MENTAL INCAPACITY, BEST INTEREST AND CRIMINAL LIABILITY. A CASE STUDY

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1. Introduction

"This is medical murder". A middle-aged woman screams these words in front of the Royal Courts of Justice in London. She is a member of the "Charlie's army", the group protesting against the decision to remove 11-month-old Charlie Gard from life support[1]. The huge media coverage of the Charlie Gard case rekindled the debate relating to withdrawing life-sustaining treatment ("LST") from patients without capacity. The choice to withdraw or withhold[2] LST is an almost unbearable burden on all the actors involved: the doctors, the parents/guardians and the judges, who are asked to make a decision in case of disagreement among the aforementioned. The legal consequences can be extreme, leading to a criminal prosecution for murder.

From a criminal point of view, it is necessary to highlight the difference between voluntary and non-voluntary active euthanasia and withdrawing/withholding LST. Voluntary active euthanasia consists in administering lethal treatment to a patient, in accordance with his/her wish to die. It is a crime under the Suicide Act 1961 (Art. 2, Criminal liability for complicity in another's suicide). Non-voluntary active euthanasia is the euthanasia of a person without capacity and amounts to murder or manslaughter.

[1] Lusher A., 'Meet Charlie Gard's army as they take on Britain's courts and medical experts: 'This is murder. The doctors are lying'', Independent, 13 July 2017.

[2] Withdrawing means the removal of a therapy that was started in an attempt to sustain life but is not, or is no longer, effective. Withholding means the decision not to make further therapeutic interventions. See J.L. Vincent, 'Withdrawing may be preferable to withholding', Critical Care, 2005, 9(3), 226-229.

Although some commentators dismiss such distinction as "moral fictions"[3], withdrawing/ withholding LST is generally considered lawful. Indeed, the principle of consent to treatment means that the patient has the right to refuse treatment, but not to ask "active assistance in death"[4]. The structure of criminal liability, i.e., the difference between action and omission, has consequences for the doctors' liability.

The request to withdraw the LST can be made only by a mentally capable patient. In case of incapacity, according to the Mental Capacity Act 2005 ("MCA"), doctors must act according to the best interest of the patient[5].

If continuing the treatment is in the best interest of the patient, withdrawing or withholding the treatment has the same criminal significance of murder. Indeed, the elements of murder are present: the unlawful killing of another person (*actus reus*) and the criminal intent (*mens rea*)[6]. On the contrary, if the LST is not in the best interest of the patient, the doctors have no duty to continue with it. Because an omissive conduct is criminally relevant only if there is a duty to act, withdrawing a futile treatment does not give rise to criminal liability. The patient's death is deemed to be caused by his pre-existing illness or injury and there is no *mens rea* (or, more properly, in absence of the objective element, the issue of *mens rea* does not arise at all)[7]. Therefore, the application of the best interest principle should protect doctors from the risk of facing prosecution following their decisions on LST. But is it sufficient?

The *Bland* case

The first English case relating to withdrawing LST was the Bland case in 1993[8]. The conclusions reached in this case are the result of a twenty-year debate among scholars, that arose from *Quinlan*, a landmark American case. In 1975 the 21 years old Karen Ann Quinlan went into a persistent vegetative state following assumption

[3] Miller F.G. *et al.*, 'Moral fictions and medical ethics', Bioethics, 2010, 24(9), 453-460, p. 453.

[4] Brazier M., Ost S., Medicine and Bioethics in the Theatre of the Criminal Process, Volume 3, Cambridge University Press, 2013, p. 153.

[5] Mental Capacity Act 2005, part 1, art. 1(5).

[6] Williams G., 'Intention and causation in medical non-killing: the impact of criminal law concepts on euthanasia and assisted suicide', in edited by McLean S., Biomedical Law and Ethics Library, Routledge, 2007, p. 1.

[7] Ibidem, pp. 55 and 73.

[8] *Airedale National Health Service Trust v Bland* [1993] AC 789.

of a mix of alcohol and Valium. The New Jersey Supreme Court, requested by Quinlan's parents, authorized to remove the patient from the respirator. Unexpectedly, she continued to breath alone and could live for nine years more, receiving artificial nutrition. Taking into account both legal arguments and moral concerns, English commentators developed principles that are the basis of today's approach to end-of-life issues: the definition of withdrawing treatment as an omission, the rule of consent for capable patients, the relationship between best interest and quality of life[9].

In *Bland*, although it was a civil case, criminal law matters were widely discussed[10]. Indeed, a Roman Catholic activist, Fr. Morrow, unsuccessfully required the Bingley Magistrates to issue a summon charging Anthony Bland's treating doctors for murder. The High Court dismissed the appeal on grounds that "a declaration by a civil court should normally inhibit a future prosecution"[11].

Anthony Bland was 17 years old when he suffered "a severe crushed chest injury which gave rise to hypoxic brain damage". This led to a "persistent vegetative state" without any hope of recovery or improvement of any kind. The Airedale NHS Trust (which was responsible for administering the Airedale General Hospital, where Bland was hospitalized), in agreement with Bland's parents, asked the Court to declare "that the trust and their responsible physicians may lawfully discontinue all life-sustaining treatment and medical support measures designed to keep Anthony Bland alive in his existing persistent vegetative state including the termination of ventilation, nutrition and hydration by artificial means"[12].

The *Bland* case raised for the first time in the English courts the following question: in what circumstances, if any, a doctor can lawfully withdraw the LST, thus leading to the patient's death? Furthermore, it raised the question of the difference between the treatment of capable patients and incapacitated patients. The Court highlighted the risk that an unconscious patient might be "subjected to thera-

[9] Huxtable R., 'Euthanasia, ethics and the law: from conflict to compromise', in edited by McLean S., Biomedical Law and Ethics Library, Routledge, 2007, pp. 117-118.

[10] In the words of one of the Lords who heard the case, the judiciary was "embarked on a kind of proleptic criminal trial, without charge, jury or verdict", *Bland*, p. 71.

[11] *R v Bingley Magistrates' Court, ex parte Morrow* [1985] (unreported), cited in Coleman M., The Assessment and Rehabilitation of Vegetative and Minimally Conscious Patients, Psychology Press, 2005, p. 241.

[12] *Bland*, p. 2.

peutically useless treatment contrary to good medical practice and medical ethics which would not be inflicted upon those able to choose"[13]. Indeed, administering a treatment to a capable patient without his consent constitutes both a tort and a crime (battery)[14]. In case of unconsciousness, the refusal to treatment might have been expressed at an earlier date, before the patient became unconscious[15]. However, as noted by the Court, "in many cases not only may the patient be in no condition to be able to say whether or not he consents to the relevant treatment or care, but also he may have given no prior indication of his wishes with regard to it"[16]. The last is obviously the most problematic case from a juridical (as well as ethical) point of view, since the doctor's criminal liability cannot be excluded on the basis of the patient's refusal to treatment.

One of the Judges in *Bland*, Lord Mustill, complained that the criminal court, and not the civil court, was the appropriate place to discuss the case. He pointed out that "it is a great pity that the Attorney-General did not appear in these proceedings between private parties to represent the interests of the state in the maintenance of its citizens' lives and in the due enforcement of the criminal law"[17]. According to Lord Mustill's view, the criminal justice system had failed its duty to protect the life of the incapacitated person. Ultimately, the doctors who withdrew the LST in *Bland* did not face prosecution. But the sole fact that such a hypothesis was advanced shows that doctors who are called upon to decide between the life and death of patients without capacity are exposed to a great risk.

2. The criminal justice response to euthanasia and withdrawal of LST

The difference that exists between patients with and without capacity does not only affect the medical treatment they receive, but also the criminal justice response to their death. It is generally agreed that "a fatal failure to meet a duty to care for a

[13] Ibidem, p. 28.

[14] The concept has been reiterated by Lady Hale in *Aintree University Hospitals NHS Foundation Trust v James* [2013] UKSC 67.

[15] Within the MCA, any adult and capable person can make an advance directive, refusing treatment in the future should certain circumstances arise (art. 24). Planning for future incapacity can also take the form of a Lasting Power of Attorney (art. 9).

[16] *Bland*, p. 49.

[17] Ibidem, p. 72.

dependent can amount to murder or manslaughter"[18]. Following the adoption of the Mental Capacity Act, the best interest principle and the establishment of a new concept of quality of life increased the medical rights of the persons without capacity. But has the criminal justice system succeeded in protecting the interests of the weakest?

The *Arthur* case and the *Re B (A minor)* case

In 1981 Doctor Leonard Arthur was charged with the murder of a new-born patient, John Pearson. Pearson had Down syndrome and additional abnormalities (unknown at the time of the birth). The parents did not want him to survive. Arthur prescribed an opiate based painkiller and, as a result, the child died three days after his birth[19]. Ultimately, the doctor was acquitted because the jury thought it necessary to "draw the line" between murdering the patient and letting him die (or, in the words of the Judge, "allow nature to take its course"[20]).

This decision leaves room for several questions. Firstly, it considered Down syndrome in the same way as a lethal disease, impairing the patient's life so much that it would have been preferable for him to die. Secondly, the difference with capable patients is self-evident: if the patient, who suffers from an almost certainly lethal disease, is a capable person and consents to treatment, no one would justify letting him die as "allow nature to take its course".

In the *Re B (A minor)* case, also of 1981, the Court of Appeal authorized life-saving surgery for a child suffering from Down's syndrome against her parents' wishes[21]. In so doing, the Court applied the best interest principle, as there was no evidence that the patient's life was going to be intolerable. As expressed by one commentator, "the homicide law at that point held that a duty of care was owed to even the most compromised individual"[22].

The best interest principle has since been codified in the MCA[23]. The duty to

[18] Huxtable R., 'Clinic, courtroom or (specialist) committee: in the best interests of the critically ill child?', J Med Ethics, 2018, 44(7), 471-475, p. 471.

[19] *R v Arthur* [1981]12 BMLR 1.

[20] *Arthur*, p. 5.

[21] *Re B (A Minor)* [1981] 1 WLR 1421.

[22] *Re B*, p. 126.

[23] Mental Capacity Act 2005, part 1, art. 1(5).

consider the best interest of the person without capacity represents a milestone in the doctor-patient relationship, but it is also a vague formula that may be difficult to apply in practice. Paragraph 5.31 of the MCA Code of Practice states that: "All reasonable steps which are in the person's best interests should be taken to prolong their life. There will be a limited number of cases where treatment is futile, overly burdensome to the patient or where there is no prospect of recovery".

This rule leads to multiple questions. In particular, legal commentators and practitioners are divided over the meaning of futility[24]. In *Aintree v James*[25] the definition of "futile treatment" was analyzed from two different points of view. The treatment could be deemed futile in the sense that it could only return the patient "to a quality of life that is not worth living"; accordingly, "recovery does not mean a return to full health, but the resumption of a quality of life that [the patient] would regard as worthwhile"[26]. From a different point of view, futility should be judged in relation to "the real prospect of curing or at least palliating the life-threatening disease or illness"[27].

The Supreme Court concluded that "where a patient is suffering from an incurable illness, disease or disability, it is not very helpful to talk of recovering a state of 'good health'. The patient's life may still be very well worth living. Resuming a quality of life which the patient would regard as worthwhile is more readily applicable, particularly in the case of a patient with permanent disabilities. [...] it is not for others to say the life which the patient would regard as worthwhile is not worth living"[28].

The principle, that ultimately led to doctor Arthur's acquittal, that in treating incapacitated patients doctors can "allow nature to take its course" seems to have been definitively abandoned. Moreover, as noted by one commentator, in the *Arthur* judgement "of all the judge's references to John Pearson, 70 per cent were impersonal ("the child"), 7 per cent used his name and, most shockingly, 23 per cent

[24] Hoyano L., 'Withholding potentially life-sustaining treatment and the Mental Capacity Act 2005', Journal of Social Welfare and Family Law, 2014, 36(2), 214-216, p. 215.

[25] *Aintree University Hospitals NHS Foundation Trust v James* [2013] UKSC 67.

[26] *Aintree*, p. 14.

[27] Ibidem, p. 2.

[28] Ibidem, p. 18. The same idea was expressed by one of the judges in *Re B*: "[The patient] should be put in the same position as any other [down] child and must be given the chance to live an existence" (p. 930).

objectified the patient as 'it'"[29]. In *Re B* the Court showed a different sensitivity towards the patient without capacity, who should be entitled to the same rights as any other, i.e. the right to live a life accordingly to his possibilities and to be cared for in the best possible way. The fact that he has an incurable disease or disability should be irrelevant, as long as his future life is likely to be worth living from his point of view. This new approach was consolidated by the adoption of the MCA, the subsequent jurisprudential evolution, together with a new social attitude towards mental incapacity. A case similar to *R v Arthur* nowadays would probably have a very different outcome.

3. Futility of treatment and best interest in relation to different categories of patients

The concept of "futility of treatment" introduces a subjective element in the assessment of best interest. Best interest does not necessarily coincide with medical interest, because the first one encompasses consideration of the future quality of life of the patient. The existence of different categories of patients involves a differentiated approach in the research of their best interest.
If the patient is unconscious and with no prospect of improvement, medical interest and best interest coincide: withdrawing the treatment is the best option beyond the strictly medical point of view[30]. Conversely, a chance of future improvement can justify the ordeal of being kept artificially alive. Patients in permanent vegetative state "are unconscious, dependent on the care of others even for the most elementary physical needs and face gradual physical degradation. Immobility and the impossibility of ingesting food – among other conditions – cause extreme weight loss, sores, and mean that patients are highly vulnerable to infections. The physical appearance of the patient changes dramatically, notwithstanding passive physiotherapy and nursing care"[31]. Indeed, the image of a motionless and peacefully sleeping patient, that most people have, is far from the reality. Moreover, there are cases in which it is impossible to ascertain if the patient is in pain. When this happens, receiving the LST can be in the interest of the patient, but not in his best interest: as

[29] Huxtable R., 'Euthanasia, ethics and the law: from conflict to compromise', in edited by McLean S., *Biomedical Law and Ethics Library*, Routledge, 2007, p. 111.

[30] Skene L., 'Disputes about the Withdrawal of Treatment: The Role of the Courts', *International and comparative Health, Law and Ethics: a 25-year retrospective - winter 2004*, 701-707, p. 703.

[31] Moratti S., The Englaro case: withdrawing treatment in Italy from a patient in permanent vegetative state, EUI Working Papers, MWP, 2012/04, p. 6.

the *Gard* case will illustrate, a weighing operation must be performed between the suffering that the patient is (or might be) experiencing and the perspectives of recovery, especially when the chance is minimal.

Withdrawing LST from patients without capacity: the *Gard* case[32]

Charlie Gard was born with a rare genetical disorder that affected his brain, muscle and ability to breathe. In addition, he had congenital deafness and severe epilepsy. His heart, liver and kidneys were also mildly affected. In the same period, an American physician, Dr. Hirama, was working on an experimental treatment called nucleoside therapy. The doctors who treated Charlie judged such therapy potentially painful but incapable of achieving anything positive, due to the patient's severe and irreversible brain damage. Moreover, it was impossible to ascertain whether or not the patient felt pain. While the treatment was discussed, Charlie suffered epileptic seizures that damaged his brain further. Eventually, all the treating doctors (including Dr. Hirama) agreed that the patient was "beyond any help even from experimental treatment". After months of medical discussion and judicial battle, Charlie's parents withdrew their challenge to stopping ventilation and proceeding with palliative care. Charlie Gard died on July 28, 2017 at the age of one.

Withdrawing life sustaining treatment from a child should be the result of a joint decision between doctors and those who have parental responsibility. Within this shared decision-making process, parents have a duty to act according to the child's best interests and doctors cannot be compelled to provide a certain treatment[33]. If a dispute between the parents and the treating doctors arises, either of the parties can apply to the court for a determination of whether it is in the child's best interests to provide the requested treatment.

As mentioned above, the concept of best interest is broader than the concept of medical interest. In the words of Justice Francis in *Gard*, "the term 'best interests' encompasses medical, emotional, and all other welfare issues. The court must conduct a balancing exercise in which all the relevant factors are weighed"[34].

Ultimately, Charlie's parents acknowledged that their child's present life was

[32] *Great Ormond Street Hospital v Yates and Gard* [2017] EWHC 972 (Fam).

[33] Close E. *et al.*, 'Charlie Gard: in defense of the law', J Med Ethics, 2018, 44(7), 476-480, p. 476.

[34] *Gard*, p. 8. According to the Children Act 1989, part 1, art. 1(2), "the child's welfare shall be the court's paramount consideration".

not worth sustaining unless treatment was available[35]. Nonetheless, the *Gard* case was different from *Bland*, where the patient's condition was irreversible: Charlie had a minimal hope of recovery, but there was the risk that he was suffering, and that treatment would only increase his pain. From this point of view, Charlie's situation was more similar to that of John Pearson in the *Arthur* case. Indeed, according to Doctor Arthur's defence, he had acted to prevent baby Parson from future suffering.

One of the many activists, who gathered outside the Supreme Court waiting for the judgement on the *Gard* case, said: "I don't believe for one minute that Charlie is suffering, and if he is suffering, it's better than being dead"[36]. This may seem a trivial feeling but establishing when doctors could (or should) let the patient die to prevent him from suffering is a very difficult task, especially when there is some hope of recovery. In conclusion, the *Gard* case shows that the question of how to ascertain the best interest of the persons without capacity is far from being answered in practice. That is why this case attracted so much public attention, becoming "the embodiment of a passionate debate over his right to live or die" and "inflam[ing] an international debate over end-of-life rights"[37].

Physical disability and intellectual disability

With particular reference to new-born children, physicians highlight how "the single most important factor in discussions on withdrawal of treatment is the presence (or predicted presence) of severe intellectual disability. [As a consequence,] "where intellectual disability is not present (or predicted), even when the child's prognosis is very grim, or includes substantial physical disabilities, there is often a reluctance to countenance anything less than maximal treatment"[38]. But does severe intellectual disability necessarily impair the quality of life of the patient to such an extent that it would be better to end it? Quality of life is a flexible concept and "even very severely handicapped people find a quality of life rewarding which to the unhandicapped may seem manifestly intol-

[35] *Gard*, p. 14.

[36] Lusher A., 'Meet Charlie Gard's army as they take on Britain's courts and medical experts: 'This is murder. The doctors are lying", Independent, 13 July 2017.

[37] Bever L., "Our beautiful little boy has gone': Parents of Charlie Gard say he has died', The Washington Post, 28 July 2017.

[38] Wilkinson D., 'Is It in the Best Interests of an Intellectually Disabled Infant to Die?', J Med Ethics, 2006, 32(8), 454-459, p. 455.

erable"[39]. Moreover, severe intellectual disability does not cause physical suffering per se, although "many people with severe intellectual disability also have major physical disabilities or illnesses [...] and intellectual disability may impair an individual's ability to bear suffering. For people with severe intellectual disability, even a routine trip to the dentist or to the doctor can be a terrifying ordeal"[40]. Nonetheless, the idea that severe intellectual disability alone justifies a lack of treatment (or terminating LST) is highly discriminatory. As it will be explained in the following section, the introduction of a new offense of mercy killing could end this discrimination.

4. Murder, voluntary manslaughter and mercy killing: current discipline and future perspectives

The *Inglis* case and the *Gilderdale* case

In both cases, parents faced a criminal trial for having killed their children in order to terminate their sufferings. In 2014 Frances Inglis was convicted of murdering her son Thomas, who was in a vegetative state due to serious head injuries[41]. Four years before, in 2010, Kay Gilderdale, was acquitted of the attempted murder charge, following the death of her paralyzed daughter, Lynn[42].

The only difference between the two cases is that Lynn was only physically disabled, while Thomas was unconscious[43]. This circumstance did not lead to a different incrimination but was decisive to the verdict of not guilty in *Girdeldale.* In the words of one newspaper report, the jury "had been visibly moved by the account of two parents struggling to come to terms with the realization that their daughter had lost the will to fight a debilitating condition"[44]. Indeed, "Kay Gilder-

[39] Justice Cazalet in *A National Health Service v D* [2000] 2 FLR 687.

[40] Wilkinson D., 'Is It in the Best Interests of an Intellectually Disabled Infant to Die?', J Med Ethics, 2006, 32 (8), 454-459, p. 457.

[41] *R v Inglis* [2011] 1 WLR 1110.

[42] *R v Gilderdale* [2010] (unreported).

[43] Art.4(5) of the MCA states that "Where the determination relates to life-sustaining treatment [the person making the determination] must not, in considering whether the treatment is in the best interests of the person concerned, be motivated by a desire to bring about his death".

[44] Bird S., 'Devoted mother Kay Gilderdale should never have been prosecuted, says judge', The Times, 26 January 2010.

dale's actions were presented by the defence as reluctant assistance in the face of her daughter's determined wish to die, carried out because of her devotion to her"[45].

The portrait of Mrs Inglis during the trial was completely different. She emerged as unstable and obsessed with ending her son's life. Her defence was ultimately of no use: "The definition of murder is to take someone's life with malice in your heart. I did it with love in my heart, for Tom [...] I believed it would have been Tom's choice to have been allowed to die rather than have the intervention to keep him alive"[46].

It is evident that motivation, which should be irrelevant in criminal law, had a fundamental importance in determining the different outcome of the two cases: Mrs. Gilderdale "responded to her daughter's desperate request for help, whereas Thomas Inglis did not have capacity to consent"[47]. When the victim is physically incapacitated, homicide law is applied in a different way than when the victim is mentally incapacitated. Nowadays the principle of consent governs the doctor-patient relationship, also in relation to life-saving treatments. In the word of one commentator, "the patient's interest in self-determination gives the patient a right to die"[48]. Do we have to conclude that persons without mental capacity, who do not have the right to self-determination, are also deprived of the right to die?

A new offense of mercy killing

The introduction of a new autonomous offense of mercy killing could remove the above-mentioned discrimination. It would allow to focus the attention on the perpetrator and not on the victim (and the fact that the last has – or lacks – mental capacity). Under the current law, mercy killing can constitute murder or manslaughter by reason of diminished responsibility, depending on the circumstances[49].

[45] Brazier M., Ost S., Medicine and Bioethics in the Theatre of the Criminal Process, Volume 3, Cambridge University Press, 2013, p. 132.

[46] Pidd H., 'Mother guilty of murdering disabled son', The Guardian, 20 January 2010.

[47] Brazier M., Ost S., Medicine and Bioethics in the Theatre of the Criminal Process, Volume 3, Cambridge University Press, 2013, p. 132.

[48] Mclean S., 'Assisted dying: reflections on the need for law reform', in edited by Mclean S. Biomedical Law and Ethics Library, Routledge, 2007, p. 96.

[49] Art. 2 of the Homicide Act 1957. The doctrine of diminished responsibility provides a mitigating defence in cases in which a person suffers from such abnormality of mind as to substantially impair his responsibility in committing or being a party to an alleged violation, and the mental disease or defect is not of such magnitude as to exclude criminal responsibility altogether. Generally, the de-

In particular, mercy killing can be defined as "a killing where the killer genuinely believes that it is in the best interests of the victim to die, for example, because the victim is terminally ill and in great pain. A mercy killing is a consensual killing only if the victim consents to being killed. Under the current law, a mercy killing that is not a consensual killing is always murder, unless the defendant can prove diminished responsibility in which case, he or she is guilty of manslaughter"[50]. Legal commentators and the public opinion both coincide in believing that "mercy killing occupies the lower end of the murder spectrum"[51]. Indeed, there are elements that are generally common to this kind of killings and reduce the gravity of the crime (for example, the confession, the good character of the offender and the unlikelihood of re-offending)[52].

The proposal to create a distinct crime for mercy killing has existed for many years. Considering that complicity in suicide is a crime under art. 2 of the Suicide Act 1961, but the maximum penalty is far less than that for murder, it is desirable that "the moral compromise that exists in relation to assistance in suicide must similarly obtain for other mercy killings that do not involve the participation of the patient and so cannot be categorized as such"[53]. In 1976 the Criminal Law Revision Committee proposed to create a new offense of consensual mercy killing. However, the proposal was strongly criticized by commentators because it gave relevance to the intent. They argued that it is very difficult in practice to ascertain that the killer acted only for a merciful purpose. Motives can be mixed, and the concrete circumstances of the crime certainly play a role. For example, a conduct that has caused sufferance to the victim cannot be considered merciful, even though the aim is a noble one[54].

Moreover, American commentators highlighted a very serious risk: that murderers could benefit from mercy killing. If a child is unconscious because of the physical abuses allegedly inflicted by one or both parents, they have all the interest

fendant who successfully establishes his abnormal mental condition is found guilty of manslaughter instead of murder (adapted from https:// www.britannica.com/topic/diminished-responsibility).

[50] The 2005 Law Commission Consultation Paper no. 177, available at www.lawcom.gov.uk/app/uploads/2015/03/cp177_Murder_Manslaughter_and_Infanticide_consultation_overview_.pdf.

[51] Huxtable R., 'Euthanasia, ethics and the law: from conflict to compromise', in edited by McLean S., Biomedical Law and Ethics Library, Routledge, 2007, p. 35.

[52] Ibidem, p. 45.

[53] Ibidem, p. 166.

[54] Ibidem, pp. 46-47.

to refuse withdrawing LST and so keep him alive in order to prevent the charge of murder[55]. Even outside this extreme case, parent's (or guardian's) choices relating to withdrawing LST can be clouded by many mixed motives. Indeed, "any decision to withdraw or continue life support will have tangible effects on the patient's family - psychologically, socially and even economically"[56].

In 2005 a legal commission was established in order to promoting the reform of the Homicide Act 1957. The Law Commission Consultation Paper highlighted the main issue in relation to mercy killing. As mentioned above, art. 2 of the Homicide Act provides a defence only when the killer acts under diminished responsibility. However, there are many cases in which the "mercy killer" is able to control his actions (as in the *Inglis* case). In these cases, homicide is the result of a rational choice. Moreover, doctors or nurses who carry out consensual mercy killings are highly unlike to satisfy the requirements of such defence. Accordingly, the main proposal of the Commission was to create an autonomous offense of mercy killing in order to cover the cases that cannot be included under art. 2. The alternative proposal was to reformulate art. 2: the "abnormality of mind" that justifies diminished responsibility should not be only an "arrested or retarded development of mind or any inherent causes or induced by disease or injury", as in the original text, but any "adverse circumstances with which the offender has had to cope"[57]. Art. 2 was subsequently amended in 2010 in order to broaden the application of the diminished responsibility defence, for example when the offender suffers of severe depression. Nonetheless, mercy killing remains a crime and there is no statutory defence for medical professionals, nor a desirable "explicit consideration of context role and motive" of this kind of killings[58].

Non-voluntary active euthanasia

Commentators are divided over the possibility to envisage "non-voluntary ac-

[55] Appel J.M., 'Mixed motives, mixed outcomes when accused parents won't agree to withdraw care', J Med Ethics, 2009, 35(10), 635-637, p. 635.

[56] Ibidem, p. 636.

[57] See footnote no 50.

[58] Williams G., 'Intention and causation in medical non-killing: the impact of criminal law concepts on euthanasia and assisted suicide', in edited by McLean S., Biomedical Law and Ethics Library, Routledge, 2007, p. 4.

tive euthanasia", *i.e.,* euthanasia of patients without capacity. If "the concept of euthanasia should apply only in cases where the intent is to benefit a person by relieving that person's suffering"[59], it cannot be applied to unconscious patients, because they are not in pain (or it is impossible to ascertain if they are in pain). According to this view, withholding life supports from unconscious patients does not count as euthanasia. On the other hand, proponents of active euthanasia suggest that "active killing is sometimes more humane, and therefore, more ethically acceptable than allowing to die"[60]. The same concept was expressed by Lord Brown Wilkinson in *Bland*[61].

It is difficult to find a "moral answer" to the question of why active euthanasia is a crime while withdrawing LST should be lawful. Indeed, letting the patient die by removing life support can be a long and painful process. There are two main reasons. Firstly, positive killing is generally perceived as more wicked than killing by omission. Secondly, legalizing one kind of active euthanasia, might lead to allowing all kinds of active euthanasia. Indeed, if their conduct is the same, why a doctor should be acquitted while a parent, relative or friend will almost certainly be convicted? Withdrawing LST is a medical procedure, that can be performed only by professionals, while everybody can practice active euthanasia, as shown by the *Inglis* case. As of today, involuntary active euthanasia is legal only in two countries: the Netherlands and Belgium[62] [63].

The defence of necessity: the *Conjoined twins* case

Jody and Mary were two Maltese conjoined twins, born in Manchester in

[59] Macklin R., 'Which way down the slippery slope? Nazi medical killing and euthanasia today', in edited by Harris J.M., Bioethics, 2001, p. 117.

[60] Ibidem. pp. 117-118.

[61] *Bland*, p. 61: "how can it be lawful to allow a patient to die slowly, though painlessly, over a period of weeks from lack of food but unlawful to produce his immediate death by a lethal injection?".

[62] Deliens L., Van der Wal G., 'The euthanasia law in Belgium and the Netherlands', Lancet, 2003, 362(9391), 1239-40.

[63] In particular, the Groningen Protocol for neonatal euthanasia (adopted in The Netherlands in 2005) is a medical protocol that identifies the criteria under which neonatal euthanasia might be deemed appropriate: "the diagnosis and prognosis must be certain; hopeless and unbearable suffering must be confirmed by at least one independent doctor; both parents must give informed consent; the procedure must be performed in accordance with the accepted medical standard". Available at https://www.nejm.org/doi/full/10.1056/NEJMp058026.

2000. They shared a common bladder and aorta. Mary had severe abnormalities in her brain, hearth and lungs and could not survive if separated from Jody[64]. Their parents refused any medical intervention on religious grounds and the case was referred to the court. The Judge authorized the operation to separate the twins, arguing that the separation would have been not only in the best interest of Jody (who could live a normal life) but also of Mary. Indeed, she could survive only for a few months and those months "would not simply be worth nothing to her. They would be hurtful"[65]. The parents appealed the decision. The Court of Appeal rejected the idea that Mary's best interest was to die. On the contrary, her life had value and dignity. Within this conflict of interest between the sisters, the Court had to "undertake a balancing exercise"[66] between the right to life of each child, considering also the manner in which they were able individually to exercise such right. Although Mary had the right to life, her existence was described as a parasitic one. The principle of best interests imposed "to give the chance of life to the child whose actual bodily condition is capable of accepting the chance to her advantage even if that has to be at the cost of the sacrifice of the life which is so unnaturally supported"[67].

The Court of Appeal authorized the operation on two bases. Firstly, the operation was not considered as a positive act (to kill Mary) but as an omission. When the two bodies were separated, Mary ceased to receive the blood supply necessary to her life. Such operation could be considered equivalent to withdrawing LST from Mary: "she would die, not because she was intentionally killed, but because her own body cannot sustain her life"[68]. Secondly, the principle of necessity was taken into account. Mary's death was considered as an inevitable consequence of an operation necessary to save Jodie's life. In balancing the interests of both twins, Jodie's interest to live was considered prevalent. Indeed, "the principle of necessity could be invoked where the doctors' conduct was not harmful because, when faced with a choice of two evils, the choice of avoiding the greater harm was justified"[69].

[64] *A (children) (conjoined twins: surgical separation)*, Re [2001] Fam 147, [2000] 4 All ER 961.

[65] *Conjoined twins*, p. 26.

[66] Ibidem, p. 48.

[67] Ibidem, p. 43.

[68] Ibidem, p. 89.

[69] Williams G., 'Intention and causation in medical non-killing: the impact of criminal law concepts on euthanasia and assisted suicide', in edited by McLean S., Biomedical Law and Ethics Library, Routledge, 2007, p. 185.

The reasoning is very interesting from a criminal point of view. The principle of necessity is rarely applied in criminal law and only for minor offenses. In particular, following a long-established case law, necessity cannot be invoked as a defence for murder[70]. Nonetheless, the principle can be applied when a life-threatening medical condition involves two or more persons and the death of one is more harmful than the death of the other(s). Killing (or letting die) the latter, as a result of such balancing between their respective interests, is not a crime. Conjoined twins are very rare, but the same principle is applicable to more frequent cases, such as the sad choice to save the mother or the baby during childbirth.
This is yet another field of application of the best interest principle in criminal law. The death of the ill or disabled person, being "the least detrimental alternative"[71], is justified as necessary to save the life of the healthy person. Therefore, the doctor's (or parents/ guardian's) criminal liability is excluded.

5. Conclusion

The *Bland* case established that the decision to withdraw/withhold LST from a patient without capacity is lawful as long as is taken in the best interest of the patient. The 2005 Mental Capacity Act codified the principle of best interest as the cornerstone of medical treatment of patients without capacity. Accordingly, the omission of treatment may be criminally relevant if the best interest of the patient is to be kept alive. On the contrary, active conducts that cause the death of the patient (non-voluntary active euthanasia) are always illegal. As confirmed in the *Inglis* judgment, the best interest principle is not applicable to euthanasia.

Best interest can be difficult to identify in practice. Firstly, each case is different from another. Secondly, the best interest should be evaluated in relation to the quality and worthiness of the patient's life. However, as the *Arthur* and the *Gard* cases show, these are subjective and ever-changing concepts. Lastly, the idea that human existence is something more than illness, disability or, indeed, consciousness

[70] The rule was established for the first time in the well-known *R v Dudley and Stephens* case [1884].

[71] *Conjoined twins*, p. 38.

is part of our culture[72]. The legislator (and, consequently, the judges) have the hard task to establish to what extent, if any, different logics must prevail on it. But the difficulties in ascertaining if the best interest of the patient is to live or to die cannot result in depriving him of the right to die. Capable patients can deny consent to any treatment, including life-saving ones. Granting the right to die to patients without mental capacity is the only way to avoid a discrimination.

From a criminal law point of view, the best interest defence implies to take into account the motives of the offense which, instead, should be irrelevant. This has been identified as the major obstacle to the introduction of an autonomous crime, that would unify all the various kinds of mercy killing. Indeed, the commentators highlight the risk of "manipulation of fundamental criminal law concepts"[73].

However, today's uncertainty over the consequences of these conducts (similar cases, different outcomes) is a much more serious breach of the fundamental principles of criminal law. Establishing the consequences of mercy killings cannot be left entirely to prosecutorial discretion or the sensitivity of the jury. The time has come for lawmakers to intervene to bring order in this matter.

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