid.

<sup>121</sup> [2000] 4 All ER 961.

<sup>122</sup> K Greasley, 'R (Purdy) v DPP and the Case for Wilful Blindness' (2010) 30 OJLS 301, 318, discussed in Herring, above n 11, 10.

<sup>123</sup> Freeman, above n 94, 267, regards this as the greatest concern about euthanasia, and says this played a significant role in the judicial reasoning in cases such as *Pretty v DPP* [2002] 1 All ER 1.

<sup>124</sup> The concern is that vulnerable people will be pressured to seek out euthanasia, so as not to become a burden on their families. See Werrem, Yuksel and Smith, above n 81, 189, Herring, above n 11, 10.

<sup>125</sup> Werrem, Yuksel and Smith, above n 81, 189, say this argument is based on the idea that once voluntary euthanasia is legalised other forms of euthanasia will become politically, culturally and socially acceptable.

<sup>126</sup> Freeman, above n 94, 269.

<sup>127</sup> [2012] EWHC 2381, [50].

approach would give effect to the patient's right to autonomy, self-determination and dignity but would require an exception to the accepted legal position that only medical omissions that result in death can be lawful. By confining the application of necessity to cases where a patient is physically unable to kill him or herself, but is competent and provides fully informed consent to doctors who agree to help him or her to die, judges would not be making the major changes of controversial social policy that so concerned Toulson LJ in *Nicklinson v Ministry of Justice*.<sup>128</sup> As Herring says, the law 'needs to be tempered in the rare cases where upholding (the distinction between acts and omissions) works harshly for those seeking death or assisting them. We can acknowledge that in rare cases, compassion is met ... by using a defence of necessity'.<sup>129</sup>

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<sup>128</sup> Ibid [79].

<sup>129</sup> Herring, above n 11, 2013.

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