Is the Doctrine of Double Effect irrelevant in end-of-life decision making?

ALLMARK, Peter <http://orcid.org/0000-0002-3314-8947>, COBB, Mark, LIDDLE, B. Jane and TOD, Angela

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Abstract

In this paper, we consider three arguments for the irrelevance of the doctrine of double effect in end-of-life decision making. The third argument is our own and, to that extent, we seek to defend it. The first argument is that end-of-life decisions do not in fact shorten lives and that, therefore, there is no need for the doctrine in justification of these decisions. We reject this argument; some end-of-life decisions clearly shorten lives. The second is that the doctrine of double effect is not recognised in UK law (and similar jurisdictions); therefore, clinicians cannot use it as the basis for justification of their decisions. Against this we suggest that whilst the doctrine might have dubious legal grounds, it could be of relevance in some ways, for example, in marking the boundary between acceptable and unacceptable practice in relation to the clinician's duty to relieve pain and suffering. The third is that the doctrine is irrelevant because it requires there to be a bad effect that needs justification. This is not the case in end-of-life care for patients diagnosed as dying. Here, bringing about a satisfactory dying process for a patient is a good effect, not a bad one. What matters is that patients die without pain and suffering. This marks a crucial departure from the double effect doctrine; if the patient's death is not a bad effect then the doctrine is clearly irrelevant. A diagnosis of dying allows clinicians to focus on good dying and not to worry about whether their intervention affects the time of death. For a patient diagnosed as dying, time of death is rarely important. In our conclusion we suggest that acceptance of our argument might be problematic for opponents of physician-assisted death. We suggest one way in which these opponents might argue for a distinction between such practice and palliative care; this relies on the double-effect doctrine's distinction between foresight and intention.

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Key words

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Introduction

"The doctrine of double effect is largely irrelevant in everyday practice" (Forbes and Huxtable 2006).

The doctrine of double effect is used in reasoning about the permissibility of acts that have both good and bad effects. It has featured extensively in the discussion of end-of-life decisions that appear to have the good effect of providing patient comfort but the bad effect of shortening their lives, for example through large doses of opiates. Its key use has been in arguing for the acceptability of some end-of-life decisions that appear to shorten life, such as heavy sedation, and the unacceptability of others, such as euthanasia (Gillon 1999, Chappell 2002). In this paper we examine three arguments in support of the claim that the doctrine is now largely irrelevant. In outline these are:

A: Empirical (or evidence based): End-of-life decisions do not have the bad effect of shortening lives.

B: Legal: The doctrine of double effect relies on a distinction between foresight and intention that is not recognised in United Kingdom (UK) law (or in jurisdictions with similar bans on physician-assisted death). When deciding which end-of-life decisions are permissible, practitioners cannot rely on a distinction the law does not recognise.

C: Ethical: Some end-of-life decisions have the effect of shortening lives but where they do, this is not a bad effect.

We argue that the first two of these arguments are unsuccessful. The third is our own and we seek to show its plausibility here. The main thrust of our argument is that the doctrine of double effect becomes irrelevant when the patient's dying is no longer viewed as an evil to be avoided. If our argument is correct then this presents a problem for those who wish to distinguish, say, euthanasia (as morally wrong) from terminal sedation (as permissible). However, such people might be able to draw on one element of the doctrine of double effect, its use of the distinction between intention and foresight. Whilst we set out this argument, we do not seek to defend it here. Our aim only is to show that where death is no longer an evil to be avoided, double effect is irrelevant. We begin our argument with some background.

Background

Often the deaths of patients are preceded by health-care-team decisions that appear to shorten the lives of those patients. Quill, Lo and Brock (1997) distinguish three types of such decisions:

- Standard pain management - this may involve high doses of opiates that some clinicians believe will shorten the patient's life.

- Withholding or withdrawing life-sustaining care - there are many variations; these include withholding or withdrawing antibiotics, dialysis, ventilation, enteral feeding and intravenous hydration.

- Sedation - again there are many variations. The one most likely to play a significant role in a patient's death is terminal sedation: "sedating a patient to the point of unconsciousness to relieve one or more symptoms that are intractable and unrelieved despite aggressive symptom-specific treatments, and maintaining that condition until the patient dies" [p. 8] (Taylor 2003, National Ethics Committee., Veterans' Health Association. 2007). Often, other treatment is withdrawn, such as artificial hydration and nutrition. In the discussion which follows, we are generally referring to terminal sedation rather than, say, palliative sedation which palliates symptoms but does not induce unconsciousness and is not so often associated with withdrawal of other treatments.

- Physician-assisted suicide - where the physician provides the patient with lethal medication to kill herself knowing that she will probably do so.

- Euthanasia - where the physician administers a lethal drug to the patient with the intention of ending her life for the patient's benefit.

In the UK and most of the world legal condemnation of such acts extends to physician euthanasia and assisted suicide (henceforth, "physician-assisted death"). In certain common circumstances the other types of end-of-life decision are permitted in the UK and elsewhere. This is often explained in terms of the doctrine of double effect.

The doctrine of double effect arises from the fact that some actions appear to have both a good and bad effect. For example, heavy sedation can calm a patient's symptoms but may also shorten his life. The doctrine is used to distinguish life-shortening acts that are widely held to be acceptable, such as standard pain relief or withdrawing life-sustaining treatments in some circumstances, from those widely held to be unacceptable, such as euthanasia. The doctrine states that double-effect actions are justified only if four criteria are met (Cavanaugh 1996, Beauchamp and Childress 2001, Cavanaugh 2006):

a) The act must itself be good or permissible.

b) The bad side effect must not be the cause of the good effect.

c) The bad side effect must be foreseen but not intended by the agent.

d) The good must outweigh the bad.

Physician-assisted death is always wrong because it violates at least two of the criteria, b and c. The other types of end-of-life decision (standard pain management, withholding or withdrawing life-sustaining care, and sedation) can meet all four criteria and in such circumstances are justified.

The arguments for the irrelevance of the doctrine come from at least two sides that are opposed on the issue of physician-assisted death. Supporters of these practices have sustained an assault on the doctrine of double effect over many years. They believe that its defeat would be a significant step in the campaign to change law and practice. Perhaps sensing this and the strength of the critique of the doctrine of double effect, opponents of physician-assisted death have sought to show that current practice can be defended without resort to the doctrine. Let us now turn to those arguments, starting with an empirical (evidence-based) argument that has recently been put by opponents of euthanasia.

The empirical irrelevance of the doctrine of double effect

The argument is that there is no empirical evidence showing that opiates and sedation given appropriately at the end-of-life will shorten a patient's life. Indeed, the research available suggests the opposite (Sykes and Thorns 2003a, Sykes and Thorns 2003b, Thorns 2002, Good, Ravenscroft and Cavenagh 2005). This argument is explicitly linked to the doctrine of double effect in the editorial by Forbes and Huxtable (2006) quoted at the outset of this paper. They cite Sykes and Thorns' work also in stating that there is "no evidence that their [opiate] use 'in palliative care requires the doctrine of double effect as a defence'".

This argument is unconvincing. In the first place, the research evidence is not particularly strong. It is impossible to do randomised trials of these end-of-life decisions. You could not, for example, randomise dying patients into groups that do and do not receive opiates and sedation. Therefore, you need to look for secondary markers. For example, you could look for an association between doses of opiates or sedatives and length of life from hospital or hospice admission to death. However, a co-author of one of the most important papers elsewhere points to the need for caution in the interpretation of such results (Thorns 2002). Patients with more troublesome symptoms might be admitted earlier; their longer survival on higher doses from admission could skew the results.

There is a further concern in relation to the use of terms such as "appropriate" and "proper" (Sykes and Thorns 2003b). Sykes and Thorn define as appropriate the use of opioids and sedation only where carefully titrated to specific symptoms. In the first place, one might ask why this limitation is specified; why, for example, should opioids not be given for their euphoric effect and sedation to induce sleep? The answer would seem to be in part because the latter uses might hasten death. Thus, having stated that the uses of opioids and sedation which hasten death are inappropriate, it is not surprising to find that appropriate use does not hasten death: it is a circular argument

Furthermore, many clinicians appear unconvinced by the argument. Seale's work shows that practitioners believe that opiates and sedation sometimes shorten life (Seale 2006a, Seale 2006b). A recent literature review of palliative sedation therapy shows that clinicians repeatedly invoke the foreseen/intended distinction of the doctrine of double effect in setting the therapy apart from euthanasia (de Graeff and Dean 2007). And there seem to be many clinicians who draw upon the doctrine of double effect in their justification for their practice of sedation in palliative care (Levy and Cohen 2005, Lo and Rubenfeld 2005, Carr and Mohr 2008).

Even were we to grant that opiates and sedation at the end of life do not shorten life it seems clear that many other end-of-life decisions unquestionably shorten life. These are, in particular, decisions to withdraw or withhold treatment. If clinicians withhold or withdraw treatments such as antibiotics, hydration, nutrition, ventilation and dialysis then the patient will almost certainly die earlier than if they had not. In the recently updated British Medical Association (BMA) guidelines on withholding and withdrawing life-prolonging medical treatment it states (British Medical Association. 2007):

> "Although the health care team may foresee that withholding or withdrawing life-prolonging treatments will result in the patient's death, this is fundamentally different from action taken with the purpose or objective of ending the patient's life." (Section 14.1, p.18)

We conclude, then, that the empirical argument for the irrelevance of the doctrine of double effect fails. Clinicians make life-shortening decisions that might be justified by the doctrine and they invoke the doctrine in their ethical justification. However, does UK law support its use? We turn to this question next. Non-UK readers are asked to bear with this discussion as it sheds light on the doctrine's central concepts of foresight and intention. Furthermore, UK law mirrors many other jurisdictions where physician-assisted death are banned (Price 1997).

The legal irrelevance of the doctrine of double effect

Knowingly to bring about the death of another is legally and morally problematic; usually it is a serious wrong. Where the agent bringing about the death has a duty of care to the person killed the wrong can be done both by act (such as giving a lethal injection) or omission (such as failing to give life-saving aid). Many have claimed that clinicians may escape legal liability for a death caused by an end-of-life decision provided they act in accord with the doctrine of double effect (British Medical Association. 2007).

However, this interpretation of the law is rejected by many legal scholars (Kennedy and Grubb 2000, Tur 2002). They argue that whether someone intended an outcome is crucial where the law requires a *Mens Rea*, or guilty mind. In homicide, for example, it marks the distinction between murder and manslaughter. For the former to be established, the

prosecution must show that the defendant intended either death or grievous bodily harm; if he did not, then the lesser charge of manslaughter applies. This legal notion of intention is non-idiomatic and has developed through case law, including the cases of *Nedrick* [1986] *Smith* [1961] (see also, Kenny 1966) and *Woollin* [1998]. In the latter, a man who killed a baby by throwing it on a hard surface was found guilty of murder even though he said he did not intend its death. The court's ruling was that where someone knows that an outcome is certain or nearly certain then he cannot claim he did not intend it. Thus in those cases where a clinician makes a decision she is almost sure will shorten life (say, switching off a ventilator or withdrawing dialysis) she cannot say the patient's death was not intended. And yet it is in such cases where the doctrine of double effect, which would render the death foreseen but unintended, seems most to be needed. Kennedy and Grubb (2000; p.2112))state,

'[I]t is clear that a defendant does, *in law*, intend a consequence of his actions if he knows it to be a virtually certain outcome…"

Thus those arguing against the use of the doctrine of double effect in law say the legal justification for life-shortening end-of-life decisions other than physician-assisted death must lie elsewhere. On this account, the most likely basis is in the notion of the duty to the patient (Kennedy and Grubb 2000, Tur 2002). Clinicians will be said not to have culpably caused a patient's death provided their acts or omissions were taken in pursuit of their duty to relieve pain or suffering. This will be the case even though similar actions taken by others would be illegal. For example, a health care team might decide to withdraw artificial hydration and nutrition from a patient as a result of which the patient dies. Provided this decision accords with the duty to relieve pain or suffering it would generally be legal. Were a relative to make the same decision for the same reason, to relieve pain or suffering, her act would not be legal.

This only extends so far; it does not include physician-assisted death. The key cut-off point is, claims Tur (2002) the contingency of death. Death is causally contingent if it results causally from the same act that relieves the pain or suffering. For example, death results from the terminal sedation; relief of suffering also results from the sedation. But the death is not causally necessary for the relief of suffering; it is an accidental concomitant. In other words, in many cases sedation is given to patients to relieve suffering without death occurring. By contrast, death is causally necessary if the act must cause death in order for it to relieve pain and suffering. For example, an injection of potassium chloride will not relieve pain and suffering except by killing the patient.

Does this analysis of the law show that the doctrine of double effect is legally irrelevant? The Law Commission's consultation paper on the Homicide Act considers whether the doctrine is applicable to medical practice before concluding in favour of Kennedy and Grubb's duty-based analysis, that clinicians intend the deaths they foresee but are not culpable for them (The Law Commission. 2005). Nonetheless, the report goes on to say that recognition of the doctrine can be made elsewhere in law (paragraph 4.89).

Unfortunately, the report doesn't make clear how this recognition might occur. Several commentators have remarked that *Woollin* only *entitles* juries to find intention in bad consequences foreseen; it does not *compel* them to do so (Williams 2001). Thus when a life-shortening end-of-life decision is made the court might choose not to find intention in the *mens rea* sense, particularly given that clinical end-of-life decisions are beneficent, unlike the violence in the *Woollin* case. Perhaps this is how the British Medical Association in its guidance on withdrawing and withholding life-supporting treatment uses *Woollin* to support its line that foresight and intention are important in the law's judgement of such end-of-life decisions (British Medical Association. 2007).

Does the Human Rights Act have any implication for the doctrine of double effect? It has certainly played a part in some end-of-life cases. Article 2 of the Act grants a right to life; section 2(1) states that "No one shall be deprived of his life intentionally…" In one case, of conjoined twins called Mary and Jodie, intention was taken to imply a specific purpose rather than virtual certainty; thus surgeons were taken not to intend the death of the so-called weaker twin when separating them, even though its death was certain (Watt 2001). Thus Robert Walker LJ states in the conclusion,

> The proposed operation would not be unlawful. It would involve the positive act of invasive surgery and Mary's death would be foreseen as an inevitable on sequence of an operation which is intended, and is necessary, to save Jodie's life. But Mary's death would not be the purpose or intention of the surgery, and she would die because tragically her body, on its own, is not and never has been viable (HRLR. 2000).

However, this view was a minority view in the case. One problem with it is that the operation appears to violate the second criterion of the principle of double effect, that the bad effect must not be the cause of the good one. In the case of the

conjoined twins it appears that the good effect (Jodie's survival) is brought about by the bad (Mary's death). Grubb (2004) suggests that this case is probably better seen as a case of someone being destined to die. He compares it to a climber who cuts the rope that links him to a colleague who is pulling both of them into an abyss. Cutting the rope is justified because the colleague is destined to die not because of double effect (although Grubb is not clear whether this would constitute a legal defence or not). Furthermore, the doctrine has not been supported in other cases; for example, Dame Butler-Sloss took withdrawal of artificial nutrition and hydration to be intentionally hastening death but not a violation of Article 2 because it was an omission rather than an act (Samanta and Samanta 2005). There is, then, no consistent line in these cases that would support the doctrine of double effect; there is, however, ambiguity. Hence Grubb (2004, p. 1110) describes the law relating to double effect as 'worryingly opaque'.

This ambiguity is reinforced by the wording of the *Mental Capacity Act* (HMSO 2006) which at section 4(5) states that a person, such as a palliative care professional, making a decision about life-sustaining treatment "must not … be motivated by a desire to bring about his death." This gives *prima facie* support to double effect in that it implies that the professional's desire (or motivation) in relation to the outcome is of legal relevance.

A final way in which the doctrine might be recognised in law is in the content of the clinician's duty. It will be recalled that, according to some commentators opposed to double effect, this appears to be the basis upon which life-shortening decisions could be justified. However, it is noteworthy that the limits to that duty are allegedly set by the notions of contingency and necessity. A death that is causally necessary in the relief of symptoms is not acceptable. This appears to reflect closely the clause of the doctrine of double effect which states that the bad effect must not be the cause of the good effect. It also appears to reflect the clause stating that the bad effect may be foreseen but must not be intended by the agent. It is plausible to say that a clinician foresees but does not intend side effects (where death is a foreseen side effect of treatment); it is surely not plausible to say a clinician does not intend death where it is a chosen means to an end.

We conclude, therefore, that whilst there is certainly some legal ground to question the relevance of the doctrine of double effect, the debate is far from settled. Furthermore, the doctrine seems important in relation to the area of clinicians' duty to relieve pain and suffering. The doctrine effectively marks the boundary between acceptable and unacceptable practice under that duty. We turn finally to an ethical argument for the irrelevance of the doctrine.

The ethical irrelevance of the doctrine of double effect in the light of a diagnosis of dying

There might be another tack that opponents of physician-assisted death could take in doing without the doctrine of double effect. This would involve drawing on the use of the diagnosis of dying. The National Institute for Health and Clinical Evidence (NICE) is the official body that makes decisions concerning which treatments should be provided by the National Health Service in the UK and provides guidance on how those treatments should be provided. It has published guidance on palliative care for adults with cancer (National Institute for Health and Clinical Excellence 2004). These are reinforced by the Department of Health's "End of life care strategy" (Department of Health. 2008). Both make repeated approving reference to the Liverpool integrated care pathway for the dying patient and similar pathways (Ellershaw, Ward and Neuberger 2003, Ellershaw and Wilkinson 2003). Central to the Liverpool care pathway is the importance of diagnosing dying. Once such a diagnosis is made the pathway instructs clinicians to stop non-essential and inappropriate treatments and to start treatments that are essential for symptom relief of the dying, particularly those that control pain, agitation and secretions.

The diagnosis of dying appears to bring a conceptual and material change to end-of-life decisions. Once a patient is diagnosed as dying the clinicians following the Liverpool integrated care pathway cease concern with saving the patient's life; their primary intention becomes to ensure the patient dies well, for example, with good control of symptoms. The time of death becomes irrelevant. If a patient dies with good symptom control on Tuesday rather than bad symptom control on Wednesday then there is no harm done.

Someone might reply that other things being equal a longer life is better than a shorter one; it is better to live until Wednesday rather than Tuesday. But this is questionable once a patient is dying. One way of showing this is to imagine a situation in which terminal sedation is used and has successfully controlled symptoms. Should we now think that a good death for this patient requires that we ensure he lives longer rather than shorter? If that were so we should feed and hydrate him perhaps - but it seems unlikely that anyone would view living, say, an extra 24 hours in this state would make for a better death. Or consider a situation where a patient with terminal lung cancer has good control of all symptoms, is fairly sedated but occasionally conscious, and has seen the family and friends he wishes to see. We could make him live longer by, say, giving antibiotics but should we? Would an extra day or two make for a better death? The Liverpool Care Pathway appears to suggest not, or not necessarily.

Once a patient is diagnosed as dying, his death is no longer something the health care team seeks to avoid. This change in attitude to a patient's death is central to end-of-life care. And it appears to undermine the relevance of the doctrine of double effect. The doctrine is relevant only where a bad effect is foreseen and a good effect intended. In end-of-life care clinicians intend patients have a good dying process. They no longer seek life-prolonging or avoid life-shortening interventions. In many, perhaps most, cases, the timing of death is irrelevant for a dying person. A diagnosis of dying appears to remove the assumption that dying is a harm to be avoided; as such, it renders irrelevant the doctrine of double effect; when clinicians give treatment that helps a patient to die well, that dying is a good effect, not a bad one.

Thus far, both opponents and proponents of physician-assisted death might agree. It seems, then, that some decisions which hasten death might be justifiable without recourse to the doctrine of double effect. The problem then for opponents of physician-assisted death becomes whether decisions that they would deem appropriate with a diagnosis of dying can be insulated from those forbidden acts such as euthanasia. If some life-shortening acts are permitted in order to ensure a good death, such as terminal sedation or withdrawal of antibiotics, then why not others, such as lethal injection? Could not such actions be said to intend and achieve a good death with no bad effect foreseen, once we have declared a shorter life not to be necessarily bad?

It seems, then, that giving up the idea that the death of a dying patient is the bad consequence of acts with good intent causes a problem for opponents of physician-assisted death. These opponents might respond that even where a patient's death without suffering is unequivocally good, there is an important moral difference between bringing it about by killing the patient rather than by symptom control. Here, the main objection to physician-assisted death is not based on the doctrine of double effect. Rather, it is an objection to clinicians acting as beneficent killers. Nonetheless, this response still requires the doctrine's distinction between intention and foresight. Take the example of life-shortening terminal sedation *versus* euthanasia. In both cases, the clinicians intend that the patient dies well. But it is only when giving a lethal injection that the clinician intends to kill the patient *simpliciter*. Hence the discussion of the rights and wrongs of physician-assisted death in relation to those diagnosed and dying does not turn on the idea that there is a double effect in which the patient's death is an evil to be avoided, because *ex hypothesi* it is not. Rather it turns on the idea that to act with the intent to kill is wrong (or wrong in such cases) even though the patient's death is not an evil. In this paper we shall not contribute to the discussion over whether to act with intent to kill is wrong even when the death itself is not an evil. For now, it is enough to highlight the need for this debate.

Conclusion

We have surveyed three arguments for the irrelevance of the doctrine of double effect. Of these, the ethical argument seems most powerful. It seems that the diagnosis of dying could mark a significantly different way of thinking about the ethics of end-of-life decision making and remove the relevance of the doctrine of double effect. This could be a helpful way of thinking that would

remove the is-it-or-is-it-not-euthanasia anxiety that sometimes attaches to these decisions. We have suggested, however, that the doctrine's distinction between intention and foresight would remain important for those who wish to distinguish physician-assisted death from palliative care; when clinicians follow the end-of-life care pathways linked to the diagnosis of dying they intend that the dying patient will die well; they do not intend ever to kill the patient. We have not sought to defend the ethical soundness of the intention/foresight distinction. If we have successfully shown that much end-of-life care does not meet the second criterion of the doctrine of double effect (that the bad effect must not be the cause of the good one) then that is enough to establish the claim that the doctrine is irrelevant in such cases.

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