
Point of view

The Voluntary Euthanasia (Legalisation) Bill (1936) revisited

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Author's abstract

In view of the continuing debate on euthanasia, the restrictions and safeguards which were introduced into the Voluntary Euthanasia (Legislation) Bill 1936 are discussed. Proposals for a new Terminal Care and Euthanasia Bill are suggested, based on some of the principles of the Mental Health Act 1983.

Introduction

On 8th May 1990 a motion by Mr Roland Boyes to bring in a Bill to permit voluntary euthanasia was negatived in the House of Commons by 101 votes to 35 (1). In opposing the motion, Mr Anthony Nelson quoted from the report by the British Medical Association of May 1988 that:

'There is a distinction between an active intervention to terminate another person's life and a decision not to prolong life'.

and consequently that:

'An active intervention by anybody to terminate another person's life should remain illegal' (2,3).

However, there appears to be considerable support for the principle of active voluntary euthanasia, demonstrated both in surveys of public attitudes, which suggest that about three-quarters of the population are in favour of the concept (4,5), and in recent academic and professional opinion. For instance, the working party report of the Age Concern Institute of Gerontology and the Centre of Medical Law and Ethics at King's College, London, entitled 'The Living Will', commented in its introduction that:

'To change the law would appear to be in keeping with the logic of respect for autonomy reflected in this report' (6).

The arguments for legalising euthanasia may be divided, somewhat artificially, into the moral and the material, the moral arguments having been further divided by Glanville Williams several years ago into

those concerned with the prevention of cruelty and those involving the protection of liberty (7). The material arguments, particularly regarding the economic cost to families and the demographic burden to society of the increasing number of elderly members of the population (8), are perhaps more likely to prevail than the moral ones, but, in view of the inevitability of the potential for conflicts of interest between patients and those on whom they are dependent, these should give rise to caution in advocating any change in law or practice, and may be a reason for contemplating relatively restrictive rather than permissive legislation. The safeguards proposed in the 1936 Bill (9) may therefore be a more suitable model from which to start than the 'wide discretion' originally put forward by Glanville Williams (10) and currently defended by the Voluntary Euthanasia Society in their efforts to 'extend the options' open to the medical profession (11).

The 1936 Bill

The Voluntary Euthanasia (Legislation) Bill was introduced to the House of Lords by Lord Ponsonby, owing to the death of Lord Moynihan, President of the Royal College of Surgeons and first President of the Voluntary Euthanasia Legalisation Society. It was debated during its second reading on 1st December 1936.

The object of the Bill was to allow voluntary active euthanasia for patients requesting it who were of sound mind, who were over the age of 21 and who were suffering from an incurable and fatal illness accompanied by severe pain. It was not intended to provide for mercy-killing on a non-voluntary basis, and it set out to provide stringent safeguards against abuse. The proposal was that a patient requesting euthanasia would be required to sign an application in the presence of two witnesses. This application, accompanied by two medical certificates, would then be sent to an official euthanasia referee appointed by the Minister of Health, who would be obliged to interview the patient himself and be satisfied that the criteria of the Bill were being fulfilled and that the patient genuinely wanted to be enabled to die. If satisfied, he would then issue a licence so that euthanasia could be administered, but only in the presence of an official witness.

The Bill was defeated by 35 votes to 14, largely as a result of the speeches of the two medical peers, Lord Dawson of Penn and Lord Horder. In view of the intervention of World War II and the horror of the Nazi extermination campaigns, it was not until 1969 that another Bill was introduced, again unsuccessfully.

Lord Dawson's speech

Lord Dawson was openly sympathetic to the principle of euthanasia, stating, for instance that:

'When the patient is carrying a great load of suffering, our first thoughts should be the assuagement of pain even if it does involve the shortening of life'.

However, his speech is in some ways confusing. In discussing the Church's then refusal to allow suicides a consecrated burial, he stated that 'humanity compels a deception' in providing a verdict of temporary insanity but that 'such matters would have been very much better settled within the Church itself'.

He went on:

'And so it is with euthanasia. This is a matter the guidance of which properly lies within the medical profession itself: a profession very sensitive for its own honour and for the welfare and feelings of those it serves. The machinery of this Bill, not dissimilar from that employed for the certification of the insane, would turn the sick-room into a bureau and be destructive of our usefulness. The very idea of the sick-chamber being visited by officials and the patient, who is struggling with this dire malady, being treated as if it was a case of insanity – and the machinery is not very far from that – is something of which I hate to think. I believe I am right in saying – my noble friend may support me or not in this, but I think he will – that far from promoting that gentle growth of euthanasia in case of illness it would have the opposite effect. The doctors of this country would hesitate to touch it. They would not like to introduce such an atmosphere into the sick-chamber, and I believe not only that the law would remain nugatory but that it would deter those who are, as I think, carrying out their mission of mercy'.

This is a forthright defence of paternalistic authority. However, having criticised an intransigent Church for compelling humanity to use deception, he then appears to be advocating just such a deception in his argument for a wise and beneficent discretion. This has its place, and at times is entirely necessary, but the appropriate limits of the paternalistic role need to be carefully considered. Secondly, although he accepts the analogy between the suggested euthanasia legislation and that for mental illness, he regrettably shows a distinct contempt for the latter. Lastly, he demonstrates a remarkable and, some would think, significant inversion in his argument. The Bill was designed to

allow patients themselves to apply for voluntary euthanasia. Whether the doctors of this country would hesitate to touch such legislation is therefore irrelevant. The question, surely, is whether there are circumstances in which the patients of this country should have the right to appeal against their compulsory care.

Lord Horder's distinction

Lord Horder disclosed similar 'misgivings' at the proposed 'intervention of the bureau, as replacing that complete confidence and understanding which is one of the most satisfactory of all human relationships'. Again one wonders whether all patients feel quite so ecstatic about their relationships with their doctors.

He also acknowledged that when a doctor was unable to cure, he had twin duties; 'to prolong life so far as may be, and to relieve pain, that worst of evils, both bodily and mental'. He went on to suggest:

'Be it observed that the good doctor is aware of the distinction between prolonging life and prolonging the act of dying'.

This distinction is both interesting and important. It leads to the possibility that there may be a significant difference between acts which are seen to affect the cause of death and those which merely influence the mode of dying.

Consider the following clinical vignette:

A few years ago I was called one evening to see a middle-aged man who had been suffering from respiratory insufficiency for a number of years as a consequence of fibrosing alveolitis, for which he had been extensively investigated and treated in the local hospital. I was called to see him by his wife, who was herself in a state of considerable distress as she had watched him suffering from increasing breathlessness for the previous three days, and he had refused readmission to hospital. During this time he had been seen by his own doctor on several occasions.

After discussion with his wife in his presence, and with her approval and his apparent agreement although he was no longer capable of giving an unambiguously valid consent, I gave him a small dose of diamorphine. About an hour later I certified his death, and was profusely thanked by his wife for my intervention.

Presumably it could be argued that I killed him and that I should be regarded as negligent if not legally culpable. This would undoubtedly have been true had he been suffering from a potentially reversible asthmatic attack. I think that my defence is due to Lord Horder's distinction. While I obviously influenced the mode of his dying from that of exhaustion as a result of his respiratory effort to stupor associated with respiratory depression, I do not feel that I altered the cause of his death, which remained respiratory insufficiency secondary to fibrosing

alveolitis. The important diagnosis to make was that he was inevitably dying in any case.

Parallels with the Mental Health Act 1983

The distinction between influencing the mode of dying and altering the cause of death is perhaps arbitrary and arguably captious. However, it resembles the distinction between an emergency decision and an elective one to treat a psychiatric patient against his wishes, when an elective decision has to be taken under the terms of the Mental Health Act, but an emergency one may sometimes be justified under common law on grounds of urgent necessity. It may therefore be of relevance in attempting to excuse an 'active intervention' which 'terminates a patient's life' when the patient is already near to death. The concept of 'emergency' apparently constitutes an accepted defence under Article 40 of the Dutch Penal code (12).

This corresponds to Glanville William's argument for 'the prevention of cruelty', and may only require clarification rather than any change in the law. However, at what may be seen as the other end of the Mental Health Act, there is a mechanism which corresponds to his argument for 'the protection of liberty'. This is the right of a detained patient to appeal to a Mental Health Review Tribunal against the decision of his doctor to treat him against his wishes. This is clearly reminiscent of the bureau mentioned in the debate on the 1936 Bill. It may be that this is the most appropriate model for a machinery to control patients' requests to have their lives ended on an elective basis.

However, between the two extremes it could be argued that the BMA's current stance should be encouraged to continue; to allow for passive non-treatment decisions but to forbid active euthanasia, even if voluntary. Perhaps the best that could be achieved here would be to extrapolate from the Mental Health Act Commission to set up a Terminal Care Commission to facilitate models of terminal care on the lines evolved by the hospice movement so as to 'promote that gentle growth of euthanasia' in its more general sense.

Suggestions for change

Three suggestions for change or consolidation can be offered:

1. In order to 'prevent cruelty', the law on Lord Horder's distinction should be clarified so as to reassure patients that they need not suffer unnecessarily when *in extremis*, and to ensure that doctors do not expose themselves to undue risk of retrospective legal censure. This is in keeping with current practice in Holland.

2. In line with both the 'cruelty' and the 'liberty' arguments, a Terminal Care Commission could be set up so that doctors, patients, and, if desired, relatives, would be able to request second opinions to facilitate

the taking of non-treatment decisions, to reduce the incidence of inappropriately aggressive therapeutic interventions in those with inevitably terminal illnesses, and to help contain the anxieties associated with uncertainty.

3. Emphasising the 'liberty argument', it would be possible to institute a system of Euthanasia Tribunals to whom patients (and perhaps their next of kin or guardians) could appeal, in order to legitimate elective active voluntary euthanasia on a prospective, or anticipatory, basis. Criteria could be specified to ensure that it would only be carried out on those who, for instance:

- a) Understood the nature of the application that they were making;
- b) And had an enduring and a considered wish to die, and were not under any form of external duress or coercion, either for financial or for other reasons;
- c) And were suffering from a condition which was both permanent and incurable, and which was causing them significant distress;
- d) And were not suffering from any distortion of judgement due to temporary or treatable psychiatric illness.

The intention would be to assist patients in the exercise of their present liberty, under the Suicide Act 1961, to choose to die, but only if and when it appeared compassionate to do so, and without in any way converting that liberty into a right which could be acted upon inappropriately or capriciously.

In view of the greater gravity of the issue being examined, the Tribunal might comprise five members, rather than the three of the Mental Health Review Tribunals.

1. A chairman, with a suitable legal qualification and experience.
2. A medical practitioner, with a special interest in the illness from which the patient suffers.
3. A psychiatrist, in order to exclude the presence of treatable mental illness, and to provide a psychotherapeutic input if required.
4. A solicitor or social worker, to examine the social and especially the financial implications of the death being contemplated, in order to minimise the possibility of duress.
5. A layperson, to provide a balancing and general perspective.

This is clearly the most radical of the three suggestions, in that it overturns the tradition of compulsory submission to theological doctrine and to medical authority. However, it is difficult to see that in a free society it should not be available. Perhaps it is appropriate to illustrate it with a second vignette:

A 75-year-old widow recently underwent a laparotomy

for a cancer of the stomach which was found to be inoperable. She lives alone, having witnessed her husband's slow death from cancer of the lung in a nursing home a few years ago. While she has nothing but praise for the care that he then received, she personally does not think that she would feel that life in such a home would be 'worthwhile' to her, and therefore she would like to request assistance to take her own life, sitting in the garden that she made with her husband, when she no longer has the ability to look after herself at home. Her family, who visit her regularly, have no objections to this decision if this is what she wants.

It seems to me that tribunal members would not have to take it on themselves to decide whether they personally thought that such a life would be worthwhile, or even whether or not they approved of her choice, but merely whether such a request met the criteria and was freely made in good faith while of sound mind. For society to refuse to tolerate such requests seems an infringement of the liberty of the individual, and perhaps indicates a willingness to use the lives of patients as means for somewhat doubtful social or philosophical ends. If, therefore, such requests should be granted in the absence of strong arguments to the contrary, what are these arguments to the contrary?

The arguments to the contrary

Returning to Mr Nelson's speech in opposition to Mr Boyes's motion, he listed four fundamental objections:

1. 'It would materially undermine the sanctity of life'.

Mr Nelson then used the wedge argument to defend the theological concept of the sanctity of life. While no one would dispute Mr Nelson's right to hold and use such concepts, it is less obvious that it should be considered acceptable for society to overrule a patient's wish to terminate his own suffering if the end justifying this decision is the defence of a theocratic world view that the patient himself does not share.

2. 'It would open the way to serious abuses'.

This seems a much more substantial argument and I believe needs to be reflected in relatively 'restrictive' rather than 'permissive' legislation as outlined above.

3. 'It is far from clear that the medical profession would go along with the proposal'.

It is very unclear, bearing in mind that the BMA's report was commissioned as a result of a vote at its annual representative meeting, that the views expressed in the report reflect those of the majority of the profession. It is in any case debatable to what extent our legislators should be bound by the opinions of one particular vested interest, however powerful, respected and well-informed this may be. As Ludovic

Kennedy and others have pointed out (13), the medical profession has historically also opposed the introduction of analgesia in childbirth, of contraception and of abortion.

4. 'It would undermine much of the splendid work of the hospice movement'.

I suppose that this would be by depriving them of clinical material, rather in the same way that abortion services presumably might be held to undermine the splendid work of those who seek to care for single mothers. This argument is nonsense. The proposal for a tribunal outlined above would merely complement the achievements of the hospice movement, and could be available within an integrated service as an option for those who might wish to consider it, and be entirely ignored by those who might prefer to reject it on religious, philosophical or any other grounds.

If the balance to the protection of liberty is the defence of security, perhaps one underlying reason for the opposition to the change in the law on euthanasia concerns the containment of anxiety at both personal and social levels (14) by the means of defensive solutions, and the increase in perceived anxiety if these solutions are challenged. If society, as represented by our legislators, elects to avoid anxieties over death by postures of dependency on the medical profession, as exemplified by Mr Nelson's speech, the profession is likely to respond by adopting restrictive solutions in order to cope with the responsibilities involved, principally in order to contain its own levels of anxiety. It is not then useful for laymen like Ludovic Kennedy to accuse the profession of being 'prejudiced, irresponsible and cowardly' even if all these things may possibly be true. A more useful response might be to design and advocate models whereby, on the liberty argument, patients would take responsibility for their own decisions rather than being encouraged to project this responsibility onto their doctors, and on the more paternalistic cruelty argument concerning non-voluntary euthanasia, adequate resources were provided to support the profession so as to be less defensive in taking non-treatment decisions in anticipation of patients' deaths.

However, there is also a realistic concern that any attempt to legalise euthanasia as a 'right to die' would be open to abuse by those with a masochistically motivated lust for renunciation, or would provide an opportunity for the manipulative control of others by patients with patterns of passive hostility towards those on whom they become dependent. It would be necessary for society to construct an adequate administrative process for the containment of such destructive patterns and passions, and the tribunals described may be offered as one suggestion whereby this might be achieved.

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