

**Principle and Practice: An Analysis of
Nineteenth and Twentieth Century
Euthanasia Debates (1854 – 1969)**

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I declare that this thesis is my own work throughout.

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5th December 2003

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Abstract

Such is the powerful, emotive nature of the subject of euthanasia that its reach stretches beyond the pages of specialised medical journals or the conference rooms of an interested few. Despite this, investigation into the historical origins of current euthanasia debates has, until very recently, been a neglected area of academic interest. Contemporary euthanasia debates are often presented in a manner where the values at stake are viewed as essentially ahistorical and my thesis seeks to address this imbalance.

Beginning in the late nineteenth century and continuing throughout the twentieth century, the medical profession and lay writers in Britain mobilised an array of philosophical and technical arguments in order either to support or oppose euthanasia. My thesis elucidates and explores these arguments, tracing them through two centuries of changing attitudes towards death, suffering and pain. The thesis starts by examining how powerful pain-relieving drugs that rendered the patient unconscious were adopted into the repertoire of nineteenth-century medical practice. Then, with the position of this new form of pain relief consolidated, the first lay demands for euthanasia surfaced in the form of proposals that the incurable, suffering patient be made irrevocably unconscious so as to secure a medically-managed, painless death.

Moving into the twentieth century, the official line of the medical profession was one that defended the use of pain relief that potentially shortened life but contested any suggestion that death be brought about at the patient's request. However, by the middle of the twentieth century, support for legalised euthanasia was more sustained and organised. The question of pain – whether it could be relieved and how it was to be managed – was now entrenched in the debate over euthanasia. It was in this context that the hospice movement emerged, where sophisticated pain-relieving technologies were harnessed with a distinct ideology that rejected legalised euthanasia. As I explore at the end of my thesis, this provided an institutional 'solution' to the problem of how to care for the dying patient in pain as well as a template for an 'ideal' form of death that stood as an alternative to legalised euthanasia.

Informed by the methodological approaches of history and sociology, my analysis incorporates close readings of unpublished archive literature, set alongside wider surveys of pertinent primary and secondary sources. I focus on the process of how the values and ideas connected with arguments over euthanasia were articulated, placing particular emphasis on the way in which the negotiation and interpretation of medical practice fed into debates about the management of death. Throughout the thesis, I examine how the concept of 'natural' death was mobilised in a variety of ways, serving as part of the rhetorical strategies used by those on both sides of the debate. I conclude that the medical profession's commitment to the Hippocratic principle, that the physician should not kill, involved the accommodation of medical interventions in order to relieve pain in the dying patient. At the same time, however, this tended to exclude any notion that such interventions disrupted the concept of 'natural' death. This negotiation between principle and practice, I contend, is central to understanding historical arguments over euthanasia and, indeed, remains an ongoing process underpinning the construction of current debates.

INTRODUCTION

I. Situating the Thesis: Existing Literature on the History of Euthanasia

Turn the pages of any one of the growing number of books devoted to the subject of 'medical ethics' and the likelihood is that there will be a section devoted to the subject of euthanasia debated from varying philosophical, theological and medical perspectives. 'Should a doctor ever kill his or her patient?' – the absorbing nature of the question is such that its reach stretches across academic disciplines. Indeed, interest in euthanasia spills over into popular consciousness providing what has been described as "a secular form of religion ... a forum for the personal exploration of the human condition, a platform for defending human values".¹ Much has been written and spoken about euthanasia and at first it seems as if there is little new argumentative or analytical space in which to move.

Every so often, frequently in response to a high-profile case that gains widespread attention, the ritual airing of well-rehearsed argument and counter argument is publicly conducted. Thus, with familiarity, 'respect for autonomy' and 'individual choice' are pitted against 'sanctity of life' and 'slippery slope' positions.² The debate reaches a philosophical impasse, concludes without change in the law and the sometimes dormant but ever present issue of euthanasia waits to be stirred once more. Engaging and interesting though it undoubtedly is, the difficulty with philosophical 'ethical' deliberation, at least when approaching the question of euthanasia from a historian's perspective, is that it tends to freeze the contextually specific and contestable outcomes of past medical-ethical discourse into an immutable catalogue of competing claims.³ The result is that euthanasia debates are often presented in a manner in which the values at stake are viewed as essentially ahistorical.

My thesis seeks to address this imbalance by examining euthanasia debates in their particular historical contexts. Throughout the nineteenth and twentieth centuries, the medical profession and lay writers in Britain mobilised an array of philosophical and technical arguments in order to either endorse or reject euthanasia. The thesis elucidates and explores these arguments, tracing them through two centuries of changing attitudes to death and suffering. The focus is predominantly, though not exclusively, on arguments marshalled by the British medical profession and in this sense the thesis is located in the realm of values and ideas. However, these values and ideas of the medical profession are embedded in an

ever-changing culture and for this reason the thesis sets the arguments in context by considering the impact of new medical practices, particularly in relation to pain relief, alongside wider societal attitudes towards death and pain.

The thesis starts by examining how powerful pain-relieving drugs that rendered the patient unconscious were adopted into the repertoire of nineteenth-century medical practice. Then, with the position of this new form of pain relief consolidated, the first lay demands for euthanasia surfaced in the form of proposals that the incurable, suffering patient be made irrevocably unconscious so as to secure a medically-managed, painless death. Moving into the twentieth century, the official line of the medical profession was one that defended the use of pain relief that potentially shortened life, but contested the suggestion that death be induced at the patient's request. The question of pain – whether it could be relieved and how it was to be managed – was now entrenched in the debate over euthanasia. It was in this context that the hospice movement emerged, where sophisticated pain-relieving technologies were harnessed with a distinct ideology that rejected legalised euthanasia. As I explore at the end of the thesis, this provided an institutional 'solution' to the problem of how to care for the dying patient in pain as well as a template for an 'ideal' form of death that stood as an alternative to legalised euthanasia.

I am interested in the language that was used when constructing arguments in opposition to or support of the proposal that the physician should end life. I am also interested in the ways in which changing medical practices designed to relieve pain were understood and articulated in relation to the medical profession's ongoing commitment to the professed principle that the physician should not kill. My analysis incorporates close readings of archive literature and key primary texts, set alongside wider surveys of pertinent primary and secondary sources that relate to nineteenth and twentieth-century attitudes (both medical and non-medical) to death, pain and euthanasia. This thesis, then, is not a history of the practice of euthanasia in the nineteenth and twentieth centuries, but it is a history of the ways in which the articulation of principles and practices fed into public debates about euthanasia and the medical management of pain in the dying patient.

Until very recently, historically orientated analysis of euthanasia debates has been limited. A number of short papers have examined the precedent for suicide in classical antiquity and considered the attitude of the Hippocratic physician to cases of incurable and painful illness.⁴ In chapters of books primarily concerned with the philosophical, medical

and legal dimensions of euthanasia, other writers have surveyed the history of arguments relating to the ethics of suicide and assisted suicide. Considering religious attitudes to the taking of life, they have highlighted, amongst other points, Sir Thomas More's apparent support for suicide and euthanasia in cases of incurable and painful disease in the sixteenth century.⁵ This literature serves as a useful reminder that debate concerning the rights and wrongs of ending life (either one's own life or the life of another) has a long history.

However, some of its content contains analysis that arguably causes confusion. For example, Ludwig Edelstein has suggested that "euthanasia was an everyday reality in classical antiquity", with the implication being that during this period physicians were regularly ending the lives of those in their care.⁶ Such an interpretation perhaps shows insufficient sensitivity to changing historical definitions of the term 'euthanasia'. A compound of two Greek words, *eu* meaning 'good' and *thanatos* meaning 'death', 'euthanasia' has been defined in different ways depending on the historical context in which the word was applied. There are indeed examples of the term 'euthanasia' being used in classical literature, but here the 'good death' meant simply a gentle and peaceful death with no suggestion that 'euthanasia' implied the physician intervening to deliberately end life. That is not to say that physicians at this time did not end the lives of those suffering from incurable and painful illness. Indeed, Edelstein provides evidence to support the claim that some of them did and argues that since the Hippocratic Oath explicitly prohibited the physician from ending life the subject must have been a source of concern. Without attempting to reconstruct the world of medical practice in classical antiquity, as Edelstein has done, it is extremely difficult either to verify or disprove the claim that physicians deliberately ended the lives of their patients at this time. That is not the matter in question here. What is in question, is the meaning that is ascribed to the term 'euthanasia'. Edelstein takes a twentieth-century definition of the word 'euthanasia' and applies it to a period when there is no indication that it meant the physician intervening in order to end life.

Before continuing with any further discussion of existing literature that relates to this thesis, it is important to try to seek some clarity with regard to the meaning of the word 'euthanasia'. No one definition can be given since, as I have already suggested, it has had different meanings at different points in history. Even in current debates, 'euthanasia' has a range of meanings that are defined by the context in which the word is used and also by the ideological position of the individual or group using the term. 'Euthanasia' is perhaps most commonly understood as a situation in which the life of a patient is voluntarily ended as the

direct result of a deliberate intervention on the part of a physician – typically by the administration of dose of narcotics sufficiently powerful to bring about immediate death. This is sometimes described as *active* euthanasia. Yet it may also be used to describe a scenario in which the withholding or withdrawal of treatment leads to foreseeable death, a definition that is given the label *passive* euthanasia. Alternatively, it may be used to describe a situation in which the life of a patient is ended without his or her express consent but the physician is nevertheless judged to be acting in the patient’s ‘best interests’ – this is sometimes termed *non-voluntary* euthanasia.

This is a somewhat simplistic and cursory description of the various categories of meaning into which the term ‘euthanasia’ can be sub-divided. There is a great deal of sophisticated legal and philosophical literature that considers whether these distinctions are sustainable and examines the types of medical practice that should and should not be described as ‘euthanasia’. The definitions that I mention have evolved over time and continue to be the subject of negotiation and disagreement – a theme that I consider in detail at the end of this thesis. Indeed, by following the arguments that I examine throughout the thesis it is possible to trace the history of some of the various practices that may be grouped under the term ‘euthanasia’ today. I will revisit the important issue of defining euthanasia later in this introduction when I set out the thematic content and structure of the chapters that follow. For now, I merely wish to draw attention to the point that ‘euthanasia’ has not always been linked with idea of the physician ending life and that, even in current debates, its meaning is contested and disputed.

Having questioned the anachronistic style analysis of some writing on the history of euthanasia, it should be acknowledged that there are examples of literature that *is* sensitive to the different ways in which the word ‘euthanasia’ has been used at different times. In particular, papers by W. Bruce Fyfe and I. Van der Sluis on the historical background to nineteenth and twentieth-century euthanasia debates provided a valuable starting point for my own reading and I make frequent reference to their work in the course of the thesis.⁷ In addition, very recently two substantial contributions to research on the history of euthanasia debates have been made. The first is Nicholas Kemp’s book on the history of the euthanasia movement in Britain, which, with great detail, explores the links between early twentieth-century eugenic ideas and the campaign for legalised euthanasia that began in the 1930s.⁸

Kemp argues that the discussion and debate of proposals for the non-voluntary killing of those suffering from mental illness is often wrongly excluded from histories of euthanasia. This, he explains, is because the term 'euthanasia' was rarely used in connection with such discussion and because the relevant literature is to be found, not in the mainstream medical press, but in publications produced by the Eugenics Society and by individuals sympathetic to proposals for non-voluntary killing. Kemp contends, however, that this discussion of non-voluntary killing influenced debates about legalised euthanasia later in the twentieth century. Even though the proposed legislation spoke only of voluntary euthanasia for those suffering from incurable and painful illness, he argues that "the euthanasia debate after 1930 would retain an identifiable stream of opinion that sought to extend euthanasia to defectives".⁹

Kemp suggests that a number of prominent activists in the British campaign for legalised, voluntary euthanasia for incurable and suffering patients in the 1930s based their support for such a proposal on a commitment to eugenic ideas. For them, voluntary euthanasia was not simply about ending the individual patient's suffering. It was also tied to the idea that others should not be burdened by an individual perceived as contributing little or nothing of value to society. As I have stated, the non-voluntary killing of those with mental illness was not publicly advanced. Yet Kemp maintains that this was the result, not of any ideological hostility to such an idea on the part of some of those who supported legalised euthanasia, but because it was seen as too politically charged an idea to advocate openly. He argues (and provides documentary evidence to support his position) that in certain quarters of the euthanasia movement it was thought best to initially focus on voluntary euthanasia for patients suffering from incurable and painful diseases. Ultimately, however, they considered that the proposals for legalised euthanasia would be extended so that they were applied to other cases including the mentally ill and physically disabled.

The second comprehensive historical account of euthanasia debates to be published in recent years is Ian Dowbiggin's study of the euthanasia movement in America.¹⁰ As well as exploring the links between the campaign for legalised euthanasia and other social movements such as those supporting birth control and abortion, Dowbiggin, like Kemp, makes a connection between pre-Second World War calls for voluntary euthanasia and the influence of eugenic ideas. A criticism often levelled at those who currently advocate voluntary euthanasia is that such legislation would open the way for the killing of the elderly, those with mental illness and the physically disabled. Dowbiggin argues that however hard those who campaign for legalised voluntary euthanasia attempt to distance

themselves from such criticism, they will find it difficult to break the connection made between euthanasia and a certain type of eugenic thought. Whether or not such a connection can be justifiably made today remains a continuing point of dispute, but Dowbiggin's analysis reveals that the link between euthanasia and eugenic thought has, at certain points in early twentieth-century history, been strong.

Kemp and Dowbiggin give detailed accounts of the origins of organised euthanasia movements and the links between eugenic thought and the campaigns for legalised euthanasia. In presenting a substantial amount of new information on the history of euthanasia movements, their work goes a long way towards giving a fuller picture of the context in which euthanasia debates were played out. Indeed, their work proved extremely useful in directing my own thoughts and reading. For example, Kemp draws attention to the existence of a body of literature on non-voluntary killing that, he argues, is relevant to the history of subsequent debates on euthanasia but has been ignored because, at the time, the term 'euthanasia' was not used in connection with such discussion. In a similar manner (though applied in a very different context), I consider the way in which pain-relieving practices were negotiated and debated within the medical profession before the emergence of explicit debates about the legalisation of voluntary euthanasia. Again, the term 'euthanasia' was not always connected to this debate over pain relief, but as I will explain in this thesis, the themes that were raised in this discussion were to prove important precursors to arguments that would surface in later debates concerning legalised voluntary euthanasia.

However, my own study differs significantly from the work of Kemp and Dowbiggin – both in style and in content. I am interested in the relationship between euthanasia debates and arguments related to pain and pain relief. As a consequence, I do not refer to the influence of eugenic thought in the same sustained and detailed manner. Another difference is that my thesis focuses predominantly on the attitudes within the British medical profession as opposed to considering in any great detail the history of organised euthanasia movements. As I have stated, Kemp and Dowbiggin's work presents a considerable amount of new material on these movements but it does not devote quite the same amount of attention to the debates over pain relief that, I contend, were an important part of arguments over legalised euthanasia. I have attempted to move beyond writing a history that simply restates the medical profession's ongoing official opposition to legalised euthanasia. Rather, I have attempted to look at the ways in which the arguments that constituted such opposition were framed and negotiated in relation to changing medical practice. In doing so, my aim in this

thesis is to try to closely analyse and deconstruct the three-way relationship between the medical profession, the medical management of pain, and debates over euthanasia.

II. The Analytical Framework of the Thesis

When I was reflecting on material assembled during the course of my research on nineteenth and twentieth-century euthanasia debates, I was struck by a recurring theme – the concept of ‘natural’ versus ‘artificial’ death. Direct and indirect references to the notion of dying ‘naturally’ appeared repeatedly throughout the literature I had gathered, with the concept of ‘natural’ death mobilised in a variety of ways as part of the rhetorical strategies used by those on both sides of debates over legalised euthanasia. Then, after reading Jane Elizabeth Seymour’s study of death in intensive care, I began to see similarities between her analysis of the relationship between attitudes to death and medical interventions of the highly-technological kind, and my own research on the relationship between euthanasia debates and pain-relieving practices.¹¹

Seymour’s ethnographic study consisted of interviews with the friends and family of patients who died, or came close to death, in an intensive care setting. Contrary to the common image, in which high levels of medical and technological intervention are often associated with deaths that are ‘unnatural’ and inhumane, the respondents’ attitudes to such interventions were shown to be far more complex. The study revealed that technological intervention was not necessarily viewed as disrupting or interfering with the course of a ‘natural’ death if the outcomes of such intervention were seen as corresponding with the respondents’ own perceptions of a dignified and peaceful death.

For example, if the family and friends had time to say goodbye, were prepared for the death of the patient and the process of dying was perceived to be pain-free, then technological intervention was not seen as an obstacle to a humane and dignified death for the patient. Rather, such intervention was absorbed in to an image of ‘natural’ death. If, however, death was unexpected and sudden, and the type of medical intervention employed could not be absorbed into an image of a dignified and peaceful death, then death in intensive care was viewed as ‘unnatural’. Seymour persuasively argues that her findings suggest “that it is perceptions of the meaning of technology, rather than its simple minimisation or absence, which determine representations of death within highly technological surroundings”.¹²

It occurred to me that a similar process might have been at work in the debates over euthanasia and the management of pain that this thesis examines. As I will argue in the following chapters, the notion of ‘natural’ death as being peaceful and pain-free has origins in the late eighteenth century and was consolidated in the nineteenth century. This coincided with an increase in the medical use of pain-relieving drugs so as to ease the dying process and an elevation in the importance of the role of the bedside physician. Although, in this case, the question was clearly not of medical intervention of the highly technological kind, the use of pain-relieving drugs was, in a not dissimilar manner, absorbed into a concept of ‘natural’ death. Indeed, their very use by the physician enabled the dying man or woman’s final hours to conform to the model of the ‘natural’ death.

I will argue that medical profession’s commitment to the Hippocratic principle that the physician should not kill involved the accommodation of medical interventions that relieved pain in the dying patient but also potentially shortened life. At the same time, such interventions were framed in such a manner that the concept of ‘natural’ death was left undisrupted. An important element of the late nineteenth and twentieth-century euthanasia debates involved opposing parties contesting what ‘natural’ death meant and how it might be practically secured. For those who argued against the proposal that the physician should administer pain-relieving drugs so as to induce death, such a suggestion was viewed as entirely ‘unnatural’. Yet for those who argued in favour, such a proposal offered the means by which the patient could request a peaceful, dignified end that corresponded with the ideal of ‘natural’ death. This, it was argued, would avoid a death that was marked by periods of pain or loss of consciousness and confusion – features of a type of death considered neither dignified nor humane.

Mention of the concept of ‘natural’ death immediately brings into focus the work of Philippe Ariès and Ivan Illich on the relationship between medical intervention and the way in which death is experienced and understood. In influential socio-historical studies (Seymour’s paper refers to the writing of Ariès and Illich, as do many of the other secondary sources I have consulted), they posit similar historical paradigms of ‘natural’ death that stand in contrast to a bleak view of modern, ‘medicalised’ death. In a sweeping narrative, Ariès argues that attitudes to death have gradually yet radically shifted, from an acceptance of death “being the acceptance of an overwhelming Destiny” to the eventual modern “denial” of death. “Technically, we admit that we might die”, writes Ariès, but then concludes, “...

really, at heart we feel we are non-mortals.”¹³ Stripped of cultural and religious meaning, death is now “a technical phenomenon”, fragmented into medically classified parts and understood only by experts.¹⁴ The “simple familiarity” of “tame” death has succumbed to the “dirty” and “wild” experience of medicalised death, an experience that Ariès captures in his image of the modern patient dying in hospital, covered with tubes.¹⁵

Following on a similar interpretative track, Ivan Illich begins his analysis of modern medicine with the powerful assertion that “The disabling professional control of medicine has reached the proportions of an epidemic.” Then, in considering changing historical understanding of pain, he argues that “progress in civilisation” has been dominated by the quest to control and manage suffering, to the point where pain is ultimately “medically expropriated”, transforming patients into “unfeeling spectators of their own decaying selves”.¹⁶ Lay acceptance of modern medical power is such that “man has now lost his faith in his ability to die” and for this reason Illich concludes that “the right to be professionally killed” has become a “major issue”. Western man has relinquished his “right to preside at his own death”, “technical death” has triumphed over “dying” and modern medicine “has brought the epoch of natural death to an end”.¹⁷

This medicalisation thesis, as advanced by Ariès and Illich, portrays euthanasia as a symptom of an increasingly technical, bureaucratic and professionally controlled society. Illich states that “man has lost the autonomy to recognise when his time has come and to take death into his own hands”, which on first reading sounds very like the type of rhetoric employed by the pro-euthanasia lobby. However, rather than viewing euthanasia as a rejection of medicalised life, Illich argues that euthanasia epitomises ‘artificial’ death where, estranged from any meaningful understanding of death, patients relinquish control to medical experts. The “lost autonomy” that Illich has in mind refers, not to any modern notion of euthanasia, which he sees as medical engineering under the guise of individual ‘freedom’. Rather, it refers to an image of an individual reconciled to the inevitability of his or her mortality but in some sense ‘owning’ this experience of death when it occurs. This, it seems, is the paradox at the heart of euthanasia: on the one hand perceived as the antithesis of ‘artificial’ existence, through the individual reclaiming his or her own ‘natural’ death; on the other, as in Illich’s case, viewed as the ultimate extension of institutional and medical control.

Given that, as I have stated, both direct and indirect references to ‘natural’ death recur throughout my primary and secondary source material, Ariès and Illich provide valuable theoretical positions to be used and indeed critiqued. While the notion of ‘natural’ death clearly resonates throughout the euthanasia debates that I examine, what is less clear is whether this notion conforms entirely to the analysis that Ariès and Illich offer. In my study of medical attitudes towards euthanasia, I argue that the modern euthanasia debate began long before the period when Ariès and Illich maintain that technologically dominated, highly medicalised death ended ‘natural’ death. The euthanasia debate that this thesis begins with, finds its origins in the mid-to late nineteenth century, many years before the existence of intensive care units, life sustaining and supporting technology or, for that matter, an organised, state-run health service.¹⁸

It must be said that Illich does not argue that the medicalisation of death abruptly commenced with the advent of bio-technological advances. Instead, he argues that the process was a lengthy one, passing almost unnoticed as the medical “expropriation” of death gradually and incrementally took hold. From this perspective, beginning the thesis in the nineteenth century and focusing, as I do, on the introduction of powerful pain-relieving drugs, does not necessarily undermine Illich’s position. Illich does, after all, consider “the killing of pain” – which he agrees begins in earnest in the nineteenth century – as a key component in the medicalisation of death. Also, he does not advance an entirely benign view of ‘natural’ death. According to Illich, the image of ‘natural’ death has evolved over hundreds of years, with each century broadening and deepening in its medical character. “The history of natural death”, he argues, “is the history of the medicalisation of the struggle against death.”¹⁹ A close reading of Illich’s work reveals that one must tread carefully so as not to caricature the way in which he conceives ‘natural’ death.

Illich and Ariès were writing in the aftermath of the first sociological studies that examined provision for care of the dying in hospitals.²⁰ These studies, conducted during the late 1960s, revealed a depressing picture of ‘hospitalised death’, with dying patients left isolated and often heavily sedated, not simply in order to relieve their pain, but to obviate the need for hospital staff to interact with them.²¹ They also provided powerful descriptions of patients being ‘managed’ in apparently inhumane ways, leading Illich to remark that reading these studies would “cure one of any desire for professional assistance”.²² However, even after allowing for a greater degree of nuance in reading Illich and allowing for observational

empirical evidence that lends credence to the 'medicalisation' thesis, both his analysis and the analysis given by Ariès should be treated with caution.

Written into their conception of 'natural' death is an arguably nostalgic and romanticised view of history, that looks, as medical sociologist Tony Walter puts it, "back to a pre-modern era before the scientific and medical discourses of modernity 'ruined' dying".²³ Norbert Elias casts a similar sceptical eye on the work of Ariès. "Ariès' selection of facts", he argues, "is based upon a preconceived opinion ... In a Romantic spirit Ariès looks mistrustfully on the bad present in the name of a better past."²⁴ Illich and Ariès advanced an image of a 'lost', yet potentially recoverable, 'natural death'. For Illich this means recovering an original 'natural death' before it was corrupted by the creeping onslaught of medicalisation and for Ariès, it also means a return to a 'natural', pre-medicalised past.²⁵

This selective editing of the past, what historian Eric Hobsbawm terms 'invented tradition', establishes a paradigm of 'natural' death to be used as an ideal against which other deaths can be measured. It does not mean, however, that such a 'natural' death does, or indeed ever did, exist.²⁶ As I discussed earlier, the origins of the concept of 'natural death' as peaceful and painless can be traced to the late eighteenth century. Subsequently, each society has negotiated its own vision of what it means to die 'naturally'. Partly, and here I would agree with Illich, this process does involve 'natural' death incorporating and absorbing new medical techniques. However, the very existence of the idea of natural death also influences the manner in which these new techniques are deployed.²⁷ In this sense, the historically and culturally specific relationship between 'natural' death and medicine is a reflexive one, with natural death not simply being defined by medicine, but also, in some measure, directing and even limiting medical aspirations.²⁸

My historical analysis of nineteenth and twentieth-century euthanasia debates utilises ideas generated by a growing body of historical and sociological literature on death and dying. In part, my work takes up and uses the 'medicalisation' thesis but it also offers a more critical view of the notion that 'medicalisation' has somehow destroyed 'natural' death.²⁹ The process of culturally constructing a concept of 'nature', and the way in which varying understandings of what is 'natural' have historically fed into debates surrounding death, are themes that resonate throughout this thesis. Unlike Illich, I do not argue that there is an *ideal* 'natural' death, to which we can return. However, I do argue that the *idea* of 'natural' death

and competing claims to define and interpret this idea, are at the centre of historical euthanasia debates and debates relating to the practice of alleviating pain.³⁰

The paradox of euthanasia remains and, for those who have argued and continue to argue in favour of and against euthanasia, the ideal of 'natural' death remains very real. Support for euthanasia is given either in the form of rejection of the inadequacies of 'artificial' medical intervention (although significantly, euthanasia requires that medical intervention be embraced to some degree) or in a form that views euthanasia as a 'natural' extension of medical capability in the face of 'unnatural' suffering. Those against euthanasia argue that it is a wholly 'unnatural' enterprise – an 'artificial' solution to problems that medicine (and indeed society at large) must address but without disturbing the essentially 'natural' process of dying. When considering the history of euthanasia debates and debates related to pain relief, the theme of 'natural' versus 'artificial' death provides an analytical framework that is sufficiently dynamic to allow discussion of arguments drawn from very different historical contexts.

As I mentioned earlier, one of the concerns of this thesis is to reveal the changing ways in which euthanasia has been defined in the nineteenth and twentieth centuries and to show the manner in which these contested definitions of euthanasia were applied and defended. The term 'euthanasia' only took on connotations of medical intervention in order to bring about death in the latter half of the nineteenth century; before then it simply implied a calm and peaceful death. By the first half of the twentieth century, the meaning of euthanasia was the subject of increasing debate as opposing parties sought to lay claim to a definition of euthanasia on their own terms. By this stage, official medical voices conceded that the use of pain relieving-drugs carried a risk of hastening death but maintained that such a view did not compromise the earlier definition of euthanasia that implied merely a peaceful death. The idea that euthanasia should imply legal recognition of the physician bringing about death was resisted. Then, after the emergence of the hospice movement in the late 1960s, there is a distancing of the medical profession from any association with the term euthanasia, which by this time was established in its definition as the deliberate ending of life by physician administered means.

Thus, euthanasia has had multiple definitions at different times, emerging at the end of the nineteenth century to mean not only peaceful death but also being used by lay writers to evoke the concept of medical intervention that brought about death. This dual meaning of

euthanasia persists throughout the first half of the twentieth century, but also subtly alters with doctors acknowledging that they might hasten death (this was not the case in the nineteenth century) in the course of relieving suffering. At the same time, an organised lobby of support for the legalisation and formal codification of euthanasia uses the term in a different manner, in this context defining euthanasia as the explicit ending of a patient's life by a physician acting on the patient's request. It is this definition that prevails and ultimately takes hold.

The changing subtleties of meaning that are grouped under the single term 'euthanasia' must be borne in mind when discussing historical euthanasia debates in relation to 'natural' and 'artificial' death. Part of the problem when seeking a definition of euthanasia is that its meaning is constantly in the process of being re-defined and scrutinised. Nevertheless, whilst sensitive to the variable ways in which the word 'euthanasia' has been used, in the opening chapters of this thesis I refer to the word 'euthanasia' as it was used for most of the nineteenth century – to imply a peaceful, painless and easy death. At this stage the word was not connected with medical intervention that deliberately brought about death. In the 1870s, euthanasia began to be used to imply the physician intervening at the patient's request so as to intentionally end life.

Yet the original meaning remained popular, particularly with late nineteenth and early twentieth-century medical men. So to avoid confusion, I refer to the second definition, that implied patient-requested death, as 'active' euthanasia. Gradually, however, this second definition began to take hold, even when used by doctors. Consequently, as the thesis progresses I simply use the term 'euthanasia' to refer to the proposal that patient-requested death be legalised. As discussed earlier, the word 'euthanasia' has also been used to refer to other practices such as withholding or withdrawing treatment or the non-voluntary ending of life. Whenever possible, I have taken care to explicitly spell out the particular meaning that was attached to the term.

Historically, the medical profession has been divided on the subject of euthanasia. Officially, however, the profession has continually opposed any moves to alter the status of the law so as to allow physicians to end patients' lives. This thesis is an examination of the medical profession maintaining an idea of 'natural' death, such that it excludes the legalisation of euthanasia yet embraces other changes in medical practice. This thesis involves a discussion of the technical negotiations that have taken place, both inside and

outside of the medical profession, when considering what is to count as euthanasia. As I consider later, part of this negotiation has involved defining and re-defining what is to count as 'killing'.

That being said, there is one final point that should be made in relation to the way in which the term 'euthanasia' has been used. There simply is no parallel between the nineteenth and twentieth century debates explored at length in this thesis, whereby pain-relief becomes part of a debate relating to shortening life, and the so-called Nazi 'euthanasia' programme of the 1930s and 40s. The latter killed an estimated 200,000 mentally ill or physically disabled people. As the historian Michael Burleigh describes, Nazi euthanasia was indeed "a state sponsored programme of mass murder".³¹ This is a thesis about changing constructions of 'natural' death in relation to euthanasia debates and it is an analysis of the various and complex arguments employed by opponents and proponents when defining their respective positions. Clearly, however, practices that have been grouped under the term 'euthanasia' have had, at a certain point in history, the most devastating of implications. I do not look at the Nazi euthanasia programme in any great detail in this thesis, except in so far as it filters through into British euthanasia debates in the aftermath of its impact. Nevertheless, no exposition of euthanasia could omit a reference to this particularly dark chapter in the term's history, nor for that matter ignore how practices labelled as medical 'treatment' led to the deaths of so many.³²

III. An Analysis of Historical Euthanasia Debates: Three Categories of Argument

With an overarching theme of 'natural' death as a unifying reference point, I set out three central elements to the historical debates over euthanasia that this thesis examines. These three elements or 'categories of argument' thread their way through this history of euthanasia, but they represent concepts that are porous, not constant and unchanging in their formulation but rather varying with time and place. The three categories of historical argument are as follows: – 1) A category of deontological, principled arguments, utilised to either rule out euthanasia on the basis that killing is wrong and life is sacred, or to endorse euthanasia on the basis that it is right to kill in certain circumstances. – 2) A category of arguments that revolve around the significance of the practical management of pain mobilised by both supporters and opponents of euthanasia. These may be used to argue that it is 'natural' to seek to relieve pain but 'unnatural' to deliberately end life. Or alternatively, such arguments may be used to argue that euthanasia is the 'natural' extension of pain relief

and that the practice of pain relief leads to *de facto* euthanasia. – 3) A category of arguments deployed either to support or reject euthanasia that focus on the concept of ‘social death’, the notion that an individual’s ‘real’ death can precede his or her ‘biological death’.

The content of each of these three categories of argument and the manner in which they relate to one another changes according to the historical context in which they are set. Also, the argumentative weight given to the three categories shifts depending on this context. For example, in the nineteenth century, I argue that the euthanasia debate I examine revolves largely (though not solely) around the interplay between categories one and two – that is, the group of arguments made from first principles and the group of arguments relating to the alleviation of pain. By the mid-twentieth century, the third category of arguments, centring on a notion of ‘social’ death, is given greater prominence. At each stage in the debates, the categories of argument incorporate or refer to an idea of ‘natural’ death, drawing on its qualities as an ideal in order to explain and legitimise the positions of those who mobilise the various arguments.

i. Maintaining principle in the light of changing practice and attitudes

This thesis offers an historical analysis of medical responses to the question of euthanasia across two centuries of shifting medical practice and wider societal attitudes towards death. Viewed largely from the perspective of the medical community, it is not only a history of changing medical practice but also a history of the technical and philosophical arguments that the medical profession employs in defence of their official position that opposes legalised euthanasia. The first category of arguments that I identify focuses on the principled endorsement or rejection of euthanasia. These arguments from first principles are often a starting point for either opposition to or support for euthanasia, grounded as they are in positions that either hold that life is sacred or that ending life is permissible in certain cases. Throughout the euthanasia debates that I examine, the argument that it is wrong to kill emerges again and again, changing in the context in which it is applied but resolutely retaining its place within these debates. That ‘the doctor should never kill’, is a principle that has resiliently endured as the official position held by the medical profession, despite the impact of changing medical practice and societal attitudes. The arguments grouped within this first category highlight continuity through change – namely, the defence of the medical profession of a general principle in the face of the need to accommodate altering practice and values.

The tension between the principle that the doctor should not kill and the practice of relieving pain came to light in the second half of the nineteenth century when it became clear that powerful pain relieving drugs, such as chloroform and morphine, enabled doctors to render suffering patients permanently unconscious. This then led lay writers to question the overarching and professed principle of physicians that they should not kill, when, the lay writers argued, the practice of pain relief had the potential to curtail life. Rejecting the suggestion that the use of pain relieving drugs hastened death in any way, nineteenth-century doctors insisted that patients must wait for death to occur 'naturally'. In principle and often on religious grounds, it was argued that doctors could not entertain any notion of killing their patients or hastening their deaths in any way. Pain could be alleviated in its intensity but, it was argued, the length of a patient's life could not be shortened. It is towards the end of the nineteenth century that early arguments surrounding what has been described as the concept of 'double-effect' can be found – the concept where the administration of pain relief is understood not only to intentionally alleviate suffering, but also to unintentionally end life. It is also at this time that negotiation between maintaining the principle that the physician should not kill and the practice of administering potentially life-shortening drugs began. This thesis explores the history of the argumentative reasoning that began in the nineteenth century and continued in varying forms throughout the twentieth century, whereby the medical profession sought to defend the principle that the physician should not kill while at same time embracing new medical techniques. This defence required ongoing adjustments to the definition of 'natural' death so as to accommodate new medical practices when treating patients whilst excluding from these practices any notion of killing.

Thus, the interaction between this first category of principled arguments and the second category of arguments concerned with the impact of the practice of pain relief is of particular interest to this thesis. By focusing on 'principles' in relation to 'practices' the thesis looks at public, medical pronouncements on euthanasia, compared to and contrasted with public pronouncements relating to changing methods of relieving pain. Of course, both categories are largely concerned with what doctors *say they do* rather than what they *actually do* on a day to day basis. The pain-relieving practices that I analyse are, after all, practices that have been translated to the written page for varying readerships. However, this does not mean that such public pronouncements, when subject to scrutiny, cannot give an insight into how euthanasia is understood by the medical profession, debated internally within the profession and presented to the 'outside' world. Indeed, the very tension that exists between the principle that the physician should not kill and the way in which the practice of pain

relief is publicly understood, provides a valuable means of examining the rhetorical ‘work’ undertaken by the profession in order to maintain an important principle.

I suggest that this first group of ‘principled’ arguments have, to a degree, been re-configured in light of changes in medical practice. Despite this, I do not particularly want to be drawn into an elaborate debate about the existence or non-existence of Platonic, non-socially constructed ideas versus a pragmatic view of principles seen as giving practice coherency and order. That work is being done elsewhere.³³ It is enough for the purpose of this thesis to acknowledge that the principle that ‘the doctor should not kill’ clearly carries very real meaning for those who have argued against euthanasia. What I am interested in is the historical interplay between this seemingly unchanging principle and the other categories of argument (in particular the impact of pain relief) on principled opposition to euthanasia. This interplay between the Hippocratic principle of not killing and changing medical practice and societal values is a key component at the heart of historical debates over euthanasia.

Of course, challenges to deontological, principled arguments revolving round claims to ‘the sanctity of life’ have a long history. One need only quote David Hume in his 1777 *Essay on Suicide*, to realise that the introduction of powerful pain relieving drugs did not mark the beginning of such debates. Hume challenged that if the “disposal of life” was to be viewed as at the discretion of God alone, it could not then be claimed that the “preservation of life” could be legitimated by human intervention.

If I turn aside a stone, which is falling upon my head, I disturb the course of nature; and I invade the peculiar province of the Almighty, by lengthening out my life beyond the period which, by the general laws of matter and motion, he has assigned it.³⁴

Debates surrounding the rights and wrongs of human intervention in the course of nature (and ‘nature’ is often aligned with the notion of ‘divine intention’) predate the negotiation between ‘principle’ and ‘practice’ that I have set out. Indeed, in the debates that I discuss, deontological, principled arguments in favour of and against euthanasia frequently meet each other head on without any reference to the potentially life-shortening role played by medical intervention. The introduction of the pain relief dimension to euthanasia debates was not the first challenge to the principle that it is ‘unnatural’ to assist in another’s death, or in the case of Hume’s challenge, ‘unnatural’ to take one’s own life. My argument is that the introduction of pain relief added another layer to euthanasia debates, forcing the medical

profession to think through, defend and re-articulate the principle that 'the physician should not kill' in order to defend an ideal of 'natural' death.

ii. Justifying Pain Relief

The second category of arguments relates to the management and alleviation of pain. Beginning in the mid-nineteenth century, I show how the medical profession had first to establish the use of new, powerful pain relieving drugs, adopting these drugs into the repertoire of medical practice when treating the suffering patient, whilst working to uphold a notion of 'natural' death that accommodated this change. During the nineteenth century, the medical profession faced opposition to the introduction of new forms of pain relief from those who argued that such alleviation of pain was 'unnatural' and a transgression of God's will. Then, having consolidated the position of pain relief in medical practice, towards the end of the nineteenth century the medical profession faced the first lay demands for patient-requested death or 'active' euthanasia. If drugs were being used to render patients unconscious, argued lay supporters of this proposal, then why not use these drugs to end the lives of those in terrible pain?. In response, the medical profession argued that the justification of pain relief was not a justification for the physician to intervene in order to end life – a proposal considered, in the official view of the profession, to imply a wholly 'unnatural' death.

Moving into the twentieth century, the established position of the medical profession was one that continued to uphold the use of pain relief but contested any legalisation of 'active' euthanasia. Support for voluntary euthanasia by the mid-1930s (now more sustained and more organised) focused particularly on the case of the terminally ill patient in great pain. Indeed, the question of pain – whether or not it could be relieved and how it was to be managed – was another crucial component of euthanasia debates in the first half of the century. Then in the 1950s, evidence accumulated that showed the poor state of provision of care for the dying. Somewhat paradoxically, however, this served only to turn official medical opinion against proposals for legalised, voluntary euthanasia. More had to be done to relieve the pain of the dying without taking the 'unnatural' step of legitimising deliberate killing, it was argued. By the mid to late twentieth century, arguments surrounding pain relief developed into a major force for the dismissal of calls to legalise euthanasia. This new focus on the pain and suffering of the dying was a means of justifying opposition of euthanasia. Physical pain could and should be managed so as to render calls for euthanasia

redundant. The argument against euthanasia was now to be made on a practical, as well as principled, level.

In the late 1960s the emergence of hospice care offered a bolster against legalised euthanasia. I consider the way in which the hospice ‘movement’ strove to establish its own concept of ‘natural’ death in a manner that harnessed medical technology with a distinct ideology relating to death and dying. The relief of pain, both physical and mental, played a central role in the philosophy of hospices but this philosophy did not always satisfy proponents of euthanasia, who argued that physical pain could not always be controlled and that mental pain not always alleviated. Rather than viewing hospices as a means by which ‘natural’ death might be reclaimed, supporters of euthanasia offered the critique that the hospice movement functioned by imposing an ‘ideal’ view of death on those who might not share this vision. Supporters of euthanasia also made the argument that the medical profession’s justification of pain relief served as a means of tacitly endorsing covert euthanasia. Though the debates took varying forms, a common fault line between the opposing parties characterised the arguments over euthanasia in the nineteenth and twentieth centuries. This line divided those who argued that pain relief was ‘natural’ but euthanasia ‘unnatural’, from those who argued that euthanasia was but a ‘natural’ extension and conclusion to the relief of pain.

iii. The concept of ‘social death’: An added dimension to euthanasia debates

The final category of arguments relates to the concept of ‘social’ death – the idea that an individual may cease to ‘live’ prior to his or her biological death. Debates surrounding euthanasia and ‘social’ death are often located against a backdrop of bio-technological advances in medicine, since, it is argued, “medical advances have forced us to reconsider the boundaries of life and death and have made it unclear when life begins and when death occurs”.³⁵ Post-Second World War advances in life-sustaining technology and a sceptical critique of medicine, such as that offered by Illich and Ariès, shape this view of ‘social’ death, epitomised by the powerful image of the patient in persistent vegetative state.³⁶ Although a significant factor in more recent euthanasia debates, this technologically defined notion of ‘social’ death is not a major focus of this thesis.³⁷ Instead, I link ‘social’ death to an idea that is not necessarily dependent on the sustained intervention of high levels of technology, but rather depends on a notion of loss of ‘personality’ or ‘self’.³⁸ This notion of loss of ‘self’ weaves its way through the euthanasia debates that I consider, and again, the

concept of 'social' death is defined by specific medical, religious and cultural imperatives that alter over time.

Writing in the first century A.D, the philosopher, Seneca, expressed the following thoughts on disease and death:

I will not depart by death from disease as long as it may be healed and leaves my mind unimpaired ... But if I know that I will suffer for ever I will depart, not through fear of the pain itself but because it prevents all for which I would live.³⁹

Given my earlier emphasis on the need to avoid an anachronistic style of analysis, it must be stated that Seneca's attitude to illness and pain would have been shaped by its own particular set of cultural values that would have differed from those of the nineteenth and twentieth centuries. Nevertheless, this reference to disease preventing "all for which I would live" goes some way towards capturing the idea of 'social' death. 'Social' death does, to a degree, overlap with the second category of arguments that I identify in relation to pain relief, but it also encompasses other ideas that contribute to the perception (on the part of the patient, or by others) that 'life' has somehow ceased to be meaningful. The notion that the value of life can be measured in ways independent of biological existence is a theme that recurs throughout the thesis. The physical manifestations of illness play a role in shaping notions of 'social' death, but so too do the ways in which these physical symptoms are medically managed.

For example, throughout the euthanasia debates that I consider, the question of loss of consciousness and mental alertness is a recurrent theme. In the first half of the nineteenth century, 'clarity of mind' at the time of death is assigned great value. This was the 'ideal' Christian death, where the mentally alert man or woman would have time to say final farewells and time to be reconciled with God.⁴⁰ Of course, mental clarity could not always be preserved either because of the illness itself, or because of the need to relieve pain. In this case, the patient was pacified and rendered unconscious, but the 'ideal' remained that maintaining the consciousness of the dying individual paved the way for a 'good' death. Then, throughout the twentieth century, a link was made, largely by those who argued in favour of legalised euthanasia, between the erosion of consciousness (either through the processes of disease itself, or as an outcome of the administration of pain-relieving drugs) and the notion of 'social' death.

This concept of 'social' death is complex, often connected to the control or lack of control of physical pain but also embedded within wider social contexts of dying, shaping notions such as 'loss of self' or 'loss of dignity'.⁴¹ Defining 'social' death involves a qualitative assessment of what constitutes a 'good' life, and how this life may be seen to have ended. For the hospice movement in the latter half of the twentieth century, a 'good' life and consequently a 'good' death was (and, indeed, continues to be) defined by the management of physical and psychological pain in order to 'free' the personality of the dying patient. For proponents of the hospice way of managing death, the concept of 'social death' is anathema to their philosophy that the patient should never be abandoned in either physical or psychological pain.

'Social' death is often located at the point when, to use Mike Mulkey's analysis, "the actor has ceased to be taken as an active agent in the ongoing social world of some other party."⁴² This is commonly taken to mean the ability to maintain social relationships – a view that is articulated in the euthanasia debates in this thesis. However, recent ethnographic studies of care of the dying suggest that notions of the 'self' can be closely tied to the ability to physically control one's body. This view also resonates in the thesis.⁴³ If 'social' death relates to the loss of ability to maintain social relationships and the loss of ability to control one's body, then it also raises the highly sensitive issue of non-voluntary euthanasia for those who are perceived as having lost (or indeed as having never had) such capacities.

Arguably, 'social' death requires a notion of a comparative scale on which the value of life is measured and, as a consequence, the question of non-voluntary euthanasia finds its way into the debates that I consider, despite the resistance of those who sought to maintain the focus on voluntary euthanasia. Again, the concepts of 'natural' and 'artificial' death feed into this third category of arguments surrounding 'social' death. Those in favour argue that euthanasia serves as a means of limiting loss of 'self' in an increasingly 'unnatural' medicalised world. Those against argue that it is an entirely 'artificial' means of abandoning or 'editing out' of those who are not perceived as fulfilling the criteria for a socially specified notion of a 'good' life.

I have set out the overarching theme of 'nature' versus 'artifice' that appears in this thesis and have outlined the three categories of argument that I identify in this historical account of euthanasia debates. The thesis is divided into two distinct parts. The first examines nineteenth-century attitudes to death and pain relief. The second analyses

responses (predominantly from the perspective of the medical community) to the campaign for legalised euthanasia, again with a particular emphasis on the way in which these responses were filtered through attitudes to pain relief. In the following chapters I aim to illustrate that, contrary to the prevailing view, current euthanasia debates are neither an entirely radical departure from previous medical-ethical debates, nor are they a purely a symptom of a bio-technological age. Contemporary euthanasia debates can, I argue, be considered as part of a longer historical picture in which changing types of medical intervention have shaped human experiences of death. Advances in medical technology may mean that our own experience of death is different from that of generations before us, but that does not mean that we are the first to be asking questions about where the boundaries between life and death should be drawn.

Notes

¹ Roger Cooter, 'The Ethical Body', in Roger Cooter and John Pickstone (eds), *Medicine in the Twentieth Century* (Amsterdam, Harwood Academic Publishers, 2000), 451-68 at p.452.

² In January 2002, the case of motor neurone disease patient, Reginald Crew, hit the headlines of British newspapers. Through the Zurich based non-profit making organisation Dignitas, Crew travelled from Britain to a 'euthanasia clinic' in Switzerland where, at his own request, he was administered a lethal dose of barbiturates. *The Times* newspaper published letters from readers who either supported the legalisation of euthanasia, describing it "as inalienable a right as freedom of expression or the right to vote", or opposed legalisation on the basis that life was sacred and "should be enriched by faith in God". *The Times*, 'A little help with dying', letters from readers, The Register section, 10 January 2003, p.42. See also Carol Midgley, 'Dead Certain: The Last Hours of a Euthanasia Patient', *The Times*, T2 section, 10 January 2003, pp.4-6.

³ One of the best examples of thoughtful, philosophical discussion of euthanasia is Jonathan Glover's *Causing Death and Saving Lives* (London, Penguin Books, 1977).

⁴ Ludwig Edelstein, *The Hippocratic Oath – Text, Translation, and Interpretation, Supplement to the Bulletin of the History of Medicine* (Baltimore, John Hopkins University Press, 1943), Danielle Gourevitch, 'Suicide Among the Sick in Classical Antiquity', *Bulletin of the History of Medicine*, 53 (1969), 501-18 and most recently, Plinio Prioreschi, 'Did the Hippocratic Physician Treat Hopeless Cases?', *Gesnerus, The Journal of the History of Medicine and Sciences*, 49, (1992), 341-50.

⁵ Raanan Gillon, 'Suicide and Voluntary Euthanasia: Historical Perspective', in A.B. Downing, (ed.), *Euthanasia and the Right to Die – the case for voluntary euthanasia* (London, Peter Owen Ltd, 1969), 73-192, Hugh Trowell, *The Unfinished Debate on Euthanasia* (London, SCM Press, 1973), 1-22. See Thomas More, *Utopia*, Book Two, (London, Penguin Books, 1965), p.102.

⁶ Edelstein, *The Hippocratic Oath*, p.10.

⁷ W. Bruce Fye, 'Active Euthanasia: An Historical Study of its Conceptual Origins and Introduction into Medical Thought', *Bulletin of the History of Medicine*, 52 (1979), 492-502. I. Van der Sluis, 'The Movement for Euthanasia, 1875-1975', *Janus*, 66 (1979), 131-172. Other short papers that proved useful were Ezekiel Emanuel, 'The History of Euthanasia Debates in the United States and Britain', *Annals of Internal Medicine*, 12 (1994), 793-802, and Demetra Pappas, 'Recent Historical perspectives regarding medical euthanasia and physician assisted suicide', *British Medical Bulletin*, 52:2 (1996), 386-93. For a comprehensive bibliography providing details on a range on writing on euthanasia, see Charles W. Triche and Diane Samson Triche, *The Euthanasia Controversy 1812-1974: A Bibliography with Select Annotations* (New York, The Whitson Publishing Company, 1975).

⁸ Nicholas Kemp, 'Merciful Release', *The History of the British Euthanasia Movement* (Manchester, Manchester University Press, 2002). See also Robin Condliffe, 'Merciful Release? A History of the British Voluntary Euthanasia Movement', B.Sc. dissertation, University of London (1995).

⁹ Kemp, *Merciful Release*, p.62.

¹⁰ Ian Dowbiggin, *A Merciful End, The Euthanasia Movement in Modern America* (Oxford, Oxford University Press, 2003). For a less detailed but very readable account of twentieth-century American euthanasia debates, see also Peter Filene, *In the Arms of Others: A Cultural History of the Right-to-Die in America* (Chicago, Ivan Dee, 1998).

¹¹ Jane Elizabeth Seymour, 'Revisiting Medicalisation and "Natural" Death', *Social Science and Medicine*, 49 (1999), 691-704. See also Jane Elizabeth Seymour, *Critical Moments – Death and Dying in Intensive Care* (Buckingham, Open University Press, 2001).

¹² Seymour, 'Revisiting Medicalisation', p.691.

¹³ Philippe Ariès, *Western Attitudes Towards Death: From the Middle Ages to the Present* (Baltimore and London, John Hopkins University Press, 1976), p.105 and p.106.

¹⁴ *Ibid.*, at p.88.

¹⁵ Philippe Ariès, *The Hour of Our Death* (London, Allen Lane, 1981), p.18. The description of the hospitalised patient covered with tubes appears at p.614. Also cited by Jane Elizabeth Seymour, 'Revisiting Medicalisation', p.692.

¹⁶ Ivan Illich, *Limits to Medicine. Medical Nemesis: The Expropriation of Health* (Harmondsworth, Penguin Books, 1976), p.11 and p.160. Illich situates the process of medicalisation within broader social trends, namely the increasing industrialisation and bureaucratisation of western societies.

¹⁷ *Ibid.*, at p.111 and p.210.

¹⁸ Ariès uses the phrase “the cruelty of solitary death in hospitals”. He contrasts this type of death with an older type of death that took place at home and which was, in his assessment, “the occasion of a ritual ceremony, over which the dying person presides amidst his assembled relatives and friends”. See Ariès, *Western Attitudes Towards Death*, p.102 and p.88.

¹⁹ Illich, *Limits to Medicine*, p.181.

²⁰ Barney Glaser and Anselm Strauss, *Awareness of Dying* (Chicago, Aldine, 1966); David Sudnow, *Passing On: The Social Organisation of Dying* (New Jersey, Prentice-Hall, Englewood Cliffs, 1967).

²¹ Glaser and Strauss, *Awareness of Dying*, p.5 and p.40.

²² Illich, *Limits to Medicine*, footnote p.112. David Sudnow’s study of hospital care of the dying in America describes the disturbing scene of a nurse repeatedly attempting to close the eyes of a woman patient. When asked what she was doing, the nurse explained that the patient was expected to look as though asleep after death. Since it was difficult to close the eyelids of a dead patient, due, she argued, to stiffened muscles and skin, she always attempted to close the eyes of the patient *before* death. It was also “a matter of consideration towards those workers who preferred to handle the bodies of the dead as little as possible”. See Sudnow, *Passing On: The Social Organisation of Dying*, pp.192-193. Also cited in a footnote by Illich, *Limits to Medicine*, p.210.

²³ Tony Walter, ‘Sociologists Never Die. British Sociology and Death’, in David Clark (ed.), *The Sociology of Death* (Oxford, Blackwell, 1993), 264-295 at p.286. In another critique, Walter points out that Ariès documents the deaths of the rich but neglects to consider the deaths of the poor. He comments: “The poor have always been buried without much ritual, and are probably dispatched with more respect in modern welfare states than in any other epoch.” Walter, ‘Modern Death: Taboo or not Taboo?’ in Donna Dickenson and Malcolm Johnson (eds), *Death, Dying and Bereavement* (London, Sage, 1993), 33-44 at p.35.

²⁴ Norbert Elias, *The Loneliness of Dying* (Oxford, Blackwell, 1985), p.12.

²⁵ Perhaps not surprisingly, the *British Medical Journal* review of *Medical Nemesis* also took issue with Illich’s ‘romanticised’ view of death in the past. The journal argued that “...few, having read of the horrors of death bed scenes in nineteenth-century letters and fiction (including Tolstoy’s own *Ivan Ilyitch*), could agree that death then was a calm, natural event, which has since been subjected to ‘medicalisation’ robbing the modern individual of dignity at the end of his life.” *British Medical Journal*, ‘Medical Nemesis’, 7 December 1974, pp.548-549. See Leo Tolstoy, *The Death of Ivan Ilyitch*, trans. Constance Garnett (London, Heinemann, 1902).

²⁶ Eric Hobsbawm develops the idea that the past can be reconstructed and selectively ‘edited’ in Eric Hobsbawm and Terence Ranger (eds), *The Invention of Tradition* (Cambridge, Cambridge University Press, 1983). Also cited by Julia Lawton, *The Dying Process. Patients’ Experiences of Palliative Care* (London, Routledge, 2000), p.11.

²⁷ For a late twentieth-century discussion of what the author describes as the “strategic practice of withdrawing technological support for the dying patient in order to ‘mimic’ the more gradual decline of ‘natural’ death”, see Janet Harvey, ‘The Technological Regulation of Death, with reference to the Technological Regulation of Birth’, *Sociology*, 31:4 (1997), 719-35.

²⁸ Daniel Callahan, ‘On Defining Natural Death. An Idea for Public Policy’, *Hastings Centre Report*, 7:3 (1997), 32-37. Callahan maintains that a concept of ‘natural’ death is a social, economic and political necessity. Not only does such a concept provide a psychological framework for dealing with death but it also guides the limit and scope of medical intervention. Callahan specifies ‘natural’ death as the death of individual in his or her old age, free from “degrading pain” and having discharged familial obligations where children are grown and financially independent. For Callahan, a ‘natural’ death has as much to do with the *life* that an individual has led, as it has to do with dying. In his article, Callahan describes the death of his six-week old son and his reaction to this death. See also Daniel Callahan, *The*

Troubled Dream of Life. In Search of a Peaceful Death (Washington D.C., Georgetown University Press, 2000).

²⁹ Later in the thesis, when discussing the role of the hospice movement in twentieth-century euthanasia debates, I consider David Armstrong's argument that the extension of the 'clinical gaze' can be identified in medicine's growth of influence in the psycho-social context of disease and wider social spheres. See David Armstrong, *Political Anatomy of the Body: Medical Knowledge in Britain in the Twentieth Century* (Cambridge, Cambridge University Press, 1983).

³⁰ In her paper examining Japanese cultural debate over issues of technological intervention and attitudes to death, Margaret Lock argues that the concept of 'nature' is culturally constructed and cultivated. She provides the following useful analysis: "A scientific account assumes nature to be subject to experimental manipulation and ultimately understandable as a set of universal laws ... a domain entirely separate from the moral order. In practice however, 'nature' continues to serve as a moral touchstone, the effects of which are particularly evident at the culturally constructed margins between 'nature' and 'culture'." See Margaret Lock, 'Contesting the Natural in Japan', *Culture, Medicine and Psychiatry*, 19 (1995), 13-38 at p.14.

³¹ Michael Burleigh, *Death and Deliverance, 'Euthanasia' in Germany c.1900-1945* (Cambridge, Cambridge University Press, 1994), p.6. After reading Burleigh's excellent but disturbing account of the Nazi 'euthanasia' programme, conducted both prior to and during the Second World War, one can be left in no doubt of the horrendous practices that were carried out in the name of euthanasia. Burleigh declares that he has "no axes to grind regarding contemporary euthanasia discussions", if anything he is "sympathetic to its voluntaristic implementation", (p.6). Nevertheless, he makes the point that not only were the Nazi programmes economically motivated (care of the mentally ill and disabled was viewed as a burden on the public purse) but they were also underpinned by a philosophy in which a strand of eugenic thought labelled certain groups as 'sub-human'. This implied that lives were judged as 'valueless' in social as well as economic terms. Burleigh sees a danger in contemporary euthanasia debates in which, he argues, human beings are denied the status of 'personhood'. In the epilogue to his book, Burleigh criticises the controversial views of moral philosopher Peter Singer. See Peter Singer, *Practical Ethics* (Cambridge, Cambridge University Press, 1993), in particular, Chapter 4. Singer rejects what he calls the "speciesist distinctions' between persons and non-human animals. Instead he maintains that certain humans should not be classed as 'persons', while certain non-human animals such as chimpanzees or dolphins should be classed in such a manner.

³² Burleigh details how many psychiatrists followed the Nazi 'euthanasia' policy of killing mentally ill or disabled people who were classed as 'chronic' or 'unproductive' cases. Using a considerable amount of archive material, Burleigh shows how psychiatric 'reform' was often achieved by means of exterminating patients and as a result, 'hundreds of thousands of men, women and children were gassed, starved or murdered with lethal injections in a series of ever widening-programmes.' Burleigh, *Death and Deliverance*, introduction, page not numbered. See also David Thomasma, 'Euthanasia as Power and Empowerment', in Robert H. Bank (ed.), *Medicine Unbound – The Human Body and the Limits of Medical Intervention* (New York, Columbia University Press, 1994), 210-226. Thomasma describes how, because of the Nazi euthanasia programme, euthanasia "has come to represent all that is evil about state control over individual lives" and yet "it is also seen as a rescuer from suffering and the burdens of dying in a technological society" (p.6).

³³ The philosopher Richard Rorty argues that a distinction must be drawn between what he views as the more accurate conception of 'idealisation' of principles and what he considers to be the misplaced notion of 'foundations' of principles. Principles when treated as foundations are, he argues, viewed as appealing beyond practice to independent concepts such as 'human nature', 'rationality' and morality'. Yet according to Rorty, this is simply a way of "commending one's own sense of what is most worth preserving in our present practices, of commending our own utopian view of our community". 'Idealisation' meanwhile, presents principles as the product of ideals produced in order to give practice coherence. In Rorty's assessment, political and ethical theorising, even when operating at a high level of abstraction, is in some sense concerned with competing claims to how practice should best be 'idealised' and thus translated into principle. Richard Rorty, 'Idealisations, Foundations,

and Social Practices', in Seyla Benhabib (ed.), *Democracy and Difference, Contesting the Boundaries of the Political* (New Jersey, Princeton University Press, 1996), 333-5. In the 2001 Edinburgh University Gifford Lectures on the subject of 'Autonomy and Trust in Bio-ethics', the philosopher Onora O'Neill gave an alternative account of the formation of principles. O'Neill's argument, based on what she described as a "principled view of autonomy", gave a Kantian-based account of principles, rooted in the concepts of the 'autonomy' and 'authority' of reason. Her argument is a complex one, which cannot be done justice in a short footnote. However, it would be fair to state that she takes a very different view of 'principles' than Richard Rorty – arguing, as she does, from a notion of 'reason' existing independently of practice.

³⁴ David Hume's *Essay on Suicide* (1777) cited by Kenneth Boyd in 'Euthanasia: Back to the Future', in John Keown (ed.), *Euthanasia Examined: Ethical, Clinical and Legal perspectives* (Cambridge, Cambridge University Press, 1995), 72-82 at p.73.

³⁵ Sharon Kaufman, *The Healers Tale, Transforming Medicine and Culture* (Wisconsin, University of Wisconsin Press, 1993), p.354.

³⁶ The term 'persistent vegetative state' (or PVS) was first coined in 1972 by the Scots doctor Bryan Jennett and the American doctor Fred Plum. Earlier in 1959, Frenchmen Moullaret and Coulon described the syndrome of brain death (*coma dépassé*) and in 1968, a committee of the Harvard Medical School formulated neurological criteria to diagnose brain death. See Ronald Cranford, 'The Criteria for Death', in Warren Reich (ed.), *The Encyclopedia of Bio-ethics* (New York, Macmillan, 1995), 529-33. Brain stem death was recognised in the United Kingdom in 1976 when the Royal Colleges published criteria for making a diagnosis of 'brain-death'. While it would be wrong to argue that this, for the first time, 'created' a tension between definitions of social and biological death, the emergence of this new classification of death has undoubtedly opened another front in euthanasia debates. This is particularly the case in orthodox religious quarters, where brain stem death is often not recognised. See 'Brain Stem Death: Managing Care when Accepted Medical Guidelines and Religious Beliefs are in Conflict', *BMJ*, 6 May 2000, pp.1266-7. In this, the former Chief Rabbi, Immanuel Jakobovits, seeks a compromise by arguing that "While one may not actively cause or hasten the onset of death, and one may therefore never withhold normal and natural means to sustain life – such as food, drink, blood, or oxygen – one need not artificially prolong life by administering antibiotics to suppress infection. Thus, one may allow nature to take its course by withholding such treatment."

³⁷ For an interesting historical view of the role of technological developments in medicine and what the author describes as "the connotations of assault and unnaturalness borne by these technologies", see Jennifer Stanton, 'Supported Lives', in Roger Cooter and John Pickston (eds), *Medicine in the Twentieth Century* (Amsterdam, Harwood Academic Publishers, 2000), 601-15. As Stanton highlights, artificial respiration is not a novel creation of the modern intensive care unit. During the nineteenth century (and even earlier), equipment was available to help the respiration of those who had stopped breathing through paralysis, poisoning or drowning. Then in 1928, came the popularly known 'Iron Lung' designed by Philip Drinker, an engineer at Harvard School of Health.

³⁸ Stanton argues that high levels of technology do not necessarily distance medical staff from their patients or necessarily leave patients feeling dissatisfied and isolated. She gives the example of Marjan Groen's study of intensive care units in The Netherlands: Marjan Groen, *Technology, Work and Organisation: A Study of the Nursing Process in Intensive Care Units*, University of Limburg Dissertation, Maastricht, The Netherlands (1995). Cited by Stanton, 'Supported Lives', p.610.

³⁹ Seneca, first century A.D, quoted by Dr C. Killick Millard, *The Movement in Favour of Voluntary Euthanasia – An Historical Study* (Leicester, W. Thornley and Son, 1936), p.4. It should be noted that Millard, the founding Honorary Secretary of the Voluntary Euthanasia Society quotes Seneca as part of an argument for the legalisation of voluntary euthanasia. It is interesting that 'the case' of another philosopher from ancient times has also been mobilised in euthanasia debates, but this time in an argument against the legalisation of euthanasia. In a speech given to MPs and Peers at the House of Commons in December 1991, Cicely Saunders (her work is detailed at length later in this thesis) argued that Socrates drank hemlock only as an "alternative to exile". The hospice movement's commitment to prevent patients from feeling abandoned and isolated explains the point that

she is making here – that euthanasia is both undesirable and unnecessary if adequate support is given. The records, papers and personal correspondence of Dame Cicely Saunders are held at the Trent Palliative Care Centre, University of Sheffield. See Cicely Saunders, 'Euthanasia: Definitions, Dangers and Alternatives,' unpublished speech given to MPs and Peers at the House of Commons, 10 December 1991, p14: Cicely Saunders' Papers, Box 34, file 1/5/41.

⁴⁰ See Pat Jalland, *Death in the Victorian Family* (Oxford, Oxford University Press, 1996). From her analysis of the private diaries, letters and death memorials of over fifty middle/upper class Victorian families, Jalland argues that the significance of clarity of mind was particularly important in the first half of the nineteenth century in Evangelical households. By the latter half of the century it was less so and more likely to be "uncluttered by emotional confessions and farewells", (pp.117-8). Nevertheless, the importance of being conscious at the time of death can be traced long after the time of the Victorian Evangelical revival. In particular, the Roman Catholic sacrament of extreme unction, performed just before death (again, discussed later in this thesis), can be seen as shaping attitudes to death well into the twentieth century.

⁴¹ Mike Mulkay makes the interesting point that 'social death' also encompasses the notion that the dead may continue to 'live' even after the point of biological death. The dead can continue to influence the living and the observable world such that "social death sequences should be conceived of as interactive processes which may operate over long periods of time and which may extend either side of the grave". See Mike Mulkay, 'Social Death in Britain', in David Clark (ed.), *The Sociology of Death* (Oxford, Blackwell, 1993), 31-49 at p.33.

⁴² Ibid., at p.33.

⁴³ See Lawton, *The Dying Process*. In her observational study of an English hospice in 1994-95, Lawton develops the argument that it is what she terms "the unbounded" body that presents the greatest problem in palliative care. The "unbounded body" – loss of control over bodily functions and emissions – determines loss of 'self', rather than, as previously thought, the ability to maintain social relationships. Many of the patients she describes were admitted to the hospice because of problems such as incontinence or fungating wounds. She observed that these patients were often perceived (either by themselves or by their carers), to have lost their sense of 'self' – to have died a 'social death' before their biological death.

PART 1

The Nineteenth-Century Euthanasia Debate

Introduction: Death in the 1800s and a New Model of Dying

Go now my ship, launched on the public sea,
That silently hast grown in secret dock;
Nor axe, nor saw, nor hammer fashioned thee,
Hewn by poetic hand from lifeless block,
Go and expect the rude affronting shock
Of waves and winds, and elemental jar,
Nor shame thy parent soil and British stock,
True heart of oak, hight 'Euthanasia'
Following the bear with sev'n lamps and steadfast star.¹

Published in 1866, Erasmus Brodie's poetic eulogy to Sir John Franklin's fated Arctic exploration is a romantic celebration of bravery, endurance and nationalistic sentiment. It is also a poem about an idealised model of death. Titled *Euthanasia*, the later verses of Brodie's epic describe what the poet terms a 'happy death' for the ship's crew. Frozen in death and in the Victorian imagination, the conclusion to the lives of the men on board resembles sleep; it is gentle and serene, their bodies are unblemished. Risking and ultimately sacrificing life for the sake of expanding human knowledge, for Brodie this was 'euthanasia' – the good death. It epitomised Victorian virtues of endeavour and fortitude in extremes. It represented a thirst for discovery and a drive to uncover the secrets of the natural world. Most importantly, in the mind of the poet at least, it was peaceful.²

The poetic world of Brodie's *Euthanasia* resonates with a new view of death that was consolidated in the nineteenth century. Significant shifts in both theological thought and medical practice contributed to the re-conceptualisation of physical suffering, which in turn had important implications for the way in which death was understood and medically managed. The ideal of 'natural' death – a peaceful and easy transition from an earthly world to a divine kingdom – has origins in the latter half of the eighteenth century but it was in the nineteenth century that this concept became established as the dominant paradigm of an

idealised, 'good' death. In this introduction to the first section of my thesis, I examine how this new model of dying, the 'natural' death, came to the fore during the nineteenth century. I also contend that this concept of 'natural' death is rooted in a particular, ideological framework and located within a specific historical context.

The historical context to 'natural' death is important because, as I will argue, the euthanasia debate that surfaced in the latter stages of the nineteenth century was closely entwined with the theological upheavals and changes in medical practice that accompanied the rise of this new ideal of death. As I will contend in later chapters of this section, the euthanasia debate of the late nineteenth century centred on the contesting of what 'natural' death meant and how this ideal might be practically achieved. Crucially, it was also during this period that the word 'euthanasia' itself began to take on a new meaning and became subject to debate. 'Euthanasia' began to imply not only a gentle and easy death but also a death that was medically induced by the direct intervention of the doctor at the explicit request of the dying patient. The twin factors of challenges to established theological thought and changes in medical practice provided the ideological space that was conducive to such debate.

It is to these two elements of theological and medical change that I now turn in this introductory consideration of 'natural' death in the nineteenth century. Prior to the emergence and acceptance of 'natural' death, a far more terrifying vision held centre stage in the public imagination. In the seventeenth century the image of death as a dark and terrible enemy was commonplace. Underpinned by the belief in the physical existence of hell and eternal damnation, Christian theology cast death as an arbitrary force that lay in the hands of Nature ('Nature' representing the will of God) and was a punishment for sin. Death was to be feared and only through religious ritual and repentance might this fear be alleviated. For Roman Catholics, the emphasis was on repentance at the point of death, salvation by means of the sacraments, or even a lengthy period in purgatory. For many in the Protestant denominations however, such 'comforts' in the latter stages of life were treated with scorn. The hand of God could strike at any time, and it was therefore the duty of the Christian to prepare him or herself for death on a daily basis. In line with the belief that death resided in the realm of Nature and Providence, medicine played a limited role in the management of death, both in theory and in practice. In the case of the dying patient, medicine assumed a secondary role to religion. Often, the main task of the doctor was to give an honest prognosis

before withdrawing, to allow the dying man or woman to prepare for death and divine judgement.³

However, during the second half of the eighteenth century the horror of death gradually began to recede and in its place emerged the idea of 'natural' death – the concept that death was a gentle and peaceful transition from one world to the next. Death was beginning to shake off its terrifying seventeenth-century clothes. An alternative vision was taking shape, captured by what Roy Porter describes as an image of death as a “quintessentially natural process”.⁴ Importantly, the literal belief in eternal damnation and the belief in suffering as a form of divine punishment began to weaken under a growing weight of theological dissent. This process dramatically came to a head in the Church of England heresy trials of the 1860s, primarily instigated as a result of the defendants' refusal to accept the infallibility of the Bible and in particular, the literal existence of eternal damnation.⁵

While the Roman Catholic Church and the Evangelical wing of the Church of England resisted any change to the doctrinal emphasis on damnation, for many other Christians it became increasingly difficult to reconcile the cruelty of the pains of hell with the redemptive pains of Jesus Christ. Linked to this debate was a fresh assessment of the religious justifications for physical suffering. If it was difficult to contemplate a loving God inflicting an eternity of literal, physical pain on the sinner in hell, it was also difficult to perceive earthly pain as a form of retributive punishment. Once the connection between eternal damnation and physical pain had been broken, the established theological values and meanings attached to human suffering were open to radical question.⁶

In her comprehensive treatment of the different ways in which pain was understood in the nineteenth century, Lucy Bending shows how theological arguments about the meaning of physical pain shifted throughout the century. She argues that in the 1840s, debates surrounding the understanding of physical pain were closely connected with a rejection or acceptance of the belief in eternal damnation. However, by the mid-1860s onwards, arguments had largely moved on to a division between those who fought to maintain a theological explanation for suffering (pain still had a mysterious divine 'purpose' but was not necessarily a form of punishment) and those who refused to accept such a view. Part of this shift, argues Bending, was the manner in which “advances in medical knowledge breached Christian certitude as they undermined the naturalness of pain and put in its place a

bodily function that could be removed or at least alleviated by chemical or surgical interference.”⁷

Undoubtedly, the nineteenth-century introduction of powerful new pain-relieving drugs such as chloroform, morphine and ether had a significant impact on the debate over the meaning of physical suffering. As already discussed, the introduction of new pain-relieving practices came at a time when there was already theological doubt about the ‘value’ of pain. In part medicine moved into the ideological vacuum created by this uncertainty, and in part medicine helped to fuel the growing sense of doubt that pain could be understood within a religious framework of reference. In an unprecedented manner, doctors now had the ability to alleviate and even eliminate pain. Though the capacity to relieve suffering outflanked medical understanding of its causes, the search for an explanation of pain that centred on neurology had the effect of linking pain to the human body and to some extent, stripped pain of its religious connotations. Physical pain was no longer necessarily identified as a ‘natural’ manifestation of divine will in a divinely ordered world, but as a morally and religiously neutral phenomenon that could be medically treated.

In her study of death and dying as experienced by middle and upper class Victorian families, Pat Jalland charts what she views as the decline of the Evangelical ‘good’ death that was, she contends, eroded by the influence of “the forces of secularism, indifference and unbelief”.⁸ According to Jalland, such a death ideally took place at home, with the dying person reconciled to God’s will, saying their last farewells to family and stoically bearing pain “as a final test of fitness for heaven and willingness to pay for past sins.”⁹ Early in the century, a ‘bad’ death meant loss of ability to speak, or failure to make final spiritual preparations or a reluctance to die, or the taking of one’s own life. Such a death was characterised by a lack of faith and an alienation from God. By the end of the century, a ‘bad’ death was instead characterised by pain and suffering. Jalland argues that the relationship between religion and medicine played a central role in this decline of the Evangelical ‘good’ death. Initially, “Christian doctors shared with the families they treated many of the same aspirations for the ‘good’ death. By the time doctors had more substantial powers ... fewer doctors or patients were Christians.”¹⁰

As I will contend in the next chapters, the ability of doctors to alleviate pain had significant implications for the way in which the idea of ‘natural’ death was construed and the manner in which the euthanasia debate in the latter part of the nineteenth century was

conducted. Consequently, medical innovation, specifically in the development of pain-relieving techniques and practices, is one of the central themes of the chapters that follow. That being said, there are a number of provisos that require mentioning in relation to the new methods of pain relief that I discuss at length in the later chapters of this first section.

First, caution needs to be exercised when talking of the role that the medical control of pain played in 'replacing' religious views of the world. As I will argue, the elite medical practitioners of the nineteenth century who endorsed the liberal use of pain-relief were themselves religious men who often justified their actions with recourse to theological arguments. The alleviation of pain, albeit in powerful new ways, was seen by them as a Christian, moral duty. Pain and suffering might have been detached from the belief that they were a divinely intended punishment, but the ability to alleviate suffering in an unheralded manner did not represent a comprehensive secularisation of the way in which doctors perceived the practice of relieving pain. Rather, this was a time when religious beliefs were being re-defined particularly with regard to the relationship between divinity and nature, or, more narrowly, between divinity and the meaning of pain.

Secondly, though the nineteenth century was clearly a time of important and significant breakthroughs in pain-relieving techniques, it would be an over-simplification to read this period as a heroic moment in history, in which the adoption of certain types of techniques was related solely to a triumphant conquest over pain. The historian Alison Winter has argued that the introduction of inhalation anaesthesia in the mid-nineteenth century was as much about the medical community securing the supremacy of this particular form of pain relief over the rival practice of mesmeric anaesthesia. For a period, mesmeric anaesthesia was the subject of considerable controversy among physicians, surgeons, scientists and the public. Ultimately, the practice was discredited and labelled 'quackish', but not before it had proved a serious challenge to inhalation anaesthesia.¹¹

Histories of pain relief often neglect to consider the extent to which in the mid-nineteenth century mesmerism rivalled inhalation anaesthesia.¹² As Winter writes: "typically, once a dispute has come to a close, the process of negotiation becomes invisible."¹³ It is worth noting, therefore, that the adoption of certain techniques for relieving pain as opposed to others was not a foregone conclusion. Additionally, the professional need to present the impression of a powerful and united medical community that strategically closed ranks against potential challenges to authority is also part of the history of anaesthesia in the

nineteenth century. Although I do not consider mesmeric anaesthesia in the following chapters, I do discuss how the introduction of inhalation anaesthesia was far from unproblematic and was associated (especially in the early years of its use) with risk.

Thirdly, although the nineteenth century witnessed the introduction of powerful new pain relieving practices that had an important impact on debates related to the management of death, the use of drugs during the final stages of life is not exclusive to this period. It should be remembered that the eighteenth century was also a time when the use of pain-relieving drugs was in evidence – so much so that it has even been termed “the anaesthetised age”.¹⁴ Stupefying drugs such as opium and its derivatives, as well as laudanum and alcohol were readily available. Opium and its derivatives were marked by the lack of restriction on their use and could be either self administered or given by doctors. As Porter significantly comments, by the late eighteenth century, “many people increasingly died insensible, stupefied with drugs often medically prescribed”. Porter also highlights how the rise of ‘insensible death’ may be an important factor in understanding late eighteenth-century anxiety in relation to premature burial.¹⁵

It is not surprising, therefore, that the late eighteenth-century ideal of ‘natural’ death coincides with an increase in the use of drugs in the sickroom. Drugs such as opium and laudanum enabled a peaceful, sleep-like death. Indeed, they were an integral part of this “quintessentially natural process” and their use enabled the dying man or woman’s final days and hours to conform to this new model of death.¹⁶ As I will argue, the nineteenth century was a period in which religious and medical interpretations of pain were officially articulated, tested and modelled anew. The new range of nineteenth-century pain-relieving techniques undoubtedly played an important role in this process. Practically speaking, however, the use of pain relief in supporting the concept of ‘natural’ death, has, like the ideal itself, eighteenth-century origins. Although these origins pre-date any official debate over the meaning of the term ‘euthanasia’, as I discuss in the following chapters, they mark a time of increasing medical interest in death among elite late eighteenth-century physicians.

Finally, it must be acknowledged that the following chapters that examine growing interest in nineteenth-century medical management of the dying are almost exclusively based on an analysis of official, public pronouncements made by elite practitioners. I am interested in the way in which these elite physicians translated medical practice into a recognised and accepted language, giving their actions a sense of order and, latterly, a means of rebutting the

calls to legalise patient-requested death. As such, the focus of the first section of the thesis is on the *rhetoric* of managing pain and death, concentrating on the ways in which the medical community articulated its official position and how it responded when this position was challenged.

The references to the interaction between doctors and patients in the first section of this thesis are largely references that relate to an intimate, one-on-one relationship between elite practitioners and their wealthy, private patients. Yet as Clare Humphreys identifies in her excellent study of care of the dying in the nineteenth century, “historians cannot simply assume that changing attitudes among late Victorian doctors and their wealthier clientele were transplanted across the social divide to poor, working class patients.”¹⁷ Jalland’s study of Victorian death is criticised by Humphreys for failing to distinguish between the various social groups in society. In doing so, Humphreys argues that Jalland’s work rests on an assumption that the growing sensitivity to the needs of middle and upper class dying patients also applied to other social groups.

Humphreys then highlights how well into the twentieth century, hospitals and doctors continued to refuse admission to impoverished patients diagnosed as incurable. Many were left untreated, frequently in the most painful stages of disease. With the impossible task of meeting fees, the poor had to fend for themselves, often ending up in workhouse infirmaries where treatment was basic. Although the second half of the nineteenth century saw the growth of a proliferation of voluntary hospitals, particularly in London, the reality was that, aside from the Poor Law infirmaries, organised care for the dying poor was thin on the ground. Incurables and the dying were officially debarred from voluntary hospitals.¹⁸

It is important to bear in mind that the following discussion of pain relief and the management of death, is a debate located at a public, elite level. For many of the poor in the nineteenth century, death was often a harrowing and protracted experience for the very reason that they were excluded from the realm of the medically managed and potentially costly ‘natural’ death. The ideal of a peaceful and easy death remained just that – an ‘ideal’. Humphreys documents how in the late Victorian era a number of religious hospices were established, founded specifically for the care of the dying. Between 1879 and 1905 five homes for the dying were opened in London (and another in Dublin) with the aim of providing a place of rest and comfort for the dying poor. Three out of the five homes either had close affiliations with or were run by religious orders.¹⁹

The emergence of such late-nineteenth century care of the dying was, to some extent, a continuation of the wider picture of changing attitudes to death and pain relief outlined in this introductory chapter. As already discussed, this was a time when religious attitudes to death and suffering were shifting, while therapeutic advances were challenging the way in which pain was both conceptualised and practically managed. Humphreys argues that the new homes for the dying “responded to, were shaped by, and contributed towards many of these developments”.²⁰ However, she also re-emphasises the point, made earlier in this introduction, that such re-prioritisation of the management of dying did not necessarily represent a growing secularisation of attitudes. Clearly, in the case of the religiously run homes for the dying, spiritual concerns were inextricably bound to the need to provide physical relief to the dying poor.

Jalland suggests that in the nineteenth century the growing desire and ability to relieve pain by medical means had the effect of diluting the importance of spiritual concerns at the deathbed. As I have argued in this introduction and will discuss further in the following chapters, although there is evidence to support the argument that older religious conceptions of pain were weakening and being replaced with a medical model, death itself often remained rooted in a theologically ordered world. Humphreys’ analysis adds important additional weight to this position by placing the nineteenth-century management of death in an institutional context. She maintains that the ‘secularisation’ argument fails to take account of the fact that it was institutions founded by those with strong religious beliefs that “served as an important refuge to those excluded from hospitals.”²¹

The following chapters on nineteenth-century arguments over the management of death focus on public debate, conducted predominantly among the medical elite. My interest in the institutional provision of care of the dying is in the twentieth century, because, I argue, this is when the impact of such provision breaks through into publicly articulated euthanasia debates, becoming part of the official discourse of death and dying. It is important, however, to acknowledge that institutional provision for the dying did exist in the nineteenth century, partly as a result of a general growth in interest in care of the dying and partly because there was a recognised lack of provision for the dying poor. The public debates that I analyse reflect the former but not the latter of these points. In addition, the importance of spirituality in the institutional care of the dying that is evident in the nineteenth century is a theme that

will re-surface in the second section of my thesis when I examine the twentieth-century relationship between the hospice movement and the campaign for legalised euthanasia.

The following chapters reflect a number of the key themes raised in this introduction. By setting the medical concerns surrounding the management of death and suffering in their broader social context, it is apparent that the nineteenth century was a period of both therapeutic breakthrough and ideological uncertainty. This was a time when doctors were in a position where death could be medically managed as never before. Although such a picture did not apply in all instances (given that, in many cases, an individual's particular experience of death depended on his or her social status), the rise of 'natural' death saw the doctor placed in a central, managerial role, orchestrating a peaceful end to life. This, at least, was the 'ideal' vision of death, and doctors were an integral part of this vision.

Challenges to orthodox religious interpretations of pain previously entrenched in theological thought, and the introduction of new pain relieving strategies into the repertoire of medical practice, created an environment in which the idea of 'natural' death could flourish. As will be explored in the following substantive chapters of this first section of the thesis, this re-orientation of death was neither fluid nor easy. Indeed, it was marked by controversy. I will argue that the persistence of the powerful ideological view of suffering as an expression of omnipotent power and human fragility meant that the relief of pain was challenged in certain religious quarters as an 'unnatural' affront to a divinely ordered world.

By the latter decades of the nineteenth century and at the other end of the ideological spectrum, voices began to be raised (initially from outside the medical profession) that contemplated a different role for pain relief. Demands now began to be made for the use of pain relieving drugs to include the doctor officially and explicitly bringing about the death of a suffering patient at the patient's own request. If a 'good' death really implied serenity and peacefulness, it was argued, then surely the use of pain relief to induce death was merely a natural extension of this new dimension to medical knowledge. It was at this point that the debate over 'euthanasia' began in earnest. What was meant by the term? What was legitimate medical practice? How far should the relief of pain be taken? How should the practice of pain relief be publicly articulated? As the following chapters will show, these were all questions that surfaced in the latter half of the century.

Primarily, the main substantive chapters of this nineteenth-century part of the thesis focus on the arguments surrounding pain relief and how they affected the management of the dying patient. The focus is largely orientated towards the medical profession: how change in practice was accommodated and debated within the medical world, and how the practice of pain relief was articulated to the wider lay community. The first chapter consists of a close reading and analysis of an Edinburgh medical student's unpublished M.D. thesis on the subject of the duties and responsibilities of the doctor when caring for the dying patient. The second chapter widens the frame of reference and examines debates (both within and outside the medical profession) related to the introduction of new pain-relieving techniques. Chapter 3 looks at the first lay interventions that called for the relief of pain to include the recognised and official sanctioning of requested death. Chapter 4 considers the medical profession's official response to this challenge.

The first section of the thesis is predominantly concerned with the first two analytical categories of argument that I trace throughout the thesis as a whole: the category of principled arguments for or against euthanasia; and the category of practical arguments for or against euthanasia based on pain relief. The third category of social death plays a less significant role, although it does factor into some of the analysis, particularly in the third chapter on lay contributions to the debate. The overarching theme of 'natural' death provides a conceptual reference point when analysing these nineteenth-century debates over pain relief and the management of death.

In his introduction to *Euthanasia*, Erasmus Brodie argues (somewhat inaccurately it must be said) that the Victorian age was "not a poetic age", but rather "a great epoch for practical efforts and results of every sort". However, "poetry is not dead, but sleepeth", he maintained: "so long as our human nature remains the same ... so long as the world continues to be a great stage of acting and suffering ... so long will we have poetry."²² The poet's choice of words is fitting. The nineteenth century, when death was portrayed not as the enemy but as a sleep-like friend, was a time in which the medical profession and wider Victorian society was wrestling with the question of how human suffering might be reconciled with such a 'natural' view of death. As a result of "practical efforts and results" of the therapeutic kind, the medical profession now had the capacity to make the sleep-like death a reality.

As I will argue, for the medical profession, the nineteenth century was a tale of justifying pain relief, and then of defending a notion of 'natural' death so to exclude any suggestion that such medical intervention might mean the deliberate and intentional ending of life on request. The challenge for elite members of the medical profession was to maintain the image of 'natural' death as an ideal that ultimately lay outside human control and yet allowed some degree of intervention. However, for those who disagreed, medical intervention meant that such an understanding of the 'naturalness' of death could not remain undisrupted. 'Natural' death was not a fixed point of reference but was subject to varying interpretations. Closely tied to this, I argue, was the emergence of the euthanasia debate in the second half of the nineteenth century. There was to be no swift resolution to this debate. On the contrary, it was only just beginning.

Notes

¹ Erasmus Henry Brodie, *Euthanasia: A Poem in Four Cantos of Spenserian Metre, On the Discovery of the North-West Passage by Sir John Franklin, Knight* (London, 1866), p.3. See also Francis Spufford, *I May Be Some Time: Ice and the English Imagination* (London, Faber and Faber, 1997), p.169.

² In *I May Be Some Time*, Spufford describes how Arctic death was commonly viewed as a clean and peaceful departure from the world. He writes: "Though the symptoms of scurvy and frostbite were well reported, and the public were accustomed to hearing that some living polar hero's sufferings marked his body, these suggested no distinct visual images to most people – no exact close up of sores, or morbid tissue whose cell-walls had been ruptured from within by ice-crystals. Already folk wisdom had it that freezing was a gentle, drowsy way to die, a kind exit from the cold." (p.169).

³ Roy Porter, 'Death and the Doctors in Georgian England', in Ralph Houlbrooke (ed.), *Death, Ritual and Bereavement* (London, Routledge, 1989), 77-94, at pp.79-81.

⁴ *Ibid.*, p.86.

⁵ See Lucy Bending, *The Representation of Bodily Pain in Late Nineteenth-Century English Culture* (Oxford, Oxford University Press, 2000), pp.10-16. Bending explores how the rejection of the doctrine of eternal pain in hell led to a period of turbulence and dissent within the Church of England. She discusses how several figures were brought before the ecclesiastical courts due to their refusal to accept a literal interpretation of the Bible. Central to this was their rejection of the biblical descriptions of hell that formed the basis for theological teachings. H.B. Wilson, editor of the controversial *Essays and Reviews* (London, John W. Parker, 1860), and his colleague, Rowland Williams, were tried in the ecclesiastical Court of the Arches. Both were eventually cleared of heresy. The more outspoken Charles Vosey, who was raised as a strict Evangelical, was found guilty of heresy and in 1871 forced out of the Church. In a series of sermons under the title *The 'Sling and the Stone'* (Ramsgate, Thomas Scott, 1867), Vosey claimed that no sin, however terrible, could merit an eternity of punishment since a loving, benevolent God could not inflict such suffering. Vosey began publishing his questioning sermons with the like-minded Thomas Scott in 1864. Interestingly, it was Scott who, in the latter half of the nineteenth century, published a number of essays by writers sympathetic to the idea of patient-requested death.

⁶ Bending comments that "The Christian Church in Britain had no single doctrinal line on physical pain, and its manifold meanings were pulled sharply this way and that by party and denominational allegiances, remaining unstable within the boundaries of a single denomination": (*The Representation of Bodily Pain*, p.6). Broadly speaking, however, the Roman Catholic Church and the Evangelical wing of the Church of England opposed any change in doctrine, while the Unitarians and other Christians who did not align themselves with either the Catholics or Evangelicals were more likely to challenge the literal belief in hell. For a thorough exploration of the Victorian debate over eternal damnation, see also Geoffrey Rowell, *Hell and the Victorians: A Study of Nineteenth-Century Theological Controversies concerning Eternal Punishment and the Future Life* (Oxford, Clarendon Press, 1974).

⁷ Bending, *The Representation of Bodily Pain*, p.52.

⁸ Pat Jalland, *Death in the Victorian Family* (Oxford, Oxford University Press, 1996), p.183.

⁹ *Ibid.*, p.26.

¹⁰ *Ibid.*, p.77. See also Lynne Vallone, 'Fertility, Childhood, and Death in the Victorian Family', *Victorian Literature and Culture*, 28:1 (2000), 217-26.

¹¹ Alison Winter, 'Ethereal Epidemic: Mesmerism and the Introduction of Inhalation Anaesthesia to Early Victorian London', *Social History of Medicine*, 4 (1991), 1-27. For an extended discussion of this subject by the same author, see *Mesmerised: Powers of Mind in Victorian Britain* (Chicago, University of Chicago Press, 1998).

¹² For example, in Peter Fairley's study of pain and its treatment, the entry on mesmerism is in a chapter titled 'The Curious Arts'. Fairley describes how, in 1850, the London Mesmeric Infirmary was established – with others opened in Bristol, Exeter and Dublin – and then concludes (without mentioning the struggle that ensued) that "all were eclipsed before long by the advent of ether and chloroform". See Fairley, *The Conquest of Pain* (London, Michael Joseph, 1978), pp.225-6.

¹³ Winter, 'Ethereal Epidemic', p.3.

¹⁴ Porter, 'Death and the Doctors', p.91.

¹⁵ Ibid., p.93.

¹⁶ For a detailed discussion of the use of opium and its derivatives in the following century see Virginia Berridge and Griffith Edwards, *Opium and the People: Opiate Use in Nineteenth-Century England*, (London, Allen Lane, 1981).

¹⁷ Clare Humphreys, "'Undying Spirits': Religion, Medicine and Institutional Care of the Dying 1878-1938', PhD thesis, Department of Palliative Medicine, University of Sheffield (1999), p.205.

¹⁸ For a description and analysis of hospital and infirmary provision see Graham Mooney, Bill Luckin and Andrea Tanner, 'Patient Pathways: Solving the Problem of Institutional Mortality in London during the later Nineteenth Century', *Social History of Medicine*, 2 (1999), 227-69.

¹⁹ See Humphreys, 'Undying Spirits'. The Hostel of God in Clapham, founded in 1891, was run by Anglican nuns; St Luke's Hospice, Regents Park, opened in 1893 and had close contacts with the Methodist sisters who visited the home; and St Joseph's Hospice in East Hackney, founded in 1905, was run by the Irish Sisters of Charity.

²⁰ Ibid., p.204.

²¹ Ibid.

²² Brodie, *Euthanasia*, preface to poem, pp.v-vi.

Chapter 1

Death, Suffering and Duty – A Medical Student’s Analysis of Euthanasia in 1854

I. Caring for the Dying: Ethics or Etiquette?

As I have argued, by the late eighteenth century doctors were beginning to play an increasingly central, managerial role at the deathbeds of their more wealthy patients. With this grew a desire to acknowledge officially the importance of caring for the dying; a point acknowledged in John Gregory’s *Lectures on the Duties and Qualifications of a Physician* published in 1772. Gregory emphasised the importance of the doctor recognising his duties to those who were beyond cure: “It is as much the business of the physician to alleviate pain, and to smooth the avenues of death, when avoidable, as to cure disease.”¹

Then, in 1794, the reforming physician Thomas Percival published his *Medical Jurisprudence*, which in 1803 was re-worked as *Medical Ethics: or a code of institutes and precepts adapted to the professional conduct of physicians and surgeons*.² Commenting on the personal attributes required by the conscientious physician, Percival remarked: “Every case, committed to the charge of a physician or surgeon should be treated with attention, steadiness and humanity.”³ For the dying patient there was much the physician could do to make death easier “by obviating despair, by alleviating pain, and by soothing mental anguish”.⁴ So when, in 1854, the Edinburgh medical student Hugh Noble submitted his M.D. thesis titled simply, ‘Euthanasia’, he was adding to a growing body of writing on the physician’s role in relation to the dying patient.⁵ This chapter consists of a close reading and analysis of Noble’s thesis in which he considers how a peaceful, ‘good’ death might be achieved by medical means. However, before turning in detail to Noble’s writing on the care of the dying, it is important to acknowledge that the literature to which he was adding has itself been a theme of academic debate and interpretation.

Percival’s work was the main contribution to this new body of literature on medical ethics that emerged in the late eighteenth century and, perhaps as a result, has been subject to considerable scrutiny from historians and sociologists alike. For some, such as the American

sociologist Elliot Friedson, writing in the 1970s, Percival's focus was not on questions of 'ethics' but rather on matters of intra-professional 'etiquette'. His central concern, contends Friedson, was protecting the status of doctors, both materially and socially.⁶ According to Friedson, subsequent medical ethical codes inspired by Percival's writing were designed to "prevent 'unfair' internal competition" while at the same time "maintaining an impeccable front of silence to the outside world."⁷ For Friedson and others who shared his analysis, Percival's work was primarily about the regulation of fees and the prevention of disputes between the various interest groups in the medical community.⁸

More recently however, Percival's writing has been re-considered. Andrew Morrice argues that Friedson's assessment has "caricatured the content" of *Medical Ethics* and in contrast draws attention to the work of John Pickstone that locates Percival's writing in a wider tradition of Enlightenment ideals of duty, honour, civility and virtue.⁹ Morrice also points to Roy Porter's evaluation of the medical ethical writing of Percival and Gregory – work that Porter suggests was informed by the concepts of gentlemanly duty and Christianity as conceived by Thomas Gisbourne.¹⁰ In part, argues Morrice, Percival's work was concerned with preventing internal professional conflict – *Medical Ethics* was written in the aftermath of a dispute within the medical profession over the control of the Manchester Infirmary in 1794. As Morrice highlights, the opening chapter of Percival's book is pre-occupied with establishing a set of rules that would prevent the repeat of such hostility within the profession. The subsequent chapters, however, move away from narrow rule-making and address the duties of the physician – not only to fellow professionals, but also to patients.¹¹

Part of the difficulty in evaluating such late eighteenth-century medical ethical writing is the problem of defining 'medical ethics'. Morrice contends that in the aftermath of the 1947 Nuremberg Code and the 1948 Declaration of Geneva, medical ethics shifted to a new agenda founded on human rights.¹² Consequently, academics such as Friedson opted (mistakenly in Morrice's view) for a "retrospective recategorisation of earlier medical ethics as 'mere etiquette' with no ethical content."¹³ According to this "recategorisation", it was only after the Second World War that 'real' ethical issues (such as questions of patient autonomy) became subject to debate and prior to this doctors were primarily concerned with intra-professional relations and standards.

While it would be misleading to deny that current medical ethical discourse is radically different from the writing of Percival and Gregory, it is also ahistorical to suggest that these late eighteenth-century doctors were interested only in matters of etiquette. The relationship between doctor and patient was being discussed at this time, with a particular emphasis on the personal qualities required by the dutiful physician. By relinquishing a twentieth-century view of what constitutes 'ethics' and considering Percival's work in its entirety, a more balanced picture of late eighteenth-century medical writing emerges. It is fairer to suggest that both ethics and etiquette were under consideration in Percival's writing.¹⁴ The physician's duty to care for the incurable, dying patient was in integral part of this discussion.

Certainly, by the first half of the nineteenth century, attention was turning in earnest to the specific question of how best to care for the dying. In the 1830s, the influential Prussian physician Professor C.W. Hufeland discussed considerations of death and dying in his *Three Cardinal Means of the Art of Healing* and *On the Relations of the Physician to the Sick*. Hufeland advocated administering opium as a form of pain relief but also cautioned against the risks of the patient being in possession of what he termed "dangerous remedies" and "especially in such quantities that endanger life".¹⁵

In 1831, Sir Henry Hallford delivered a series of lectures at the Royal College of Physicians in London, which were published as his *Essays and Orations* in the 1840s. This dispersed through the medical community Hallford's belief that it was the duty of the physician to "smooth the bed of death and render departure from this life easy and gentle."¹⁶ Hallford, a physician to royalty and the aristocracy, counselled that the dying should be given "such aid as medicine could supply".¹⁷ Hallford's willingness to administer pain-relieving drugs to secure the ideal peaceful and painless death for those in his care made him, in Porter's words, "the most sought after physician of his age precisely because his patients had confidence that through generous medication he would not let them die in agony."¹⁸ Combined with a readiness to relieve pain by medical means was Hallford's reputation as a physician with an exemplary bedside manner. According to his biographer William Munk, Hallford's very presence "often did more for his patients than any drug could affect".¹⁹ Munk described one aristocratic woman who reported that she would rather die as a patient of Hallford than recover and live in the care of a physician considered inferior. The *Lancet* described Hallford as "a master in all that concerned the management of the dying."²⁰

In 1854, the same year that Noble submitted his thesis, Sir Benjamin Brodie published his *Psychological Inquiries*, in which he considered the mental as well as physical dimensions of death. Brodie argued that a secure religious faith was the most powerful way to ease the fear of death. Halford too believed that faith in the afterlife would do much to secure a peaceful and easy death.²¹ By combining religious faith, therapeutic techniques and a scrupulous degree of attention to their patients, these elite practitioners played an increasingly important role in the stage-management of the ideal ‘good’ death. Management of such a death had two dimensions – the practical alleviation of pain and distress and a more ideological or psychological appeal to the comforts of religious belief. In both instances, death was deprived of its terror.

This was the medical-ethical backdrop to Noble’s M.D. thesis of 1854: a world in which gentlemanly duty, religious belief and the emergence of pain-relieving drugs were interwoven, prompting medical men in the first half of the nineteenth century to address the question of how best to manage the dying patient. In spite of the assured tone of eminent and established doctors such as Hufeland, Halford and Brodie, their respective considerations of Victorian death reveal a complex array of preoccupations that did not always co-exist easily. While, for example, Hufeland recognised the invaluable role of opium in relieving pain in the incurable patient, this was tempered by his fear that such pain relief might ultimately endanger life. And while Halford maintained that “medical aid” was required to ease the suffering of death, this, he argued, could not supplant the role of religious faith in providing both bodily and mental calm. It was agreed that the incurable patient should not be abandoned, but beyond this commitment the intricate web of religious, medical and professional values meant that decisions surrounding life and death were seldom straightforward.

Noble’s thesis provides a valuable insight into the world of Victorian doctors in the middle of the nineteenth century. Unlike Hufeland, Halford and Brodie, whose names are known, Noble appears to have slipped into obscurity.²² All that remains is this glimpse of a student’s concerns in relation to death – concerns that are clearly conditioned by prior published work on death and dying. That does not mean, however, that Noble’s thesis is a mere derivation of other, more well known work. Writing from the perspective of a medical student rather than the lofty heights of the medical establishment may well have afforded Noble a degree of freedom that physicians to royalty and the aristocracy, such as Halford, did not enjoy. Certainly, there is sense of openness and directness in Noble’s writing that is

refreshing. Unafraid of acknowledging the problematic nature of discussing pain relief with regard to the dying, he seems willing to countenance uncomfortable issues such as mistaken prognosis.

While the thesis may seem strange in parts to the twenty-first century reader, with its references to death from diabetes mellitus and to practices such as “blistering, bleeding and purging”, some of the questions raised by Noble seem familiar.²³ He considers the question of when to treat the dying patient and the question of if and when to take the wishes of the patient into account. He also discusses the issue of withholding information from the patient. Though history may have altered the specific context in which the medical dilemmas are framed, many of these questions have resiliently defied satisfactory resolution. The impact of new pain-relieving drugs is also a subject of consideration, as well as the related issue of pain as a positive indicator of disease or an unwanted source of distress. The themes raised by Noble pre-empt much of the content of the following chapters in the first section of this thesis. I place particular emphasis on the manner in which I identify the practice of pain relief as being woven (sometimes directly, sometimes indirectly) into the conceptual origins of the late nineteenth-century debate over euthanasia.

If the nineteenth century was a time in which change presented new ambiguities for the medical profession, it was also a time when older, established values and beliefs vied to maintain their ideological hold. By the end of the century, the medical profession (despite careful consideration of strategies for palliative care and how these strategies might be represented) faced a very different challenge from those supporting the ultimate form of pain relief – requested death. This was, I maintain, a debate about how medical practice was interpreted and about how the peaceful, serene and ‘natural’ death might best be achieved. To begin a history of euthanasia in the nineteenth century allows an analysis of the origins of this stark interface between old and new debates. A close reading of Hugh Noble’s thesis ‘Euthanasia’ provides a revealing starting point.

II. 'Delivery at the hands of nature': The withdrawal and withholding of treatment

First coined in the seventeenth-century from the Greek *eu* and *thanatos* to stand for 'good death', for the greater part of the nineteenth century the meaning of the word 'euthanasia' would remain faithful to its classical, etymological roots. Euthanasia implied simply a calm, easy and serene death. As I discuss in the third chapter of this thesis, it is only latterly, between 1870 and 1890, that the term begins to take on connotations of requested mercy-killing of a patient by a physician. Noble's 'Euthanasia' reveals a nineteenth-century medical world that, explicitly at least, rejected any notion of the physician actively bringing about death. For Noble, in keeping with the medical orthodoxy of his time, euthanasia was strictly defined as limiting the degree of suffering endured by a dying patient. This definition rejected any suggestion that the patient's life would be shortened.

Mid-way through his thesis, Noble posed the question: "In regard to the active measures which may be adopted with the incurable or moribund, it may be asked how far the practitioner may be justified in interfering for the purposes of modifying or changing the mode of death?"²⁴ Such was the extent of suffering endured by some dying patients that Noble considered it understandable that the physician might wish "that death could triumph a little easier". Yet because "human life is held so sacred", he argued, "no combination of circumstances can be imagined in which it would be in the least bit warrantable to seek to abridge the sufferings of the dying by having any tendency to hasten the close of a fast ebbing existence." No matter how painful the death or however strongly the patient cried for death to be hastened, "no one dare dream of using means to shorten the period of his misery, we are only at liberty to endeavour to lessen its degree."²⁵

The inclusion of this admonition suggests that even if advocating shortening a patient's life was vehemently forbidden, it was also a matter judged sufficiently important and relevant to merit (albeit dismissive) consideration. Noble may or may not have been aware of the writings of Carl F.H Marx, a German academic, physician and medical historian, who in 1826 published the paper 'De Euthanasia Medica Prolusio'.²⁶ In any event, Noble's thesis struck a very similar tone to that of his German predecessor. After noting the tendency of the physician to neglect his patient once cure was judged impossible, Marx urged that the physician had a duty to provide physical and moral comfort as death approached. While the use of narcotics to relieve pain was endorsed, this did not imply that the death of the patient should be hastened in any sense. Marx wrote: "It is therefore the physician's duty to extend

the span of life in every way, and least of all should he be permitted, prompted either by other people's requests or by his own sense of mercy, to end the patient's pitiful condition by purposely and deliberately hastening death." He added: "How can it be that he who is by law required to preserve life be the originator of, or partner in its destruction?"²⁷

Professor C.W. Hufeland was also opposed to any suggestion of hastening death. He conceded that in instances in which the patient was in dire suffering and prayed for relief (Hufeland considered this to be a rare occurrence), the physician might consider whether it was possible to "rid the miserable sufferer of his burden a little earlier". However, such considerations could never translate into actions: "a mode of action based on such principles would be a crime" and the aim of medicine "was to preserve and if possible, to prolong life".²⁸ It was, according to Hufeland, the "most sacred duty" of physicians to bring about "the euthanasia" for the dying patient.²⁹

So in terms of forbidding any practice that would actively seek to shorten the life of the dying patient, Noble, like Marx and Hufeland, was clear in his condemnation. His views were not an exact duplicate of those of the earlier writers, however, and subtle differences in tone appear in his own treatise of 1854. Noble used similar language to Hufeland but applied it in a different context. While Hufeland argued that the law required the physician to "preserve" the life of each patient, Noble stated that "it would be criminal" not to obviate or relieve the suffering of the dying. While Marx, Hufeland and Noble shared much common ground, not once did the latter claim that it was the duty of the physician to "extend the span of life". Noble's concern was that the physician should not pursue treatment at the expense of the patient's personal comfort.³⁰ "The mere desire to be doing something more is surely not a sufficient warrant for pursuing the patient within the very portals of death with additional cause of distress,"³¹ he commented. He also suggested that to continue to aggressively treat might in fact have the very opposite effect to that originally intended: "The flickering lamp may be sooner extinguished if rudely puffed and poked at, though if protected and handled gently it might have burned yet a while."³²

If, according to Hufeland, the physician was "by law required to preserve life", for Noble the duty to alleviate the suffering of the dying patient had an equal claim to the physician's attention. In Noble's view, when hope of recovery was lost the physician often turned away from the patient, forgetting "that more may be done – that the time has come for restudying the case from a different point with a new object in view." He would not go so far

as to repudiate explicitly the 'prolongation of life' opinion. Yet his statement that the dying patient demanded a comprehensive reappraisal of the physician's strategy suggests that, at the very least, lengthening the patient's life was not of primary importance. The "new object in view" was now euthanasia – the calm, easy and peaceful death – and this required abandoning any curative treatment that might cause the patient pain or distress. He remarked: "Now remedies calculated to restore the health are to be laid aside and all available means for smooth passage to the grave are to be sought out and applied."³³

While Hufeland argued that it was the duty of the doctor to "preserve and if possible prolong life", he also maintained that it was the "sacred duty" of the physician to secure "the euthanasia". If the Prussian physician considered these incompatible aims, he did not share this concern. Noble, however, with his reference to the need for "restudying the case [of the dying patient] from a different point of view", was arguably suggesting that the prolongation of life and euthanasia were not, in fact, necessarily commensurable. According to Noble, the physician was forbidden from actively seeking to cut short life, but this did not mean that the attending doctor should strive to prolong the life of a dying patient.

In a remark that would be echoed by Sir Thomas Watson in his 1871 *Lecture on the Principles and Practice of Physic*, Noble stated: "Though all men must die, all do not die in the same manner".³⁴ In diseases terminating in coma, death would approach gradually and painlessly with the patient unconscious for hours or days. Noble commented: "the patient seems merely to sleep for some time after the spirit has taken flight."³⁵ Alternatively, in the case of death from sudden stoppage of the heart, life ended instantaneously. In both instances – the gradual, painless death and the sudden death – Noble concluded "euthanasia has no province, nature in the one set providing a transition from life to death free of pain, and in the other giving no time for either suffering or interference".³⁶

Sometimes, however, death was a severe and painful experience. Noble listed "the anaemic form of death as witnessed in post-partum flooding [bleeding to death after childbirth], mortal wounds and bursting internal aneurisms", but noted that such deaths, though distressing, were also rapid. Due to the speed of the patient's demise, Noble concluded there was "little being doing in the way of euthanasia".³⁷ It was in cases of diseases "which tend to death by asthenia [loss of strength]" that he considered the physician's role of greatest importance. The gradual debilitation of the patient in this

situation demanded “the earnest attention of the physician to the means of alleviating the patient’s misery and of securing an easy death”.³⁸

For Noble, the most distressing symptom of death, for both patient and onlookers, was the loss of ability to breathe. He illustrated this with a vivid description: “All the signs of exquisite anguish are forcibly depicted in the livid and sweat-bedewed features, distended nostrils, staring eye-balls, and heaving chest; and the hands, wildly tossed about seek in vain for the heavenly relief which ordinary breathing would bring.”³⁹ There was nothing to be gained, Noble argued, in causing additional pain and suffering to a patient dying in such a manner.

While acknowledging that the pursuit of futile treatment was at times the result of the difficulty in making an exact prognosis, he was explicitly critical of the physician who continued to treat aggressively without due consideration of the individual patient’s needs. In some instances where the prognosis was “as clear as noon”, Noble argued that “remedies have been continued to the last, and much suffering allowed to exist unmitigated, and some inflicted without purpose.” The first step in securing euthanasia for the patient considered beyond cure, argued Noble, was the “suspension of curative measures”, in particular those considered “painful or distressing”. According to Noble, “great relief may often be afforded by this step alone”. Bleeding patients as a cure-all remedy was common in the first half of the nineteenth century but Noble argued that such a practice, along with “blistering and purging”, be dispensed with as soon as it was judged that the patient would not recover.⁴⁰

At the time of writing his thesis, Noble may have been using the term ‘euthanasia’ in its classical form, meaning simply a calm and peaceful death, but it is clear that his use of the word also implied the medical management of death. His conclusion that “euthanasia had no province” in sudden or rapid death, or death after a period of naturally occurring unconsciousness, suggests that his use of the term applied when the physician had the opportunity to play an important role in alleviating pain and easing the dying process. Integral to this was the decision to withdraw treatment when judged appropriate. Noble’s insistence on the “suspension of curative measures” in the case of the dying patient resonates with the debate over what is now defined (and not without controversy) as *passive* euthanasia: that is, when death is allowed to occur through the withholding or withdrawal of treatment.⁴¹ This is distinguished from the definition of *active* euthanasia, in which death is intended and caused by direct, deliberate actions.⁴² To make such comparisons between

mid-nineteenth century notions of how to best manage death and a much more recent medical-ethical label such as 'passive euthanasia' may seem anachronistic. Nowhere in his treatise did Noble, for example, explicitly use the phrase 'allowing' death to occur; instead he insisted that "the patient must wait for delivery at the hands of nature."⁴³

However, within this view of 'nature' taking its course was the ideal of the easy and peaceful death that the dutiful physician was obliged to seek for the dying patient. 'Nature' might have been viewed as the ultimate arbiter of *when* death would occur, but this did not mean that the physician remained passive. Central to this idea of euthanasia, as conceived by Noble, was the importance of intervention and decision-making tailored to the needs of the dying patient. The withdrawal or withholding of treatment was part of this process. Noble stated: "if the physician cannot snatch the victim from the grasp of death, he may at least intercede to have life taken in the most merciful manner".⁴⁴ Tellingly, Noble equated the continuation of futile treatment with failure to secure euthanasia. He argued: "the protracted perseverance in the exhibition of remedies when the disease is beyond their [physicians'] influence is at least as bad as the neglect of means for securing comfort as far as possible in the last hours of the dying."⁴⁵

Clearly, when Noble referred to the moral obligation on the physician to alleviate suffering, in the case of the dying patient this meant the withdrawal of all forms of treatment that caused pain and discomfort. However, he consistently stressed that the patient could expect the physician only to "mitigate the intensity" of suffering, "without interfering in the protraction" of death.⁴⁶ Noble maintained that the withdrawal of treatment would not have the effect of hastening the patient's death. He only cautioned that such a decision be made carefully, "for it would be well considered whether in withdrawing such remedies we are not losing some chance of recovery".⁴⁷

Yet in the latter stages of his thesis, Noble appeared to move away from simply endorsing the suspension of treatment alone. Describing a patient dying from pulmonary disease, he advocated not merely the withdrawal of treatment, but rather that active steps be taken to alleviate suffering once recovery was judged impossible. According to Noble, the source of the patient's distress arose in such cases from "the disproportionate excess of the vital fluid over the amount of aerating surface left available in the lung". In a healthy lung "we would naturally seek to relieve [distress] by paracentesis [surgical tapping away of fluid]," he wrote, but in conditions where the tissue was destroyed, this was not viable. The

only remedy for relieving suffering in such a circumstance was “by readjusting the balance between blood and lung”. In this instance, Noble endorsed a course of action that earlier in the thesis he had ruled as unnecessary in relation to the dying patient – namely the practice of bloodletting. He wrote: “if we felt certain that the pulmonary lesion precluded the possibility of recovery, the idea of blood letting would appear to be not unreasonable”.⁴⁸

Eager once again to stress that such a decision would not shorten life, he added: “It might have the effect of giving some degree of comfort without to any extent precipitating the fate of the patient.” Such a course of action could not be chosen lightly, however, since the patient would be left severely weakened. “Present relief of symptoms or arrestment of the disease,” Noble argued, “is often purchased at the cost of so much subsequent debility as disables the patient from struggling with the taxes upon his powers which usually accompany such diseases.” Only in cases “indubitably beyond all chance of cure” would such treatment be justified.⁴⁹

What Noble was advocating was not only the withdrawal of any curative treatment that caused distress for the dying patient but also, in certain circumstances, the active pursuit of treatment designed expressly to give immediate relief from pain. As already discussed, Noble argued that bloodletting was, in most instances, an unjustifiable and distressing procedure when caring for the dying patient. The particular case of pulmonary disease, however, proved an exception – with bloodletting providing what was judged as the best available means of relieving pain. In the case of the patient with a lung healthy enough to have excess fluid drained, Noble thought bloodletting inappropriate. What he considered an unjustifiable course of action in the patient with a healthier lung was justifiable in the case of the patient with a lung judged beyond repair. The relief allowed by bloodletting may have been “purchased at a cost”, but in Noble’s view this was a subject of concern only if the patient was believed curable. This points to a new layer of meaning in Noble’s ‘Euthanasia’: one where, although any action that might “hasten the close of a fast ebbing existence” is expressly forbidden, Noble endorses pain-relieving treatment that might hinder recovery. Arguably, bloodletting might also have hastened the death of the patient suffering from pulmonary disease. If so, Noble was eager to distance himself from this possibility with his contention that the practice would afford comfort without “precipitating the fate of the patient.”

In treating the dying patient, Hugh Noble's thesis reveals how the Victorian physician was faced with critical decisions involving not only the withdrawal of treatment but also, in certain instances, the choice of active measures intended solely to relieve pain rather than cure. In the introduction to his thesis Noble described the physician's duty as "alleviating the pangs of death and sweetening the bitter cup of those who are doomed to await the approach of dissolution." By the end of the thesis, a far more complex picture emerges. The importance of valuing the 'sacredness' of life at all times, is now forced to co-exist with the physician's need to determine whether to concede that the patient was beyond cure. Such a decision was vital in the case of pulmonary disease, since it shaped and directed the course of action taken by the doctor. For Noble, the easy and peaceful death necessarily implied a death in which pain was eliminated or at the very least reduced. The pre-requisite for the dutiful physician in alleviating the pains of death was, I argue, acquiescence to death itself. Not only was this manifested in the withdrawal of treatment, but also, at times, in the pursuit of treatment uniquely tailored to those judged by the physician to be beyond recovery.

III. 'Days of Scientific Advancement': The Wishes of the Patient and the Purpose of Pain

Along with the withdrawal or withholding of painful or futile treatment, Noble considered that euthanasia also implied "the accession to any desires on the part of the patient which may have been inadmissible while recovery was the object of the physician's care". Careful attention to the dying patient's "expressed wishes", he argued, would help to make the patient comfortable and was conducive to "tranquillity of mind". It was at this juncture that Noble again ruled out any suggestion that the physician might hasten the end of life. He wrote: "however vehemently the wretched patient may cry for the merciful arrival of death ... no one dare dream of using means to shorten the period of his misery, we are only at liberty to endeavour to lessen its degree."⁵⁰ Evidently, Noble considered it a very real possibility that the physician might be placed in a situation in which he was asked to actively induce death. This was one desire to which the physician could not submit. He did not elaborate further on what might constitute wishes "which might have been inadmissible" in the case of the curable patient. Clearly, though, with his reference to the importance of securing "tranquillity of mind" in the dying patient, Noble did not view euthanasia simply in terms of bodily calm – the mind also had to be pacified.

Addressing the issue of the physician's duty "to the immaterial part of the sick and dying", Noble stated: "It is not enough to say that his [the physician's] duty reaches only to bodily complaints. The mind and body are intimately united." The difficulties in dealing with a diseased body were only heightened further, he argued, by a mind that was distressed. It was the duty of the physician, therefore, to "secure as far as possible mental tranquillity in patients under treatment".⁵¹ This raised the question of how truthful the physician should be with his patient. As Noble conceded, it was possible that the prognosis might be mistaken. The negative psychological impact of the patient learning, mistakenly, that he or she was to die, could have dire consequences: "the perturbation of mind which such an announcement might produce would have the effect of accelerating the catastrophe that might otherwise have been averted."⁵²

The question of what to tell the dying patient preoccupied elite Victorian doctors. Roy Porter argues that as part of the "more managerial approach to the death-bed", physicians such as Sir Henry Halford became adept at withholding the truth, instead giving "prevarications or cheerful prognostications". When physicians such as Halford became "trusted family advisers and intimates", they adopted a policy of concealment that was only abandoned in the very last stages of death so as to allow for the patient's final preparations.⁵³ For Porter, this managerial approach (not only to the therapeutic needs of the dying patient, but also to the flow of information from doctor to patient) is representative of the way in which death was increasingly becoming a medically defined event.

Pat Jalland interprets Halford's attitude to truth-telling in a slightly different manner and states that "the truth about mortal illness was divulged in the most considerate way".⁵⁴ She argues that while Halford considered that the doctor's primary duty was to prolong life by "all practicable means", he also acknowledged the importance of warning the dying patient's family of the likely outcome.⁵⁵ The family was best placed to warn the patient, Halford advised, because relatives did not completely destroy optimism. If such information came from the physician, the patient would lose all hope. However, in the absence of family, Halford counselled that the patient should be made aware of his or her predicament. The patient was not to be left to die unprepared.

According to Jalland, C.W. Hufeland was the only medical authority to advocate complete concealment of a dying patient's condition. In *On the Relations of the Physician to the Sick*, Hufeland declared that "to announce death is to give death". For the physician

“employed to save life”, the giving of a fatal prognosis was not, he maintained, a sustainable position.⁵⁶ Jalland argues that this was an isolated view and that “most Victorian authorities on medicine and medical ethics advocated telling the truth to dying patients”. The differences in opinion lay in the timing and manner deemed appropriate for disclosure. While some doctors advocated a favourable prognosis until the end was near, others took a more cautious view and advised the patient of his or her fate as soon as it was judged certain.⁵⁷

In his thesis, Noble argued that frequently “the probabilities of the patient’s fate” would be discussed before death. However, he maintained that such conversations were usually concealed from the patient and questioned whether this was always the correct choice. He elaborated: “I have heard a patient when moribund bitterly complaining that he had never been made aware that his sickness was to terminate fatally. And does not some responsibility rest upon those who are best qualified to tell beforehand that a patient is to die, and who nevertheless neglect to do so?”⁵⁸ Whether or not the relationship between physician and dying patient called for complete openness was a question that Noble did not answer conclusively.

Although there were cases where truthfulness would give the patient the opportunity to prepare for death, there were also instances where possible recovery would be jeopardised by such disclosure. Noble wrote: “It cannot be denied that there are cases of extreme difficulty in which there may indeed be but slender chances of recovery, but what there are would certainly be destroyed entirely by the fear of death. Whether in such cases the physician is justified in concealing the fact, or even if ever it is right to prevaricate or deny the existence of manifest danger I shall not here attempt to address.”⁵⁹

The common link, underpinning the psychological and the physical dimensions of euthanasia, was the question of the physician’s clinical judgement. Noble argued: “It is obviously a point of very great importance to be able to decide when a given case is beyond all hope of cure or recovery”.⁶⁰ On the physical level, the physician had to determine whether the withdrawal of treatment might risk diminishing the patient’s chances of recovery. On the psychological level, the physician had to be sure of the prognosis in order that the patient’s mental wellbeing was preserved. Risks and benefits existed on both sides – striving for the easy, calm and painless death implied a sureness of clinical decision-making that Noble would only allude to, but not discuss in detail. Though Noble was clearly aware

of the great importance that euthanasia placed on the notion of accurate diagnosis, just how and when such a diagnosis was to be made was a subject left undeveloped in his thesis.

If Noble's silence was conspicuous in relation to the specific details of how and when a patient should be considered an appropriate case for euthanasia, his consideration of how the physician should treat the patient in pain also left unanswered questions. He stated: "pain is a cause of distress which must be combated in endeavouring to afford comfort to the irrecoverable or dying."⁶¹ Yet in the very next sentence, he concluded: "the occurrence of pain in connection with the existence of most severe and fatal diseases is to be looked upon as a most valuable circumstance." Without the presence of pain, Noble argued, disease would be able to progress unchecked. Pain was a much-needed physical signal that constituted "a safe-guard to warn us of the existence of disease and direct our attention to its situation".⁶² Diseases which progressed in an insensible patient or under the cover of less painful ailments often only revealed themselves when it was too late for any curative measures to be taken. "However distressing this sign [the presence of pain] might be we would not wish it to be absent unless the condition upon which it depended were changed," he wrote. He then added, "although we could produce insensibility to the pain we would not desire to do so if thereby we deprived ourselves of a means of knowing how the disease progressed."⁶³

With regard to the presence of pain in the dying, incurable patient, however, Noble struck a very different note. In this instance he argued that "pain can serve no good purpose, and means must be had recourse to for its mitigation as part of euthanasia".⁶⁴ Rather than viewing pain in a positive light as in the case of the curable patient, for the dying patient it was now a malignant source of distress. For such a distinction to be made the weight of responsibility once again rested with the physician's diagnosis. Was the patient to be left, unrelieved of pain, in order that the progress of disease could be monitored? Or was pain relief to be the uppermost priority of the physician, since curing the patient was judged impossible? How the physician was to determine between these two very different courses of action was never made explicit by Noble.

Only at one point in his thesis did Noble come close to suggesting how the physician might make such a decision. He wrote: "the ability to determine when a case is past recovery is intimately connected with the first indication in the treatment of the dying – namely the suspension of curative measures, more especially such as are at all painful or troublesome to

the patient”.⁶⁵ At first glance this appears to be a circular argument. According to his earlier reasoning, the decision to withdraw treatment was dependent on a prior decision that the patient was beyond cure. From another interpretive slant however, Noble appeared to be suggesting that if “curative measures” appeared not to have the desired effect, they should be withdrawn. If such treatment brought only pain and suffering, this in itself was an indication that the patient was incurable – the two were inextricably bound together. This was the only time that Noble fleetingly addressed the issue of when the physician might know that euthanasia was now a priority.

Despite his reluctance to discuss in detail the intricacies of clinical decision-making, Noble’s analysis of the purpose of pain is revealing. He describes a nineteenth-century medical world with new pain-relieving techniques at its disposal and supposes that with this greater technical power comes a fundamental re-evaluation of how pain should be perceived. According to Noble, “in these days of scientific advancement”, surgical procedures “formerly so terrible in their contemplation and execution” were now “performed upon unconscious patients”, while the pains of childbirth had been “struck from the catalogue of human suffering”. Given this, he asked, “how is it that euthanasia is not made a special object of the physician’s attention?”⁶⁶ By listing wider developments in the control of pain alongside the question of euthanasia, Noble made a conceptual connection between the management of pain in patients who were not dying, and patients at the end of their lives. When pain was seen to be without purpose, the physician’s duty was to alleviate suffering. This meant confronting pain wherever it was found, with new pain-relieving drugs such as chloroform playing an important role. Noble argued: “No one now imagines it to be at all necessary that anyone should be allowed to suffer pain or distress if it can possibly be obviated.”⁶⁷

However, despite this description of a consensus that the patient should not suffer unduly, Noble was aware that the use of the new pain-relieving drugs did not go unchallenged (the debate about pain relief to which he refers is discussed at length in the following chapter of this thesis). The arguments used to oppose the use of anaesthesia in childbirth, Noble maintained, “might with as much appearance of propriety be applied to attempts on the part of the physician to alleviate the pains of dissolution”. To this he countered emphatically: “neither the sufferings of labour nor those of death need be considered as indispensable elements of the cup of human experience.”⁶⁸ With reference to how pain relief might be actively afforded, Noble argued that inhalation chloroform was “of

signal use in many circumstances”. Specifically in the case of the dying, he added, “I feel persuaded that it might be made available far more than it is in the closing scenes of many unhappy victims’ diseases.”⁶⁹

Noble described the case of a man dying from disease of the stomach “with whom many means of allaying his sufferings were tried without any good result except chloroform”. The patient had been unable to retain or digest any nourishment and was “literally starved to death”. For three days leading up to his demise, the patient was kept in a state of “imperfect anaesthesia” and as a result, “was doubtless saved much misery by its use”. In Noble’s view, chloroform should have been used more frequently in similar cases. In sparing patients the pain of surgery or childbirth, he maintained, there was the expectation that the patients would recover. This was not the case with those who were beyond cure. Nevertheless, in these “days of scientific advancement”, Noble argued that pain-relieving drugs had a significant contribution to make to achieving what he understood as euthanasia – the easy and peaceful death.

Hugh Noble’s M.D. thesis offers an invaluable thematic starting point from which the historical and conceptual origins of the nineteenth-century euthanasia debate can be mapped. Written at a time of growing therapeutic power and yet uncertainty about how pain functioned physiologically, ‘Euthanasia’ raises as many questions as it provides answers. As discussed, Noble addressed the problem of knowing if and when treatment should be withdrawn, the difficulties of accompanying questions of clinical judgement and prognosis and the issue of telling the truth to the dying patient. He also explored altering perceptions of the purpose of pain (both physical and mental) and the question of if and when to use pain-relieving drugs. All these themes are contained within his short thesis on management of the dying patient. I have considered Noble’s thesis in detail because, as far as I can establish, his writing is unknown and receives no mention in other work concerned with the history of medical ethics or, more specifically, the history of euthanasia debates. Noble’s writing is important because of the light it sheds on mid-nineteenth century attitudes to caring for the dying.

Pat Jalland argues that “the question of mercy killing was not debated with any great urgency in the nineteenth century because doctors did not then possess mechanical aids, such as cardiac stimulators and mechanical respirators, to prolong a limited form of life in a terminally ill patient.” The question of when to cease life-prolonging treatment of this kind

was not a Victorian concern, argues Jalland, therefore “avoiding one of the most difficult aspects of the modern euthanasia debate.”⁷⁰ Yet, as Noble’s thesis reveals, mid-nineteenth century doctors were faced with a range of dilemmas when it came to treating the dying patient. That these dilemmas were very different from the ones confronted by the medical profession today does not negate their existence, nor does it support the suggestion that Victorian doctors somehow ‘avoided’ critical questions of clinical decision-making.

While hastening death was explicitly forbidden, subtle distinctions were being drawn between the ‘preservation’ and the ‘prolongation’ of life. Elite doctors such as Halford and Hufeland were eager to stress the duty of the physician to extend life. Noble, however, appeared less keen to share this view when applied to the case of the dying patient, although he too shared the view that life could not be ‘shortened’ in any way. As Noble’s thesis indicates, the *principle* that the physician should not seek to shorten life was now forced to accommodate *practice* that involved making decisions concerning not only the withdrawal of treatment, but also at times, the choice of active measures intended solely to relieve pain rather than cure.

The patient was to “wait for delivery at the hands of nature” but at the same time, great emphasis was placed on the diagnostic powers of the attending physician. Clinical judgement played a critical role in Noble’s formulation of euthanasia and affected decisions that tailored either curative or palliative treatment to the individual patient’s requirements. Though the term ‘euthanasia’ was used to imply a calm and easy death and would only begin to change in meaning towards the end of the century, I argue that medical judgement and intervention was already at the centre of the debate over how to achieve a ‘good’ death. As the following chapter will discuss, many of the questions and concerns raised by the medical student Hugh Noble in 1854 remained very much alive at the end of the century. Though his name may be unrecognised and his thesis left unpublished, he appears to have had an intuitive feel for the important issues that would, for the remainder of the century, preoccupy the medical profession and wider society.

Notes

¹ Hugh Noble, 'Euthanasia', M.D. thesis, University of Edinburgh, (1854).

² Roy Porter, *The Greatest Benefit to Mankind: A Medical History of Humanity from Antiquity to the Present* (London, Harper Collins, 1997), p.286.

³ Porter provides the following bibliographical detail on Percival: "Belonging to a network of reforming physicians centred on early industrial Manchester, Percival offers an interesting example of the new physician. He undertook demographic studies, wrote on hospitals and prisons, promoted medical charities and public health, and became an early member of the Manchester Literary and Philosophical Society." (p.286).

⁴ *Ibid.*, p.287.

⁵ Roy Porter, 'Death and the Doctors in Georgian England', in Ralph Houlbrooke (ed.), *Death, Ritual and Bereavement*, (London, Routledge, 1989), 77-94, at p.88.

⁶ Elliot Friedson, *Doctoring Together: A Study of Professional Social Control* (New York, Elsevier, 1975).

⁷ Friedson, *ibid.*, p.245, cited by Andrew Morrice, "'Honour and Interests": Medical Ethics in Britain, and the work of the British Medical Association's Central Ethical Committee, 1902-1939', M.D. thesis, University of London (1999), p.18. For details of how, in 1847, North American physicians established the American Medical Association with ethical codes based directly on Percival's code, see Robert Cantrell, 'A Century of Progress in Medical Ethics', *Laryngoscope*, 107:4 (1997), 447-52.

⁸ See Ivan Waddington, 'The Development of Medical Ethics – A Sociological Analysis', *Medical History*, 19 (1975), 36-51. For a more recent appraisal of the field of medical ethics, see Roger Cooter, 'The Resistable Rise of Medical Ethics', *Social History of Medicine*, 8:2 (1995), 257-70.

⁹ John Pickstone, 'Thomas Percival and the production of Medical Ethics', in Robert Baker, Dorothy Porter and Roy Porter (eds), *The Codification of Medical Morality*, vol. 1, *Medical Ethics and Etiquette in the Eighteenth Century* (London, Kluwer Academic Publishers, 1993), 161-178, cited by Morrice, 'Honour and Interests', p.18.

¹⁰ Roy Porter, 'Thomas Gisbourne: Physicians, Christians and Gentlemen', in Andrew Wear, Johanna Geyer-Kordesch and Roger French (eds), *Doctors and Ethics: The Earlier Historical Setting of Professional Ethics* (Amsterdam, Rodopi, 1993) cited by Morrice, *ibid.* See Thomas Gisbourne, *An Enquiry into the Duties of Men in the Higher and Middle Classes of Society in Great Britain resulting from their respective Stations, Professions and Employments* (London, J. Davis, 1794).

¹¹ Morrice, 'Honour and Interests', p.18.

¹² The Nuremberg Code (written in the aftermath of the Nuremberg war crimes trials) consisted of ten ethical points to govern medical research, the first of which read: "The voluntary consent of the subject is essential": (see Porter, *The Greatest Benefit to Mankind*, pp.650-651). The Declaration of Geneva, adopted by the World Medical Association in 1948, was based on the Hippocratic Oath with a revised emphasis on human rights: (see Morrice, 'Honour and Interests', p.14, footnote 6).

¹³ Morrice, 'Honour and Interests', p.14.

¹⁴ Percival himself stated that he had initially intended to title his work 'Medical Jurisprudence', only to be persuaded that his ideas were more moral than legal in tone: see *ibid.*, p.18.

¹⁵ Jalland, *Death in the Victorian Family* (Oxford, Oxford University Press, 1996), p.88.

¹⁶ William Munk, *Euthanasia: or Medical Treatment in Aid of the Easy Death* (London, Longmans Green and Co, 1887), p.6. Munk's treatise on the care of the dying is considered at length in Chapter 4 of this thesis. Munk also wrote a biography of Halford, *The Life of Sir Henry Halford* (London, Longmans Green and Co, 1895).

¹⁷ Jalland, *Death in the Victorian Family*, p.84

¹⁸ Porter, 'Death and the Doctors', p.90.

¹⁹ Jalland, *Death in the Victorian Family*, p.84.

²⁰ *Ibid.*

²¹ *Ibid.*, p.85.

²² Hugh Noble's thesis was never published and it appears that his name is not mentioned in any nineteenth-century volume of the Medical Register. The first Medical Register was

introduced in 1859 listing the names of 15,000 doctors, see Porter, *The Greatest Benefit to Mankind*, p.356.

²³ Noble, 'Euthanasia', p.13.

²⁴ *Ibid.*, p.16.

²⁵ *Ibid.*, p.17.

²⁶ For Marx's thesis of 1826, 'De Euthanasia Medica Prolusio' or 'Medical Euthanasia' translated from Latin (a common early nineteenth-century language of medical writing and teaching) into English see Walter Crane, 'Marx's Medical Euthanasia', *Journal of the History of Medicine*, 7 (1952), 401-16. More than a dozen dissertations on the subject of euthanasia were published in Germany between 1820 and 1840. See W. Bruce Fye, 'Active Euthanasia: An Historical Study of its Conceptual Origins and Introduction onto Medical Thought', *Bulletin of the History of Medicine*, 52 (1979), 492-502 at p.494.

²⁷ Crane, 'Marx's Medical Euthanasia', p.413.

²⁸ Jalland, *Death in the Victorian Family*, p.73.

²⁹ Hufeland, *The Three Cardinal Means of the Art of Healing*, quoted by Munk, *Euthanasia: or Medical Treatment in Aid of an Easy Death*, pp.77-78.

³⁰ Noble lists a number of practices considered curative, such as bloodletting and blistering. See 'Euthanasia', pp.22-23.

³¹ Noble, 'Euthanasia', p.23.

³² *Ibid.*, p.24.

³³ *Ibid.*, p.4.

³⁴ In his *Lectures on the Principles and Practice of Physic*, fifth edition, 2 vols (London, Longmans Green, 1871), Watson remarked that 'Although all men die, all do not die in the same manner', vol. 1, p.62, (cited by Munk, *Euthanasia*, p.57).

³⁵ Noble, 'Euthanasia', p.5.

³⁶ *Ibid.*, pp.5-6.

³⁷ *Ibid.*, p.6.

³⁸ *Ibid.*, p.7.

³⁹ *Ibid.*

⁴⁰ *Ibid.*, pp.12-13. For a discussion of the practice of bloodletting see Charles Rosenberg, 'The Therapeutic Revolution: Medicine, Meaning, and Social Change in Nineteenth-Century America', in Morris Vogel and Charles Rosenberg (eds), *The Therapeutic Revolution: Essays in the Social History of American Medicine* (Philadelphia, University of Pennsylvania Press, 1979), 3-25, at pp.11-14.

⁴¹ The term 'passive euthanasia' is not recognised by the British Medical Association and continues to be a source of disagreement amongst both medical practitioners and philosophers. The withholding or withdrawal of treatment when judged appropriate is classified by the BMA simply as good medical practice; whereas euthanasia refers specifically to a situation where the physician takes *active* measures to end the life of a patient. Use of the term 'passive euthanasia' was rejected by Lord Walton, Chairman of the House of Lords Select Committee on Medical Ethics (Walton Committee) 1993-1994, at a conference on medical ethics I attended at the Freeman Hospital in Newcastle in November 1999. Against this view, writers such as John Harris (Professor of Bioethics and Applied Philosophy at the University of Manchester) have argued that 'there is no useful moral distinction to be made between active and passive euthanasia'. See John Harris, 'Euthanasia and the Value of Life,' in John Keown (ed.), *Euthanasia Examined: Ethical, Clinical and Legal perspectives*, (Cambridge, Cambridge University Press, 1995), 6-22 at p.6.

⁴² See Sissela Bok, 'Euthanasia', in Gerald Dworkin, R.G. Frey and Sissela Bok (eds), *Euthanasia and Physician-Assisted Suicide, For and Against*, (Cambridge, Cambridge University Press, 1998), 107-127, at p.108.

⁴³ Noble, 'Euthanasia', p.17.

⁴⁴ *Ibid.*, p.2.

⁴⁵ *Ibid.*, p.13.

⁴⁶ *Ibid.*, p.18.

⁴⁷ *Ibid.*, p.16.

⁴⁸ *Ibid.*, p.20.

⁴⁹ *Ibid.*

- ⁵⁰ Ibid., p.17.
⁵¹ Ibid., p.24.
⁵² Ibid., p.25.
⁵³ Porter, 'Death and the Doctors', p.90.
⁵⁴ Jalland, *Death in the Victorian Family*, p.109.
⁵⁵ Ibid.
⁵⁶ Ibid.
⁵⁷ Ibid., p.110.
⁵⁸ Noble, 'Euthanasia', p.25.
⁵⁹ Ibid., p.26.
⁶⁰ Ibid., p.12.
⁶¹ Ibid., p.10.
⁶² Ibid.
⁶³ Ibid., p.11.
⁶⁴ Ibid.
⁶⁵ Ibid., p.12.
⁶⁶ Ibid., p.1.
⁶⁷ Ibid., p.4.
⁶⁸ Ibid., p.5.
⁶⁹ Ibid., p.22.
⁷⁰ Jalland, *Death in the Victorian Family*, pp.92-3.

Chapter 2

Justifying Pain Relief – A Nineteenth-Century Ethical Debate

I. Interpreting Pain: Alleviation or Acceptance?

For the Victorian physician, while the exact moment at which death would strike was perceived as residing in the “hands of nature”, it was also seen as his duty to confront and manage the pain that accompanied death. Integral to the ideal of the calm and easy death was the notion that pain was not a necessary part of the process of dying. Moreover, securing a ‘natural’ death for the patient required that the pains of death were viewed with neither passivity nor acceptance on the part of the physician. The ability of the doctor to alleviate suffering in the dying patient, was, I argue in this chapter, part of a broader nineteenth-century debate about the acceptability of relieving pain in other contexts such as childbirth and surgery. As this chapter will explore, this was a debate that centred on the meaning and value ascribed to pain: whether its presence served a religious or physiological purpose – or, indeed, any purpose at all.

Examining this debate over the ‘purpose’ of suffering and the rise of the medical paradigm used to explain the various manifestations of pain, adds an important dimension to understanding how the euthanasia debate at the end of the century took shape. By questioning the inevitability of pain and championing the power to alleviate suffering, the medical profession was exposed to challenges that urged that this justification of pain relief be extended to include the merciful killing of the suffering patient. Of course, for centuries drugs have been used (with varying degrees of success) to control pain.¹ In addition, arguments pertaining to the rights and wrongs of ending life have a long history that predates the nineteenth-century use of pain relief.² The euthanasia debates I examine cannot be solely explained by an argument based on technological determinism. That is to say, the use of powerful pain-relieving drugs was not the only reason for the emergence of a novel set of concerns regarding the management of death in the nineteenth century. However, I do maintain that the introduction of particular kinds of pain relief, such as chloroform and morphine, added a new element of complexity to the ethical questions at stake. The deliberate and swift obliteration of pain under medical supervision and control was

achievable as never before. These drugs also allowed the patient to be rendered unconscious for hours or even days – a factor that would prove significant in the late nineteenth-century euthanasia debate discussed in the third chapter of this thesis.

The present chapter is concerned with the debate over pain relief that preceded the euthanasia debate at the end of the century. The introduction of anaesthesia in the mid-nineteenth century had a profound impact on the medical profession and on society as a whole. The administration of pain relief meant that previously inescapable suffering was no longer viewed as an inevitable feature of human experience. For the physician, the new pain-relieving drugs brought an unparalleled level of professional power that, as this chapter will examine, transformed the encounter between doctor and patient. Pain-relieving techniques were, I argue, absorbed into routine practice in such a way that the concept of a divinely ordered ‘natural’ world was left undisrupted. However, this was not a straightforward process. The authority of those who endorsed pain relief and who discerned and interpreted this natural order in such a manner was a matter of dispute. Whether or not pain should be accepted or alleviated was the subject (at least in the initial aftermath of the introduction of anaesthesia) of considerable controversy.

The following three sections of this chapter consider the impact of anaesthesia in a number of ways. First, the introduction of chloroform in childbirth contributed to a comprehensive assessment of the purpose of pain, sparking disagreement between those who supported the use of pain-relieving drugs and those who rejected their use on theological grounds. While it would be misleading to portray this debate in a manner that juxtaposes medical with theological interests (after all, many physicians held firmly religious beliefs), in broad terms, this first debate saw the medical profession closing ranks against those who were religiously opposed to pain relief. Anaesthesia in childbirth provides an extremely revealing example of the way in which those on either side of the debate drew on conflicting concepts of ‘nature’ to strengthen their respective positions. Those who opposed the use of pain relief in obstetrics argued that God intended pain to be part of childbirth. Interfering with this pain, they maintained, was interfering with God’s will and with nature. Supporters of the use of pain relief in childbirth argued that the very ability to suppress pain in powerful new ways was testimony to the God-given capacity of humans to expand their knowledge and understanding of the world. The ability to triumph over suffering was not a challenge to divine will or to nature, but rather an expression of God’s intention that unnecessary pain be

alleviated. This, in turn, meant distinguishing between 'necessary' and 'unnecessary' pain, and once again, the emphasis was placed on medical judgement.

There is an important link to be made between the alleviation of pain in childbirth and the medical management of pain in the dying patient. In simple terms, both rested on a justification of pain relief based on argument in which the physical suffering in question was viewed as serving no constructive purpose. Hugh Noble made this connection when he stated: "If half the arguments were valid that used to be made and may still be made against the use of anaesthesia in childbirth, I suppose they might also be applied to attempts to alleviate the pains of dissolution." As I argue in the second section of this chapter, the justification of pain relief in childbirth had important implications for the defence of pain relief at the end of life.

The third and fourth sections relate to another debate about the introduction of anaesthesia that was conducted within the medical community. While religious opposition to pain relief was largely dismissed, this intra-professional debate revealed another set of concerns. Although generally physicians did not oppose the use of pain-relieving drugs in principle, there were worries among medical men about the effects of the practical application of such drugs when administered in childbirth and in surgery. Here, concerns centred round differences that stemmed from conflicting views of how pain should be understood physiologically and anxiety relating to the safety of the new drugs. As the century progressed, worries emerged in relation to the safety of anaesthesia – particularly in the case of chloroform. Despite these concerns, such were the pain-relieving benefits of the new drugs that they continued to be administered (both in surgical and non-surgical medicine) even though anaesthetic death was a recognised danger. "I will not give a deadly drug to anybody if asked for it, nor will I make suggestion to this effect" states the Hippocratic Oath and yet the potential 'deadliness' of chloroform was a risk worth taking in the view of many nineteenth-century physicians.

The pain endured by the dying patient is clearly different from the pain endured by the sentient patient under the surgeon's knife. In the first instance, pain is a physical manifestation of illness, in the second pain is intentionally inflicted with the aim of securing the patient's recovery. The introduction of new pain-relieving drugs challenged the notion that either type of pain was inescapable. However, when viewed in the context of the nineteenth-century medical world, the use of anaesthesia in the case of the dying patient

reveals a number of interesting ambiguities when compared with descriptions of its use in the case of the non-dying patient. As I will discuss, while the medical community was willing to contemplate the dangers of anaesthesia when used in obstetrics and surgery, when considering pain-relief for the dying, emphasis was placed on the ability to sustain and even prolong life.

As well as considering the debate over chloroform, I look at the medical discussions relating to the use of morphine. By examining the arguments that accompanied the introduction of this drug, again, a picture of pain relief versus potential risk is revealed. In the case of morphine, the need to alleviate pain was weighed against the risk of requiring increasing (and potentially dangerous) doses to achieve a constant level of relief. I have widened my assessment of pain relief to consider not only medical practice in relation to death, but also in the context of childbirth, surgery and chronic illness. As I have outlined, this serves two purposes. First, it allows an examination of how the meaning of pain was the subject of debate and interpretation and second, it reveals an alternative medical discussion of pain relief that contrasts with accounts given by elite Victorian physicians when considering the dying patient. In contrast to statements about the prolongation and preservation of life, what emerges is a more complex equation in which the relief of pain incurs risk and possibly even death.

II. 'Natural' Birth and Chloroform: The Response to Religious Objections

Her Majesty was safely delivered of a Princess, at a quarter before two o'clock, on Tuesday afternoon last. The pains of labour commenced in the morning of that day between the hours of two and three, at which time the medical attendants and the great officers of the state were summoned. The labour was in every respect natural, as was the presentation, but the pains were somewhat lingering and ineffective. About half-past eleven o'clock, it was thought desirable that chloroform should be administered, which was continued by Dr. Snow at short intervals to the time of delivery. The anaesthetic agent perfectly succeeded in the object desired. Her Majesty has since progressed favourably, not a single unpleasant symptom having appeared. The infant Princess is in good health.³

The above announcement reporting that Dr John Snow had safely administered chloroform to Queen Victoria during the delivery of her daughter, Beatrice, appeared as a discreet and somewhat unremarkable paragraph in the *Lancet* of 18 April 1857. This public announcement, however, marked a significant moment in obstetric pain relief. According to John Bonica, the announcement was "tantamount to moral, medical, and even religious sanction of alleviation of the pain of childbirth".⁴ Four years earlier, the same Dr Snow, a

pioneer in anaesthesiology, had also successfully given chloroform to the Queen, administering intermittent doses on a handkerchief.⁵ The Queen's obstetrician, Sir James Clark, wrote to inform Sir James Young Simpson – Simpson having first administered ether during childbirth in January 1847, then substituting chloroform in November of the same year. Opposition from the editor of the *Lancet*, Thomas Wakley, meant that the first administration of chloroform to the Queen during childbirth was not publicised.⁶

Of particular interest, given the focus of this thesis, is how this first public announcement of chloroform use in 1857 was presented as part of a 'natural' and yet medically managed birth. In a manner that resembles the medical discussion surrounding the use of pain relief and 'natural' death, the notion of 'natural' birth saw new pain-relieving techniques being admitted as accepted practice while preserving the idea that childbirth of this kind "was in every respect natural". However, as I have suggested, the use of pain relief during labour was not uncontroversial. Rooted in a literal reading of the bible, nineteenth-century religious opposition to the use of anaesthesia in childbirth cited Genesis 3:16: "Unto every woman, I will multiply thy sorrow and thy conception; in sorrow shalt thou bring forth children."⁷ Opponents of obstetric anaesthesia considered the pain of childbirth to be God-given and not a matter for earthly, human interference. To attempt to interfere in the pains of childbirth by suppressing suffering that was divinely intended, was an affront to God's will. The pain of childbirth served as a continual reminder of Eve succumbing to temptation and therefore to the fallibility and weakness of mankind.

There was an additional element to this argument. The pains of childbirth were also seen as providing an intermediary link between God and man. To remove the suffering of labour would be to destroy this divinely intended connection. In her study of obstetric pain relief in the mid-nineteenth century, Mary Poovey convincingly argues that this debate centred on the social position of medicine in relation to religion or, more narrowly, the nature of women and their position in relation to medicine. Poovey maintains that whereas childbirth was "previously seen as natural territory presided over by women", the introduction of chloroform as a means of relieving pain was seen by some as a threat to this 'natural' order.⁸ She argues that those sharing this view were highly suspicious of what they perceived as an attempt to shift childbirth from "the no-man's land of 'nature' ... into the social realm", thus breaking the link with God that the pains of labour supplied.⁹

Such was the force of opposition to obstetric anaesthesia that one month after first using chloroform to alleviate the pains of childbirth, James Young Simpson felt it necessary to address his critics in his *Answer to the Religious Objections advanced against the Employment of Anaesthetic Agents in Midwifery and Surgery*.¹⁰ Rather than appealing on secular, scientific grounds, Simpson countered with the passage from Genesis in which God, wishing to provide a companion for Adam, makes him drowsy in order to remove one of his ribs – a reference to what Simpson termed “the first surgical operation on man”.¹¹ He added: “even if we were to admit that woman was, as the result of the primal curse, adjudged to the miseries of pure physical pain and agony in parturition, still, certainly under the Christian dispensation, the moral necessity of undergoing such anguish has ceased and terminated”.¹² This latter statement is an example of Simpson appealing to Christian thought that rejected the notion of physical suffering as a ‘punishment’ from God. As I have discussed, for many Christians it was becoming increasingly difficult to associate the concept of a benevolent God with the idea that pain was deliberately inflicted. Simpson’s reference to “Christian dispensation” suggests a rejection of literal interpretations of the Old Testament, with an emphasis placed instead on the redemptive powers afforded by the sacrifice of Jesus Christ.

The idea that pain is divinely intended has a long history. For medieval Christians it afforded a connection with God and a source of visionary experience in which physical suffering might be conquered by spiritual commitment.¹³ In the early Victorian period, as I have outlined, the Evangelical revival encouraged fortitude in the face of suffering. Though pain was not to be actively sought, it was considered an essential part of life, to be confronted rather than avoided.¹⁴ Simpson’s defence of the use of chloroform revealed a different view of pain that rejected its inevitability and endorsed its medical alleviation on religious grounds. Yet older, religious rationales for the pains of childbirth and the ‘purpose’ of pain remained part of the debate over anaesthesia, at least until the middle of the nineteenth century.¹⁵

It would be overly simplistic to view the debate as polarised between the medical community and religious bodies of opinion outside of medicine. For example, Poovey highlights the rejection of chloroform by an American doctor, Meigs, who argued that “to be in natural labour is the culminating point of the female somatic forces”. She then cites a clergyman’s description of chloroform as “a decoy of Satan ... it will harden society and rob God of the deep earnest cries, which arise in times of trouble”.¹⁶ It is possible, then, to find examples of medical and religious opinion united in their rejection of chloroform use. What

is interesting is the way in which those both in favour and against administering chloroform in childbirth marshalled the concept of 'nature' in defence of their positions. Those who maintained a similar position to Meigs tended to stress that the use of chloroform was an affront to nature rather than to God, but the biblical overtones in their language reveals a collapsing of any distinction between 'the natural' and 'the divine'. In an appeal to notions of the natural and the divine, Meigs stated: "There is in natural labour no element of disease ... I should feel disposed to clothe me in sackcloth, and cast me in ashes [should a patient die from] such meddlesome midwifery."¹⁷ This was also a warning about the risks of anaesthetic death, a point to which I will return in detail later in this chapter.

From an alternative perspective, an interesting letter to the *Lancet* in April 1857 is illustrative of how many in the medical community were able to reconcile changing medical practice with religious beliefs by insisting that medicine was an extension of nature, rather than a challenge to it. Criticising Sir John Forbes' publication *Nature and Art in the Cure of Disease*, Alfred Collinson, M.D, M.R.C.S, objected to what he viewed as Forbes' desire to undermine the medical profession's true claim to interpreting a divinely ordered natural world.¹⁸ In drawing attention to the deficiencies in the geographical distribution of medical care, Forbes had argued that that in rural areas many had "to rely on the old crones of the village with their herb teas from vegetables". Significantly, he concluded, "a large proportion of the patients recover".¹⁹ Collinson saw this as an irresponsible defence of the "delusion called Homeopathy" and countered that "our art possesses something more than an old crone's simples". If, he argued, "a man of great ability who wears our colours" could challenge the medical profession, what was to be expected from "the querulous and suspicious communities who depend on us for council?" Medicine, Collinson maintained, "does by God's blessing, retard the hand of Death himself, ministering in a thousand ways as a helper to Nature in the relief of pain, the checking of fatal issues of various kind, and to the happiness and blessing of our species".²⁰

Thus, rather than challenging the divine order, medicine was viewed as an extension of God's work. Human capacity for learning and the acquisition of scientific knowledge did not distance medical men from God; rather, it brought them closer to understanding the world God created. This Deist view had taken hold during the Enlightenment when the very orderliness of the world made the notion of Design, and therefore a Designer, reasonable.²¹ The nineteenth century saw a continuation of this view with superstition and "delusions" seen as the product of credulous ignorance that thrived without the light of reason. For

medical men such as Simpson, the religious justification and acceptance of pain on the basis that it was a manifestation of the will of God was testimony to the continuing influence that ‘unenlightened’ beliefs continued to wield. The debate over anaesthesia was not a battle between non-believers and believers, but a debate about who had the authority to interpret and uphold competing notions of a divinely ordained ‘natural’ order. For many in the medical profession, the physician, rather than the priest, was best placed to determine whether physical pain served any purpose.

Conceptualising pain as a function of the body in distress, to be medically understood and if necessary alleviated, led to the nineteenth-century formulation of physiological theories attempting to explain the link between pain and the body. It is not my aim here to explore these medical theories in any detail (Roselyn Rey’s history of medical understandings of pain provides a highly effective analysis), but their development, I suggest, played an important role in consolidating the position of the medical paradigm used to explain suffering.²² The growth of experimental physiology, given impetus by the work of Charles Bell and François Magendie on sensory nerves, encouraged the study of sensation and its role in relation to pain. In the 1840s Johannes Müller elaborated on this connection between sensation and pain with his theory that information from the nerves was carried to the brain via energy specific to each sensation. The rise of physiological understandings of pain led to a movement away from observational methods of research and a turn towards anatomical knowledge and vivisection.²³

Yet despite this growth in pain theories, remained sizeable gaps remained in understanding the function and purpose of pain. As Lucy Bending comments, “classifying pain as a neurological phenomenon did not imply an understanding of the nature of this classification”.²⁴ By the end of the nineteenth century explaining pain was the subject of intense controversy as physiologists lined up in opposition to psychologists and philosophers who maintained that the nature of pain lay in an explanation of its affective rather than its sensory qualities. As Noble’s thesis suggests, and as I argue in later chapters, medical understandings of pain may have shifted to physiological territory but when it came to individual clinicians and the management of pain in dying patients, the influence of the mind on the body was still considered of vital importance.

The decline of traditional religious explanations for suffering and the rise of physiological explanatory models did not mean, however, that broader cultural explanations

for pain were abandoned. Bending writes: “As one referent for pain lost its value as a framing discourse, something had to be found to fill its place. Pain simply as pain – a meaningless bodily suffering – was not to be endured and sufferers had to find new ways of contextualizing their suffering.”²⁵ The medical profession’s commitment to anaesthesia in the face of external opposition was, in part, based on a wider belief that advancements in pain relief were the mark of a society becoming ever more civilised. As one surgeon remarked in 1879: “The higher nervous sensibilities of nineteenth century life render the administration of anaesthetics more necessary than they would have done in what I may call rougher times, or amongst peoples less civilised than ourselves.” He illustrated his point with an analogy: “Compare, for instance, the rough cart-horse with the high-bred race-horse. The former seems to heed not the crash of a falling house; the latter is terrified by a clap of the hands.”²⁶

In other words, as society became more advanced, so too was sensitivity to pain judged to be refined. To relieve pain by using anaesthesia was the “duty and privilege” of the medical profession and according to such a view the fundamental tenets of Christian belief were not shaken by such an understanding of God’s world. Man’s capacity for rationality and learning were, after all, part of divine intention. For a physician or surgeon to deny a patient anaesthesia – “a great benefit to humanity” – would be to deny the God-given gift of man’s ability to learn and improve.²⁷ The link between pain and ‘civilised’ sensitivity is complex and explored at length by Bending and Martin Pernick.²⁸ Sensitivity to pain was judged according to an individual’s race, gender and social class, which in turn influenced the calculation of quantities of drugs required for anaesthesia.²⁹

Related to this idea that sensitivity to pain was a mark of civilisation was the notion that pain was the legacy of evolutionary processes. This marked a departure from previous justifications for pain relief such as that of James Young Simpson in which religious language had been used to counter religious opposition to anaesthesia. In the latter half of the nineteenth century the pains of childbirth were cast in terms where they were viewed as a remnant of the change in humans from quadrupeds to bipeds. As one contributor to the *Lancet* wrote:

Man has not gained the upright posture and his cerebral development without paying heavily for these distinctions. These two factors are responsible for most, if not all, of the obstetric difficulties which woman experiences over and above the normal pains of parturition (if such there be).³⁰

Thus, despite the decline of older religious explanations for suffering, the multiple meanings and competing interpretations ascribed to pain persisted. What was evident was the medical profession's commitment to suppressing pain by what were judged to be the most effective means. This commitment related not only to new conceptual understandings of pain, but also to the expansion of medical power that anaesthesia afforded.

Nineteenth-century pain relief transformed the encounter between the medical professional and the patient. After the publication of Simpson's *Answer to Religious Objections* the debate over anaesthesia had largely shifted from theological to medical concerns, effectively silencing those who claimed that God would be denied the "deep and earnest cries that arise in times of trouble". Yet anaesthesia implied another kind of silencing – that of the patient. Alongside his religious objections to the use of chloroform, Dr Meigs argued that the patient's response to the question: "Does it hurt you?" was worth "a thousand dogmas and precepts". For Simpson, however, removing pain from the patient's consciousness meant the patient was compliant and more readily accessible to inspection so that "the quiet and unresisting" would not shrink from "the introduction of the hand into the maternal passages".³¹

As Mary Poovey writes, "the traditional relationship between a doctor and a patient, which privileged the patient's own experience of the body over any abstract theories the doctor might possess" was now replaced with "a detailed consideration of how a doctor could read his patient's silenced body".³² Not only would God be denied the 'earnest cries' of a body in pain but, by employing anaesthesia, the doctor too would be unable to hear such sound. What remained was a body that was laid out for interpretation giving the doctor's prior knowledge and understanding of sublimated pain a new level of importance. From the mid-nineteenth century onwards, anaesthesia was to become firmly established both in surgical and non-surgical medicine, contributing to what Pernick describes as "the medicalisation of suffering".³³ As well as bringing the alleviation of pain, anaesthesia also often implied loss of consciousness on the part of the patient. For the dying patient, this meant the doctor was left to manage the final hours and days of the unconscious patient's life. This transference of control, as I will argue in chapter three, had implications for the euthanasia debate in the latter half of the century.

The medical profession's justification for pain relief in situations other than the management of the death reveals how the profession defended the use of anaesthetic drugs

when faced with external theological opposition. This defence functioned on a number of levels. First, it challenged the view that pain was a 'natural' state to be borne with stoicism. Instead, chemical intervention to suppress pain became accepted practice and established as an extension of a perceived 'natural' order. Second, the uptake of pain relief was tied to the perception that society was becoming more civilised and therefore more sensitive. The medical profession was at the forefront of the response to this perceived heightened sensitivity. Third, allied to the pain-relieving properties of the new drugs themselves, was the increased power that their use brought to the profession. In obstetrics, surgery and in caring for the dying patient, medical expertise was of central importance when managing pain. Pain itself was understood in a variety of ways and yet the medical community maintained a largely united front (with vocal exceptions such as Meigs) in its commitment to anaesthesia. However, within the confines of the professional journals, salient divisions remained over the practical use of pain relief. It is to these divisions that I now turn.

III. Risk in Victorian Medicine

What emerges from the mid-nineteenth century onwards is a story of calculated risk-taking in the Victorian medical community. Though journal literature from the latter half of the century indicates that anaesthesia was widespread, this did not preclude doubts being expressed about the safety of the drugs in question, particularly in relation to chloroform. If religious opposition to anaesthesia had been dismissed in principle, there remained division over the practical application of drugs and concern relating to unanticipated dangers – dangers that included precipitating premature death. Drugs that had initially been hailed as a breakthrough in pain relief were now being viewed with far greater caution. Anaesthesia was in fact a double-edged sword: bringing much needed alleviation of pain but also threatening unwanted side effects and even death.

Though clearly a significant moment in the history of pain relief, Bonica's description of the successful administration of chloroform to Queen Victoria in terms of "a moral, medical and even religious sanction" overstates the case. Only a fortnight before the announcement of Princess Beatrice's birth, the *Lancet* published the clinical research on chloroform of M. Chassaignac, surgeon at the Lariboisière hospital and professor of the Faculté de Médecine de Paris. The surgeon was plainly in the practice of using chloroform during childbirth, yet he raised concerns about its possible negative impact on both the mother and the child.

Chassaignac described the case of one of his patients, a woman in her fifth month of pregnancy judged to require three operations in a short period of time, “accompanied by the use of chloroform, and followed notwithstanding by severe pain”. He questioned whether the hysteria and uterine pains which followed the second operation “depended on the chloroform or the operation itself”. He concluded: “as to the hysteria which followed nearly immediately after the employment of the chloroform, it appears to us rational to attribute them to this agent”. The uterine pains, he argued, “did not come on until after the third day after the operation” and that “we ought to attribute them much rather to the results of the operation, and to the vulvar pains than to the action of the chloroform”. Despite the success of the operations, Chassaignac stated, “we would be far from concluding that this agent can always be employed with impunity... on the contrary, we ought not lightly and without serious motives to have recourse to anaesthesia during pregnancy”.³⁴ Also discussed by Chassaignac was the potential harm to a child breast-feeding from a mother administered chloroform whilst being treated for abscesses of the breast. The surgeon wrote, “in two cases, the infants suckled by women who had inhaled chloroform, were seized with a drowsiness which lasted for several hours”. It is the duty of the doctor, argued Chassaignac, “not to forget in certain cases the child suffers from the anaesthetic influence”.³⁵

Chassaignac’s report was not an isolated caution, nor were concerns restricted to the administration of anaesthesia in childbirth. For example, an 1871 editorial in the *British Medical Journal* called for greater discussion within the medical community about the use of anaesthetics and invited surgeons and other practitioners to share their experiences. The editorial described how the Senior Surgeon of the Edinburgh Royal Infirmary, a Dr Gillespie, had contacted the *BMJ*, “expressing a doubt which probably others share, whether it is desirable to give statistical information regarding deaths from anaesthetics in a medical journal”. An earlier *BMJ* article documenting deaths of patients while taking chloroform had been reproduced at length in some of the leading Edinburgh newspapers; “this it has been suggested, is likely to cause an unwholesome dread of both hospitals and chloroform”.³⁶

Gillespie's view was rejected by the *BMJ* in the most strident terms: “A professional bias, perhaps, induces us to entertain the conviction that utter frankness and complete publicity are, in all such matters as this, the most healthy and the wisest course”. The editorial argued: “a dread of chloroform, for example, based upon actual knowledge of the proportion of deaths which arise from its inhalation, is less likely to be unwholesome than

blind trust, often rudely dispelled, or an exaggerated fear, in which mystery magnifies the actual danger". Greater familiarity with chloroform had, according to the *BMJ*, "made us all the more enamoured of its manifold blessings – its rapidity of action, convenience of administration, and perfect anaesthetic powers". However, the editorial cautioned, "although daily recognising it more and more as a priceless boon to humanity, we have also learned to fear it as more deadly than at first wished to believe it to be".³⁷

Bound up with Gillespie's suggestion that any open discussion in relation to anaesthesia would lead to "an unwholesome dread of both hospitals and chloroform" is a wider set of nineteenth-century medical relations and practices. Pernick draws attention to the importance of anaesthesia in allowing what he terms "the routinised functioning of large hospitals". According to Pernick, the new pain-relieving techniques eliminated "the wild, disorderly pre-anaesthetic scenes of screaming and brutality" and permitted "the eventual emergence of a controlled, efficient, rationalised operating room, in which the quiet is broken only by the rhythmic whoosh of the anaesthetist's air bag".³⁸ Yet there was also public fear of institutionalised medicine and rising anxiety about death attributed to anaesthesia. Though chloroform and ether (ether was first used in 1846) offered an escape from suffering, there remained, as the *BMJ* editorial of 1871 indicates, a simmering suspicion of hospitals and the medical professionals who administered pain relief.

While concern for the lives of patients was, of course, important, the *BMJ* was clear that its call for open discussion of the dangers of chloroform was made in the interests of the medical profession with the aim of securing public confidence. The journal stressed that its interest was not in pointing an accusatory finger. Indeed, an editorial of 13 May 1871 opened with the remark that Gillespie had given "a full and satisfactory account of the recent cases of death at the Royal Infirmary".³⁹ In addition, the previous week's editorial stated: "the occurrence of deaths in persons taking chloroform or any other form of anaesthetic ... should by no means be considered as involving a priori, any kind of blame".⁴⁰ Nevertheless, despite this outward show of solidarity from the *BMJ* for all members of the profession, throughout the mid to late-nineteenth century and continuing through the turn of the century, the journal provided a recognised forum for debate and dissent with regard to the administration of anaesthesia.

Weaving its way though the journal discussion of the potential dangers of anaesthesia was a debate concerning the safest method of delivering the drugs. What is interesting is the

way that the debate was distanced from the patient and focused instead on that which could be quantified, such as levels of dosage, and technical aspects of administration such as the various designs of chloroform-inhalation apparatus. One of the most common forms of administering chloroform was to give the patient a proportion of the drug, inhaled to a maximum of five per cent, diffused through inhaled air. It was on this principle that John Clover's apparatus for the inhalation of chloroform was designed, and employed, according to the *BMJ*, "by leading surgeons ... in their private operations, where their individual sense of responsibility is greatest".⁴¹ This apparatus was considered superior to the simple chloroform compress. However, at a meeting of the Medico-Chirurgical Society in May 1871, Thomas Skinner M.D. rejected the graduation of dose method as a "wholly useless formula". Clover's method was judged to be "altogether wrong" by Skinner while the supporters of "the Snow school" (John Snow advocated that chloroform be administered in a similar manner) were deemed "misguided".⁴² The alternative method – advocated by Skinner and supported by James Young Simpson – was that chloroform be administered in as close to pure form as possible from the outset.

Skinner was to prove a regular contributor to the letters pages of the *BMJ*, vigorously defending the use of chloroform but rejecting the idea that, for reasons of safety, it should be diluted. He argued that in America and France medical men had frightened their patients "into fits about imaginary doubts about the dangers of chloroform". According to Skinner, they then complained "of the refractoriness, and the fearfulness, and the prejudices" of those in their care. Skinner laid the burden of responsibility of deaths under chloroform on those who were not sufficiently skilled in administering the drug. "No man has a right to condemn chloroform simply because he does not know how to apply it, or has not seen it used in skilful hands," he wrote.⁴³

Although the correspondence in the medical journals of the nineteenth century reveals a range of opinions and experiences, simply speaking, the medical community can be seen as divided into three broad schools of thought regarding the administration of anaesthetics. First, there were those such as Thomas Jones M.D., who favoured alternatives to chloroform. "I am quite sure that, if fairly tried, ether will soon replace chloroform in this country as the anaesthetic in general use," Jones wrote, adding: "nothing would induce me to take chloroform".⁴⁴ Ether and nitrous oxide were generally considered safer anaesthetic agents than chloroform, a view illustrated by the *BMJ* editorial of 6 May 1871 that concluded: "the sooner our almost exclusive preference for chloroform is reconsidered the better".⁴⁵

However, switching to alternatives implied additional difficulties. Chloroform was often chosen because it was deemed more convenient, could be handled more easily and could be readily administered in a variety of medical contexts. According to the *BMJ* editorial of 13 May 1871, there remained “the quest to find a yet unattained agent, as safe as nitrous oxide, and as portable, convenient, and continuous in its effects as chloroform”.⁴⁶

Second, there were those such as Clover and Snow who stressed the importance of limiting the concentration of chloroform and believed that by skilful measurement and calculation, risks could be minimised and benefits maximised.⁴⁷ Finally, there were those who sided with Skinner and Simpson in advocating that chloroform be administered at almost full strength for successful anaesthesia, placing great importance on the individual expertise of the anaesthetist. It is also apparent from the medical journal literature that despite grave concerns about the possibility of bringing about premature death, worries about public confidence and differences over technical practice, administration of chloroform and other anaesthetic agents continued. When the advantages of relieving pain and rendering the patient insensible were weighed against potential risks, the ability to suppress pain was judged more important than risking life. As the *BMJ* editorial of 6 May 1871 tellingly stated, “The fear of present pain is so much greater than that of remote danger.”

Anaesthetic agents clearly introduced a new element of risk into Victorian medicine. Roselyn Rey gives the number of deaths attributed to anaesthesia in England and Wales between 1846 and 1946 as exceeding 25,000, with approximately one quarter of these deaths grouped around 1880. “Pain had to be totally unacceptable if an individual would choose to put his life at risk,” she argues.⁴⁸ From the perspective of medical professionals, the opportunity to relieve pain in a manner previously unknown was also too great a prize to relinquish.

This brings into focus two arguably incompatible ethical models that also come to the fore in debates over euthanasia: one which values the preservation of life above all else and one which considers the absence of pain of greater importance. Although not discussed in such an overt manner, the arguments relating to anaesthesia could be interpreted as a utilitarian debate, in that the benefits of pain relief to the many were considered more valuable than the risks to the few. Alternatively, the debate could be interpreted as a dilemma that focuses on the encounter between the individual patient in anguish and the medical professional in charge of his or her care. Should the patient’s suffering be alleviated with a

potentially dangerous drug? At what point (if any) would the doctor or surgeon's intervention to relieve pain compromise a commitment to preserving life?

It would be an oversimplification to suggest that the new pain-relieving drugs marked the advent of 'risk' in medicine. In the case of surgery, the risk of death brought on by shock in an operation carried out in the absence of anaesthesia was great. Indeed, as Pernick writes: "Anaesthetics, many nineteenth-century physicians claimed, could lessen or avert the physical damage done by pain – damage that allegedly included shock, infection, chronic disease, and death."⁴⁹ Quite apart from the relief of suffering, these perceived physical effects of unrelieved pain also contributed to the assessment of the benefits of anaesthesia.

However, this was a time when the concept of pain was undergoing a thorough re-appraisal, both in terms of how it was understood and how it might be medically managed. Anaesthesia meant that suffering could be alleviated in powerful new ways but this brought sharply into focus the tension between the elimination of pain and the potential risk of death as a direct result of medical intervention.

When it comes to discussion of the use of chloroform in the case of the dying patient, the medical journals appear remarkably silent. There is evidence to suggest, however, that it was indeed the practice of physicians to administer chloroform as a means of relieving pain in the final stages of life. In his thesis Hugh Noble referred to a dying patient being kept in a state of "imperfect anaesthesia" and as a result being "saved much misery by its use". In addition, as the following chapter will discuss, when the first calls for 'active' euthanasia emerged in the 1870s there was a presumption that physicians were already administering chloroform to the dying. The demand was that the patient should be able to direct the levels of dosage given, "so as to destroy consciousness at once, and put the sufferer to a quick and painless death".⁵⁰ If those outside the medical profession were aware of chloroform's ability to cause death, then physicians seemed wary of discussing the dangers of using the new pain-relieving drug in the case of the dying patient.

It is particularly interesting that the *BMJ* of 7 July 1866 could publish an article by Joseph Bullar, M.D., in which he advocated using chloroform to alleviate pain in the dying, but judiciously noted that it was not his intention to shorten the life of his patients. Such interventions, he maintained, prolonged life rather than hastened death.⁵¹ Yet in the same edition, the journal reported premature deaths as a result of the administration of anaesthesia

in surgical situations. It seems that outwardly, doctors maintained that their role elevated the preservation of life above all else, whilst privately, they acknowledged that the relief of pain and increased levels of power over the bodies of their patients incurred a level of risk.

Moreover, in the nineteenth century critical decisions were being made about when it was justifiable to relieve pain even when knowingly risking death and when to condemn the use of pain-relieving drugs for ends that were judged improper. "It is said that one death in ten thousand cases is sufficient enough grounds to condemn chloroform on moral grounds," argued a manual on anaesthetics in 1859.⁵² Such a rejection of any utilitarian approach to anaesthesia positioned itself at the extreme end of what was a broad spectrum of medical opinion in relation to pain relief. However, although unwilling to use such forceful language, many medical men remained unsure of just how much benefit was required to justify the risk of fatality.

Again, Rey's work on the history of pain sheds light on the conceptual shifts involved in understanding pain. She argues that although pain was attacked in myriad ways during the eighteenth century, it was also considered to be evidence of continuing life and vitality. By the nineteenth century, however, she considers that pain had become an issue "to be weighed up in the same light as life and death".⁵³ As I have discussed, the introduction of anaesthesia in the mid-nineteenth century was part of a profound reassessment of the way in which pain was perceived. If theology had provided explanations for the role of suffering in human existence, so too had earlier physiological thinking in which pain was conceived as an essential part of the biological processes of life. The concept of pain as proof of vitality stemmed from a long-observed association between insensibility and death. According to eighteenth-century thought, pain was directly linked to healing and recovery.⁵⁴

By the middle of the nineteenth century and with the advent of anaesthesia, attitudes to pain were being reformulated. The medical profession had the means of relieving pain and the concept of purposeful suffering was being challenged. However, the eighteenth-century notion of insensibility meaning loss of vitality had a strong residual hold on nineteenth-century medical thought – a point on which I will elaborate in the following section of this chapter. "It is not the particular agent, it is the condition of insensibility, however produced, that puts the patient into such peril," stated a *BMJ* editorial in 1858. By the mid-nineteenth century, though pain itself was not viewed as necessarily purposeful, loss of sensibility was still often associated with the risk of death. Thus, the nineteenth-century physician had to

decide between what he perceived as the advantages and risks of using anaesthetics in a context in which older medical perceptions of suffering overlapped with new understandings of pain.

Pernick details the rise of the mid-century doctrine of conservative medicine that sought to legitimate the use of anaesthetics with recourse to a formalised cost-benefit analysis of the drawbacks and benefits of pain relief; what he calls “a calculus of suffering”.⁵⁵ This medical conservatism claimed to occupy a moderate, middle ground between heroic dosing and non-intervention and also sought to account for what were viewed as individual differences in reaction to drugs and sensitivity to pain. The amount of anaesthetic required was judged on the basis of a set of particularised rules depending on the social position of the patient in question (for example their gender or race) and the nature of their illness and pain. The aim was to strike a preconceived ‘proper balance’ between art and nature, non-intervention and suffering, or pain relief and risk of fatality.⁵⁶ Yet despite the existence of the ‘calculus’, Pernick notes, “the practitioner still had to decide whether that advantage [pain relief through administration of anaesthetics] was worth the costs. Which was the lesser evil – the harm likely to be caused by pain or the harm that might be caused by the painkiller?”⁵⁷

When the journal literature of the British medical community is combined with Pernick’s portrayal of the “calculus of suffering”, what emerges is a lively and at times vigorously contested debate over anaesthesia. The picture is complex, with changing theological and physiological perceptions of the role of pain adding to questions of best practice, professionalism and safety. What is clear, however, is that despite dissent and reservations, anaesthesia was in widespread use from the mid-nineteenth century onwards and that as a method of pain relief, it firmly established itself in a remarkably limited space of time. Crucial decisions were being taken to risk life for the sake of relieving suffering. Practice was far from standardised and individual doctors held contrasting positions, yet in broad terms, “the fear of pain” was indeed judged to be “so much greater than that of remote danger”. While the introduction of anaesthesia had manifold implications for both the medical profession and patients, above all else it signalled the growing legitimacy of renouncing pain – even if this implied possible death.

IV. 'A balancing of evils nearly equal': The debate over morphine

The balancing act between the suppression of pain and the risk of perceived dangers brought into sharp relief by the debate over chloroform also resonated strongly in nineteenth-century discussion of the use of morphine. Frederick Setürner's isolation of morphine (an alkaloid of opium) in 1816 and the development of the hypodermic syringe by Charles Gabriel Pravaz and Alexander Wood in the early 1850s meant that potent analgesics and anaesthetics could be administered in accurate doses and by a means where their action was rapid. Conceptually, with the use of drugs that penetrated beneath the skin, the way was opened for physicians to command unprecedented levels of control over the bodies of their patients. Initially at least, the twin 'discoveries' of morphine and the syringe were met with alacrity. Roy Porter, for example, cites an ill Florence Nightingale as declaring: "Nothing did me any good but a curious little new fangled operation of putting opium under the skin which relieved one for twenty four hours."⁵⁸

Simplicity of use, efficiency and greater safety all led a new medical journal of the time, *The Practitioner*, to announce in 1868 that "a country doctor should never start his rounds without a syringe and a bottle of morphia solution".⁵⁹ Yet in 1870 the journal published an article by Dr Clifford Allbutt (physician to the Leeds Infirmary and later Regius Professor of Physic at Cambridge University) that offered a more cautious view.⁶⁰ "I have certainly felt it a great responsibility to say that pain, which I know to be an evil, is less injurious than morphia, which may be an evil," argued Allbutt.⁶¹ Again it seemed that the relief of pain would come with a price. Although *The Practitioner* debate over the use of morphine was more restrained, it carried all the hallmarks of the parallel debate over chloroform. As with chloroform there existed the same worry over patient fatality but similar concerns were also voiced over the safest means of delivering morphine. These concerns combined with wider anxieties regarding the physiological impact of sustained use that brought withdrawal symptoms and possible dependency.

The preface to the first monthly edition of *The Practitioner*, launched in July 1868, offers a valuable insight into the general values and concerns of nineteenth-century physicians. Read retrospectively, it also raises concerns that would soon figure in the debate surrounding morphine. With the journal's publication came an explicit commitment to open discussion of therapeutics and the practical application of drugs in the treatment of disease. In the preface to the first edition, the then editor, Dr Francis Anstie, wrote that while

understanding of disease had made considerable progress, “therapeutics, or the science of healing, has remained very nearly where it was when Rousseau exclaimed, ‘Laissez moi mourir, mais ne me tuez pas.’” Anstie went on to acknowledge that physicians possessed a number of valuable remedies “such as cod-liver oil, chloroform, iodide of potassium”, but qualified this by stating: “it is none the less certain that an *exact* knowledge of the mode of handling these remedies does not exist”.⁶²

Wary that he might be accused of exaggeration, Anstie cited the “highest authority” of the Professor of Medicine at Kings College, London, Sir Thomas Watson, who had argued that there were sizeable gaps in therapeutic knowledge.⁶³ “We know tolerably well *what* it is we have to deal with, but we do not know so well, nor anything like so well, *how* to deal with it,” argued Watson. Only by controlling or directing “the natural forces of the body” could the physician reasonably hope to govern disease, he maintained, adding, “to me it has been a lifelong wonder how vaguely, how ignorantly, and how rashly drugs are often prescribed”.⁶⁴ Echoing this view, Anstie concluded that the medical profession was in great need of a journal devoted expressly to “the intercommunication of ideas respecting the action of remedies”.⁶⁵

This rallying call for open and transparent debate surrounding the operation of the new therapeutic drugs pre-empted the later *BMJ* editorials on anaesthesia that followed in the early 1870s. Though general in nature, these opening remarks from *The Practitioner* could equally have been applied to morphine. While recognising the contribution of the drug to the medical repertoire of pain relief, there remained uncertainty surrounding how exactly the drug affected the body and mind. There were also suspicions, as Watson’s remarks suggest, that the drug was being used “vaguely and ignorantly”. With Anstie’s preface as a backdrop, articles on the hypodermic injection of remedies (with particular reference to morphine) would dominate the first year of the new journal’s publication. Indeed, from July 1868 to October 1874, a succession of leader articles appeared on the subject of subcutaneous injection.

The advantages and disadvantages of injections of morphine as viewed by the nineteenth-century physician are distilled in two *Practitioner* articles written by Anstie, the first following on from his preface to the first edition in 1868 and the second in March 1871. While the first of these articles was buoyant in tone, the second was more cautious and reserved. In 1868, prompted by a Report of the Committee of the Medico-Chirurgical

Society, Anstie concluded that his experience of the subcutaneous injection of remedies had convinced him of the “satisfactory working of the method”.⁶⁶ He elaborated: “I infrequently meet practitioners who will not admit that there *can* be any particular advantage in this method which the old way of giving medicines does not offer, and who are, moreover, possessed with a great dread of the dangers which they think that it must involve.”⁶⁷

In a tone similar to that adopted by Skinner in the debate over chloroform, in which expertise in handling was given great emphasis, in the case of hypodermic method, if properly executed, Anstie stated: “as to the question of *danger*, let me say positively that there is *absolutely none*”. He then listed a large number of drugs which he had personally administered by syringe successfully, one of which was morphine.⁶⁸ “The advantages of the hypodermic injection of morphia over its administration by the mouth are immense,” declared Anstie. When given by syringe morphine was more powerful, he argued, and “the majority of the unpleasant symptoms which opiates can produce are entirely absent”. Taken by mouth, morphine “disorders the function of the stomach,” Anstie concluded, but this unpleasant symptom was lost when morphine was injected. He commented: “In acute diseases, we ought never to use opiates by the mouth when subcutaneous injection of morphia is possible.” The hypodermic use of morphine, argued Anstie, could transform the life of a patient “from being a horrible and intolerable burden” to being “not cheerful indeed, but comparatively peaceful and calm”.⁶⁹

By March 1871, in a leader article titled ‘On the Effects of the Prolonged Use of Morphia by Subcutaneous Injection’, Anstie had revised his position somewhat. He concluded: “that the morphia syringe has been greatly abused cannot be doubted; indeed, I possess ample evidence that it has been employed with a carelessness that is almost impossible when one remembers the powerful nature of the drug.”⁷⁰ After warning of the dangers of patients administering opium and morphine to themselves, Anstie noted, “even within the limits of its employment under direct medical orders, the prolonged use of morphia injections has produced, I fear, considerable mischief”.

Large amounts of morphine given by syringe were not simply the result of patients independently indulging in what Anstie termed “the special delights and special dangers” of the drug. Physicians too were in the business of administering large quantities of morphine, unaware of or perhaps unwilling to face the consequences of prolonged use at such a level of dosage. Anstie drew attention to the gradual but pervasive effects of hypodermic morphine

use that, over time, left the patient addicted to the drug. “So far it must be considered a much smaller evil than the constitutional habit induced by the old-fashioned forms of opium excess,” he argued, but warned: “it is as fatally effective as the latter in weaving a chain of habit.” According to Anstie, the patient would either be permanently trapped by such a habit, or would only be weaned from the drug “by efforts involving much distress”.⁷¹

Opium was widely used, beginning in the late eighteenth century and reaching a peak in the first half of the nineteenth century (though its use continued throughout the 1800s). It relieved pain in a variety of contexts – from minor complaints such as headaches (aspirin only became available in 1899) and stomach cramps to the severe pain of incurable disease. Initially, the drug was freely available and was commonly self-administered. The “old fashioned forms of opium excess” to which Anstie refers relates to the change in attitudes in the second half of the nineteenth century, resulting from fears of what were perceived as the destructive and addictive qualities of the drug. As historians Virginia Berridge and Griffith Edwards have documented, restrictions on the availability of opium were introduced in 1868 and 1908 in an attempt to prevent easy access and unregulated use of the drug.⁷² The growth of controls on opium use and greater precision in delivery of morphine by syringe meant that once again, pain relief became an increasingly medically managed event – though it should be stated that Drs Anstie and Allbutt both refer to the dangers of patients injecting themselves.

Yet as Anstie’s leader article of 1871 reveals, concerns remained about the potential risks of morphine use, even when administered by medical men. According to Anstie, a failure to regulate the use of morphine could lead to pain relief that the physician initially instigated giving way to a permanent state of addiction. He cautioned: “Narcosis, it can never be too frequently repeated, is a *depression of nervous life*.” Initially, he argued, this depression was slight and temporary, “but if the morbid process be repeated too frequently and too strongly, then there is no recovery, or only a partial one”.⁷³ Anstie concluded that the prolonged effect of morphine use was a disruption of the nervous system so that eventually the patient could not function “without the constant presence in the blood that feeds of it, of a calming and regulating agent like morphia”. The effect of morphine, he argued, disturbed both the body and mind, dragging the patient downwards to a life that was impossible without the presence of increasing doses of the pain-relieving drug on a daily basis.

Through sustained use of morphine, Anstie maintained, the patient became hypersensitive to pain, with trivial sources of irritation causing more suffering with each day that passed. “The pain returns with an agony incomparably more severe than that which would attend the disease when uncomplicated by the results of the prolonged use of morphia,” he concluded.⁷⁴ Thus, with the hypodermic use of morphine, a new “calculus of suffering” was established. Presented with an efficient and rapid means of relieving immediate pain, the physician had to consider whether he was establishing a pattern of drug dependence that would disrupt what Anstie termed “the vital forces” of the patient.

This reference to “vital forces” relates to late eighteenth-century and earlier nineteenth-century medical theories in which sensibility was perceived as an important feature of health and recovery. Sensibility (or irritability) was viewed as a measure of animation in muscles and nervous tissue – indeed, as an indication of life itself.⁷⁵ In Anstie’s writing the influence of this theory lingers in his concern that morphine somehow depressed life by encouraging insensibility. Pain relief was welcomed, but anxiety remained about the long-term use of a drug that was seen to dull the senses and perhaps even hinder recovery. Moreover, the initial benefits of intervention with morphine had to be weighed against the type of life that the patient might lead after such medical intervention.

Anstie’s endorsement of the hypodermic method of morphine use and subsequent statements of reservation regarding its use established a pattern that was evident in the writing of other clinicians discussing this new form of pain relief. Clifford Allbutt echoed Anstie’s views in two articles – ‘On the Hypodermic use of Morphia in Diseases of the Heart and Great Vessels’ published in *The Practitioner* in 1869 and ‘On the Abuse of Hypodermic Injections of Morphia’ published in the same journal in 1870. In the first of these, Allbutt could only praise the benefits of morphine given by syringe, arguing that it was “likely to bring great comfort to many sufferers”. He added: “anyone of my readers who has watched at the bedsides of those who have died of heart disease or thoracic aneurisms will never lose sight of the painful memory of their sufferings, or forget that of all the modes of death, these are perhaps the most terrible.”⁷⁶ Allbutt noted that in the latter stages of such diseases, the dying patient often maintained “a clear head and good stomach”. Despite this, the patient could “only cling convulsively to a life he would willingly lose, and with gasping breath, a striving heart, and swollen limbs, hardly finds a moment of rest from torment”. In treating the patient in the latter stages of heart disease, Allbutt remarked: “I believe in the morphia syringe we have found an invaluable ally.” So confident was Allbutt of the benefits of

hypodermic morphine that he found himself “justified in using it fearlessly in any form and in any stage of heart and aortic disease”. He argued: “No matter how swollen the limbs, no matter how agitated the pulse, ... I now never hesitate to inject morphia, and scarcely ever fail, even up to the time of the dying agonies, to give relief decided enough to earn the warm gratitude of the patient.” It was at times such as this, that Allbutt felt “the blessings of being a physician”.⁷⁷

Revealingly, many of the instances in which Allbutt praised the pain-relieving qualities of morphine by syringe involved repeated references to the final stages of disease, when the death of the patient seemed imminent. Allbutt’s reference to the pacifying influence of morphine “even up to the dying agonies” further indicates that morphine was used when hope of cure was lost. The priority in such circumstances was the relief of pain and, importantly, Allbutt made no suggestion that morphine use would in any way shorten the life of the patient. He only stressed the “unspeakable solace of the patient” once given the drug, adding: “the patient who has been tossing and turning in misery, feels the first tranquil sleep that he has enjoyed for weeks.” As Allbutt indicated, the hypodermic administration of morphine was used to facilitate a peaceful, medically managed death. In such circumstances, in which the patient was judged beyond cure, the relief of pain was the physician’s priority and morphine was used freely without suggestion that the onset of death was accelerated in any way.

By December 1870, Allbutt, like Anstie, had modified his confident assurance that morphine could be administered by syringe “fearlessly”. Now, Allbutt judged that it was the duty of those who used morphine to consider the dangers as well as the virtues of morphine. Keen to portray himself as a medical conservative who did not hastily administer the drug, he commented: “although I may seem to have used morphia extensively, I cannot compare myself with those practitioners of whom the syringe and phial are as constant companions as was the lancet to their fathers.” While physicians now knew much of the benefits of morphine when administered under the skin, “little or nothing has been said of any harm which may result from it, or the evils which may come of its careless use”, argued Allbutt in this later article.⁷⁸

Allbutt maintained that his fears relating to morphine had been simmering for some three years, during which time he had written his initial article in praise of the drug. In 1869, however, he felt that his “fears were indefinite, I felt the time had not yet come for me to

speak". Now he believed that his experience was greater and "the uncomfortable fear of mischief was growing not diminishing". He could call to mind nine patients who had been or continued to be under his care, on whom the hypodermic use of morphine had been constantly practised for periods varying from nine months to three years. Allbutt termed this "the formulation of a new class of patient" whose suffering was only alleviated by daily injections of morphine. When the effects of the injections were no longer felt, "pains which do not appear to be intractable" returned with "a wearisome obstinacy".⁷⁹

Allbutt was willing to acknowledge that he administered morphine wherever intense pain presented itself, so that "a substantive sensation of well-being, of conscious activity, and of cheerfulness" was restored. He was also willing to concede that he had himself been faced with the dilemma of balancing the need to relieve pain with the potential risks that such intervention potentially brought. He wrote: "here lies to me, the anxious responsibility of the medical adviser. Is he to withhold the relief of pain, which restores appetite, which encourages activity and promotes ease and cheerfulness? I honestly confess that, during a long period, I could not see my way to forbidding the repetitions of morphia."⁸⁰ In a further remark that shows how pain relief was traded against risk, he argued: "injected morphia seemed so different to swallowed morphia, that no-one had any experience of any ill effects from it." Injections of morphia brought "peace and comfort" while pain was "certainly the forerunner of wretchedness and exhaustion". Only in time, argued Allbutt, did the important question arise: "Does morphia tend to encourage the very pains it pretends to relieve; or if not, does it at any rate induce in those who use it constantly, an artificial state which makes its further use a necessity?"⁸¹

With Allbutt's question left unanswered, the dilemma over the subcutaneous use of morphine continued, feeding into a wider nineteenth-century ethical debate that saw the relief of pain juxtaposed with potential risks to the physical and mental wellbeing of the suffering patient. Morphine undoubtedly brought much-wanted calm to the patient but it also brought worries that chronic pain would become a daily burden that was only fed by the very drug that was administered to bring relief. Once again, the fear of immediate pain had to be balanced against potential dangers and again, the physician was left to decide whether to intervene to alleviate pain or whether the use of morphine carried unjustifiable risks. For one nineteenth-century physician, George Oliver, the question was whether in relieving pain, morphine stood in the way of giving "nature the most favourable opportunity of restoring some of the damage done and of effecting her own cure". In Oliver's view, the choice

between unrelieved pain and the risks associated with morphine was a “balancing of evils nearly equal”.⁸²

That morphine use might have impeded healing and recovery is particularly interesting when contrasted with Allbutt’s admission that morphine was used to secure tranquillity and calm in the dying patient – a notion that fitted with the ideal of the ‘natural’ death. Allbutt did not explicitly use the term ‘natural’ death, this is my inference, but again, it is notable that there was no discussion of risk when using morphine to pacify the dying patient. This may well have been because the arguments relating to the dangers of creating a morphine ‘habit’ simply did not apply in the case of the dying patient, in which the use of the drug may not have been over a prolonged period, as for the chronically ill patient. However, the arguments concerning potential dependency and the potential need for increased levels of doses of morphine have proved highly relevant in twentieth-century euthanasia debates. As I will discuss in the second section of this thesis, the twentieth-century doctrine of “double-effect” (based on the argument that pain relief required increasing doses of morphine that ultimately led to death) is, I argue, pre-empted by the nineteenth-century discussion of risk in morphine use. Tellingly, these risks were seldom discussed in the context of the dying patient in the nineteenth century.

In this chapter I have widened the focus to look at pain relief in a variety of situations and have not restricted my view simply to discussion of the alleviation of suffering in the dying patient. At first glance, some of the nineteenth-century arguments over pain relief do not immediately appear connected to the management of death, or, for that matter, to euthanasia. Other histories of euthanasia have acknowledged the role played by new developments in pain relief in the conceptual origins of the debate, but have argued that the medical profession played a minimal role in discussing the ethics of hastening death or prolonging life. Nicholas Kemp states that the nineteenth-century medical debate “was essentially a philosophical enterprise in which the medical profession played no part”.⁸³ Jalland, meanwhile, argues: “Victorian doctors were not faced with the same degree of difficulty in addressing this ethical question [prolonging life], for they lacked the technological means.”⁸⁴

Up to a point, these are legitimate arguments. In the nineteenth century the medical profession was not involved in a heated debate over the rights and wrongs of hastening death or prolonging life and certainly, none of the technology associated with contemporary

medical-ethical debates was available. However, there was an important debate over the ethics of pain relief versus potential risks to life being conducted within the medical profession in the second half of the century. There is already a great deal of scholarship in this area, but so far, the idea that this debate might be linked to nineteenth-century medical attitudes to the management of death has been little explored.

It was a debate that centred on professional values and the negotiation of both principles and practices. In public, the profession maintained that new pain-relieving techniques could be absorbed into a notion of a calm, peaceful and 'natural' death. Indeed, the argument was that life was often prolonged by such intervention. The principle of the sanctity of life remained undisrupted. Internally, however, the profession was less united – almost universally committed to pain relief, but uncertain about how best to administer the new drugs and anxious of the risks such practice entailed. This discussion of risk was rarely mentioned when elite Victorian doctors wrote about death, but this silence does not necessarily imply that the ethical issues at stake were straightforward.

Moreover, many aspects of the arguments over pain relief and risk that later fed into nineteenth and twentieth century euthanasia debates were being discussed by Victorian medical men – albeit not explicitly in relation to the dying patient. As I examine in the following chapter, the influence of debates about the meaning of pain, the justification of pain relief, the medical management of suffering and the preservation of life versus potential risk had important implications for the first explicit debate concerning what is now understood as euthanasia.

Notes

¹ W. Bruce Fye, 'Active Euthanasia: An Historical Study of its Conceptual Origins and Introduction into Medical Thought', *Bulletin of the History of Medicine*, 52 (1979), 492-502, at p.496.

² See Raanan Gillon, 'Suicide and Voluntary Euthanasia: Historical Perspective', in A.B. Downing, (ed.), *Euthanasia and the Right to Die – the case for voluntary euthanasia* (London, Peter Owen Ltd, 1969), 73-192. See also Hugh Trowell, *The Unfinished Debate on Euthanasia* (London, SCM Press, 1973), 1-22.

³ *Lancet*, 18 April 1857, p.389.

⁴ John Bonica, *The Management of Pain*, vol.2 (Philadelphia, Lea and Febiger, 1953), p.1314. Bonica's work remains a key reference book for medical students today.

⁵ Interestingly, in a recent poll conducted by the publication *Hospital Doctor*, Dr John Snow (1813-1858) was named the 'greatest doctor'. In second place was Hippocrates (460-370BC), and in third place came Dame Cicely Saunders (1913-), founder of the modern hospice movement, whose work is discussed in detail in the second section of this thesis. See *Hospital Doctor*, 20 March 2003, p.5.

⁶ Thomas Wakley's opposition to the use of chloroform in childbirth was based on physiological concerns rather than orthodox religious objections. In professional terms, Wakley was very much the reformer who challenged the privileges of the medical elite and called for a single national register for all medical men. He was the first editor of the *Lancet* in 1823. See Roy Porter, *The Greatest Benefit to Mankind: A Medical History of Humanity from Antiquity to the Present* (London, Harper Collins, 1997), p.354.

⁷ Bonica, *The Management of Pain*, p.1314.

⁸ Mary Poovey, "'Scenes of an Indelicate Character': The Medical "Treatment" of Victorian Women', in Catherine Gallagher and Thomas Lacquer (eds), *The Making of the Modern Body: Sexuality and Society in the Nineteenth Century* (Berkeley, University of California Press, 1987), 137-68, at p.138.

⁹ *Ibid.*, p.140.

¹⁰ James Young Simpson, *Answer to the Religious Objections advanced against the Employment of Anaesthetic Agents in Midwifery and Surgery* (Edinburgh, Sutherland and Knox, 1847).

¹¹ Poovey, 'Scenes of an Indelicate Character', p.140.

¹² Bonica, *The Management of Pain*, p.1314.

¹³ David Morris, *The Culture of Pain* (California, University of California Press, 1991), p.48.

¹⁴ Pat Jalland, *Death in the Victorian Family* (Oxford, Oxford University Press, 1996), p.77.

¹⁵ For an excellent exploration of the relationship between Judeo-Christian scriptures and attitudes to pain, see Elaine Scarry, *The Body in Pain* (Oxford, Oxford University Press, 1985), Chapter 4.

¹⁶ Poovey, 'Scenes of an Indelicate Character', p.140

¹⁷ *Ibid.*

¹⁸ Alfred Collinson, 'Sir John Forbes on Nature and Art in the Cure of Disease', *Lancet*, 11 April 1857, p.389.

¹⁹ *Ibid.*

²⁰ *Ibid.*

²¹ Christopher Berry, *Social Theory of the Scottish Enlightenment* (Edinburgh, Edinburgh University Press, 1997), p.5.

²² Rosalyn Rey, *The History of Pain*, (Cambridge, Mass., Harvard University Press, 1993).

²³ Bonica, *The Management of Pain*, vol.1 (Philadelphia, Lea and Febiger, 1953), pp.7-8. See also Lucy Bending, *The Representation of Bodily Pain in Late Nineteenth-Century English Culture* (Oxford, Oxford University Press, 2000), p.53.

²⁴ Bending, *The Representation of Bodily Pain*, p.55.

²⁵ *Ibid.*, p.68.

²⁶ C. Meymott Tidy, 'On Anaesthetics', *British Medical Journal*, 4 January 1879, p.3. Meymott Tidy, a lecturer on Chemistry and Forensic Medicine at the London Hospital, first presented 'On Anaesthetics' to the Association of Surgeons practising Dental Surgery. His lecture is reproduced in full in the *BMJ*.

²⁷ *Ibid.*, p.4.

- ²⁸ See Bending, *The Representation of Bodily Pain*, pp.177-239, and Martin Pernick, *A Calculus of Suffering* (New York, Columbia University Press, 1985).
- ²⁹ Pernick details the nineteenth-century practice of using criteria such as race, gender, class or age to calculate the quantities of anaesthetic administered. For example, women, the elderly, and non-labourers were judged to be more sensitive to pain and were likely to receive more anaesthetic, while black men and women supposedly suffered less and were given less pain relief. Pernick cites the *London Medical and Chirurgical Review* of 1817 as illustrating this point: "Negresses ... will bear cutting with nearly, if not quite as much impunity as dogs and rabbits". See *A Calculus of Suffering*, p.156.
- ³⁰ W.J. Collins, 'Pain and its Interpretation', *Lancet*, 20 August 1887, p.391, cited by Bending, *The Representation of Bodily Pain*, p.67.
- ³¹ Poovey, 'Scenes of an Indelicate Character', pp.140-141.
- ³² *Ibid.*, p.140.
- ³³ Pernick, *A Calculus of Suffering*, p.233. I return to the 'medicalicalisation of suffering' argument in later chapters, specifically in the context of the dying patient and the concept of 'natural' death
- ³⁴ M. Chassaignac, 'Of Chloroform During Pregnancy and Suckling', *Lancet*, 4 April 1857, p.336.
- ³⁵ *Ibid.*
- ³⁶ 'Deaths from Anaesthetics', editorial, *BMJ*, 6 May 1871, p.480.
- ³⁷ *Ibid.*
- ³⁸ *A Calculus of Suffering*, p.235.
- ³⁹ 'Deaths from Anaesthetics', editorial, *BMJ*, 13 May 1871, p.510.
- ⁴⁰ 'Deaths from Anaesthetics', *BMJ*, 6 May 1871, p.480.
- ⁴¹ 'Deaths from Anaesthetics', *BMJ*, 13 May 1871. Clover's apparatus is pictured in the *BMJ*, 23 November 1872, p.575. He was reported to have anaesthetised Florence Nightingale, Sir Robert Peel, and the Prince of Wales (later Edward VII). See Fairley, *The Conquest of Pain*, p.203.
- ⁴² 'Deaths from Anaesthetics', *BMJ*, 13 May 1871, p.510.
- ⁴³ Thomas Skinner, 'Ether and Chloroform', *BMJ*, 5 June 1875, p.761.
- ⁴⁴ Thomas Jones, 'On Anaesthetics', *BMJ*, 23 November 1872, pp.575-6.
- ⁴⁵ 'Deaths from Anaesthetics', *BMJ.*, 6 May 1871, p.480.
- ⁴⁶ 'Deaths from Anaesthetics', *BMJ*, 13 May 1871, p.510. The editorial drew attention to the problems of using ether and nitrous oxide, judged to be "more bulky, more costly, less readily to hand, less transportable and less universally applicable than chloroform". Mary Poovey highlights how Dr John Snow considered ether to be safer than chloroform but continued to use the latter because of what he termed its "ready applicability": Poovey, 'Scenes of and Indelicate Character', pp.141-2.
- ⁴⁷ J. T. Clover, 'Deaths from Anaesthetics', *BMJ*, 4 January 1873, p.10.
- ⁴⁸ Rey, *The History of Pain*, p.174.
- ⁴⁹ Pernick, *A Calculus of Suffering*, p.95.
- ⁵⁰ Samuel D. Williams, *Euthanasia: Reprinted from the Essays by the Members of the Birmingham Speculative Club* (London, Williams and Norgate, 1872), p.12. Chapter 3 of this thesis examines the calls for 'active' euthanasia that first surfaced in the late-nineteenth century.
- ⁵¹ Joseph Bullar, 'Chloroform in dying', *BMJ*, 7 July 1866, pp.10-12. Bullar's article is also cited by W. Bruce Fye, 'Active Euthanasia: An Historical Study', p.497; by Nicholas Kemp, 'Merciful Release', *The History of the British Euthanasia Movement* (Manchester, Manchester University Press, 2002), p.14, and by Ezekiel Emanuel, 'The History of Euthanasia Debates in the United States and Britain', *Annals of Internal Medicine*, 12 (1994), 793-802, at p.795.
- ⁵² Charles Kidd, *A Manual of Anaesthetics* (London, Henry Renshaw, 1859), p.90, cited by Pernick, *A Calculus of Suffering*, p.123.
- ⁵³ Rey, *The History of Pain*, p.170.
- ⁵⁴ This notion, linking pain with vitality, was illustrated by the theory of 'counterirritation' developed by the surgeon John Hunter, who maintained that treatment had to be painful in order to secure recovery: see Pernick, *A Calculus of Suffering*, p.44.
- ⁵⁵ *A Calculus of Suffering*, p.122.

- ⁵⁶ Ibid.
- ⁵⁷ Ibid., p.95.
- ⁵⁸ Porter, *The Greatest Benefit to Mankind*, p.663.
- ⁵⁹ Francis Anstie, 'The Hypodermic Injection of Remedies', *The Practitioner*, 1 (July 1868), 32-41, at p.32.
- ⁶⁰ Clifford Allbutt is described by medical historian Christopher Lawrence as "one of the greatest clinicians of the century". See 'Incommunicable Knowledge: Science, Technology and the Clinical Art in Britain 1850-1914', *Journal of Contemporary History*, 20 (1985), 503-520, at p.508.
- ⁶¹ Clifford Allbutt, 'On the Abuse of Hypodermic Injections of Morphia', *The Practitioner*, 5 (December 1870), 327-31, at p.329.
- ⁶² *The Practitioner*, 1, (July 1868), Preface. A neuralgia specialist, Francis Anstie was the author of a number of books including *Stimulants and Narcotics: Their mutual relations with special researches on the action of alcohol, ether and chloroform on the vital organism* (New York, D. Appleton and Company, 1872) and *Neuralgia and the diseases that resemble it* (London, Macmillan, 1872). He was appointed the first Dean of the London Medical School for Women in 1874.
- ⁶³ Sir Thomas Watson's 1871 *Lectures on the Principles and Practice of Physic*, was as a source referred to regularly by other nineteenth-century physicians such as William Munk and, as discussed earlier, seems also to have influenced Hugh Noble's writing.
- ⁶⁴ Watson's remarks are quoted by Anstie in *The Practitioner*, 1 (July 1868), Preface.
- ⁶⁵ Ibid.
- ⁶⁶ Practical experience with the hypodermic administration of morphine was gained in the American Civil War and a scientific study of the dosage and effects of subcutaneous administration of the drug was commissioned by the Royal and Medical Chirurgical Society of London in 1867.
- ⁶⁷ 'The Hypodermic Injection of Remedies', p.32. Anstie's article considered the general working of subcutaneous injections with reference to the application of a number of drugs. Morphine, however, is explicitly mentioned on a number of occasions during the course of the article.
- ⁶⁸ Ibid.
- ⁶⁹ Ibid.
- ⁷⁰ Francis Anstie, 'On the Effects of the Prolonged Use of Morphia by Subcutaneous Injection', *The Practitioner*, 6 (March 1871), 148-157, at p.153.
- ⁷¹ Ibid.
- ⁷² See Virginia Berridge and Griffith Edwards, *Opium and the People: Opiate Use in Nineteenth-Century England* (London, Allen Lane, 1981).
- ⁷³ 'On the Effects of the Prolonged Use of Morphia', p.153.
- ⁷⁴ Ibid.
- ⁷⁵ See Hermione De Almeida, *Romantic Medicine and John Keats*, (Oxford, Oxford University Press, 1991), pp.98-110.
- ⁷⁶ Clifford Allbutt, 'On the Hypodermic Use of Morphia in Diseases of the Heart and Great Vessels', *The Practitioner*, 3 (December 1869), 342-346, at p.342.
- ⁷⁷ Ibid.
- ⁷⁸ 'On the Abuse of Hypodermic Injections of Morphia', p.327.
- ⁷⁹ Ibid.
- ⁸⁰ Ibid.
- ⁸¹ Ibid.
- ⁸² George Oliver, 'On Hypodermic Injections of Morphia', *The Practitioner*, 6 (February 1871), 75-80, at p.76.
- ⁸³ Kemp, *Merciful Release*, p.11.
- ⁸⁴ Jalland, *Death in the Victorian Family*, p.91.

Chapter 3

Explicit Calls for 'Active' Euthanasia

I. 'Euthanasia': A Shift in Meaning

While discussions over the benefits and costs of pain relief continued between medical men, outside the profession another debate was taking shape. The widespread use of new pain-relieving techniques such as the inhalation of chloroform and subcutaneous morphine played an important part in opening the way for a wholly new type of discourse. What was now being called for was 'active' euthanasia in which the physician would intervene with the explicit intention of ending life at the request of the dying patient. I use the term 'active' euthanasia so as to distinguish this use of the word 'euthanasia' from its older meaning implying 'good death'.

In his survey of the nineteenth-century origins of debates over euthanasia, W. Bruce Fye also uses the term 'active' euthanasia, defined in his paper as "an intervention that shortens the life of a patient who is suffering from a painful, incurable disease".¹ Fye argues that during the first two hundred years of its use in both medical and non-medical literature, the word 'euthanasia' "did not imply the shortening of life". He calls this earlier use of the term, "spiritual" euthanasia, where the meaning of euthanasia was characterised by an emphasis on the dying patient's state of mind. "The dying patient was supposed to be tranquil and the means by which this was supposed to be achieved included physical comfort and moral support," he argues, adding: "this was essentially a passive process that was largely independent of the physician".²

This contrast between what Fye describes as "spiritual" and "active" euthanasia is arguably misleading. As I have discussed, historical evidence supports the idea that from the late eighteenth century onwards, rather than assuming a passive role, the physician was becoming increasingly involved in the management of death. Though an emphasis was indeed placed on the patient's mental preparedness, it was the doctor who, giving the assurance that suffering would be alleviated by medical intervention, often supplied the

“physical and moral support” to which Fye refers. Fye’s description of “spiritual” euthanasia more accurately portrays a period that predates the rise of the professional, medical-management of death in which the physician played a significant role in alleviating pain at the deathbed of the wealthier patient. Yet Fye seems to suggest that his particular definition of “spiritual” euthanasia is applicable up until the late nineteenth century. While the word ‘euthanasia’ found a fixed point of reference in the notion of the ‘good death’, this did not mean that the ideas that contributing to this ideal remained unchanged over two hundred years or that medical influence and intervention at the deathbed was always limited.

As Fye correctly identifies, it is important to draw attention to the shift in the meaning of the term ‘euthanasia’ that took place in the latter stages of the nineteenth century. However, his definition of “active” euthanasia as an “intervention that shortens the life of a patient” requires further explanation and clarification. Certainly, in the nineteenth century and into the first half of the twentieth century, the suggestion that the physician might in any way shorten the life of a patient was strongly resisted in official statements issued by the medical profession. Gradually, however, it became accepted that medical intervention to relieve suffering might have the effect of shortening life, but that this accepted practice of relieving pain was not a way of legitimating claims that the dying patient should be able to legally request his or her own death.

In the second section of my thesis I examine the medical profession’s accommodation of the idea that pain relief might potentially shorten life while simultaneously rejecting any moves to legalise ‘active’ euthanasia allowing the incurable and suffering patient to request death. At this point, I simply wish to highlight that Fye’s definition of ‘active’ euthanasia poses difficulties when applied in the second half of the twentieth century because “an intervention that shortens the life of a patient” has become, under certain conditions, accepted medical practice. However, “medical intervention with the explicit intention of ending life at the request of the patient” (my definition of ‘active’ euthanasia) has continually been resisted in Britain. Setting aside the later twentieth-century debate regarding the accommodation of pain relief and potential shortening of life, it is, in any case, a definition that more accurately describes the meaning that lay writers attached to the word ‘euthanasia’ when it took on a new meaning in the 1870s and 1880s.

Ethical arguments about suicide for the terminally ill and those suffering from extreme pain were not new but the suggestion in 1870 that death might be deliberately induced by the

doctor at the patient's request was novel. Those in support of 'active' euthanasia may have drawn on philosophical ideas that pre-dated nineteenth-century innovations in pain relief, but it was the use of these drugs that allowed the advancement of a particular notion of painless death. The term 'euthanasia' was now used to describe a situation in which the patient's consciousness was voluntarily extinguished (with a drug such as chloroform) to achieve a rapid and pain-free death. Non-medical writers who held a very different idea of what the medical management of death should imply were now giving euthanasia a radical new meaning. For the first time, 'euthanasia' was being used in a manner that implied the doctor deliberately ending the life of a patient.

In this chapter I focus primarily on the role that changes in pain-relieving practices played in contributing to this new formulation of the meaning of euthanasia. However, in setting the scene for this late nineteenth-century debate, it must be acknowledged that the arguments involved were drawn from an assortment of influences and ranged outside the bounds of developments in medical techniques. As I have argued, throughout the nineteenth century the meanings and values ascribed to pain were undergoing dramatic upheavals. The rejection of suffering as a necessary part of life influenced the growth of diverse social movements such as those opposed to vivisection and slavery.³ Different fields of interest shared common ground, where an ideological rejection of the inevitability of pain led to an intersection of arguments uniting seemingly disparate causes. Thus, the opposition of anti-vivisection campaigner Frances Power Cobbe to the notion of eternal punishment was linked to her rejection of the deliberate infliction of pain on animals.⁴ Similarly, the socialist and birth-control campaigner Annie Besant also dismissed the idea of eternal damnation and simultaneously advocated 'active' euthanasia for those suffering terrible pain on earth.⁵ I discuss her writing at length in this chapter.

Another influence on the late nineteenth-century euthanasia debate was the impact of social Darwinism. In his paper on the historical origins of 'active' euthanasia, Fye illustrates the power of social Darwinism by quoting Charles Singer's observation that Darwin's work "was soon extended also to man's habits customs, religion, social organisation, even ways of thinking".⁶ Making a similar conceptual connection between evolutionary and social thought, Kemp points out that the calls for 'active' euthanasia came around the same time as the publication of Darwin's *Origin of Species* (1859) and *Descent of Man* (1871).⁷ As my earlier discussion of pain relief suggested, in the latter half of the century evolutionary ideas were influencing certain medical views. The pain of childbirth, for example, was perceived as a

legacy of the transition in women from quadrupeds to bipeds. In the case of advocacy of 'active' euthanasia, Kemp argues that the contribution of Samuel D. Williams (a schoolteacher from Birmingham who called for patient-requested death) was "replete with evolutionary thought".⁸

By the 1880s, evolutionary ideas (whether endorsed or rejected) were firmly established as a key influence on intellectual debates. It would be oversimplifying matters to characterise the arguments in the 'active' euthanasia debate in terms of religious versus evolutionary doctrine. Nevertheless, the notion that man had evolved from animals rather than being created in the image of God had profound implications for the 'sanctity of life position', which was often religiously upheld. In addition, conceptually, the impact of social Darwinism widened the scope of the euthanasia debate so that as well as being concerned with arguments relating to pain, it also took on a dimension where discussion turned to evolutionary concepts of the 'fit' or 'unfit' and the 'weak' or 'strong'.

Although I do not explore the impact of social Darwinian thought or eugenic ideas on nineteenth-century euthanasia arguments in great detail here (other historians and sociologists have already tapped this rich source of influence) the part that they played in the debate cannot be ignored.⁹ In 1868 the German social Darwinist, biologist, eugenicist and 'active' euthanasia supporter Ernst Haeckel praised the ancient Spartan practice of killing deformed and weak children in his book *Natürliche Schöpfungsgeschichte* (*The History of Creation*). Haeckel contrasted this Spartan custom with nineteenth-century medical practice, characterised by what he termed "anti-selection", in which "modern civilised nations by means of their perfect art of healing" encouraged "artificial medical breeding".¹⁰ Haeckel's influence can be traced in the origins of Monism, a German anticlerical movement rooted in Darwinian ideology, in which the 'survival of the fittest' maxim was distilled into a simple goal: the triumph of the 'strongest' members of the human species and the elimination of the 'weakest'.¹¹

In 1904 Haeckel elaborated on his thoughts in relation to 'active' euthanasia. Nature continually sacrificed individuals in the struggle for life, therefore it was cruel to permit suffering in those who had to die anyway, he argued. "Many hundreds of thousands of incurables, especially mentally ill patients, lepers and cancer patients, are kept artificially alive in our modern civilised nations, and their unending ills are carefully prolonged, without any consideration of themselves and society," Haeckel stated. "What a tremendous sum of

pain and grief for the unhappy patients, what an immense amount of sadness and sorrow for their relatives, what losses of property, private and public,” he continued. Much of this loss could be saved, he argued, if only a decision was made to “release” the incurable with a dose of morphine.¹²

Late nineteenth-century writing, in which social Darwinian and eugenic thought converged, was to pre-empt early twentieth century discussion of euthanasia in Germany. In 1913, for example, the Monist League’s publication, *Das Monistische Jahrhundert*, founded by Haeckel, considered whether the doctor should end the life of the incurable patient in suffering. Examining the connection between eugenic ideas and ‘active’ euthanasia, Ian Dowbiggin comments: “Not everyone in the Monist League agreed that there was a right to a speedy, pain-free death, but there was little disagreement with the theory that all suffering diminished the individual by restricting his or her contribution to the community.”¹³

Clearly, Haeckel’s ideas and those of his Monist League contributed to a further layer of meaning in the interpretation of the term ‘euthanasia’. That the physician would intervene with the intention of ending life was evident; what was less clear was whether this would always be at the expressed wish of the patient. Haeckel stated that he wanted to restrict such a form of euthanasia to those who formally requested that their lives be ended, yet his reference to what he perceived as the burden placed on society by the mentally ill raised the question of how such patients could give their consent. Mention of mental illness also moved the issue of ‘active’ euthanasia away from the focus on physical suffering and introduced the notion of a comparative scale measuring the worth of human life, even in the absence of pain. ‘Suffering’ was no longer restricted to the pain of the terminally ill, but was also applied to those judged to be leading mentally ‘inferior’ but quite possibly pain-free lives.

This brings me to the sources to which I give detailed consideration in this chapter. The late nineteenth-century euthanasia debate in Britain centred on the contributions of a small group of non-medical writers who stressed that their proposals entailed that death should come only at the expressed request of the incurable, terminally-ill patient suffering unnecessary pain. The supporters of ‘active’ euthanasia defended their respective positions (and they were drawn from a variety of backgrounds) by challenging the validity of the ‘sanctity of life’ principle and by arguing that their arguments were simply an extension of new pain-relieving medical techniques that were already widely practised. Their proposals did not consider the case of the patient who could not give consent, nor did they consider the

case of the patient who was mentally ill. However, reference was made to the declining “usefulness” of the terminally ill patient, not only to him – or herself, but also to society as a whole. As I argue when I consider the third category of arguments that I trace throughout my thesis – those that relate to ‘social death’ – the influence of ideas that stretched beyond the simple desire to eradicate pain can be detected in the writing of those who advocated ‘active’ euthanasia. The contributors to the euthanasia debate in Britain also, at times, employed the language of social Darwinism. In doing so, they left themselves open to the charge that ‘active’ euthanasia would leave the weakest in society most vulnerable.

The word ‘euthanasia’ may have shifted to new ground in the 1870s, but ambiguity surrounded just what this new use of this new term meant and to whom exactly the proposals applied. As I have argued, this is not to suggest that prior to this semantic change, decisions surrounding how best to medically manage death and relieve pain were uncomplicated and subject to standardised decision-making. However, the new use of the term ‘euthanasia’ presented a set of questions about the practice of pain relief that were now, to a greater extent than before, open to public scrutiny. Yet this was not just a debate about the alleviation of incurable suffering. Different writers proposing that the doctor intervene to bring about death continued to use the word ‘euthanasia’ in different ways – sometimes these variations were subtle, at other times, as in the case of Haeckel, there seemed the distinct possibility that euthanasia might imply the non-voluntary killing of the mentally ill.

Even within the British debate, there were those who argued that the terminally ill patient should decide when he or she wanted to die while simultaneously stressing the burden such an individual placed on the community. This suggested that factors other than the patient’s own experience of illness and pain contributed to proposals that the doctor should induce death at the patient’s request. This uncertainty in relation to the exact meaning and scope of late nineteenth-century formulations of the term ‘euthanasia’ was to remain a hallmark of future debates as they continued and intensified in the twentieth century.

In this chapter I examine in detail three main contributions in support of ‘active’ euthanasia: that of S.D. Williams, whose essay of 1870, titled ‘Euthanasia’, was first to use the term in its newly formulated sense; the philosopher Lionel Tollemache’s article ‘The New Cure for Incurables’ that was published in 1873; and an essay by Annie Besant, also titled ‘Euthanasia’, published in 1875. I consider the three categories of argument that I identify in my thesis – principled support of euthanasia, practical arguments in support

concerned with the practice of pain relief (the central focus of the chapter), and finally, the third category relating to 'social' death. At the end of the chapter, I look at the response to the proposals – a response that initially came from non-medical publications and then from an editorial in the *Lancet* that endorsed the “shortening of pain” but not the “shortening of life”. This emphasis on the importance of professional palliative care was to prove another hallmark of future euthanasia debates.

II. 'A very ingenious essay': Samuel D. Williams and 'Euthanasia'

In 1870 the Birmingham Speculative Club published a collection of essays on a number of diverse themes dealing with philosophical and social issues.¹⁴ Although none of the contributors to the collection was a professional writer and the circulation of this volume of essays was initially limited, it was, as Kemp observes, “brought to the attention of a much larger audience by the scholarly periodicals which were enjoying their heyday during the 1870s”.¹⁵ The late nineteenth-century witnessed a flourishing of “higher journalism” characterised by a proliferation of publications that often debated and reviewed the work of a growing body of amateur philosophers otherwise employed in trades or professions.¹⁶ This meant that essays, published by literary and philosophical societies and distributed locally, were later reprinted in better known journals and magazines, reaching a wider readership. University reform and expansion played a part in providing a market for such literature cultivating what Kemp describes as “a new calibre of reader and contributor”.¹⁷

One of the contributions to the Birmingham Speculative Club's publication was an essay by a teacher, Samuel D. Williams Jun., in which he concisely spelt out a new proposal:

... in all cases of hopeless and painful illness it should be the recognised duty of the medical attendant, wherever so desired by the patient, to administer chloroform, or such other anaesthetics as may by and by supercede chloroform, so as to destroy consciousness at once, and put the sufferer at once to a quick and painless death; all needful precautions being adopted to prevent any possible abuse of such duty; and means being taken to establish beyond any possibility of doubt or question that the remedy was at the express wish of the patient.¹⁸

Of particular significance was the name of Williams' article. Like Hugh Noble's thesis of 1854, it carried the title 'Euthanasia'. In this instance, however, the term 'euthanasia' was used in a very different way. No longer did it simply mean a death that was calm and peaceful. It now implied a situation in which the physician would take active steps to deliberately terminate life if asked by the incurable and suffering patient. Also significant

was Williams' use of the word "duty" to describe the moral obligation he placed on the physician when presented by such a request. This was the first time that the "duty" of the nineteenth-century doctor had been formulated in such a manner. It is worth considering Williams' essay in detail because his proposals included what would become some of the most consistently raised and well-rehearsed arguments used by advocates of 'active' euthanasia in future debates. Viewing the essay in its historical context, it also reveals how older arguments relating to the ethical permissibility of taking life were combined with arguments that drew on the new methods of relieving pain, setting the scene for a revision in the meaning of the term 'euthanasia'.

Beginning with Williams' challenge to the 'sanctity of life' position, it is interesting to note that he questioned the very existence of such a principle. "It may well be doubted if life have any sacredness about it," he wrote, "apart from the use made of it by its possessor." Nature knew of no distinction between the supposed "sacredness" of human life and the value of any other form of existence, he argued, adding: "a man's life in Nature's eyes, is of no more value than a bird's".¹⁹ Williams also depicted Nature as a cruel and savage force. "For let it be borne in mind, death by disease is always death by torture and the wit of man has never devised torture more cruel than some of Nature's methods of putting her victims to death," he wrote. Nature was a "dread power, working with a blind force" manifested in great beauty in the world, but also in scenes of great suffering and torment.²⁰

Using language that resonated with the influence of social Darwinism, Williams described life as "a field of mortal struggle" in which "a universal preying on the weak by the strong is incessant".²¹ As society advanced, the vulnerable were increasingly protected so that "Nature's provision for stamping out the weak is thwarted", Williams maintained. Setting aside the medical "remedies and alleviations" that challenged Nature, "the fact remains that man's existence, like that of other animals, is rooted in pain", he wrote. Pain was "the one primordial fact lying at the root of existence in all its forms", and at the end of life lay "fierce suffering terminating in death".²² Williams argued that a society that was "less cruel, less indifferent to inflicting pain on our fellow man and more desirous of shielding the animals we make use of from wanton torture", should also be a society that permitted quick, painless and easy death. Left in the hands of nature, death was often brutal and terrifying, but there were now the means available to modify this situation. "Let the medical attendant bring the relief of swift and lasting unconsciousness; since we must die, let us, at all events, have the consolation of dying by the least painful death that beneficent skill

can compass for us," he stated.²³ The "real alleviation" of pain was "the greatest service which man can render to man".²⁴

Williams also challenged the 'sanctity of life' principle by arguing that life was sacrificed when waging wars and killing for "national or political passions". In this context, he concluded, "man shows as little sense of value of human life as Nature herself".²⁵ Anticipating religious objections to his proposals, Williams was equally forthright. "Submission to God's will has no meaning for us," he wrote. Every human intervention in the world was an attempt to alter and improve the surrounding environment. If the phrase "submission to God's will" was to have any real meaning, then the whole of human history was in "systematic opposition to the will of God".²⁶ What those who used the phrase really meant, he argued, was that pain be endured without complaint. Death was an inevitability that could not be escaped – in that sense, he conceded, men and women did submit to the will of God. Yet, Williams argued, there was nothing worthy about submitting to "fruitless suffering", and the rejection of such submission was "only carrying out the principle that has lain at the heart of every useful act; that of struggling to the utmost to remedy whatever lies within reach".

Though emphasising that he had no interest in offering a general defence of suicide, Williams allowed himself a side-swipe at religious opposition to those who took their own lives. Religious condemnation of suicide was "the fruit of ecclesiastical, not Christian discipline; and one of the legacies of the Roman Catholic Church", he argued. Williams maintained that suicide often required bravery – to brand the individual who took his or her own life as a "coward" was wrong until all the circumstances and reasons for the particular case were known. However, he stressed that the arguments in his essay were expressly directed towards the case in which there was, in his view, justification for the medical attendant to take the life of the patient "stricken with fatal and painful disease". This, he contended, was simply allowing such a patient to take "advantage of the palliatives won for him by man's genius".²⁷

This proposal – that pain relieving drugs be administered to end the life of a suffering and incurable patient – added a novel emphasis to Williams' point that all human intervention in the world effectively rendered meaningless the phrase, "submission to God's will". His arguments (which in many ways resembled those offered by Hume in the essay *On Suicide*) were given a new slant when he considered the practice of administering anaesthetic

drugs. When pain relief was given, the principle of “sacredness of life” was regularly “set aside by medical men”, he maintained, then elaborated:

The very medical attendant who would revolt from the bare idea of putting a suffering patient to death outright, though the patient implored him to do so, would feel no scruple in giving temporary relief by opiates, or other anaesthetics, even though he were absolutely sure that he was shortening the patient’s life by their use. Suppose, for instance, that a given patient were certain to drag on through a whole month of hideous sufferings, if left to himself and nature, but that the intensity of his sufferings could be allayed by drugs, which nevertheless, would hasten the known inevitable by a week:— There are few, if any medical men who would hesitate to give the drugs; few, if any, patients, or patient’s relations or friends, who would hesitate to ask that they should be given. And if this is so, what becomes of the sacredness of life?²⁸

By arguing that the practice of pain relief left the ‘sanctity of life’ principle unsustainable, Williams advanced his case for ‘active’ euthanasia. While officially the medical profession endorsed the use of pain relief but maintained that the dying patient’s life was not shortened by such use, Williams maintained that the administration of pain relief *did* shorten life. Further, he argued that no distinction could be drawn between cutting life short because of the desire to alleviate pain, and his proposal that life be ended at the explicit request of the patient. Those who administered pain relief and in the process shortened life could not then appeal to “the inviolability of life” when met with his proposal. “You have already violated it [the sacredness of life] and rightly violated it; and the same reasoning which justifies what you have already done,” argued Williams, “will justify further violation.”²⁹

Williams described the anaesthetic properties of chloroform as “one of the greatest practical benefits which science has hitherto conferred on mankind”. He then reminded the reader that chloroform’s introduction was initially opposed by those who viewed the drug as what he termed “evidence of impatience with the ways of Providence”. However, such objections, he argued, had “given way” once chloroform’s “clear, undisputed benefits” were recognised and there was no longer resistance to its use in childbirth or surgery. He was sure that his proposed use of chloroform for the incurable patient in pain would be considered “too outrageous” to merit serious discussion and yet predicted that the arguments of those who objected would not be “one whit better founded than were those earlier protests”.³⁰

Williams found it difficult to understand why chloroform was used, rightly in his view, “to render less painful the naturally painful passage into life” and yet “it should almost be an offence to so much as suggest a like recurrence to it in the still more painful passage out of life”. Here, Williams was perhaps overstating his case because as I have already

discussed, doctors were in the habit of administering all kinds of pain relief to dying patients. By the late nineteenth-century this included, for some doctors at least, an open admission to using chloroform (as discussed in Chapter 2, III) when caring for the dying. It was not so much the “recurrence” to chloroform that Williams’ opponents were likely to find “outrageous”, but more the particular use to which he wished the drug be put – namely a swift and painless death at the request of the patient. After all, Hugh Noble used the same argument, about chloroform being initially opposed by some and then absorbed into medical practice, to defend his proposal that the drug be used more frequently to alleviate the pain of dying. Noble did not, of course, advocate that the drug be put to the same use as described by Williams.

Nevertheless, it is interesting to note how Williams’ arguments shared a degree of common ground with the medical defence of anaesthesia made earlier in the nineteenth century. Just as in Simpson’s defence of chloroform use, Williams challenged orthodox religious interpretations of God’s will, while his conclusion that “custom-ridden folk” would see “moral and physical evils” in his proposal is reminiscent of Alfred Collinson’s remark that “querulous and suspicious communities” required the medical profession’s guidance (Chapter 2, II). By and large, the medical profession’s support of anaesthetic drug use had been based on an argument in which the concept of a divinely ordered ‘natural’ world was left undisrupted by the practice of relieving pain. As discussed in Chapter 2, the alleviation of pain was absorbed into routine medical practice so that a painless death, managed medically, was viewed as entirely ‘natural’. This view located the exact timing of death beyond human intervention – placing it instead in the realm of God’s will. Yet while it was forbidden to shorten a patient’s life, it was acceptable to alleviate pain. Rather than challenging the notion of a divinely willed ‘natural’ order, this was seen as an expression of God’s intention that unnecessary pain be relieved through the human application of God-given knowledge, revealed in growing medical expertise.

While Williams shared the view that pain should not be borne with acceptance, his essay was a direct challenge to the medical profession’s official interpretation of a ‘natural’ order. For him, nature was often brutal, cruel and terrifying, particularly during death. Nature operated outside the influence of any beneficent, divine force; therefore, to talk of death residing solely in the hands of God was misconstrued. All men and women had to face death, and Williams conceded that this might be interpreted as a manifestation of the supremacy of God’s will. However, in his view, ‘natural’ death was often nasty and brutish but far from

short – inflicting on the dying patient a protracted period of suffering that could be immediately ended if only sufficient quantities of pain relief were administered to bring about death. Williams advanced his proposal as the most rational and civilized response to the question of how best to manage the dying patient. In doing so, he challenged the authority, not only of religious calls that the process of dying be seen as “a submission to God’s will”, but also medical authority that claimed that pain relief neither shortened life nor disrupted an appeal to the “sacredness of life”. There was no such principle as the “sacredness of life”, argued Williams, adding: “life is a thing to be used freely and given freely”.³¹ As in the medical defence of anaesthesia, Williams linked what he perceived as a growth in society’s civility with an increasing sensitivity to pain. This ‘sensitivity’, however, related as much to a rejection of witnessing others’ suffering as it did to the individual’s own capacity to feel pain. “Indifference to others’ pain”, he wrote, was an “unheroic quality”.³²

It was Williams’ emphasis on the relationship between the incurable patient in pain and other members of society that, I argue, introduced the notion of ‘social’ death into his arguments. While the patient’s own experience of pain was clearly a central factor in his call for ‘active’ euthanasia, another element was added to justify his proposal when he described the impact that such suffering had on society. Life could only be described as “sacred”, he argued, “in so far as the word may signify the duty laid on every man of using his life nobly while he has it”. Yet in the case of the patient Williams had in mind, life had ceased to be ‘useful’ in what he judged as any meaningful sense:

There is no question here of making a noble use of life, for, by the supposition, all the uses of life are over, and nothing remains to its possessor but to bear its pains; and again, as there can be no violation of the sacredness of property when it is laid aside with the owner’s consent, so there can be no violation of the sacredness of life, when, with the consent of the sufferer, a life is taken away that has ceased to be useful to others and has become an unbearable infliction on its possessor.³³

Here, the suggestion was that the ‘worth’ of a patient’s life be judged in two ways. The first depended on the patient’s own relationship with pain, when the individual judged that life had become what Williams described as “an intolerable burden”. The second was the perception that the patient’s life had diminished in its usefulness to society. Indeed, throughout ‘Euthanasia’, Williams scattered references to the dying patient’s life being “no longer of use to others”.

There might have been a blurring between these two ways of measuring the 'worth' of life – after all, a patient's experience of suffering and desire to die might have been heightened by a sense of burdening family and friends. However, Williams' claim that the incurable, suffering patient could no longer make "a noble use of life" suggests that the dying patient's life was no longer considered as making a contribution to the wider good of society. The patient might have been biologically alive, but was no longer 'living' in a purposeful way that benefited others. 'Active' euthanasia, it seemed, was not just a means of ending life characterised by intolerable pain, but also a means of ending life considered 'useless' to society. This ending of life, was, of course, to be with the patient's express consent and with the assumption that the patient would share the view that his or her life was so diminished in value as to be no longer worth living. However, quite apart from the ethical controversy linked to Williams' proposal that the physician end life at the request of the patient, this emphasis on the comparative 'worth' of human life to society supplied an additional target for Williams' critics. I discuss the objections to his essay later in this chapter.

We can thus find in Williams' essay the three analytical categories of argument that I trace throughout the euthanasia debates examined in this thesis. Williams' defence of 'active' euthanasia, I argue, rested on an attack on the principle of the 'sanctity of life', on arguments that related to the practice of pain relief, and on arguments that alluded to a notion of 'social' death. These three strands of argument continued in the contributions of others supporting 'active' euthanasia. Williams, however, was the first nineteenth-century writer to set out his ideas in such a comprehensive manner. Within three years, 'Euthanasia' was on its fourth reprint and was described by the journal *The Saturday Review* (though not supporting Williams' proposal for 'active' euthanasia) as both "remarkable" and as "a very ingenious essay".³⁴ Further writing that expressed very similar ideas to those found in Williams' essay soon followed.

III. Lionel Tollemache and Annie Besant

Three years after S.D. Williams' essay was first published, the Hon. Lionel Tollemache wrote an essay for the *Fortnightly Review* in which he voiced similar views to those found in Williams' 'Euthanasia'. Tollemache was a Balliol graduate, philosopher, writer and member (like many of the academic elite) of London's exclusive Athenaeum Club.³⁵ In his essay, 'The New Cure for Incurables', Tollemache argued that doctors were

already giving powerful doses of drugs to alleviate the agony of disease and that attitudes to pain and suffering were changing.³⁶ “I am told on medical authority that in the last stages of cancer it is now not uncommon to give strong narcotics, which no one would have dreamt of giving half a century ago”, he wrote.³⁷

Supporting Williams’ proposal that the patient should be able to request death, Tollemache maintained that the same arguments that justified use of drugs in childbirth also justified the administration of pain relief during the process of dying. He argued that drugs should be given in sufficient quantities so that, if the patient desired, pain was not merely temporarily alleviated but permanently put to an end by means of death. This, wrote Tollemache, was the consistent application of an already established precedent that allowed medical intervention to mitigate pain. “As Williams argues, all suffering is represented as the effect of sin, especially the suffering of childbirth,” he stated, adding that “Evangelicals were quite consistent in the opposition that they raised to the use of chloroform in confinements, until fortunately public opinion became too strong for them.”³⁸

While rejecting the religious objections that had been made to any medical intervention that sought the relief of pain, Tollemache argued that this, at least, was a position that did not deviate from the (albeit misguided in his view) principle that it was wrong to interfere with divinely intended suffering. If this position was to be abandoned, it could not be done so partially. Once the medical alleviation of suffering was permitted at all, then this could not allow for degrees of intervention in which pain relief was allowed in certain circumstances, but not in cases where the physician was asked to end life in order to extinguish pain. Thus, in ‘The New Cure for Incurables’, Tollemache questioned whether it was possible to speak coherently of a principle of ‘sanctity of life’, given the impact of the accepted practice of intervening medically in order to relieve pain. The main focus of Tollemache’s argument was what he identified as the unsustainable idea that life and death were subject to divine control, in spite of examples of human intervention that to him obviously undermined this position. However, he also duplicated another of Williams’ arguments by making passing reference to what he perceived as the shortening of life that occurred when doctors administered pain relief. In addition, throughout his essay Tollemache used the term ‘euthanasia’ in its re-formulated sense to mean the doctor deliberately bringing about a quick and painless death at the patient’s request. This reflected the change in meaning that the word ‘euthanasia’ was undergoing in the late nineteenth-century.

In March 1871 an editorial in the *Spectator* had strongly condemned Williams' essay, warning that his proposal would not allow the patient to change his or her mind. The editorial questioned what would happen if chloroform failed to instantly render the patient unconscious and the patient had a change of heart. The patient would be left to "vainly beg for the life, which it would then be impossible to restore".³⁹ Tollemache took the opportunity to address this objection in his own writing:

I apprehend that after any decisive step in one's life – marriage for example – it is a sad thing if one repents when it is too late. But a wise man will first determine what suits him best, and then will not much trouble himself much about the possibility of future repentance ... Also, between marriage and euthanasia there is a difference: the husband of a scold may have to bemoan his lot through many long years, while in the other case the time available is somewhat limited.⁴⁰

Clearly, Tollemache was adopting a rather more irreverent tone than that of Williams. More serious, however, was his suggestion that the friends of the dying patient were exposed to a "sort of moral suicide" – an indication that he considered 'active' euthanasia a source of release, not just for the dying, but for those who had to witness suffering. His reference to the impact that suffering had on others apart from the patient suggests that wider social factors extending beyond a concern for the individual in pain contributed to his arguments.

On this point, Tollemache's essay provoked its own response from the *Spectator*. An editorial in 1873 stated: "Tollemache's new cure for the incurable has certainly no claim to be represented as sanctioning only the powers of sufferers to take their own destinies into their hands." According to the editorial, Tollemache's proposal allowed, "on far stronger grounds, the right of bystanders to take the destinies of sufferers into their own hands". This, the editorial argued, would lead to "impatience of hopeless suffering rather than tenderness towards it". Moreover, the *Spectator* judged that 'active' euthanasia, if permitted, would foster the growth of a social climate in which any standard used to measure the 'worth' of lives deemed a burden to society would be continually lowered. It would be difficult to avoid "a sort of moral pressure on poor invalids to demand the right of ridding the world of themselves".⁴¹

The language employed by Tollemache strongly supports the suggestion that his advocacy of 'active' euthanasia was underpinned by more than a concern about extinguishing the pain of the suffering individual. There is clear textual evidence in 'The

New Cure for Incurables' supporting the argument that Tollemache considered the suffering patient no longer useful to society and he judged this a legitimate consideration when supporting Williams' proposal. In a section of his essay with distinctly social Darwinian overtones, he wrote:

Modern science informs us that in an overcrowded population there is a sharp struggle for existence, so that an unhealthy, unhappy and useless man is in a manner hustling out of being, or at least out of means of enjoyment, someone who would probably be happier, healthier and more useful than himself.⁴²

This statement points to more than a concern that intimate friends and relations were spared the ordeal of witnessing the pain of someone they knew. Rather, it suggests that the patient, though biologically alive, was no longer contributing to society and was standing in the way of those considered by Tollemache as "happier, healthier and more useful". The *Spectator* concluded that Tollemache's arguments encouraged ending the lives, not only of the sick but also of those judged to be "the cause of more pain than pleasure to others". In a letter to the *Spectator*, Tollemache countered by stressing that he rejected the notion of "relief ever being given without the dying man's express consent", and in later years he retreated somewhat from his original energetic support of 'active' euthanasia.⁴³ In collecting a number of his essays to form a book, he admitted to hesitating when considering the inclusion of 'The New Cure for Incurables'. He decided to do so, he explained, because "my article is philosophical discussion, it is not revolutionary propaganda".⁴⁴

"Philosophical discussion" it may have been, but the response to Tollemache's essay in the editorial and letters pages of the *Spectator* suggests that the potential practical application of his ideas caused considerable concern. Interestingly, this concern hinged, not so much on a defence of an absolute principle of 'sanctity of life', but rather on the danger of exposing vulnerable members of society to the judgement that their lives were without worth. Kemp describes this late nineteenth-century concern as "the first concrete example of the 'slippery-slope' argument".⁴⁵ The thrust of this argument is that, if allowed, 'active' euthanasia would not be restricted to the consensual ending of the lives of those dying in pain, but would descend into the killing of other vulnerable members of society such as the elderly or the mentally ill. The 'slippery-slope' argument has been a constant feature of twentieth-century euthanasia arguments and I return to this theme in the second part of the thesis. However, it is important to acknowledge that the late nineteenth-century debate over 'active' euthanasia revolved, not only round questions of pain relief, but also round questions of what constituted a 'worthwhile' life.

While the contributions of Williams and Tollemache provoked discussion and debate, another essay on the subject of 'active' euthanasia does not appear to have elicited a similar response. *Euthanasia*, by Annie Besant, was one of a number of short papers published as part of a series of theological and philosophical essays in 1875. Again, Besant used the word 'euthanasia' in its new sense, proposing:

... that where an incurable disorder is accompanied by extreme pain – pain, which nothing can alleviate except death – pain, which only grows worse as the inevitable doom approaches – pain, which drives almost to madness, and which ends in the intensified torture of the death agony – that pain should be at once soothed by the administration of an anaesthetic which should not only produce unconsciousness, but should be sufficiently powerful to end a life, in which the renewal of consciousness can only be simultaneous with the renewal of pain.⁴⁶

Like the earlier writing of Williams and Tollemache, Besant (who referred to Williams in her own essay) advocated that in cases of incurable suffering the patient should be able to ask for what she termed "the mercy of a speedy death instead of a protracted one". She argued that such a request should come "without the dangers of the penalties of manslaughter being inflicted on the doctors and nurses in attendance".⁴⁷

On the principle of 'sanctity of life', Besant criticised what she perceived as the unevenness of its application. While "the ordinary man or woman" advocated that life was sacred and any objection to this position was branded "wrong and dangerous", she maintained that such a line of argument, though common, was the product of "the inconsistency of the thoughtless". Those who defended the sanctity of life in one set of circumstances, would swiftly abandon the principle and "glow with passionate admiration at some noble deed" in which life was sacrificed out of a sense of duty or honour. Patriots died for their country, martyrs gave up their lives for beliefs that they would not deny – these, stated Besant, were examples of life being given for principles judged more worthy than an absolute commitment to the principle that life was, at all times, sacred.⁴⁸

"That life is sacred is an undeniable proposition; every natural gift is valuable and is not to be lightly destroyed," she wrote, but added: "it is *not* the most sacred thing on earth." The question for Besant was "whether there are present, in any proposed euthanasia, such conditions as overbear considerations for the *acknowledged* sanctity of life". While life was not to be voluntarily abandoned "without grave and sufficient cause", she concluded that in the case of the incurable, suffering patient for whom 'active' euthanasia was intended, the

'sanctity of life' principle could be justifiably set aside.⁴⁹ In a similar fashion to Williams and Tollemache, Besant introduced the idea that such a patient was no longer a 'useful' contributor to society. "They have become a burden to themselves and all about them and have in reality outlived themselves," she stated.⁵⁰ She even maintained that those caring for the dying and witnessing suffering were themselves at risk of shortening their lives as a result of anxiety and fatigue. "Has the nurse the right to sacrifice her own life – and an injury to health is a sacrifice of life – for an absolutely unequivocal advantage?" she asked.

Such an emphasis, again, appeared to open up an area of argument in which 'active' euthanasia was linked, not only to the incurable patient's experience of pain, but to the perception that such a patient negatively affected others and indeed, society as a whole. Besant was sensitive to the earlier criticism that had suggested that the proposals for 'active' euthanasia left the vulnerable in society exposed to the danger of non-consensual killing. "It is sometimes thoughtlessly stated that the supporters of euthanasia propose to put to death all persons suffering from incurable disease – no assertion can be more inaccurate or not or more calculated to mislead," she argued. Misleading criticism or not, the notion that the worth of an individual's life be measured in relation to others in society was a common theme in the writing of those who proposed 'active' euthanasia.

Having stated her objection to those who attacked the idea of 'active' euthanasia on the grounds that it might be abused, Besant drew her argument back to the issue of the patient experiencing pain at the end of life. There was nothing noble or honourable in enduring such suffering, and it was wrong to view pain as "a remedial agent inflicted by God" which was to be borne patiently, she maintained. "Pain *as* pain has no recommendations, spiritual or otherwise, nor is there the smallest merit in a voluntary and needless submission to pain," she wrote.⁵¹ Rejecting the view that physical suffering was a manifestation of divine power, Besant utilised an argument already rehearsed in the writing of Williams and Tollemache:

If God is directly acting on the sufferer's body and is educating his soul by racking his nerves, by what right does the doctor step between with his impious anaesthetic, and by reducing the patient to unconsciousness, deprive God of his pupil, and man of his lesson? ...if this argument be good for anything at all, we must henceforth eschew all anaesthetics, we must take no steps to alleviate human agony, we must not interfere with this beneficent agent, but must leave nature to torture us at will.⁵²

According to Besant, the established practice of medically intervening in order to relieve suffering undermined any argument that the pain of dying had to be accepted as God's will. As discussed in Chapter 2, many nineteenth-century medical men would have shared the view that pain should not be interpreted as an expression of divine intention that was to be left unchallenged. Yet for Besant, to allow one type of medical intervention in order to alleviate pain and not another was wholly inconsistent. If pain relief was at all permissible when caring for the dying patient, then the logical extension of such practice was 'active' euthanasia, she maintained. Besant described how a common utterance by those at the bedside of a recently deceased patient was "It is a mercy God has taken him." She argued that this "mercy" should extend to 'active' euthanasia so that "man should be allowed to give man, when human skill and tenderness have done their best, ... a speedy and painless death".⁵³

Although a footnote in *Euthanasia* stated that Besant "expressed no opinion" on theological questions concerning the existence or non-existence of a God, the author's own biographical history provides revealing contextual detail to her writing. The daughter of a doctor, Besant was married at the age of nineteen to member of the clergy, but after questioning her religious beliefs and refusing to attend communion she was ordered out of the family home by her husband. A legal separation followed and by 1874, a year before writing *Euthanasia*, Besant had renounced Christianity completely to become a leading figure in the National Secular Society. Although, as far as I can establish, there is no published evidence to suggest that her essay provoked any substantial response, by the late nineteenth-century Besant's name would have been widely recognised.

In 1877 Besant and Charles Bradlaugh, the leader of the secular movement in Britain, published a book promoting birth control. Both were found guilty of publishing an "obscene" text and were each given six month prison sentences that were later quashed at the Court of Appeal. Besant subsequently produced another book in support of birth control. Helped by the negative publicity this second book attracted, in a high-profile case her former husband won custody of their daughter who had been living with her mother in London.⁵⁴ Later in life, Besant returned to religion but in a very different form. In the 1890s she became a follower of Theosophy, a religious movement based on the Hindu ideas of karma and reincarnation.⁵⁵

The details of Annie Besant's life offer more than interesting biographical colour when considering her writing. It is telling that Besant advocated 'active' euthanasia in the aftermath of abandoning her Christian faith. Unlike religious medical men who defended the use of pain relief for the dying patient but maintained that the exact moment of death remained the province of God, Besant was, I suggest, ideologically predisposed to constructing an argument in which the timing of death was considered the province of man. That is not to argue that religious beliefs necessarily preclude support for 'active' euthanasia. As I consider in the second part of this thesis, a number of leading religious figures were vocal advocates of legalised euthanasia in the twentieth century. Similarly, opposition to 'active' euthanasia need not be motivated by obvious religious concerns. As discussed in this chapter, some of the nineteenth-century criticism of Williams and Tollemache's writing related to fears that 'active' euthanasia would be abused and extended to non-voluntary killing. This criticism was not necessarily dependent on a religious commitment to the belief that God alone could take life.

My argument is simply that Besant's writing is a striking example of the nineteenth-century negotiation over how forms of medical practice, viewed as legitimate or illegitimate, should be articulated when applied to the management of death. The introduction of powerful new pain-relieving drugs added a new layer of complexity when it came to demarcating the boundary between acceptable and non-acceptable forms of medical intervention. Where this boundary was drawn was subject to a range of influences that often involved the accommodation of different systems of belief and ideology. Interestingly, when Besant returned to religion in the later years of her life, her description of pain and its purpose was re-cast in a way that radically differed from her previous statements on suffering.

In 1894, addressing a meeting of fellow followers of Theosophy, Besant spoke of pain as "... an instrument that the Soul may use. Pain becomes the surgeon's knife that cuts away the spot of danger. Therefore, pain is no longer to be resisted as the enemy, but is to be welcomed as a friend."⁵⁶ Without documentary evidence it is impossible to know if Besant's position on 'active' euthanasia had changed by the 1890s. However, her description of pain written in 1875 stands in stark contrast to her later pronouncement – exemplifying, I suggest, how wider beliefs and ideologies could impact on the explanations offered for suffering.

Clearly, multiple influences were at work when Williams, Tollemache and Besant wrote in support of 'active' euthanasia in the 1870s. Concern for the individual in pain was combined with a form of utilitarian argument based on the view that the incurable and suffering patient burdened society. The very meaning of the term 'euthanasia' had embarked on a process of negotiation and redefinition, albeit outside the confines of the medical profession. It was left to a non-medical journal, the *Spectator*, to provide a forum for discussing the idea that the doctor should end life at the request of the patient. That is not to say, however, that the debates over pain relief taking place within the medical profession had little to do with the calls for 'active' euthanasia from lay writers. Without the developments in anaesthesia, Williams, Tollemache and Besant would not have been able to conceive of 'active' euthanasia in the manner in which they did. Moreover, if within the medical community questions of life, death and the meaning of pain were being worked through, then a similar process was occurring in the non-medical world. Of vital importance, therefore, was the public response of the medical profession to the proposal that the doctor should explicitly and deliberately end life.

IV. A Medical Response

When William's essay was quoted at length and reviewed in detail in an edition of *Popular Science Monthly* in 1873, it reached an audience that included scientists and physicians.⁵⁷ However, it would be nearly two decades until the first medical journal, the *Lancet*, would publicly address the proposals for 'active' euthanasia. In an editorial titled 'Euthanasia Secundum Artem', the journal struck a tone that, initially at least, seemed not altogether hostile to Williams' position. The editorial began by quoting a Dr. B.W. Richardson – "the inventor of the lethal chamber for the painless extinction of the life of the friend of man, the dog".⁵⁸ In his address, 'Euthanasia for the Lower Creation', delivered before the Royal Society of Arts, Richardson had argued "that man could never hope to secure for himself so painless and happy a death as had thus come through the hand of science to the lower animals of the kingdom".⁵⁹ From this sympathetic reference to suffering animals being painlessly put to death, the *Lancet* then considered the proposals set out by Williams. "He [Williams] urged that man ought, as a being of free will and judgement, to claim the right when death was inevitable, to have the act of death made painless," stated the editorial. However, the proposal that the physician, if asked, should administer quantities of anaesthetic so as to end life was rejected and condemned.

Though the *Lancet* conceded that Williams was a “very able and observant man”, as a teacher he “had not the practical knowledge of the subject to enable him to work it out in such a manner as to carry conviction of sufficient quality to institute a practice”. Demands that called for the physician to actively shorten life at the request of the patient failed to appreciate the moral and legal implications that accompanied such proposals, the journal maintained. Moreover, lay writers who called for the deliberate ending of dying patients’ lives turned to the medical profession in order to “settle the difficulty”. The editorial continued: “The doctors are to be the men to give the coup de grâce to writhing or flickering, or hopeless men, women, and children ... and the profession very wisely – nay, even humanely – withdraws from the proposition.”⁶⁰

Doctors were against administering drugs to end life, because, argued the *Lancet*, the purpose of the medical profession was to sustain life, even when this appeared to be impossible. On this point the editorial elaborated:

The members of the profession feel that it is their duty to prolong life in a very large number of instances to the very last flicker. They sometimes see by this action life restored when all has seemed to be lost. They have in fact, no correct measure of death itself, and there are cases where death seems actually to have taken place in which there is doubt whether an inappreciable spark of life may not remain and once more declare itself. Such facts as these have ever stood, and promise long to stand, and thwart the practice of euthanasia *secundum artem* as a system, if the professors of medical science and art are to be the administrators.⁶¹

For the medical profession to become involved in administering doses with the intention of ending patients’ lives would only serve to precipitate the “criticism of suspicious relatives and friends”. Further, such a move would unquestionably lead to “many serious legal inquiries”. In the event of any proposal to change the law in order to allow for ‘euthanasia *secundum artem*’, the *Lancet* considered that the medical profession “would undoubtedly have a powerful voice for or against”.

The journal concluded that even if the law ever did change, the medical profession would remain resolutely against any suggestion that physicians deliberately administer fatal doses. “There is no more reason that a representative of medicine should take part in the production of the euthanasia than anyone else,” stated the editorial. The diagnosis of a physician might determine that a patient would die from disease and “his evidence might be required to determine that death had taken place”. However, it was for the State alone “to determine the mode of death and the manner in which it should be carried out”.⁶² In the event

of Williams' proposals becoming law, the State would have to appoint a legal administrator, or would have "to permit the applicant for relief from life to take the cup, like Socrates, and wilfully seek his own dissolution".⁶³

These editorial remarks were largely located in the realm of hypothetical debate and there was little suggestion that the journal saw any change in the law as either a real or imminent possibility. Williams was portrayed as a man of genuine intentions but whose lay intervention into the explicitly medical world of managing death was made with neither sufficient knowledge, experience nor expertise. Nevertheless, the journal conceded that the issue of 'active' euthanasia was "to some minds very important".⁶⁴

The emphasis of the editorial was on the professional implications of the introduction of Williams' proposals rather than the moral connotations of deliberately ending life. While the medical profession would play no active part in this revised formulation of euthanasia, there was the suggestion that the physician might play a consultative role should the State ever see fit to legalise the proposals. Particularly interesting is the *Lancet's* statement that the medical profession had "in fact, no correct measure of death" and that patients at times recovered, apparently against all odds. According to the editorial, this was an important argument against 'active' euthanasia. Yet as discussed in Chapter One of this thesis, prior to the interventions made by Williams and Tollemache considerable weight was already placed on the question of accurate diagnosis when it came to formulating appropriate treatment for the dying patient. As Noble's thesis illustrated, both the withdrawal of treatment and, in certain instances, the particular choice of treatment, were determined by decisions relating to clinical judgement – and this often involved deciding whether or not a patient was likely to recover. There was no mention of such difficult decision making in the *Lancet* editorial.

What the *Lancet* did propose, however, was that "if the physician or surgeon may not shorten life methodically even under the most pressing circumstances, he may shorten pain and make inevitable death easy and tranquil". Palliative care of this sort was "a divine and blessed art at the discretion of every medical man", argued the journal. This, of course, was the same line of reasoning adopted by medical student Noble in 1854 – that life could not be shortened in any way, but that pain could and, indeed, should be alleviated in the dying patient by every available medical means. At the end of the editorial, the *Lancet* endorsed the work of Dr William Munk whose newly published work on care of the dying also carried the title *Euthanasia*, but used in its older, classical sense, free from any association with patient-

requested death. According to the *Lancet*, Munk had successfully “put into a nutshell the duties of the medical profession in regard to euthanasia, in a style as simple as it is classical”. The journal warmly recommended *Euthanasia* as a guide to doctors on how they far they could ethically aid in securing easy and painless deaths for their patients. According to the *Lancet*, the duty of the doctor was to ensure that the end of life was peaceful and to “alleviate acute suffering without hastening death”. “To this extent,” stressed the journal, “medical art may go no further.”⁶⁵

This argument, that emphasised the comfort and relief afforded by palliative care but rejected the suggestion that the physician should deliberately end life, was to form the centre-piece of the medical profession’s public position in later debates over ‘active’ euthanasia. It is not surprising that the *Lancet* directed its readers to the writing of William Munk. His assessment of how the end of life should ideally be medically managed comprehensively set out the position of the late nineteenth-century medical profession in relation to the dying patient. While the principle that the physician should not end life was left unchallenged, the practice of relieving pain was wholeheartedly embraced. The following chapter considers in detail Munk’s contribution to late nineteenth-century medical discourse on caring for the dying patient.

Notes

¹ W. Bruce Fye, 'Active Euthanasia: An Historical Study of its Conceptual Origins and Introduction into Medical Thought', *Bulletin of the History of Medicine*, 52 (1979), 492-502 at p.492.

² Ibid.

³ Martin Pernick, *A Calculus of Suffering* (New York, Columbia University Press, 1985), p.104.

⁴ Lucy Bending, *The Representation of Bodily Pain in Late Nineteenth-Century English Culture* (Oxford, Oxford University Press, 2000), p.2.

⁵ Ibid. See also Nicholas Kemp, 'Merciful Release', *The History of the British Euthanasia Movement* (Manchester, Manchester University Press, 2002), p.25.

⁶ Charles Singer, *A History of Biology*, 3rd ed. (New York, Schuman, 1959), p.316, cited by Fye, 'Active Euthanasia', p.499, footnote 23.

⁷ Kemp, 'Merciful Release', p.19.

⁸ Ibid.

⁹ See Ian Dowbiggin, *A Merciful End, The Euthanasia Movement in Modern America* (Oxford, Oxford University Press, 2003), and Martin Pernick, *The Black Stork: Eugenics and the Death of 'Defective' Babies in American Medicine and Motion Pictures Since 1915* (Oxford, Oxford University Press, 1996).

¹⁰ I. Van der Sluis, 'The Movement for Euthanasia, 1875-1975', *Janus*, 66 (1979), 131-172 at p.137.

¹¹ Ibid., p.138.

¹² Haeckel, *Die Lebenswunder*, cited by Van der Sluis, 'The Movement for Euthanasia', p.138. For a discussion of Haeckel's view that society had no responsibility to maintain the lives of those he described as "utterly useless" see Anne Kerr and Tom Shakespeare, *Genetic Politics: From Eugenics to Genome* (Cheltenham, New Clarion Press, 2002), pp.22-3.

¹³ Dowbiggin, *A Merciful End*, p.66.

¹⁴ As well as S.D. Williams' contribution, the essays included in the Birmingham Speculative Club's publication were 'Hold Fast to your Colonies', 'The Relation of Universities to Practical Life', 'Some Thoughts on Pauperism', 'The Natural History of the Law', 'The Future of Women', and 'Method and Medicine', cited by Kemp, 'Merciful Release', pp.30-1, endnote 1.

¹⁵ Kemp, 'Merciful Release', p.12.

¹⁶ Ibid.

¹⁷ Ibid. See also Stefan Collini, *Public Moralists, Political Thought and Intellectual Life in Britain 1850-1930* (Oxford, Oxford University Press, 1991).

¹⁸ Samuel D. Williams, *Euthanasia: Reprinted from the Essays by the Members of the Birmingham Speculative Club* (London, Williams and Norgate, 1872), p.12. All further references are to this edition when quoting the essay directly.

¹⁹ Ibid., p.14.

²⁰ Ibid., p.21.

²¹ Ibid., p.23.

²² Ibid., p.25.

²³ Ibid., p.28.

²⁴ Ibid., p.25.

²⁵ Ibid., p.14.

²⁶ Ibid., p.12.

²⁷ Ibid., p.17.

²⁸ Ibid., p.15.

²⁹ Ibid., pp.15-16.

³⁰ Ibid., p.11.

³¹ Ibid., p.16.

³² Ibid., p.30.

³³ Ibid.

³⁴ *The Saturday Review*, 12 November 1870 and 17 June 1871. The quotes are reproduced on the cover of the 1872 reprint of Williams' 'Euthanasia'.

- ³⁵ Located at 107 Pall Mall, The Athenaeum Club was founded in 1823 for those judged by their peers to be eminent contributors to science, literature, the arts or public service. New members to this gentlemen's social club were elected annually by a ballot of existing members. See Kemp, *'Merciful Release'*, p.17 and, for a discussion of the connection between the Athenaeum Club and intellectual life in Victorian London, see Collini, *Public Moralists*, pp.13-21.
- ³⁶ Lionel Tollemache, 'The New Cure for Incurables', *Fortnightly Review*, 13 (February 1873), 217-30, was republished a year later in a collection of essays by Tollemache titled *Stones of Stumbling* (London, William Rice, 1884).
- ³⁷ Tollemache, 'The New Cure for Incurables', p.218.
- ³⁸ Tollemache, *Stones of Stumbling*, p.7.
- ³⁹ 'Euthanasia', *The Spectator*, 18 March 1871, p.314, cited by Van der Sluis, 'The Movement for Euthanasia', p.132.
- ⁴⁰ Tollemache, 'The New Cure for Incurables', p.218.
- ⁴¹ 'Mr Tollemache on the Right to Die', *The Spectator*, 15 February 1873, p.206, cited by Van der Sluis, op. cit., p.133.
- ⁴² Tollemache, 'The New Cure for Incurables', p.227.
- ⁴³ Lionel Tollemache, 'The Limits of Euthanasia', *The Spectator*, 22 February 1873, p.240, cited by Kemp, *'Merciful Release'*, p.25.
- ⁴⁴ Tollemache, *Stones of Stumbling*, preface, p.vi..
- ⁴⁵ Kemp, *'Merciful Release'*, p.24.
- ⁴⁶ Annie Besant, *Euthanasia* (London, Thomas Scott, 1875), p.5.
- ⁴⁷ *Ibid.*, p.6.
- ⁴⁸ *Ibid.*, p.7.
- ⁴⁹ *Ibid.*, p.8.
- ⁵⁰ *Ibid.*, p.3.
- ⁵¹ *Ibid.*, pp.16-17.
- ⁵² *Ibid.*, p.17.
- ⁵³ *Ibid.*, p.18.
- ⁵⁴ See Nancy Anderson, "'Not a Fit or Proper Person": Annie Besant's Struggle for Child Custody 1878-9', in Claudia Nelson and Ann Sumner Holmes (eds), *Maternal Instincts: Visions of Motherhood and Sexuality in Britain, 1875-1925* (New York, St. Martin's, 1997), 16-36.
- ⁵⁵ Despite the setback of losing custody of her daughter, Besant founded a campaigning newspaper called *The Link* in which she condemned the poor conditions and levels of pay for women working in large factories in London. She encouraged women employed at the Bryant & May match factory to form a union and after a three week strike, the company was forced to make concessions. After becoming a follower of Theosophy in the 1890s, Besant went to live in India and, as a vocal supporter of Home Rule, was interned by the British authorities during the First World War. After being reunited with her daughter, she died in Madras in 1933. See Olivia Bennett, *Annie Besant*, (London, Hamish Hamilton, 1988).
- ⁵⁶ Annie Besant, *The Meaning and the Use of Pain* (London, Adyar Pamphlets, Theosophical Publishing House, 1932). This is a published version of a lecture Besant delivered in 1894.
- ⁵⁷ Fye, 'Active Euthanasia', p.498, footnote 19.
- ⁵⁸ 'Euthanasia Secundum Artem', *Lancet*, 10 December 1887, p.1178.
- ⁵⁹ *Ibid.*
- ⁶⁰ *Ibid.*
- ⁶¹ *Ibid.*
- ⁶² *Ibid.*
- ⁶³ *Ibid.*
- ⁶⁴ *Ibid.*
- ⁶⁵ *Ibid.*

Chapter 4

Euthanasia by William Munk – Pain Relief for the Dying

I. ‘Administering the resource of the medical art’: Risk Taking or Benign Influence?

This chapter brings together a number of the themes and theoretical concerns raised earlier in the thesis by considering the public position of the medical profession at the end of the nineteenth century with regard to the dying patient. Again, the articulation of medical attitudes and medical practice in relation to pain and death provides a central point of reference for my analysis. As discussed in Chapter Three, the medical community played a marginal role in the explicit debate over ‘active’ euthanasia in the 1870s. However, the years between Hugh Noble’s thesis of 1854 and the *Lancet’s* 1887 response to lay demands that the physician deliberately end life on request, saw a continuation of intra-professional discussion on caring for the dying patient.

When, in 1862, Dr C.J.B. Williams (a physician at the Brompton Hospital for Consumption and Diseases of the Chest) delivered his Lumleian Lecture at the Royal College of Physicians, London, he drew attention to the importance of medical care for the incurable patient in the latter stages of life. “I speak of the Prolongation and Utilisation of Life, and the Alleviation of Suffering. These may seem very subordinate at first [to curative medicine], but often they are far from being so in the estimation of the patient,” he wrote.¹ According to Williams, it was when the patient was faced with death that life frequently assumed the greatest value. “More gratitude is often testified to the physician when he succeeds in achieving the minor triumph of prolonging life and relieving pain,” he stated, “than in the case where he may have accomplished a perfect restoration of health and ease.” While Williams stressed that medicine could not “confer immortality ... or conquer death, or triumph over all forms of disease”, he maintained that the nineteenth-century physician “may be expected to say what he can cure, what he cannot cure – to recognise and define the limits of his powers”.²

Williams’ lecture is revealing in a number of respects. First, it exemplifies the nineteenth-century medical view that successful care of the dying consisted of “prolonging

life and relieving pain". Williams portrayed the two aims as entirely compatible. The principle that the physician should not kill was interpreted in such a way that, certainly in public statements on managing the dying, the practice of alleviating pain was often seen, not only as commensurable with the "prolongation of life", but as the means by which such "prolongation" was secured. Secondly, Williams' reference to the importance placed on the physician "to recognise and define the limits of his powers" points to a wider mid to late nineteenth century debate concerning the position of the medicine in society, or, more narrowly, the position of the doctor in relation to the patient. When it came to publicly articulating the practices involved in managing death, "the prolongation of life" and the "alleviation of pain" were established as twin goals. Given these aims, the question, then, was how medical practice was defined in relation to the dying patient, particularly with regard to the administration of pain-relieving drugs.

Martin Pernick describes the nineteenth-century endorsement of pain relief as "a new willingness to take risks purely for the relief of suffering".³ Pat Jalland, who unlike Pernick specifically considers medical practice in the context of the dying patient, views the medical management of pain somewhat differently. Though acknowledging that the role of the medical professional at the deathbed became of greater importance in the nineteenth century, according to Jalland, the physician's presence was a "benign influence".⁴ Whereas Pernick stresses the risk-taking dimensions of administering pain relief, Jalland frames the role of the nineteenth-century doctor in terms that emphasise "a very limited power to cure disease" which was, as a result, "compensated by a remarkably good record of terminal care, comfort and palliative management".⁵

One Victorian doctor in particular pre-empted the interpretative slants given by Pernick and Jalland to the nature of nineteenth-century pain relief, incorporating them into his influential textbook on the best management of the dying patient. Published in 1887, Dr William Munk's *Euthanasia: Or Medical Treatment in Aid of an Easy Death* drew on Munk's own experience, combined with that captured in the writing of other elite physicians such as Sir Benjamin Brodie, Sir Henry Hallford and Professor C.W. Hufeland (see Chapter 1, D). *Euthanasia* offered a comprehensive guide to medical treatment of the dying, discussing, as Jalland suggests, the comfort and assurance afforded to the patient when pain was relieved, but also, as I will argue in this chapter, implicitly acknowledging the risks associated with administering powerful drugs.

The *Lancet* endorsed Munk's book in glowing terms and described the author as "a thoughtful and experienced physician".⁶ According to the journal it was "high time now to recall the practitioners of our art to the fact that their place in the social system of today is conceded to them in the virtue of their office as healers of the sick and ministers at the bedside".⁷ Munk's contribution to medical literature on the management of death was timely. In joining a discussion that had been going on for some time and in drawing on the writing of established names such as Halford and Hufeland, Munk was effectively setting out and consolidating the position of the medical profession at the end of the nineteenth century. Whether or not Munk was aware of the interventions made by Williams and Tollemache on the subject of 'active' euthanasia is unclear. There is certainly no reference to their proposals in his book. What is evident, however, is that the *Lancet* viewed Munk's consideration of the care of the dying as a fitting response to lay calls that the physician should deliberately end life on request.⁸

"Much has been ably written on death and the physiology of the various modes of dying," stated Munk in the preface to *Euthanasia*, "but little has been written on the medical management of the dying, or on the Euthanasia, to which such management should contribute."⁹ The whole subject of "the Euthanasia" (Munk's formulation) was in need of special and systematic treatment, he stated. Here, of course, Munk was using the term 'euthanasia' in its classical sense implying a calm and peaceful death, rather than evoking any sense of mercy killing or requested death. According to Munk, caring for the dying was not specifically taught in any medical school, and on entering the medical profession the young doctor was left unsupported to learn "what to do and what not to do in the most solemn and delicate position in which he can be placed". In attending the dying patient, the importance of "administering the resource of the medical art in aid of an easy, gentle and placid death" was not to be underestimated, he argued.¹⁰

Just as I began this nineteenth-century section of the thesis with a close reading of a treatise on the management of death, I conclude with a detailed consideration of another treatise on the same subject. Unlike the first, the work of medical student Hugh Noble, Munk's *Euthanasia* is the work of an established and experienced physician, perhaps writing with a heightened sense of awareness of the judgement of his peers who would read his book. However, there are continuities between the two. Both are concerned with how best to relieve pain in the dying patient and with how this practice of pain relief fits into the notion

that death cannot be hastened in any way. Both seek to define the limits and powers of medical practice in relation to care of the dying.

In this chapter I consider Munk's writing on the alleviation of both physical and mental suffering. The final section then discusses Munk's emphasis on unwritten knowledge, that could, I argue, only be gained through the individual clinician's own repeated experience of managing death. In concluding the chapter, I illustrate how the language used by doctors played such an important part in defining the relationship between pain-relieving practices and the medical management of death.

II. Calming the Body: Acceptable Intentions

Invaluable in relieving pain and calming the bodies of dying patients, stated Munk, was opium. "Opium here is worth all the rest of the materia medica," he wrote.¹¹ The *Lancet* was in agreement. "It is simply a neglect of duty, and a fault in our conduct of the last days and hours of many patients to withhold the inestimable boon afforded by opium in full doses," the journal stated. Illustrative of the medical view that pain relieving-drugs were an integral part of securing a calm and peaceful death, the journal criticised doctors who neglected or were reluctant to give opium in the latter stages of life. "We have no right to stand aside and withhold our skilled labour in this direction, and we rather suspect such a promotion of euthanasia is not uncommonly neglected, or but imperfectly carried out in many cases," argued the *Lancet*.¹²

Yet Munk was clear that the physician's reasons for administering opium had to be strictly defined. He argued that it was to be given as an anodyne to relieve pain, or as a cordial to ease "the sinking feeling and anguish about the stomach and heart that is so frequent in the dying and is so often worse than pain, however severe". Rarely, if at all, should it be administered "as a mere hypnotic, or with a view to enforce sleep". To do so, Munk stated, "would be to risk throwing the patient into a sleep from which he may not wake".¹³ Interestingly, the *intentions* of the physician were deemed extremely important when administering opium. To give the drug with the objective of inducing sleep in the patient was rejected, whereas if opium brought about sleep "indirectly", as Munk stated it often did, then this was judged the "kindest way" of relieving the pain and discomfort that often made sleep impossible.

While Munk explicitly demarcated the acceptable range of intentions that the physician might have when administering opium, he did not consider the possibility of the patient failing to wake from opium that had induced sleep “indirectly”. The distinction between opium as an unacceptable hypnotic as opposed to an acceptable source of pain relief was not at all clear. Munk’s writing appeared to conflate conceptual ethical ‘intentions’ on the part of the physician, with physiological outcomes in the patient being treated. In other words, if administered in the “kindest way”, rather than expressly as a hypnotic, there seemed the implicit assurance that pain would be alleviated without the patient slipping into permanent unconsciousness.

In Munk’s experience it was rare for the administration of opium to cause mental confusion. Where this did occur, he attributed it to “idiosyncrasy” on the part of the patient. Yet Munk’s discussion of the acceptable intentions on the part of the doctor administering opium might be read as an acknowledgement that the drug carried the risk of inducing coma in the patient. Clarification of the physician’s intentions was necessary if pain relief was to be justified without raising the question of the physician hastening death. If the issue here concerned levels of dosage, with opium given in greater strength when the intention was to induce unconsciousness rather than simply alleviate pain, then this was not discussed. Interesting also was Munk’s statement that opium should “rarely” be used with a view to enforcing sleep, suggesting that there might be isolated cases in which such an action would be appropriate. Just when opium might be used as a hypnotic agent was an issue that, again, was not addressed by Munk, but the suggestion was that he did not rule it out in all instances.

Even in the most hopeless case when the patient was troubled by “unspeakable inquietude”, Munk argued that opium, if given for reasons judged acceptable, would provide the patient with relief “without dying at all sooner”. However, though maintaining that opium could be used safely to relieve the pain of the dying patient, Munk’s writing suggests an awareness of the risks of precipitating a death deemed premature. Death as an unwanted by-product of opium administration might be avoided, Munk argued, by scrupulous examination of the patient. “So long as the air passages are clear of secretion, so long as there is neither lividity nor duskiness of the face, opium, if indicated, may be given in the aid of Euthanasia, but if they are present, it is hazardous and might even hasten death,” he explained.¹⁴ Thus, Munk’s treatise on care of the dying supports Jalland’s argument that late Victorian medicine was concerned with “comfort and palliative management”. However, it

also reveals a sub-text in which risk, or at least the avoidance of risk, was a matter of consideration.

Munk stated that opium “if judiciously and freely administered ... is equal to most of the emergencies in the way of pain that we are likely to meet with the dying”.¹⁵ Yet he also maintained that there were times when non-intervention was most appropriate. “All that the dying person then requires, is to be left alone and allowed to die in peace,” he wrote.¹⁶ His position was that of the medical conservative, advocating pain relief for the dying patient when required, but rejecting any heroic-style therapies that pushed for cure. The case of each patient, argued Munk, should be treated as unique. “No medicine should be given without a distinct – I had almost written urgent – need for it; and the physician should form a clear idea of the special requirements of the case before him,” he stated.¹⁷ In many cases he maintained that there was no need for medicine of any kind and that light nourishment sufficed.

Munk emphasised that when death approached, the doctor should “dismiss all thoughts of cure, or the prolongation of life”, to concentrate instead on the “relief of pain and discomfort”. It is significant that in the case of the dying patient he ruled out “the prolongation of life”, while C.J.B. Williams had argued that such “prolongation” was one of the central aims of medically managing death. Again, as in the case of Hugh Noble’s thesis, the subtle distinction between ‘preserving’ and ‘prolonging’ life was raised. Munk drew on the writing of Henry Halford and C.W. Hufeland who both explicitly spoke of the doctor’s duty to prolong life, even if death seemed imminent. Yet Munk appeared to reject such a view. It might be argued that this was purely a question of differences in the use of language as opposed to evidence of variations in medical practice. However, I suggest that these semantic variations point to the importance of individual clinical judgements that were far from standardised and that these differences were detectable even in public statements on caring for the dying.

Munk’s *Euthanasia* was more than a call for the fastidious use of pain-relieving drugs. It was a wide-ranging consideration of all the factors that the author deemed important when relieving suffering and making the dying patient as comfortable as possible. The question of suitable nourishment at the end of life was viewed as requiring special attention in order to facilitate bodily calm. Well-meaning errors in feeding were, Munk stated, “the cause of much of the disquietude and many of the sufferings that attend the dying”. He maintained that it was frequently assumed that the dying patient was able to eat as normal and that

medical attendants forgot that “the stomach shares in the exhaustion, and has lost its tone – and in great part, if not wholly, its power of digesting”. Food was often given in too large quantities and too frequently caused the stomach to distend and to be distressed, argued Munk. “The dying patient is induced to take food or stimulants against which nature and his stomach revolt ... the difficulty in swallowing and retching which eating induces is really a salvation from what under the circumstances is an act of cruelty,” he wrote.¹⁸ Munk cautioned that the “wishes of the patient” should be taken as a correct indication of how food should be administered.

Similarly, when the ability to swallow stopped, Munk counselled that the giving of liquids should not be zealously pursued. “If after rubbing the lips with a spoon of the spout of a feeding vessel, no evident or distinct act of swallowing persists, it is useless and it may be cruel to persist,” he stated.¹⁹ Without the ability to swallow, liquid would only block the mouth and impede the breathing of the dying patient. Munk advocated giving such a patient ice to dissolve in the mouth, or at most, a spoonful of ice water. For patients who were still able to swallow, he considered distilled or fermented alcohol highly appropriate since it was seen to pass quickly into the blood, stimulate the heart, promote circulation and aid digestion. Another suggestion was Henry Halford’s “celebrated mixture” of brandy with sugar and the yolk of an egg.

Central to Munk’s analysis of the most appropriate forms of giving nourishment to the dying patient was the view that physical indications were the best guide when judging when to feed or give liquids. He advocated a regime that was not to be seen as a prescriptive set of rules, but was instead attuned to the individual needs of each patient through scrupulous observation, discretion and care. For example, alongside his discussion of appropriate feeding of the dying patient, he considered the impact of the patient’s environment on his or her comfort. “Many of the sufferings of the deathbed are not naturally or necessarily incident to the act of dying,” he remarked, pointing out that much restlessness was often due to the weight of bed-coverings. Such discomfort could “at once be removed”, he stated, adding that difficulty in breathing was often relieved simply by allowing fresh air into the room and “by change of posture and by pillows carefully adapted to the efficient support of the trunk and body”.²⁰

Yet such attention to the feeding and nursing of the dying patient, in which the “wishes of the patient” were seen as providing the best and most “correct indication” of how

to treat, focused on the physical, bodily manifestations of pain and discomfort. Though Munk placed the individual patient at the centre of his prescription for deathbed calm, the physician was ultimately responsible, I argue, for reading and interpreting the patient's body. Thus, when Munk referred to the "wishes of the patient", he was using language located at the physical level, discussing, for example, the bodily rejection of food that represented the visible draining away of life. That a patient might reject food and renounce life when the body remained willing, was not a subject of consideration. Such a wish on the part of the patient was simply not a consideration in Munk's repertoire of palliative language. Moreover, "the Euthanasia", as he termed the peaceful and easy death, was not possible with bodily calm alone. Mental quiet at the end of life was of as much if not greater importance, and for this spiritual devotion and commitment were required.

III. Calming the Mind: The painlessness of death and the importance of religion

Munk contested the view that death was always a painful and difficult process. "In fact, all of the best and most direct evidence that the subject admits of, goes to show, that as a rule, the immediate act of dying is in no sense a process of severe bodily suffering," he stated. He maintained that "suffering at the time of death is rare, physicians, the clergy and intelligent nurses – all, indeed, who are practically conversant with the dying testify to the truth of that statement."²¹ In support of this argument, he described how Henry Halford had "expressed his surprise that of the great number of whom it had been his professional duty to administer in the last hours of their lives, so few exhibited signs of severe suffering". Similarly, Munk quoted Benjamin Brodie's belief that "the mere act of dying is seldom, in any sense of the word, a very painful process". This view was supplemented further by a quote from the surgeon William Savory, who had argued that "except in extreme cases, the actual process of dying is not one of intense agony, or indeed for the most part even of pain". Munk's final anecdotal example of the painlessness of death were the words of the obstetrician William Hunter whose last utterance before death was reported as being, "If I had strength enough to hold a pen, then I would write how easy and pleasant a thing it is to die."²²

The idea that death was frequently an experience free from pain stood in stark contrast to the descriptions offered by those who had argued in favour of 'active' euthanasia. While, for example, Annie Besant wrote of the "intensified torture" and "agony" that accompanied death (see Chapter 3, III), elite practitioners such as Halford and Brodie challenged this

image by arguing that death was frequently a peaceful experience. Within the nineteenth-century medical community the opinion was commonly expressed that death was not nearly as terrifying as often thought. For example, in 1840, the surgeon Forbes Winslow argued that the notion that death was agonising and painful was “erroneous”. Again, Winslow maintained that the medical men who witnessed death testified that it was not a painful process. “In some delicate and irritable persons, a kind of struggle is indeed sometimes excited when respiration becomes difficult – but more frequently the dying obviously suffer nothing and express no uneasiness,” he wrote.²³ Munk’s *Euthanasia* was effectively a late nineteenth-century restatement of this view that death was often painless and peaceful.

Though Munk conceded that there were isolated instances in which the dying did suffer greatly, he argued that these cases were extremely rare and were not to be used as the basis of any general perception of the experience of death. Occasional terrible cases of suffering during death fixed themselves in the public imagination and came to be “regarded as but extreme instances of what is assumed to be the universal and inevitable lot of the dying”, he stated. Munk maintained that this fear of death was misplaced. Evidence supporting his conclusion was provided in his consideration of several cases of apparent drowning, which, he stated, “differed only from actual death in the possibility of re-animation under the influence of external treatment”.²⁴ According to Munk, instances of apparent drowning carried “far greater weight than the observations and conclusions of medical men no matter how eminent” in demonstrating the painless nature of death. The personal testimony provided by those who had been “restored” to life offered reassuring proof, he argued, that the approach of death was painless, “or at the most attended with a feeling of oppression across the chest”.

Munk stated that such near death experiences, though varying in their specific details, revealed a common element in which “although the mind was keenly active throughout, there was an entire absence of pain or other bodily suffering”. He then quoted the words of a young admiral who, on board a ship in Portsmouth, had fallen into water and was unable to swim. The admiral recalled:

From the moment all exertion had ceased, a calm feeling of the most perfect tranquillity superseded the previous tumultuous sensations ... I no longer thought of being rescued – nor was I in any bodily pain. On the contrary, my sensations were now rather a pleasurable cast, partaking of that dull, but contented sort of feeling that precedes the sleep produced by fatigue. Every past incident of my life seemed to glance across my recollection in retrograde succession ... and each act was

accompanied by a consciousness of right and wrong, or by some reflection of its cause and consequence.²⁵

According to the admiral it was only on being rescued and resuscitated that he was “tortured with agony” instead of being “absolutely free from all bodily pain as in the drowning state”. For Munk this was clear evidence that death itself was, for the most part, painless and that it was the process of recovery that was often one of great bodily suffering. Thus, the notion of pain and vitality as inextricably bound, a concept established more than a century before and discussed earlier in this thesis (see Chapter 2, IV), maintained its presence in Munk’s *Euthanasia*. Earlier writing on death again influenced Munk’s view that death was often a painless draining away of vitality. C.W. Hufeland had argued that “man can have no sensation of dying, for to die means nothing more than to lose vital power; and it is the vital power which is the communication between the body and the soul.”²⁶

However, despite going to considerable lengths to establish the idea that death often occurred in the absence of physical pain, Munk maintained that death was as much a psychological process as it was about bodily pain and suffering. “The Euthanasia” required a calm mind and for Munk, who in 1842 converted to Roman Catholicism, such tranquillity was to be found in Christian faith. It was through religious belief that the dying patient would reconcile him – or herself with the life they had led and would find comfort in the certainty of a future after death. According to Munk, a peaceful and calm death was extremely difficult to achieve for those who did not share such faith. “If I may trust myself I should say that in the aggressive disbeliever, as in the mere passive agnostic, doubt and anxiety as to his future is sure to obtrude on his last moments, disturb them and render such a euthanasia as we contemplate impossible,” he wrote.²⁷

What Munk described as “the influence of religion on the mind” was deemed an essential element in securing calm at the end of life. Such an influence took time and preparation, however, and would only be effective after an initial period of shock when the patient learned that he or she was going to die. This brought Munk to a discussion of how information regarding prognosis should best be shared with the patient. As already considered earlier in this thesis (see Chapter 2,III), the question of what to tell the dying patient was a subject that preoccupied elite Victorian physicians. For Munk, the question of ‘truth-telling’ took on a distinctly religious tone. For him the issue was not so much that the physician might be mistaken in giving an unfavourable prognosis, but rather than the doctor not only had the power, but also the moral duty to foster hope in life itself. The mental and

physical states of the patient were seen to be intertwined, so much so, that improvements in the patient's physical condition were often considered by Munk to be the results of giving an optimistic prognosis. If in Christianity the dying patient was able to find hope in the belief of an afterlife, in the physician the patient invested hope of a different kind – the hope that life might be saved. This created a tension that Munk acknowledged. "I think it my first duty to interpose myself between him [the patient] and everything that may possibly aggravate his danger. And unless I shall have found him averse from doing what was necessary in aid of my remedies, from want of a proper sense of his perilous situation, I forbear to step out of my province in order to offer any advice which is not necessary to promote his cure."²⁸

In a view that echoed Henry Halford's position on telling the truth, Munk stated that the best way of giving an unfavourable prognosis was to allow friends and family to tell the patient that he or she was dying. He stressed, however, that this was to be done under the strict supervision of the physician. The relationship between doctor and patient would then be left undisrupted and the patient could maintain a sense of hope by placing faith in the doctor. According to Munk, this faith would be shattered if the doctor gave the gloomy prognosis and pronounced "a sentence of death against which there is no appeal". In the absence of friends or family, however, he argued that it was the responsibility of the physician to be honest with the patient as it was "lamentable to think that any human being should leave the world unprepared to meet his Creator". Drawing on his own experience, Munk described how in such instances he had "departed from strict professional duty" and had "apprised my patient of the great change he was about to undergo".²⁹

The psychological state of the dying patient was clearly considered by Munk to be extremely important, with mental calm and religious faith acting as lynchpins that supported a bodily sense of quiet. No amount of opium could adequately substitute for Munk's "firm belief in the mercy of God". Yet in spite of his argument that religious belief secured a peaceful death, even the most faithful of patients were viewed as requiring hope that was based, not only on the prospect of an afterlife, but on the belief that their own physical survival on earth was a real possibility. Thus, at the end of life "faith" operated in two different ways, being first invested in the salvation of God and secondly, in the salvation of the bedside physician. What emerges from a close textual analysis of *Euthanasia* is an image of a late nineteenth-century physician attempting to position himself between God and the dying patient – between nature and the physician's art. According to Munk, "nothing but good" would come of the patient being allowed to prepare for death, and yet the news that

death was imminent was to come, whenever possible, from family and friends. The role of the physician was to prompt and direct the giving of such a prognosis so that information might be released without “faith” in the medical practitioner being in any sense weakened. Moreover, the physician’s role was not only concerned with interpreting and responding to the physical manifestations of illness and pain, but also involved the management of the dying patient’s psychological state.

IV. Hippocratic Principle and Unwritten Practices

It was not only a formal medical education that informed the judgement of Victorian physicians when deciding how to treat the dying. In *Euthanasia* there were implicit and explicit references to the importance of the physician’s own experience that could only be afforded by multiple encounters with death. Munk stated in the preface to his book that he considered it a shortcoming of medical training that the management of death was not taught to students. However, although Munk’s writing consolidated and expanded upon the existing literature on dying, there was much in *Euthanasia* that relied on what can arguably be described as the intuition and discretion of the individual clinician. For example, Munk stated that opium should be administered “judiciously and freely” and yet he also stated that there were instances in which “all that the dying patient requires is to be left alone”. He declared it his duty to “interpose” himself between the patient and “everything that may possibly aggravate” the patient’s condition, while maintaining that “the act of dying is so easy, that nature herself sometimes provides the perfect euthanasia”.

As in the case of Hugh Noble’s thesis, Munk’s *Euthanasia* revealed a complex picture in which the nineteenth-century physician was portrayed in some instances as battling against nature and at other times allowing nature to run its course. Munk gave some suggestion as to how such judgements might have been made in his comments on the physical manifestations of approaching death – for example, the bodily rejection of food. For the most part, however, he was no more explicit than stating that “in almost all cases, at a certain period of their course [referring to the patient], the less of these [food and nourishment] that is given the better”. Indeed, though clearly offering a guide as to *how* to manage the dying, Munk was less clear on the question of *when* such decisions should be made.

Jalland argues that Munk's *Euthanasia* was "the authoritative text on medical care of the dying" in the late nineteenth century. I would not dispute this, but an interesting issue is to consider the nature of the ground on which this authority was anchored.³⁰ The silences and omissions in Munk's treatise also have much to say about the way in which the relationship between the doctor and patient was perceived in the nineteenth century – a relationship that relied heavily, I argue, on the doctor's own experience and judgement. As the historian Christopher Lawrence writes: "Between the science and the art [of medicine] the only mediator was experience. In this regard experience took on a mysterious, indefinable quality that made it the touchstone of all the physician's judgements."³¹ Tellingly, Lawrence gives the example of one physician who believed it was not possible to communicate (either orally or in writing) the knowledge gained by years of practising medicine. Only clinical experience could provide the basis from which the individual doctor could form and perfect medical judgement.³²

In an 1883 edition of *The Practitioner*, a book review praised the publication of a series of lectures intended for the training of nurses. According to the journal, the lectures were based "on the excellent principle, that if you want a thing to be well done, you must explain to the doer not only the how but the why". The journal continued: "the author is, therefore, not afraid that the nurse should know too much of what is properly the doctor's business. It is an inadequate smattering of this knowledge which makes the ill-trained nurse presume beyond her true sphere."³³ Yet perhaps paradoxically, when it came to demarcating what was "properly the doctor's business" and defining the "true sphere" of the physician's knowledge, the underlying emphasis in much of the nineteenth-century medical literature on death was on unwritten practices and the experiential nature of clinical judgements. Though the book review from *The Practitioner* appeared to convey an image of the medical profession in possession of a body of knowledge that might be released with discretion to nurses and other bedside attendants, the picture was more complex.

As discussed earlier (see Chapter 2, III), the scientific breakthroughs in pain-relieving therapies left uncertainty with regard to the physiological action of new pain-relieving drugs. In addition, however, there was uncertainty over the question of professional identity. Was medicine to be grounded in the codified and scientific? Or was it an 'art' with foundations in observation, experience and intuition? In treating the dying patient, nineteenth-century physicians embraced scientific developments in pain relief, but both in practice and in the articulation of practice an indefinable element was involved. As Lawrence suggests, clinical

medicine “needed the ineffable wisdom and experience that came only with advanced years ... and the bearing of a gentleman”.³⁴

In *Euthanasia* Munk offered a detailed consideration of how to treat the dying patient, drawing on the work of other leading nineteenth-century physicians in cautioning that, once death approached, “we dismiss all thoughts of cure”. Yet on the question of determining when the physician should acknowledge that death was approaching Munk drew, not on the work of his peers, but on Hippocrates. “It is often difficult to determine when the act of dying really begins – the Father of Physic is still perhaps our best guide,” he stated. The patient approaching death would have “eyes that sunk into their orbits” and a face that “was pale, livid or black” but before such a stage was reached Munk gave little specific indication of how the young physician might come to a decision that curative measures should be stopped.

Euthanasia did not present the inexperienced doctor with a codified set of rules that determined decisions on when to intervene or when to let nature take its course. The newly-qualified doctor would have found much of value in Munk’s book, but only through knowledge of unwritten and accepted practices would he become fully acquainted with the management of death. This knowledge was gained through direct experience. In many ways, despite Munk’s contribution to medical literature on the management of death, the physician remained alone, deciding in Munk’s own words “as best he may, what to do and what not to do, in the most solemn and delicate position in which he can be placed”.

Munk’s position might best be described as ‘conservatively progressive’. While willing to use pain-relieving drugs in order to secure a peaceful and calm death for the patient, there was an explicit rejection of the idea that life could be shortened. If Munk referred to Hippocrates when looking for signs of imminent death, the Hippocratic oath that prohibited the doctor from ending life provided the principle by which his statements on the management of death were guided. In considering the role of the physician in relation to the dying patient, Munk endorsed the use of pain relief but also reasserted established values such as the importance of religious faith. The strength of bedside physicians such as Munk lay in the ability to offer palliative care that provided both physical and psychological comfort.

In order to divest death of its terror, nineteenth-century doctors adopted a number of rhetorical strategies. First, death itself was described as often being 'naturally' painless and easy, secondly, the importance of religious faith was emphasised as a source of indispensable support; and thirdly, medical intervention in order to relieve pain was assured. However, beyond the commitment to the principle that it was wrong for the physician to end life lay a more subtle picture in which an awareness of the risks associated with the practice of pain relief and a reliance on the physician's own clinical judgement fed into clinical decision making. The negotiation between principle and practice may not have been as overt as it was in the debate over the general use of anaesthesia, but, nevertheless, Victorian doctors were faced with difficult decisions when treating the dying.

In concluding this section of the thesis, I argue that there were two distinctive forms of discourse at work in nineteenth-century discussions of the management of death and pain. The first was the explicit debate over 'active' euthanasia that I detailed in Chapter Three. In this, the principle that life was sacred was challenged, as was the idea that nature was a benign force that inflicted little or no pain on the dying. The accepted practice of administering pain relief offered the means by which 'active' euthanasia could be achieved. Proponents of 'active' euthanasia argued that requested death was simply a logical extension of the medical ability and desire to alleviate suffering. They also, however, drew on arguments that ranged outside a debate over pain relief. The impact of illness and pain on others (not only on those known to the patient but also on society as a whole) became a subject of consideration, as did notions of the 'usefulness' of the incurable and suffering patient.

The second form of discourse was not a debate as such, but rather the negotiation, interpretation and articulation of medical practice – a process that was conducted within the medical profession. This included defining justifiable and unjustifiable forms of medical intervention and the subtle drawing of distinctions between the 'preservation' and 'prolongation' of life. All this was filtered through a professional emphasis on the importance of the individual clinician's own experience when caring for the dying. At an ideological level, pain was no longer understood in terms that associated suffering with divine will. It was seen as the physician's duty to alleviate the pain of the dying patient whenever possible. The exact moment and timing of death, however, was viewed as the province of God. The medical profession called on notions of both scientific knowledge and clinical experience in order to establish the authority required to discern and uphold this

view. Moreover, medicine was viewed, as Christopher Lawrence argues, “as a resource to understand the natural and moral world”.³⁵ Nowhere was this more evident than in the decisions made when caring for the dying. ‘Euthanasia’ in this context may have retained its classical meaning of the calm and peaceful death, but it was also a word that continued to raise questions about the nature of the relationship between doctors and their patients and the way in which medical practice was understood.

Part of defining the role of the physician in the medical management of death was the translation of medical practice into a recognised and accepted form of language that could be applied when discussing how best to care for dying patients – Munk’s *Euthanasia* being an example. Yet by the turn of the century this shared language was beginning to come under pressure, as medical men themselves were willing to publicly pronounce that they were using pain-relieving drugs with the intention of ending patients’ lives. The following statement appeared in an edition of the *Lancet* in 1900:

The North Devon Herald of August 16th contains a letter signed ‘A Physician’ in which the writer lays it down as his opinion that it is justifiable for a physician to kill, or as he prefers to call it ‘to end a patient’s inevitable suffering and hasten his certain death’. He states with perfect calmness that he has relieved the suffering of a good many patients. So we trust has every medical man but not in the sense that ‘A Physician’ evidently means it to be taken. He cites two instances in which he kept patients under chloroform until they died. With this procedure we have no quarrel. It is a recognisable practice in cases involving great pain. But apparently ‘A Physician’ gave the chloroform to kill for he says, ‘I have always used chloroform, it arrests the heart’s action in systole’. If he wanted to kill his patient why did he not push the chloroform, or directly that his patient was under its influence divide the medulla? According to him both the patient and the patient’s friends were willing that life should be terminated. If so, why prolong the agony? We can only repeat that the well-known opinion that it is not the duty of the medical man to take life.³⁶

This extract is illustrative of how the language used to describe medical practice would prove so important in the twentieth-century debate over ‘active’ euthanasia. Significantly, the *Lancet* did not condemn the doctor’s actions, but the journal did object to the explanation he gave for his actions. The language he used to describe his decision to administer chloroform (acknowledged by the journal as “a recognisable practice”) could not be accommodated by the principle that it was wrong for the physician to end life (a principle which the *Lancet* firmly restated). Later in the twentieth century this negotiation between principle and practice was to intensify and, in contrast to the nineteenth century, medical professionals were to become vocal and influential contributors to both sides of the debate over ‘active’ euthanasia.

Notes

- ¹ C.J.B. Williams, 'Lumleian Lecture: The Successes and Failures of Medicine', *Lancet*, 5 April 1862, 345-7 at p.346. Pat Jalland also quotes Williams' lecture in *Death in the Victorian Family* (Oxford University Press, 1996), p.83.
- ² Williams, 'Lumleian Lecture', pp.346-7.
- ³ Martin Pernick, *A Calculus of Suffering* (New York, Columbia University Press, 1985), p.111.
- ⁴ Jalland, *Death in the Victorian Family*, p.81.
- ⁵ *Ibid.*, p.77.
- ⁶ 'Euthanasia, or Medical Treatment in aid of an Easy Death by William Munk', book review, *Lancet*, 7 January 1888, p.21.
- ⁷ *Ibid.*, pp.21-22.
- ⁸ I refer here to the earlier *Lancet* editorial in which Munk's *Euthanasia* was offered as an alternative position to proposals for 'active' euthanasia. See 'Euthanasia Secundum Artem', editorial, *Lancet*, 10 December 1887, pp.1177-8.
- ⁹ William Munk, *Euthanasia: Or Medical Treatment in Aid of an Easy Death* (London, Longmans, Green and Co, 1887), p.1 of preface.
- ¹⁰ *Ibid.*, preface, p.4.
- ¹¹ *Ibid.*, p.73.
- ¹² *Lancet*, 7 January 1888, p.22.
- ¹³ Munk, *Euthanasia*, p.73.
- ¹⁴ *Ibid.*, p.81.
- ¹⁵ *Ibid.*
- ¹⁶ *Ibid.*, p.87.
- ¹⁷ *Ibid.*, p.86.
- ¹⁸ *Ibid.*, p.66.
- ¹⁹ *Ibid.*, p.72.
- ²⁰ *Ibid.*, p.66.
- ²¹ *Ibid.*, p.9.
- ²² *Ibid.*, p.10. Munk drew on earlier published work on the management of dying, quoting from Henry Halford's *Essays and Orations*, 3rd edition (London, 1842); Charles Hawkins (ed.), *The Works of Sir Benjamin Collins Brodie*, vol.1 (London, 1865); and William Savory, *On Life and Death* (London, 1863).
- ²³ Forbes Winslow, *The Anatomy of Suicide*, (London, Henry Renshaw, 1840), p.99.
- ²⁴ *Ibid.*, p.11. Roy Porter refers to the late eighteenth-century development of the Humane Movement which was, he states, "designed to resuscitate those apparently drowned – clearly a mark of a medical campaign to snatch people back from the jaws of death itself". See Roy Porter, 'Death and the Doctors in Georgian England', in Ralph Houlbrooke (ed.), *Death, Ritual and Bereavement* (London, Routledge, 1989), 77-94, at p.87. See also Erwin H. Ackernecht, 'Death in the History of Medicine', *Bulletin of the History of Medicine*, 42:1 (1968), 19-23, at p.20.
- ²⁵ Munk, *Euthanasia*, p.12. For Munk's source of the admiral's account of nearly drowning, see John Barrow Bart, *The Autobiographical Memoirs of Sir John Barrow Bart* (London, 1847), p.398.
- ²⁶ See Winslow, *The Anatomy of Suicide*, p.100.
- ²⁷ Munk, *Euthanasia*, p.10.
- ²⁸ *Ibid.*, p.12.
- ²⁹ *Ibid.*, pp.29-30.
- ³⁰ Jalland, *Death in the Victorian Family*, p.85.
- ³² Christopher Lawrence, 'Incommunicable Knowledge: Science, Technology and the Clinical Art in Britain 1850-1914', *Journal of Contemporary History*, 20 (1985), 503-520, at p.510. See also W.F. Bynum, *Science and the Practice of Medicine in the Nineteenth Century* (Cambridge, Cambridge University Press, 1994), p.219.
- ³³ *The Practitioner*, 30 (May 1883), p.361. The book reviewed was Dr. J. W. Anderson's *Lectures on Medical Nursing* (Glasgow, Maclehose, 1883).
- ³⁴ Lawrence, 'Incommunicable Knowledge', p.510.
- ³⁵ *Ibid.*, p.506.
- ³⁶ 'The Physician's Duty', editorial, *Lancet*, 25 August 1900, p.1314.

PART 2

The Twentieth-Century Euthanasia Debate

Introduction: Moves to Legalise Euthanasia – Medical Support and Resistance

In the final years of the nineteenth century and the early part of the twentieth century, overt medical interest in euthanasia (and throughout this chapter I use the term to imply the physician deliberately precipitating death at the patient's request) was intermittent and somewhat muted. When considering the medical management of the dying, much of the literature written during this period essentially restated the thoughts and sentiments expressed earlier by William Munk. In *On Care of the Dying*, a pamphlet published in 1894 that was intended for nurses, the physician Oswald Browne extolled the virtues of attending to patients at the end of their lives. According to Browne, the duty of caring for the dying was one of the highest privileges that “amply repays the most careful study”.¹

Other literature reaffirmed the importance of the individual clinician's judgement and of abandoning aggressive treatment when death seemed imminent. Harrington Sainsbury, a physician at the Royal Free Hospital in London, counselled that when death approached “no healing herb in all the gardens will avail anything”.² Sainsbury acknowledged the great responsibility involved in coming to the decision that a patient was past recovery. He maintained, however, that “if the futility of the strife is irresistibly borne upon us, then we should put aside our remedia as cures, and ranging ourselves upon the side of Death make easy the couch with such solatia as we may offer”. Death was to be viewed “as a friend”, he argued, adding: “let us not compel him [death] to hostility, since he must prevail.”³ Though Sainsbury spoke openly in terms that positioned the physician “upon the side of Death” (no reference was made to the ‘prolongation’ of life, a consideration deemed important by a number of elite nineteenth-century physicians) the notion that the physician might deliberately bring about death remained expressly forbidden.

This view was evident in Robert Saundby's *Medical Ethics*, published in 1902. Saundby, a physician, academic and prominent member of the Medical Defence Union, included the following entry on euthanasia in his influential text:

By euthanasia, I understand the doctrine that it is permissible for a medical practitioner to give a patient suffering from mortal disease a poisonous dose of opium or other narcotic drug in order

to terminate his sufferings. This teaching is contrary to the fundamental rule that we must hold human life sacred, and to do no act which has for its object wilfully to destroy it, but a distinction may be drawn between a dose of opium given with the intention to cause death and one regulated to relieve suffering, although the latter may impair the nutritive and digestive functions, and indirectly hasten the fatal termination of the disease. It may be a choice of evils, but although the endeavour to alleviate pain is supported by general opinion, nothing should be done to warrant any suspicion that the sanctity of human life is trifled with by the medical profession.⁴

Within the medical community, Saundby's book would have been widely consulted.⁵ Like Thomas Percival in his eighteenth-century *Medical Ethics*, Saundby considered matters of etiquette, such as the importance of respecting the opinions of colleagues and of promoting a positive image so that the profession was seen as "discreet and sober".⁶ Clearly, however, medical-ethical matters involving the relationship between doctor and patient were also subjects of concern – as illustrated in his statement on euthanasia.

Significantly, Saundby used the word 'euthanasia' to imply the deliberate and intentional ending of life by a physician – a definition that, as I detailed in Chapter 3, had only emerged in the 1870s. This is the earliest example that I have been able to locate in which a doctor uses the term 'euthanasia' in such a manner. In addition, he explicitly referred to the risks associated with opium administration when he stated that medical intervention of this kind had the potential to "indirectly hasten" death. Again, as discussed earlier in this thesis, the risks associated with pain relief had been debated before in medical journals. Saundby's reference to choosing between the "evils" of pain relief that entailed risk, or the consequences of leaving the dying patient in pain, was reminiscent of George Oliver's nineteenth-century caution that the choice between morphine use and unrelieved pain was "a balancing of evils nearly equal" (see Chapter 2, IV).

The difference in Saundby's *Medical Ethics* when contrasted with earlier medical literature, was that the perceived risks of pain relief were now being directly linked to the medical management of the dying and with an acknowledgement that such intervention might "hasten death". This connection may have been hinted at in the past, but it had not been made in an overt manner. Indeed, a number of elite nineteenth-century physicians, such as C. W. Hufeland and Henry Halford, had stressed that death should not be hastened in any way. William Munk did suggest that pain relief implied a degree of risk, but seemed to argue that this might be avoided if drugs were only administered with the intention of relieving pain rather than inducing sleep.

Saundby's writing appeared to acknowledge that risks could not always be avoided, regardless of the physician's intentions, but like Munk, he drew a distinction between

acceptable and unacceptable aims on the part of the physician relieving pain. By acknowledging that the use of pain relief might “hasten death” but simultaneously emphasising the distinction between legitimate and illegitimate “intentions”, Saundby was anticipating a central element of the debate over legalised euthanasia and pain relief that would be played out later in the twentieth century. The relationship between this principled rejection of life being ended by medical means and the ongoing changes to the way in which the practice of pain relief was articulated and understood, is a central theme of the remaining chapters that follow in this thesis.

This, of course, is my own interpretation and reading of the significance of Saundby’s discussion of euthanasia. The fact that at the time of the publication of *Medical Ethics* Saundby used the term ‘euthanasia’ in a way that had only relatively recently been defined, appears to have passed without comment. The reaction from the medical community may well have been very different had he endorsed the practice of physicians deliberately ending life, but Saundby clearly stated that such a notion was neither desirable, nor ethical. Discussion of euthanasia (as defined in the terms set out by Saundby) did spill over into the medical journals in the early part of the twentieth century, but in a way that, as I have already suggested, was sporadic rather than sustained in nature.

Articles written in response to American attempts to legalise euthanasia at State level appeared in the *British Medical Journal* in 1904, 1906 and 1907.⁷ Then, in 1911, after the publication of the book *Death* by Maurice Maeterlinck and considerable coverage of this book in the British press, the *BMJ* responded with a leading article on ‘The Right to Die’.⁸ Maeterlinck, a Belgian poet, playwright and Nobel-prize winner for his contributions to literature, had argued that doctors were frequently in the habit of prolonging the agony and suffering of the dying. Patients should be allowed to die swiftly and easily, he argued.⁹ In its leading article, the *BMJ* rejected Maeterlinck’s “plea for euthanasia” and took the opportunity to restate its opposition to Lionel Tollemache’s ‘New Cure for Incurables’. The journal argued that no patient was duty bound to submit to surgery or any other type of treatment. However, this did not affect “the cardinal principle expressed in the Hippocratic oath – that the doctor, whatever the circumstances, must ‘give no deadly medicine to any one, even if asked, nor suggest any such counsel.’”¹⁰

Maeterlinck’s book also provoked a response from Sir William Osler, who in 1911 wrote to the *Spectator* to say that he was disappointed by Maeterlinck’s “hysterical” and “unfortunate” remarks. “The truth is”, Osler wrote, “an immense majority of all die as they were born – oblivious.”¹¹ In stating his opposition to the notion that physicians should

deliberately bring about death and by reinforcing the view that death was often painless and easy, Osler's views were characteristic of commonly held medical opinion in the late nineteenth and early twentieth century. Yet, for other reasons, Osler is a particularly interesting case. In his 1905 valedictory address given on his departure from John Hopkins University (Osler was leaving to take up a chair in medicine at Oxford), Osler referred to Anthony Trollope's novel, *The Fixed Period*, in which it was proposed that those over sixty be put to death by chloroform.¹²

While his speech received no adverse criticism from medical colleagues, it did generate hostile criticism from the American press. In the words of one of the Osler's biographers, Harvey Cushing, the doctor was portrayed as advocating the killing of older people and as "a cold scientist who would condemn man as a productive machine".¹³ Osler was forced to clarify his remarks. He explained that his comments had merely been made as an attempt at a joke about retirement and to illustrate his observation that, after the age of sixty, many professional men began to take on less work and to slow down. The *BMJ* remarked that the incident was simply an example of what it perceived as the American deficiency in sense of humour and that to suggest that a professor of medicine would have seriously proposed such a policy was ridiculous.¹⁴

Aside from a few articles in medical journals on the more general subject of death and dying, it was not until the 1930s that there was any sustained discussion of the proposal that physicians should induce death.¹⁵ Prior to this, however, when the term 'euthanasia' was used it was frequently taken to mean a death that was deliberately brought about by medical means. Doctors, though arguing against the idea, were increasingly using the term in this way. Nicholas Kemp argues that historical accounts of euthanasia commonly "portray a brief but concerted debate in the 1870s, followed by a trickle of articles up to 1906, and then a period of comparative silence until the 1930s."¹⁶ This assessment, he maintains, neglects to consider the links between a particular strain of early twentieth-century eugenic thought that endorsed non-voluntary killing and the movement for voluntary euthanasia in the 1930s. I will not explore this connection at any great length here, but Kemp makes a convincing case for reading this eugenic literature as a relevant background to later twentieth-century debates over legalised euthanasia.

The events and repercussions of the First World War, of course, dominate the landscape of early twentieth-century British history. The war led to the deaths of approximately three-quarters of a million Britons, claiming, in particular, the lives of many young men. In 1914, 30.58 per cent of all men aged between twenty and twenty-four were

killed.¹⁷ Interestingly, Kemp argues that there was little discussion in relation to the mercy killing of soldiers who were mortally wounded and suffering terrible pain (though that is not to say that it was not practised). There was, however, a debate about what were perceived to be the draining costs of supporting the mentally ill within British asylums when huge economic resources were required for war. The *Eugenics Review* described modern warfare as “entirely dysgenic” because it was the young and fit who were killed, not the physically disabled or mentally ill.¹⁸ Kemp contends that certain strains of this argument can be detected in later literature that proposed legalised euthanasia. Certainly, if one wished to explore the non-voluntary dimensions that arguably lay behind the proposals of some of those who advocated legalised voluntary euthanasia in the 1930s, then Kemp’s book would be a very good place to begin.

My interest, however, is the medical profession’s role in relation to moves to legalise voluntary euthanasia and, in particular, the way in which the practice of pain relief fed into these euthanasia debates. So far, I have tended to suggest that the profession was reacting and responding to calls for voluntary euthanasia that originated outside of the medical community. By the 1930s this was no longer the case. Early in the twentieth century, the *BMJ* had considered it ludicrous that a respected professor of medicine would seriously advocate death by chloroform. In 1936, doctors were proposing exactly this – though they had in mind voluntary death for cases of incurable and painful disease, a very different proposition to Trollope’s fictitious policy of compulsory death for those over sixty.

When I argue, therefore, that the official position of the medical profession has been one that has rejected legalised euthanasia, it should be stated that this refers to the collective position of the profession and cannot be applied to each and every individual doctor. As I argue in the following chapter, legalised euthanasia has both been supported and resisted by medical professionals throughout the twentieth century. From what appeared to be a unified position of opposition to the proposal that physicians should end life, by the 1930s onwards, a number of doctors were prepared to openly campaign for the legalisation of voluntary euthanasia. Explaining why medical professionals became involved in such a campaign involves exploring a number of complex factors – some of which I will only briefly allude to in the remaining chapters of this thesis. One important concern that I examine in detail was the alleviation of pain in incurable and suffering patients. Eugenic thought might have influenced the arguments of some of those who advocated legalised euthanasia, but for others, the issue was one of pain relief and the perceived inconsistency of the medical profession’s official opposition to legalised euthanasia but endorsement of other forms of medical intervention.

In 1931, Dr C. Killick Millard, Medical Officer of Health for Leicester, raised the issue of legalising voluntary euthanasia in his presidential address to the Society of Medical Officers of Health, a speech that was later published in pamphlet form.¹⁹ Millard argued that patients often endured harrowing and protracted deaths, and he quoted statistics showing that deaths from malignant disease, in particular cancer, were higher than ever. The time had come, he argued, to legalise the right of a patient to request death by means of medical intervention, and by way of preparing the ground for such a move he set out a model voluntary euthanasia bill.²⁰ Then, in 1935, the Voluntary Euthanasia Legalisation Society (VELS) was founded and held its first public meeting in BMA House.²¹ Prior to this meeting, an executive committee of three ministers, three physicians and a solicitor had been formed, with Mr C. J. Bond, Senior Consulting Surgeon at the Leicester Royal Infirmary, appointed chairman and Millard appointed as honorary secretary.²² Their attempts to recruit eminent figures from the medical, religious and legal fields were a success. By early 1937 the VELS could count 268 members, with 70 doctors making up this number.²³ Now euthanasia was no longer a subject purely of philosophical discussion, it was the focus of a practical, legislative programme and this meant that the medical profession had to officially respond.

In the chapter that follows (Chapter 5) I begin by giving an analysis of the 1936 Bill that sought to legalise euthanasia and then consider publications produced in the same year that supported this attempt to change the law. I go on to examine medical responses to these moves to legalise euthanasia from a range of perspectives, from those who supported euthanasia (albeit to varying degrees) to those who vigorously resisted. The theme of 'natural' death once again surfaces, particularly in the literature from the 1940s that I consider. In addition, the three categories of argument that I identify throughout the thesis – principled support/opposition to euthanasia, practical debates centred round pain relief, and conceptions of 'social death' – figure in these debates. At the end of the chapter I examine the second attempt to legalise euthanasia in 1950 and the subsequent arguments and negotiations that took place in relation to pain relief. In the final substantive chapter of this thesis, Chapter 6, I look at debates that accompanied the emergence of the hospice movement, debates that, as I will argue, attempted to bring some sort of resolution to the question of legalised euthanasia and the pain of dying patients.

Notes

¹ See Pat Jalland, *Death in the Victorian Family* (Oxford, Oxford University Press, 1996), p.85.

² Harrington Sainsbury, *Principia Therapeutica* (London, Methuen and Co, 1906), p.224.

³ *Ibid.*, p.226.

⁴ Robert Saundby, *Medical Ethics, A Guide to Professional Conduct* (London, Charles Griffin and Company Ltd, 1902), p.12.

⁵ Andrew Morrice describes Saundby's *Medical Ethics* as "arguably the most influential text on the subject written in early twentieth-century Britain". Morrice also notes that in Saundby's 1918 obituary in the *British Medical Journal*, the journal considered *Medical Ethics* "a valuable volume" which "laid the foundation for medico-ethical work of the [British Medical] Association". See Andrew Morrice, "'Honour and Interests': Medical Ethics in Britain, and the work of the British Medical Association's Central Ethical Committee, 1902-1939", M.D. thesis, University of London (1999), p.334.

⁶ Saundby, *Medical Ethics*, pp.2-3.

⁷ The *British Medical Journal* chastised the *Daily Mail* for "sensationalism" in publishing articles under the headline "Merciful Murder". The *Daily Mail* articles described how several doctors in America had openly advocated the hastening of death in cases of hopeless suffering. In the British newspaper's view, "the private conviction of English doctors that such measures would be desirable and humane seems to be gaining ground". The *BMJ* countered by stating that "a medical practitioner who should make himself the instrument of carrying out such a wish [euthanasia] would be guilty of a crime against his patient, against society and against his profession". See 'Euthanasia', *BMJ*, 11 June 1904, 1384-6, at p.1386. In its 1906 article, the *BMJ* discussed the submission of a euthanasia bill to the Iowa State Legislature. The journal concluded that the legislation was "a mischievous proposal" which was "the outcome of the degeneracy, mental and physical, that is a by-product of high civilization". See 'Euthanasia', *BMJ*, 17 March 1906, p.639. See also 'A Counterblast to Euthanasia', *BMJ*, 31 March 1906, p.760 and 'Euthanasia', *BMJ*, 7 April 1906, p.817. In 1907, the *BMJ* reported that "A League Against Death" had been formed in Iowa but concluded dryly that "the custom of dying is so deeply ingrained in the human race that its eradication will prove harder than the Society appears to imagine": *BMJ*, 7 May 1907, pp.1143-4.

⁸ 'The Right to Die', *BMJ*, 4 November 1911, pp.1215-7.

⁹ Maurice Maeterlinck, *Death*, translated by Alexander Texiera de Mattos (New York, Dodd, Mead and Company Ltd, 1912), especially pp.10-25.

¹⁰ 'The Right to Die', *BMJ*, 4 November 1911, p.1217. The *BMJ* noted that it had heard nothing more of the euthanasia bills submitted five years before to the state legislatures of Ohio and Iowa. It commented: "we are inclined to believe that they [the euthanasia bills] have been quietly disposed of by the process of euthanasia, which is quite often the fate of legislative 'freaks'."

¹¹ See Shelagh Jones, 'Sir William Osler's Views on Euthanasia', *McGill University Osler Library Newsletter*, 77 (October 1994), 1-3 at p.2.

¹² William Osler, 'Valedictory Address at John Hopkins University', *Journal of the American Medical Association*, 44 (1905), p.706.

¹³ Harvey Cushing, *The Life of Sir William Osler* (Oxford, Oxford University Press, 1925), p.665, cited by Jones, 'Sir William Osler's Views on Euthanasia', p.1.

¹⁴ See Michael Bliss, *William Osler: A Life in Medicine* (Oxford, Oxford University Press, 1999), pp.321-8.

¹⁵ The exception to this is an article on euthanasia that surveyed literary references to the subject. See C. J. G. Taylor, 'Euthanasia', *BMJ*, 23 April 1927, p.772. There is also an interesting letter in the *Lancet*, written by an American doctor encouraging 'systematic and scientific study of the dying hour'. See Arthur MacDonald, 'The Study of Death in Man', *Lancet*, 18 September 1926, p.624. Also, in the *BMJ* there is an article that examines death and dying in 'primitive' Scottish, English and French societies, considering the role of 'hastening the death of the aged, infirm and sick'. See David Rorie, 'Hastening the Death of the Aged, Infirm and Sick', *BMJ*, 30 September 1933, pp.611-2.

¹⁶ Nicholas Kemp, *Merciful Release, The History of the British Euthanasia Movement* (Manchester, Manchester University Press, 2002), p.60.

¹⁷ Ibid., p.62.

¹⁸ Ibid., p.65.

¹⁹ C. Killick Millard, *Euthanasia: A Plea for the Legalisation of Voluntary Euthanasia* (London, C. W. Daniel, 1931). Prior to Millard's address to the Society of Medical Officers of Health, Canon Peter Green, an Anglican minister, published *The Problems of Right Conduct: A Textbook of Christian Ethics* (London and New York, Longmans Green, 1931). Canon Green questioned why Christianity and the State prohibited those suffering fatal and painful diseases from terminating their own lives. Green made the point that at one time the use of chloroform in surgery had been opposed in religious quarters on the grounds that it interfered in 'the divinely appointed discipline of trial and suffering'. That view had changed rapidly and Green found it impossible 'to discover any real conclusive argument against suicide under due restrictions'. Millard was clearly aware of this publication as he cited it in in his later publication *The Movement in Favour of Voluntary Euthanasia – An Historical Study* (Leicester, W. Thornley and Son, 1936).

²⁰ A report of the publication of Millard's pamphlet appeared in the *Lancet*, 5 March 1932, p.523. The journal saw the drafting of Millard's 'serious bill' as a 'good method of stimulating public discussion' but concurred with the opinion of an earlier editorial in the *Spectator* that such proposals stood little chance of passing into law.

²¹ The proceedings of the inaugural meeting of the VELs were published in full in the *Lancet*, 14 December 1935, pp.1385-7.

²² An explanation for the significance of Leicester as a centre for the Voluntary Euthanasia Legalisation Society is given by Ian Dowbiggin in his paper "'A Prey on Normal People": C. Killick Millard and the Euthanasia Movement of Great Britain, 1930-1935', *Journal of Contemporary History* 36 (2001), pp.59-85. Dowbiggin describes how 'Leicester had a long and distinctive history of religious dissent and non-conformist and radical politics stretching back to the early nineteenth century, a current that emphasised heterodox Christianity, personal autonomy and social activism', (at p.63).

²³ 'Euthanasia Society', *BMJ*, 2 May 1937, p.552.

Chapter 5

Defining Euthanasia – Parliamentary Debate, Private Correspondence and a Papal Declaration

I. The Voluntary Euthanasia (Legalisation) Bill 1936

On 1 December 1936, Lord Ponsonby of Shulbrede, President of the Voluntary Euthanasia Society, introduced The Voluntary Euthanasia (Legalisation) Bill for its second reading in the House of Lords. The Bill set out legislative proposals for voluntary euthanasia for patients “of sound mind” over the age of 21, suffering from “incurable and fatal illness” and in “severe pain”. The Bill, based on the model set out by Dr C. Killick Millard, specified that the patient requesting euthanasia first be diagnosed as “incurable” and two medical certificates issued, “just as in the case of the cremation”. The two certificates and the application for euthanasia would be sent to an official euthanasia referee appointed by the Minister of Health, who would then interview the patient in person. If satisfied with the request, a license would be issued, in the presence of an official witness, and the request for voluntary euthanasia granted.¹

Beyond the bureaucratic details of the proposed legislation (though they in themselves were a source of concern, particularly for the two medical peers who spoke against the Bill) the 1936 Lords debate provides an interesting insight into establishment thinking on euthanasia in the first half of the twentieth century. Primarily the debate centred round the first two categories of argument that I identify, that is, arguments relating to principle and arguments relating to the practice of managing pain. However, also explicit in this debate were frequent references to the “despair” of the patient who “prolonged the anxiety of others” and the “burden” such a patient felt when others were forced to watch his or her bodily and/or mental decline. Tellingly, Lord Ponsonby remarked in his opening address that the “consciousness of being a burden” and the “despairing view that you are no longer of use” was perhaps “as poignant as the suffering itself”.² This reference to the perceived loss of ‘self’ and loss of ability to sustain relationships, at least in the manner they were prior to

illness, also suggests that a notion of 'social' death factored into the euthanasia debate of 1936.

During the debate three Lords spoke in favour of the Bill, whilst six spoke against. In proposing the Bill, Ponsonby maintained that a society re-examining its attitudes to suicide also needed to re-examine its attitudes to euthanasia. He argued that a far more lenient view of suicide was emerging, whereby the decision to take death into one's own hands was no longer forcefully condemned as it had been in the past. Despite this change in societal attitudes, it remained the case that a person who knowingly and deliberately took their own life was denied a Church of England burial. To avoid such a situation, coroners' juries were using what Ponsonby viewed as a legal sleight of hand, by bringing a verdict of 'suicide while of unsound mind'. This, Ponsonby argued, "may be proved in a few cases, but in many more is not, strictly speaking, justified by the evidence".³

In principle, it was not wrong in certain specified circumstances to take one's own life, nor was it wrong to ask for assistance, he maintained. "We all know cases of suicide", he stated, "which were not only innocent but very noble."⁴ Seeking to end one's life, as a means of escaping pain, was no less an act of heroism than the accepted examples of self-sacrifice for others or for higher causes. Indeed, consideration for others was "uppermost in the minds of the patients" who sought to bring their lives to an end.⁵ As for euthanasia being against the teachings of Christianity, Ponsonby disagreed, but added that when principles came down to a question of varying interpretations of religious belief, euthanasia was then "beyond argument". There would be those who opposed his view, but there were many other religious men who supported his position.⁶

On the practical issue of pain relief, leaving the management of pain to the individual discretion of the doctor was not a satisfactory answer. Narcotics were, in the first instance, "detrimental to the prolongation of life" but in addition, pain could recur and was not always sufficiently managed. This placed too great a responsibility on the doctor, leaving the management of death to the "unfettered discretion of a single individual". Ponsonby cited a case that had recently come to his attention, of a patient suffering from incurable cancer. Great pain and suffering had been endured, only temporarily relieved by morphine, and the patient had "begged to be released". Concluding this anecdotal case, Ponsonby emphasised that inadequate management of pain was not the only question at issue. Perhaps more important was "the suffering, the anxiety, the burden" that the patient felt was imposed on

the others around him. Patients were often forced to muster a “pathetic attempt at cheerfulness” when in fact this was only to prevent “being weighed down with the burden he feels himself to be to his friends”.⁷ Thus, the three strands of argument that I identify throughout this thesis emerge in Ponsonby’s defence of the 1936 Voluntary Euthanasia Bill. His principled support of the concept that it is right to take life in certain circumstances, based on a defence of suicide; his practical argument that pain relief neither prolongs life nor is effective in all situations; and his suggestion of perceived loss of ‘self’: all factor in his arguments.

Though Ponsonby was quick to stress that the Bill had outside support from a number of leading medical and religious figures, in the debate itself, both medical and religious opinion unanimously opposed the Bill.⁸ Most strident in his denunciation of the Bill and all that it stood for was Viscount Fitzalan of Derwent, who rejected an earlier appeal that had asked that denominations of Christians opposed to the Bill stand aside so as not to inhibit those in favour of legalising euthanasia.⁹ “Of course the religious question comes in,” he argued, “it cannot be ignored.” He went on to argue that the Bill was not only contrary to Christian thinking, it was also ‘unnatural’:

This Bill is not opposed only on Christian and moral grounds, it is opposed because it is contrary to the law of nature. We do not oppose it because the Church condemns it, but because it is an evil and a cowardly act.¹⁰

Significantly, the Viscount’s statement revealed an image of ‘nature’ that operated outside the sphere of human influence. According to this view, man was not to attempt to control such “laws of nature”. To sanction euthanasia would be an “evil” and “cowardly” dismissal of these laws and (implicit in his view I argue) an ‘artificial’ means of seeking to control death.

Not only did Fitzalan oppose the bill on principle but he also challenged the idea that pain should be continually fought. “I have no wish to volunteer for any greater degree of pain of suffering than is likely to fall my share,” he maintained, “but ... when you think of the modern mania for luxury I cannot help thinking it is rather a warning to us against the degeneration of the race.”¹¹ Directly linking his principled opposition to euthanasia with the notion that the practice of pain relief somehow led to over sensitivity and lack of endurance he argued:

If we allow sentiment to run away with us, then it means an abandonment of principle, it means that we are governed by our emotions, and we sacrifice that great virtue of grit that has been such a great characteristic of our race.¹²

This view, that the presence and experience of pain in human life is part of a ‘natural’ order in the world was a view that, as I discussed earlier, was also articulated in nineteenth-century debates over the introduction of anaesthesia in childbirth and surgery. However, whereas medical writers in the late 1800s had linked sensitivity to pain to the notion that society was becoming ever more civilized, Fitzalen argued that this sensitivity was a negative by-product of a society that was indulgent and lacked endurance.

In contrast to Viscount Fitzalen, the Archbishop of Canterbury gave a very different religious view, conceding that at times there were exceptions to the principle that that life was sacred and that taking one’s own life was forbidden. “Is there any moral principle in the world”, he asked, “which in the infinitely varied and tangled circumstances of human life does not admit some exceptions?”¹³ He agreed with Lord Ponsonby, who had given examples of heroic acts of self-sacrifice, that life could be voluntarily relinquished without blame, indeed, in a manner that was to be praised.¹⁴ However, in his view, this did not mean the endorsement of legalised euthanasia:

But it is one thing to admit exceptions to the principle that a man may not lay down his life, and it is another thing to give public statutory authority to the counter principle and to say that in certain cases a man, in his own interests and for his own sake, may bring his life to an end.¹⁵

The Archbishop questioned if a dying patient would be capable of “sound moral judgement” and thought that the possibility of relatives exerting “illegitimate pressure” on the patient should not be dismissed. He could not, however, accept the view that “pain and the duration of pain need be accepted as ... means of moral and spiritual discipline”. The “marvellous, far-reaching and beneficent use of anaesthetics” meant that such a view was untenable. The Archbishop’s opinion was that the law should not interfere in what he viewed as the “relationship of mingled intimacy and responsibility that exists between doctor and patient”. If in relieving pain the doctor was aware that such intervention might lead to the shortening of a patient’s life, then it was a “perversion of language to say that such a doctor could regard himself as guilty of murder or manslaughter, or could even be charged with it”.¹⁶

The two medical peers who spoke in the debate, Lord Dawson of Penn and Lord Horder, sided against the Bill but, interestingly, their reasons for opposition had as much to

do with practicalities as they did with principles.¹⁷ Lord Dawson rejected what he saw as the intrusive nature of the proposals that, he claimed, “would turn the sick-room into a bureau and be destructive of our usefulness”. Revealingly, he argued that there *had already* been a change in medical practice regarding care of the dying patient. The prolongation of life was no longer the primary purpose of medicine in such a case. Rather, the easing of pain, even if this ultimately hastened death, was now the goal of ‘enlightened’ physicians. This change in practice had “evolved without intervention or change of Statute”.¹⁸ Lord Dawson challenged the notion that such an attitude was due to “degeneration” in attitudes to pain, but argued that the change was due “to a truer conception of what life means and what the end of its usefulness deserves”. This “truer conception” of what life meant was the result of man’s “natural habit of freedom of thought” and “the evaluation of morals and manners”.¹⁹

What is significant, is that Lord Dawson’s opposition to the Bill neither involved the rejection of the notion that the doctor may hasten death, nor did it challenge the use of the term ‘euthanasia’ to describe this practice.²⁰ Where his opposition did lie, was in the idea that medical practice could be standardised and legalised. The Bill would have the opposite effects to those that it desired, since, he argued, it would deter the doctors who were “carrying out their mission of mercy”, and the “gentle growth of euthanasia” would be disrupted.²¹ Lord Dawson’s words revealed an understanding of ‘euthanasia’ which was viewed as a practice that was not regulated by law, but had more to do with what the Archbishop of Canterbury referred to as “the relationship of mingled intimacy and responsibility between doctor and patient”.

Lord Horder’s speech, similar to that of the other medical peer, also voiced concern in relation to the logistical details of the Bill. The very fact that the Bill made provision for euthanasia to be administered by someone other than the doctor attending the patient throughout illness was a worrying scenario, he argued. In his view, replacing the “intimate relations” between doctor and patient with “the introduction of strangers from Whitehall” was not the solution to the problems of a suffering patient.²² In concluding his speech to the House, he stated:

The two extremes of dying in pain and being killed do not exhaust the possibilities for the stricken patient, because there is a middle position created by a kindly and skilful doctor, who gives assistance to an equally kindly Nature, and that is what is implicit in the patient’s question: ‘You will stand by me, won’t you?’ and the doctor’s assurance: ‘Yes I will.’²³

Here, the principle that the physician should not kill was upheld by means that not only stressed the technical competence of the doctor, but also gave an assurance that the dying patient would be psychologically supported. Lord Horder's conception of 'nature' differed in a number of respects from that mobilised by Viscount Fitzalen. Rather than viewing nature as a phenomenon not to be controlled, Lord Horder's argument allowed for the idea that nature could be 'assisted' by medicine. Of course, both conceptions were based on the notion that 'nature' could be understood as existing independently of human experience – one view opposing intervention on the grounds that this violates natural 'laws', the other sanctioning intervention in order to ease an inevitable 'natural' passage of events. Lord Horder's view of nature was one that was benign, even "kindly", whereas Viscount Fitzalen's view of nature was one that incorporated concepts of pain and suffering. Both views were representative of wider attitudes to the role of medicine, some of which have already been examined in the discussion of nineteenth-century medicine in the first part of this thesis.

However, the views represented by Lords Horder and Dawson reveal a shift in official medical opinion from that of the late nineteenth century. At first glance this shift is difficult to discern, since in the late nineteenth century doctors were already incorporating changes in practice, most notably the use of pain-relieving drugs, into a conception of a 'natural' order to life. By the early decades of the twentieth century, however, a change had taken place. This change is detectable in Robert Saundby's definition of euthanasia in 1902, but becomes increasingly apparent by the 1930s. Doctors were now acknowledging that they might indeed be hastening death by administering drugs and by giving priority to pain relief. They were acknowledging the risks that might be involved in such practice, but once again attempting to build these risks into a conception of 'natural' death. This conception of 'natural' death, as newly conceived in the first half of the twentieth century, excluded any notion of legalised regulation but instead placed a relationship of trust between doctor and patient at its centre.

Christopher Lawrence describes the medical world of elite physicians (such as Lord Horder) during the inter-war period as a "patrician social order", such that moves to standardise and intrude on this world were perceived as a threat to "disrupt their clinical universe".²⁴ As Lawrence details, Horder spoke explicitly of the privileged position in which medical professionals were placed – a position that called, in Horder's own words, for the doctor "to be a priest as well as a physician".²⁵ According to Horder, physicians were required to be civilized, dutiful and, importantly, humane. The last of these qualities meant alleviating the incurable patient's pain with all the knowledge and expertise at the individual

clinician's disposal, but with the privacy and confidentiality afforded to the relationship between priest and confessor.

It should be made clear that the actors participating in the euthanasia debate of 1936 did not explicitly draw a distinction between 'natural' and 'artificial' death. As such, the categories of 'natural' and 'artificial' death are ones that I use for my own analytical purposes. By utilising these categories, I argue that in effect, a distinction between a notion of 'natural' death – the physician relieving pain within the confines of a private, unscrutinised sphere – and 'artificial' death – the legalisation of state controlled 'killing' – was being drawn in the medical peers' contributions to the debate over the Euthanasia Bill. The principle that the physician should not kill was maintained, not only by rejecting the suggestion that it was right to kill in circumstances where suffering patients requested an end to their lives, but also by challenging any necessary connection between 'hastening death' and 'killing'. The practice of pain relief was justified on the basis that nature was merely being assisted. Fears of 'loss of self' were assuaged with reassurances that the doctor would 'stand by' the anxious patient. Above all, it is significant that the physicians in this debate were comfortable with the word 'euthanasia', though they offered a different interpretation of its meaning to that proposed in the 1936 Bill. As I will argue, later in the twentieth century, the medical profession relinquished its claim to the term 'euthanasia', seeking to distance itself from any connection with the word.

II. Debate in the 1930s: Defining 'Real' Euthanasia

Despite the unanimous rejection of the 1936 Bill, interest in legalised euthanasia did not diminish during the latter half of the 1930s, nor for that matter was it silenced during the years during and preceding the Second World War. In the medical journals of the 1930s and 1940s, articles and correspondence appeared at steady intervals, revealing a range of medical views that either challenged or legitimated medical practice of the time. For example, in a letter to the *BMJ* in December of 1940, Killick Millard argued that despite medical advances, particularly in the fields of surgery and radiology, deaths from cancer were at least twice as great as in the early 1900s.²⁶ Though accepting that not all patients suffering from cancer died in agony, Millard maintained that there remained cases of extremely painful, incurable disease that could not be helped by attempts to relieve pain. For such cases, he would continue to press for a change in the law, "so that, with properly considered limitations, painless death might be administered".²⁷ Responding to Millard's letter, Dr C. O. Hawthorne

(who had strongly rejected proposals to legalise euthanasia in 1935) argued that publishing a list of eminent members of the Voluntary Euthanasia Legalisation Society was “little likely to impress opinion within the medical profession.” The task of doctors was to “relieve suffering”, not to “destroy life”. A test of Dr Millard and his supporters would be to ask if they were personally willing to volunteer to “administer the final draught”. In the assessment of Dr Hawthorne, Millard was “but a feeble disciple whose record was one of faith without works”.²⁸

In the aftermath of the 1936 Bill, the debate over euthanasia remained complex, fraught with ideological tensions that combined with claim and counter-claim in relation to the efficacy of pain relief. Thus, with Millard’s intervention euthanasia was supported, not only on the grounds that it was right to kill in certain circumstances, but also on the basis that conventional medical intervention was at times inadequate in the face of terrible suffering. With Hawthorne’s intervention, euthanasia was rejected on the grounds that doctors should do all they could to “relieve suffering” but should not “destroy life”. The contrast between “destroying life” (Hawthorne’s phrase) and “painless death” (Millard’s phrase) was sharply drawn: the first carrying negative connotations that violated the parameters of the doctor’s duty to relieve pain, the second carrying more positive connotations located within a context of physician administered treatment. Significantly, it is worth noting the subtleties of language at work in Millard’s own definition of euthanasia. In his letter of 1940, Millard described euthanasia as “artificial release from extreme suffering”, supplementing an earlier view in which he stated that it was “no more a sin to shorten life than to try to lengthen it beyond its natural span.”²⁹ Legalised euthanasia was thus portrayed in ‘artificial’ terms, but in addition, medical intervention that was seen as illegitimately prolonging life was also classed as interference with ‘nature’ – a conceptual move that called into question the distinction drawn between unacceptable ‘destroying’ of life and other accepted forms of medical practice.

Another view of euthanasia emerges in literature from the 1930s. This view challenged the legalisation of euthanasia on much the same lines as Lords Dawson and Horder opposed the 1936 Bill. However, it then went further than the medical peers by endorsing not only the ‘hastening’ of death, but also suggesting that it was right, in certain circumstances, to end the life of a suffering patient. In the essay ‘Euthanasia and Voluntary Death’ in his book on *Euthanasia and Other Aspects of Life and Death*, Dr Harry Roberts supported euthanasia both on the basis of principle and as a practical extension of the need to

relieve pain.³⁰ These two facets of Roberts' support for euthanasia were brought together in the opening to his essay, in an excerpt from the memoirs of Berlioz in which the author describes the painful and protracted death of his sister from breast cancer.

... From cancer of the breast and after six months of horrible suffering ... And not a doctor dared have the humanity to put an end to this martyrdom by letting my sister inhale chloroform. This is done to save a patient the pain of surgical operations that last a quarter of a minute: but this was not done to deliver one from a torture lasting six months ... The most horrible thing in the world, for us living and sentient beings is inexorable suffering. We must be barbarous or stupid, or both at once, not to bring it to an end.³¹

To allow patients to suffer in such a manner was indeed inhumane, agreed Roberts. Although the law and the "acknowledged code" of the medical profession prohibited the ending of life, it was "cowardice rather than conscience or professional honour" that led doctors to "observe the established convention", he argued. However, Roberts suspected that many doctors did on occasion allow feelings of sympathy and pity to "override their prudence". He continued, "to humane man the inclination to administer a merciful overdose is often almost, not unsurprisingly, quite irresistible."³²

Here, euthanasia was construed, not in terms defined by the administration of pain relief that might 'hasten' death, but in terms that explicitly referred to overdosing the patient, albeit mercifully. This concept of euthanasia was more in line with the practice advocated by Dr Millard and opposed by Dr Hawthorne. Roberts, however, criticised and rejected the formal proposals of the VELS. So far as the defined objectives of the society were stated, "most informed people outside of the Catholic Church will be in general sympathy," he argued. However, he cautioned whether the voluntary dimension to the euthanasia bill could be guaranteed, noting that during the inaugural meeting of the VELS in 1935, two "distinguished doctors" had spoken of legalising "a painless destruction of 'mental monstrosities'".³³ Similarly, at the same meeting, C. J. Bond, the Chairman of the Executive Committee, had stated that the proposals were limited only to voluntary euthanasia. However, Bond then proceeded to argue that, "as public opinion developed it would be possible to form a true estimate of the value of human life" so as to allow "further progress along preventative lines".³⁴

Roberts' suspicion of the non-consensual potential of legalised euthanasia was matched by an equal suspicion of bureaucracy. Like Lords Dawson and Horder, Roberts rejected the notion of "forms going from one official to another", a process that he deemed

“stressful for both doctors and patients alike”. The proposed official arrangements seemed more suitable for the cremation of a dead body, he argued. Then there was the “gross but accurate term ... the finishing off” of the patient who had “previously looked to the doctor for succour”.³⁵ Placing himself in the hypothetical position of a cancer sufferer in the situation where nothing more could be medically done, Roberts hoped that his doctor would “make that necessary modification in my medicine, which would hasten the pace over a bad bit of going.” That, in Roberts’ assessment, “would be real euthanasia.”³⁶ He concluded:

Personally, I would not hesitate to painlessly end the life of an acquiescent patient at an advanced stage of such a painful and incurable disorder as cancer of the larynx or oesophagus – regardless of the convention of formal legality. When my sympathy outweighs my fear of, and respect for the law, I obey the orders of the former.³⁷

This view, as articulated by Roberts in his essay, offered a further variation on the interpretation of the term ‘euthanasia’. Roberts presented a principled argument in favour of ending life, at odds with legal or professional convention, but ruled out any formal change in the law. He opposed altering the law because of his fears of allowing non-voluntary killing and over-bureaucratisation of dying. In relation to pain relief, Roberts viewed a “merciful overdose” as entirely in line with good medical care when all that could be otherwise done, had been done.

Such a definition of “*real*” euthanasia positioned itself between the proposals that sought to legalise euthanasia and the official endorsement of the Hippocratic principle that the physician should not kill. It was a definition that accommodated the idea of the physician deliberately ending life but rejected any suggestion of state regulation in such a practice. In defining the doctor-patient relationship, this “real euthanasia” preserved the Archbishop of Canterbury’s view of “mingled intimacy and responsibility”, but interpreted the question, “you will stand by me, won’t you”, as implying the ending of a patient’s life. This was different from the terms set out by Lord Horder in the House of Lords debate. It was an image of death governed by humane sentiments that went further than the notion of ‘hastening death’, but instead explicitly permitted the painless ending of life in certain circumstances.³⁸ However, like the view expressed by Lords Dawson and Horder, this position ruled out the imposition of structures of rules or external state scrutiny.

III. 'Natural' Death and Pain Relief in the 1940s

Ambivalence surrounding whether medical intervention in order to shorten life represented 'natural' or 'artificial' death continued into the 1940s. Euthanasia once again found its way into the pages of the medical journals, alongside wider theoretical discussion of how death should be located within an understanding of the 'natural' world. In November of 1940, Dr Frederick Parkes Weber, a physician who specialised in rare diseases but who also fostered an interest in attitudes to death and dying, wrote to the *BMJ* offering his support for legalised euthanasia.³⁹ Re-iterating the view of nineteenth-century physicians such as Henry Halford, Benjamin Brodie, William Osler and William Munk, Parkes Weber maintained that "the act of dying" was "not in any way as terrible to the dying individual as it seems to his friends present at the deathbed".⁴⁰ Nevertheless, there were "occasional cases" of extremely painful, chronic disease in which the patient "who longs for artificial release" should be administered a legalised "painless death".⁴¹

Despite his use of the phrase 'artificial release', Parkes Weber placed medical intervention in order to bring about death, within a particular view of 'nature'. He regarded nature as "one of the manifestations of God" over which humans had "gradually been permitted more and more control". He continued:

We have been enabled to avoid much suffering and death by aseptic surgery, anaesthetics, anodynes, chemotherapeutic means, etc. Why should we not in exceptional cases of chronic painful incurable disease relieve the patient of his life at his repeated request? One often hears Nature blamed for cruelty, which we ourselves – a part of Nature – might nowadays, and possibly are intended to, prevent.⁴²

Rather than being set apart from an independent natural realm, human action, in particular medical practice, was a constituent part of Parkes Weber's understanding of 'nature'. Just as the use of pain relieving drugs was now established in the technical repertoire of other areas of medicine, so too should the ultimate form of pain relief – death – be available to the suffering patient.

This conception of human life as an integral part of 'nature' was reflected in other non-medical publications of the time. In 1941, an edition of the *News Chronicle* carried an article by Julian Huxley (grandson of T. H. Huxley and brother of Aldous), the then secretary to the Zoological Society of London, in which he called for "an overdue revolution in theology."⁴³ This was to be accomplished by "doing away with the idea of a personality of

God.” ‘Nature’ would then be understood in terms defined by the “human personality” encountering and experiencing the external world. It was man’s own capacity for “experiencing things as sacred”, Huxley maintained, that formed the basis of religious belief. The “human tendency” to organise knowledge and to understand experiences such as death and suffering created notions of the divine. If there was suffering in the world, it was because “we have not yet made our God look good enough, nor believed in it actively enough”, he argued. The history of religion showed that conceptions of God had changed and adapted. The Christian God for example, was conceived of very differently from the “cruel God of the Aztecs or the all too human God of ancient Greece”. It was in this changing and developing image of God that Huxley believed “the central hope of religion for the future” lay.⁴⁴

This view, that linked ‘nature’ with the ‘divine’, suggested that human understanding of experiences such as death was continually changing and adapting to new circumstances. All that was ‘natural’ was in effect ‘man-made’. Humans were not simply part of ‘nature’ as in Parkes Weber’s view; rather, they were the on-going constructors and creators of the very concept that was ‘nature’. Implicit in this conception of ‘nature’ was that death could be viewed in whatever way humans chose; suffering did not need to be seen as a ‘natural’ part of dying. Medical intervention in order to end life could just as easily be incorporated into an idea of ‘natural’ death because ‘nature’ in itself was a human construct. Not surprisingly, given this view, it is interesting to note that Julian Huxley was a vice president of the Voluntary Euthanasia Society.⁴⁵ He was also a supporter of eugenic thought. As I have stated, I do not wish to delve too deeply into the connection between the eugenic ideas and the movement for legalised euthanasia. However, the text of the Galton Lecture that Huxley delivered to the Eugenics Society in 1936, appears to support Nicholas Kemp’s argument that a concern for those suffering from incurable and painful illness was not all that underpinned the ideology of some vocal advocates of voluntary euthanasia.⁴⁶

Returning to the theme of notions of ‘natural’ death – adding another voice to the debate over the management of pain and euthanasia was John Ryle, a Cambridge University academic and consulting physician at Guy’s Hospital, London. In 1940, his article ‘Of Death and Dying’ triggered a series of letters to the *Lancet*, both in praise and in criticism.⁴⁷ “To die is as natural as to be born,” wrote Ryle, arguing that religion and superstition engendered an unnecessary fear of death in the living. In reality, the actual process of dying was never as terrible as imagined, he maintained, voicing a similar view to that of Parkes Weber. This was

due to what Ryle described as the “wonderful compensatory relief which nature allows”.⁴⁸ Nature for the most part, ensured that fever and shortness of breath “imitated the twilight sleep of morphine”. Nevertheless, for the “blessed help of morphine itself, we can never be too grateful”, he concluded.⁴⁹

Interestingly, despite maintaining that death was for the most part a painless experience, Ryle conceded in private correspondence with Parkes Weber, that in certain circumstances medical intervention in order to end life should not be ruled out. He wrote:

I believe that there are, in fact, few cases in which a proper use of drugs fails to make the declining phase of painful illness tolerable. We give them perhaps, a slow euthanasia, but without incurring undue responsibility or laying ourselves open to criticism or regrets. There are however, probably still others in which a quick euthanasia should be permitted.⁵⁰

“Slow euthanasia”, the everyday practice of administering pain relief to the dying patient, was contrasted with “quick” euthanasia, implying administering a fatal dose. Indeed, the letters pages of the *BMJ* reveal other examples of the term euthanasia being used in a dual sense, to evoke the accepted practice of administering pain relief or the purposeful ending of life. In a letter of January 1940, one doctor contrasted “barbarous euthanasia” – administering ever-increasing doses of morphine that leave the patient in what he argued as a “pitiable” state – with what the author saw as humane, legalised euthanasia secured by means of a lethal dose.⁵¹ On the same page however, another doctor argued strongly against euthanasia, stating that though doctors “need not try to prolong life that is coming to a natural end”, the interference of the law would only lead to “many difficulties” for all concerned.⁵²

The question of the relationship between ‘natural’ death and euthanasia in these debates is clearly complex with the word ‘nature’ and the word ‘euthanasia’ being used in different contexts and to define different concepts. Thus, ‘nature’ was presented as an entity that could be shaped and directed through medical intervention, or as a benign force that pacified and eased the dying process, or, finally, as an entirely man-made concept that absorbed changing moral, theological and ideological thought. However, despite their varying understandings of ‘nature’, it is significant that those who articulated these differing views allowed (either publicly or in private correspondence) for medical intervention that was intended to end life.

IV. Pain Relief and ‘Social’ Death in the 1950s

In 1947, the subject of euthanasia came to the attention of the British newspapers after a London-based general practitioner, Edwin Barton, publicly admitted that he had deliberately ended the life of a patient in his care after being expressly asked by the patient to do so.⁵³ Barton made his admission at a meeting of the VELS and in a later interview with a newspaper stated, “we all know things are done, but they are not done legally. It is wilful shortening of life and it is we, the general practitioners, who are willing to accept the heaviest responsibility, risking our status as doctors and our necks if it came to the courts ... Voluntary euthanasia should be legalised.”⁵⁴ Neither the police, nor the General Medical Council took any action against Barton. The GMC argued that because no official complaint had been made against the doctor, the case was “outside our province”. An unnamed member of the British Medical Association was quoted as stating that “a doctor is legally entitled to say, I am not going to prolong the life of a sufferer.”⁵⁵ Again, the issue seemed to be one of definitions: were Dr Barton’s actions to be construed as the illegal “wilful shortening of life”, or were they the acceptable result of a doctor who did not wish to “prolong the life” of a patient who was in pain?

Despite the defeat of the 1936 Bill, the Barton case, and a similar case involving an American doctor that received a great deal of publicity in both the United States and Britain, contributed to the issue of legalised euthanasia remaining an active subject of debate.⁵⁶ A further attempt was made in the House of Lords to legalise euthanasia 1950, but again without success. Significantly, all four medical peer – Lord Horder (who spoke in the 1936 debate), Lord Webb-Johnson, Lord Haden-Guest and Lord Amulree (a key figure in geriatric medicine) – spoke against the Bill.⁵⁷ In his opening speech in support of legalised euthanasia, Lord Chorley immediately drew attention to the question of pain relief. One of the “outstanding triumphs” of the medical profession in the last century, had been the ability to alleviate “an enormous amount of misery”. Nevertheless, doctors could not take this “beyond a certain point” and on occasion, particularly in cases of protracted illness, patients developed high levels of tolerance to morphine. They were unable to lose consciousness and a “terrible state of affairs” resulted.⁵⁸ Lord Chorley then suggested that Lord Dawson of Penn (who was no longer alive in 1950), although voting against the 1936 Bill, had in effect made “an eloquent plea for voluntary euthanasia” when he suggested that it was entirely acceptable to hasten death by using pain-relieving drugs.⁵⁹ Lord Haden-Guest immediately

challenged this view, stating that he had a copy of Lord Dawson's speech in front of him and that it did not advocate the doctor giving a lethal dose of any drug to a patient.⁶⁰

In his speech, again in opposition to legalisation of euthanasia, Lord Horder sought to clarify his earlier statement of 1936 in which he had used the rhetorical question of the patient asking "you will stand by me won't you?". This did not mean "abolish my pain", argued Lord Horder, rather it meant, "Help me get rid of this pain, and if it cannot be got rid of entirely then help me to bear with fortitude what I am able to bear."⁶¹ From just a few brief extracts from the House of Lords debate of 1950, it is apparent that the practice of pain relief occupied a central position in relation to euthanasia. This was evident in Lord Chorley's assessment that when Lord Dawson spoke of hastening death in 1936, he was in effect advocating euthanasia. In addition, there was Lord Horder's interesting insistence that he was not advocating killing when he spoke of "standing by" the patient in pain. The way in which the practice of pain relief was understood and publicly represented was of crucial importance when either supporting or opposing euthanasia

Outside the confines of formal parliamentary discussion, the role of pain relief continued to occupy a central position in euthanasia debates in the 1950s. A view that linked the perceived inadequacies of pain relief and the notion of 'social death' was voiced by The Very Reverend W. R. Matthews, the Dean of St Paul's Cathedral, London. Rather than emphasising an argument based on sanctity of life, the Dean stressed the "sacredness of human personality".⁶² Elaborating on this point, he argued:

When a Christian first hears the proposal to legalise voluntary euthanasia he naturally thinks that it is a dangerous one, because it may weaken or even contradict the principle of the sacredness of human personality ... but it seems plain to me that the principle of sacredness of human personality cannot be stretched to cover the case of those whom the proposed legislation has in mind.⁶³

The "disintegration of personality" of the patient in terrible pain, so that he or she was unrecognisable to family and friends, meant that the Dean endorsed legalised euthanasia. This "gradual degeneration of a firm and fine character" into an "existence" that the Dean described as a "continuous drugged dream" had led him to reconsider his position in relation to euthanasia, initially opposing its legalisation, but now arguing in support. Sacredness of human life, but also, importantly, sacredness of human personality, was a "fundamental tenet of Christian faith", he argued.⁶⁴ The Dean wanted to "make it quite clear" that he held no sympathy for the notion that human lives could be disposed of "at the convenience or

pleasure of the State, or some other human institution such as the family”. Nevertheless, in considering the case of the incurably ill patient who was “destined to have a period of agonising suffering relieved only by the administration of narcotic drugs”, then the “doctrine of the sacredness of human personality”, he argued, no longer applied.⁶⁵

In contrast, in the case of Letitia Fairfield, a doctor, barrister and convert to Catholicism, the practice of pain relief was used to bolster opposition to legalised euthanasia.⁶⁶ A great principle in Christianity was that the sanctity of human life and human suffering could not, “in a Christian civilization be met by the destruction of the sufferer”, she argued.⁶⁷ Regarding life in such a manner, she maintained, meant that there was an incentive to pursue research into pain relief and the treatment of chronic illness. Each year brought new methods of relieving pain and, in Fairfield’s view, this was merely “at the beginning of what mankind can do”.⁶⁸ The proposed legalisation of euthanasia was nothing more than “confused thinking swayed by emotion” and whilst Catholics should never give the impression that religion left them “callous or smug about other people’s troubles”, they were on “firm ground ... in refusing to regard murder as the proper solution”.⁶⁹ Although opposing on principle the suggestion that the lives of chronically ill patients be ended at their request, Dr Fairfield also called into question the practical repercussions of legalising voluntary euthanasia. Once a law was passed and the “commandments flouted”, legalised euthanasia would open the way for all kinds of abuse – including the prospect of non-consensual killing of those deemed to be “troublesome”.⁷⁰

At the annual general meeting of the VELS in 1955, members voted to change the name of the organisation to the Euthanasia Society.⁷¹ This, it was argued, was for practical reasons as opposed to any change in the fundamental philosophy of the movement. With a simpler and less cumbersome title, the society would be more readily identifiable and easier to locate in telephone directories. To make clear that the campaign was only for *requested* death, a sub-title was added that defined the movement as “A society for obtaining the legalisation of voluntary euthanasia”.⁷² However, despite this explicit reference to the voluntary nature of the society’s proposals, there remained a suspicion that legalised euthanasia would lead to a broader interpretation of the specified terms so that the elderly and mentally ill were put at risk. Given this fear, dropping the word ‘voluntary’ from the society’s title was, as Kemp suggests, “perhaps not the most politic gesture”.⁷³

The view, that legalised euthanasia would leave the vulnerable in society exposed, was a concern that was commonly expressed by opponents of such legislation. Indeed, in the House of Lords debate of 1950, the Archbishop of York had argued against legalised voluntary euthanasia by suggesting a connection between the proposed legislation and the dangers of the Nazi euthanasia programme, stating that Germany had already “placed its feet on a very slippery slope”.⁷⁴ When asked in 1957 how she envisaged her own death, Letitia Fairfield responded by stating that she hoped that the doctors and nurses at her bedside “kept their respect for human life” and did not consider it their right to end her life because she was “old and feeble”. She continued: “I want to feel that my going is as peaceful and as free from pain as possible, not unduly delayed if the body has done its work, but certainly not unnaturally hurried.”⁷⁵

Returning to the question of the use of anaesthetic drugs in the medical-management of the dying, the examples provided by Dean Matthews and Letitia Fairfield reveal how pain relief was tied to a notion of ‘social’ death in the 1950s. By drawing on a range of different arguments, euthanasia was either supported or opposed. In the first instance, legalised euthanasia was supported with an argument that stressed how poor relief of pain led to loss or “disintegration of self”. In the second, euthanasia was opposed with an argument that rejected any qualitative assessment of human life but stressed the growing effectiveness of medical intervention that relieved pain. In the first instance, the principle of sanctity of human life was re-formulated and presented as “sanctity of human personality” so as to exclude from this latter term those who, in a “drugged dream”, were perceived as artificially “existing”, rather than living. In the second instance, the use of pain relief was construed as a potential means of securing a peaceful, painless and ‘natural’ death. This positive view of the pain-relieving power of medicine was then contrasted with euthanasia, perceived in this instance as a form of legalised “murder” that left the vulnerable subject to qualitative assessments of the value of their lives. Once again, by modifying and defining the terms of debate in order to accommodate particular and differing views, euthanasia was supported as either an extension or violation of divine will, as either ‘natural’ or ‘artificial’

The significance of consciousness and mental alertness alluded to in Dean Matthews’ reference to the dying patient’s “drugged dream” of an existence, plays an interesting role in euthanasia debates during the first half of the twentieth century. For supporters of euthanasia, at least until the mid-1950s, the argument that the administration of pain relieving drugs was not always adequate was supplemented by the condemnation of a certain strand of religious

thinking, particularly Roman Catholic, regarding the use of pain relief. In 1936 Killick Millard described “the Catholic dogma” connected to what he perceived as “the excessive importance which many have attached to a man’s state of mind on his death bed, and which has found expression in the sacrament of ‘extreme unction’”.⁷⁶ This ceremony (mirroring the ritual of baptism but marking the end, rather than beginning of a Catholic’s religious life) involved the priest reciting a special prayer, absolving the patient of his or her sins, and anointing the body of the dying person with oil that had been blessed. Significantly, the ritual required that the person had “full use of his senses” in order to reap the “spiritual benefit and the comfort of mind” afforded by the ceremony.⁷⁷

There were variations within Roman Catholicism on the administration of pain relief at the end of life. The 1909 *Catholic Encyclopedia*, avowedly dedicated “to the sanctity of life from conception to natural death”, stated that “pain relief ... in so far as it may be artificially brought about by the employment of anaesthetics, deprives the sufferer of reason at a time when competency is most necessary”.⁷⁸ However, the Latin text of *Summa Theologiae Moralis*, first published in 1904, suggested a slightly more lenient line and stated that drugs could be given so long as “the use of reason is not permanently removed or at any rate is soon restored.”⁷⁹ The use of pain relieving drugs divided Catholic opinion, with some writers maintaining that the preservation of consciousness should be given greater consideration than the need to alleviate suffering on the part of the dying patient. It was this view that Killick Millard and the Euthanasia Society opposed, arguing that at times pain relief was not only inadequate but also that its administration was, in certain circumstances, constrained by religious “dogma”.

Interestingly, both the Euthanasia Society and Roman Catholics who strictly held to this notion of consciousness, though arguing on opposite sides of the euthanasia debate, placed an emphasis on the dying patient’s capacity for mental awareness. Though the Euthanasia Society opposed any restraint being shown in administering pain relief, Dean Matthews’ reference to the “drugged dream” of existence, if compared with the Catholic insistence on preserving mental clarity, hints at some shared idea that consciousness constituted a key element of a patient’s ability to function fully. Significantly, one Catholic writer went so far as to suggest that as long as drugs did not deprive the patient of consciousness, then the “artificial hastening of death” (and here I quote the author rather than imposing my own analytical category of ‘artificial’ death) might even be permitted.⁸⁰

However, this view that death might be ‘artificially’ hastened was not representative of predominant Catholic thinking in the first half of the twentieth century. If consciousness on the part of the dying patient was judged to be of vital importance, then so too was the notion that death could not be hastened but rather should occur at a ‘natural’ divinely appointed time. Killick Millard was clearly criticising what he saw as an overly zealous attachment to the concept of a dying patient’s consciousness when he condemned “the excessive importance placed on a man’s state of mind on his death bed”. Yet by 1936, the same year in which Dr Millard made his criticisms, there is textual evidence to suggest that Catholic thinking in relation to pain relief and mental clarity was adapting to the demands of changing medical practice and techniques.

In a reference book for priests, Henry Davis, a professor of moral and pastoral theology at Heythrop Jesuit College, London, gave the following definition:

The term [euthanasia] is a euphemism for the deliberate taking away of the consciousness of another, so that it will not return before death. The patient passes away in painless sleep. We are assuming that drugs do not shorten life. If they do then euthanasia is murder and indefensible. It is clearly defensible on moral grounds, to administer drugs to relieve suffering or to produce necessary sleep.⁸¹

This endorsement of inducing “necessary sleep” by medical means was qualified by an insistence that the patient should not be rendered unconscious unless he or she was “spiritually prepared for death”, having had “all possible ministrations of the Church”.⁸² Also, the writer maintained that it was possible “with great care and attention” for pain to be relieved without destroying consciousness, and concluded by adding that it was “a serious sin against charity to be the direct and voluntary cause of another dying unprepared”.⁸³ This illustrates how the administration of pain relief was gradually being absorbed into a particular religious conception of a ‘good’ death. The emphasis on mental clarity was maintained, as was the notion of spiritual preparedness on the part of the patient – but there was also a concession to loss of consciousness in extreme circumstances. Davis added: “...it appears to be morally right to employ drugs to relieve pain and incidentally take away consciousness.”⁸⁴ It also is interesting to note how this view of pain relief – benign if given to produce “necessary sleep”, malign if administered to “shorten life” – resonates with the late nineteenth-century discussion of morphine use by the Catholic physician William Munk.

If, in the mid-twentieth century, the Catholic position on the dying patient’s mental state was adjusting in order to accommodate the practice of pain relief, then this adjustment

in no way stretched to any re-consideration of legalised euthanasia as proposed by the Euthanasia Society. Despite examples of Catholics, such as Henry Davis, using the word euthanasia as a “euphemism” for relieving pain and inducing sleep, the use of pain relief, as newly re-articulated by the Catholic Church, was increasingly becoming disconnected from any association with the term euthanasia. As one Catholic writer wrote: “it is not euthanasia to give a dying person sedatives merely for the alleviation of pain, even to the extent of depriving the patient of the use of sense and reason.”⁸⁵

In 1937, the author of *The Catholic Doctor*, Fr. A. Bonnar, was scathing in his reproach to those members of the Anglican clergy who supported legalised euthanasia, arguing that:

It is not surprising that the Euthanatists have been able to get from the Anglican clergy a more or less imposing list of supporters for their cause. It seems, and I say it in sorrow rather than in contempt, that any crank or lunatic, if he be of sufficient social standing, can get ample support from that disintegration of Christianity.⁸⁶

While Dean Matthews used the term “disintegration” with particular reference to the personality of a dying patient as a basis for supporting euthanasia, Catholic theologians like Bonnar used the same word, “disintegration”, when articulating what they saw as an attack on principled Christian values. In particular, *The Catholic Doctor* criticised the Rev. Dr W. G. Inge, the then Dean of St Paul’s and a predecessor of Dean Matthews, for his support of legalised euthanasia. Inge had reportedly stated that he hoped, even if his death was painful, that he “should have the courage to wait until the end”. This position was judged hypocritical by Bonnar: “He approves of suicide, or its more recent suicide-cum-murder form which is called Euthanasia, provided it is not for him or those connected with him.”⁸⁷

Nevertheless, despite this robust rejection of legalised euthanasia, the impact of pain-relieving drugs on the medical management of dying patients was such that, in 1957, a papal declaration spelling out the Catholic position regarding the administration of pain relief was issued. This declaration stated that even if the doctor anticipated that the use of narcotics would shorten life, pain-relieving drugs could legitimately be used. In such cases, death was not to be intended or sought by the doctor; the intention was solely to be that of relieving pain.⁸⁸ With this official announcement, the debate over consciousness at the time of death was effectively ended, endorsing the use of pain relief with the proviso that the ‘intentions’ of doctors met specified criteria. Thus, what has become known, and not without controversy, as the principle of ‘double-effect’ was written into Catholic doctrine. This

'principle' maintained that if a doctor administered drugs with the intention of relieving pain, providing the patient's death was a secondary and unintentional effect of the administration of pain relief, then medical intervention of this type did not constitute killing, or for that matter euthanasia. Medical intervention of this sort was described as merely good medical practice.

It was on this basis that doctors such as Letitia Fairfield endorsed the use of pain-relieving drugs and yet rejected the suggestion that they entertained any notion of intentional killing. In the script for a television programme on euthanasia in which she participated in 1957, Fairfield supported the principle of double-effect by referring to the recent papal pronouncement on pain relief.⁸⁹ Answering an argument made by moral philosopher and honorary vice president of the Euthanasia Society, Professor Glanville Williams, who had stated that the notion double-effect did not withstand scrutiny, Fairfield defended the principle by maintaining that 'intention' held the key in determining acceptable medical practice. The doctor's duty was to diminish pain, she argued, and "intention tells us how to draw the line between shortening life and accelerating death".⁹⁰ In a hand-written note in her script, Letitia Fairfield added, "People do not really want Jehovah doctors with powers over life and death."⁹¹

When challenged by Glanville Williams as to whether doctors were "frank about their normal practices" and did "in fact administer euthanasia fairly often, and cover up by pretending that real intention was simply pain relief", Fairfield insisted that pain relief was "not a cover but a legitimate motive".⁹² Some Catholics were too strict on the issue of pain relief when there was now a papal declaration stating that "there is no particular grace in suffering", she argued.⁹³ Just as she maintained that she did not want her own death "unnaturally hurried", she also argued that by administering drugs with the sole aim of relieving pain, doctors left the patient with "a natural chance to recover".⁹⁴ Dr Stewart Noy Scott, a general practitioner, also taking part in the debate, stated that "deliberately cutting short life has a criminal purpose, it is murder. We have sworn not to do it."⁹⁵ A producer's note in the script added: "If Noy Scott is willing, he should tell how he eased the death of his own son. He kept him under [sedation] and gave him drugs at such intervals that the son did not regain consciousness. The point is that his son died in comfort and peace."⁹⁶

This discussion reveals how, to a large extent, support or opposition for euthanasia depended on the way in which the practice of pain relief was understood and, indeed,

articulated. What is interesting is the way in which, although this support or opposition remained firm, the content of the arguments and the manner in which they were structured changed, depending on the particular context in which the arguments were being made. For example, in the early part of the twentieth century there was a particular preoccupation with mental clarity at the time of death, certainly within Roman Catholic quarters, but by the late 1950s this was becoming less of a concern. Instead, by 1957 a position that endorsed the liberal use of pain relief had emerged, even if this implied hastening death. This form of opposition to the legalisation of euthanasia – opposition that rested on a particular defence of pain relief – was gaining ground across a range of different constituencies: medical, legal and religious.

In the same year as the papal declaration of 1957, the principle of double-effect was effectively written into English law when Dr John Bodkin Adams was cleared of murder after being accused of administering overly high doses of morphine when treating elderly patients. The summation of the trial that the presiding judge Lord Patrick Devlin made to the jury, encapsulated the concept of ‘double-effect’:

He [the doctor] is entitled to do all that is proper and necessary to relieve pain and suffering, even if the measures that he takes may incidentally shorten life. This is not because there is a special defence for medical men but because no act is murder which does not cause death. ...The cause of death is illness or injury, and the proper medical treatment that is administered and that has an incidental effect on determining the exact moment of death is not the cause of death in any sensible use of the term. But ... no doctor, nor any man, no more in the case of the dying than of the healthy, has the right to cut the thread of life.⁹⁷

In a manner that mirrored the acceptance of pain relieving-practices in the nineteenth century, this twentieth century justification of pain relief accommodated the use of anaesthesia whilst upholding a concept of ‘natural’ death. The difference in the twentieth century, was the explicit acknowledgement that medical intervention of this kind potentially hastened death and that, as a consequence, the timing of death was no longer, in every case, solely the province of God or nature. Although a subject of discussion in the late nineteenth-century, the ‘intentions’ that lay behind the administration of pain relief were now given even greater emphasis. Stressing that it was only the desire to relieve pain that motivated “proper medical treatment”, opponents of legalised euthanasia understood pain relief in a manner that was very different from that of those who supported legalisation. Advocates of legalised euthanasia such as Glanville Williams argued not only that the concept of double-effect was questionable, but also that an ‘artificial’ existence under the influence of drugs

should not be inflicted on those who wished to end their lives. For euthanasia's opponents, pain relief was a means of securing a 'natural', peaceful end to life, an image that portrayed the doctor not disrupting but rather assisting the 'natural' course of a patient's death.

In this chapter I have traced a number of different strands of the euthanasia debates in the first half of the twentieth century. From the first attempt to legalise euthanasia in 1936, to the subsequent rather generalised and abstract debates that sought to define euthanasia, it is clear that euthanasia was a subject of increasing debate as opposing parties sought to lay claim to a definition of euthanasia on their own terms. By the early decades of the twentieth century, official medical voices, such as those of Lords Dawson and Horder, were conceding that the administration of pain relieving drugs carried a risk of hastening death. Other medical voices, such as that of Harry Roberts, went further. 'Real' euthanasia, he argued, involved 'ending life' rather than 'hastening death', but again without the need for legislative change. Then there were those such as John Ryle who advocated the administration of 'painless death' for patients in extreme pain; a position that distinguished 'slow' euthanasia – the everyday practice of hastening death by giving pain relief – and 'quick' euthanasia – the administration of a fatal dose of pain relief.

The term 'euthanasia' was used in different ways and in different contexts, but despite contributions to the debate of the kind offered by John Ryle, the idea that euthanasia should imply the legal recognition of the physician deliberately bringing about death was largely resisted. By the late 1950s, a more unified position within the medical profession was once again emerging – one that endorsed the use of pain relief, even if this potentially hastened death, but rejected the legalisation of euthanasia. In both medical and religious discourse, those opposed to legalised euthanasia began to distance themselves from the any association with the term 'euthanasia'. Resolving the arguments in relation to pain relief and euthanasia would not prove easy. Yet, as the final chapter of this thesis explores, the justification and consolidation of a position that endorsed the liberal use of pain relief but rejected the notion of the physician 'intentionally' ending life, prepared important ground for arguments over legalised euthanasia in the remaining decades of the twentieth century. The debate over pain relief and euthanasia was now to be played out in a new setting – in the emergent context of the hospice movement.

Notes

¹ House of Lords, 'Voluntary Euthanasia (Legalisation) Bill', *Hansard*, 1 December 1936, cols.465-506, at 473. See also Tim Helme, 'The Voluntary Euthanasia (Legalisation) Bill (1936) revisited', *Journal of Medical Ethics*, 17 (1991), 25-29.

² 'Voluntary Euthanasia (Legalisation) Bill', col.469.

³ 'Voluntary Euthanasia (Legalisation) Bill', col.468. For a detailed discussion of cultural attitudes to suicide in the nineteenth and first half of the twentieth century, see Olive Anderson, *Suicide in Victorian and Edwardian England* (Cambridge, Cambridge University Press, 1995).

⁴ In his opening address to the House of Lords, Lord Ponsonby linked acts of suicide to the concept of voluntary euthanasia. One example that he gave was that of Captain Oates, who walked out into an Antarctic blizzard to save the lives of others on the expedition. House of Lords, 'Voluntary Euthanasia (Legalisation) Bill', col.469.

⁵ 'Voluntary Euthanasia (Legalisation) Bill', col.475.

⁶ *Ibid.*, col.470.

⁷ *Ibid.* col.469.

⁸ Speaking in favour of the Bill were Lord Ponsonby, Lord Denman and the Earl of Listowel, the latter being a vice president of the Voluntary Euthanasia Legalisation Society. In opposition to the Bill were the Marquis of Crewe, Lord Dawson of Penn and Lord Horder (the two medical peers), the Archbishop of Canterbury, the Bishop of Norwich and Viscount Fitzalan of Derwent.

⁹ Lord Moyhihan, a well-known and respected surgeon, Past-President of the Royal College of Surgeons and former President of the Voluntary Euthanasia Legalisation Society (VELS), had made this appeal at the inaugural meeting of the VELS prior to his death on 4 September 1936. Numerous references to Lord Moyhihan expressing regret at his death are made throughout this debate. *The Times* described Moyhihan as "the most successful and respected surgeon of modern times", 8 September 1936. Clearly, the loss of Moyhihan's support for the bill was a blow, given his credibility as a respected medical figure.

¹⁰ 'Voluntary Euthanasia (Legalisation) Bill', col.479. Viscount Fitzalan described himself as a "layman in this House" but although not holding office in the Church, he clearly did hold robust religious views.

¹¹ 'Voluntary Euthanasia (Legalisation) Bill', col.479.

¹² *Ibid.*

¹³ 'Voluntary Euthanasia (Legalisation) Bill', col.486.

¹⁴ For an analysis of the way in which language is used to represent the taking of one's own life with either positive or negative connotations see Margaret Battin, 'Assisted Suicide: Can We Learn from Germany?' *Hastings Centre Report*, 22:2 (1992), 44-51. In this article Battin considers the German term *Selbstmord* which is associated with suicide as a result of despair, anger or depression, and *Freitod* which invokes the idea of suicide as an expression of voluntary, idealistically motivated choice without religious or altruistic overtones. In English, the only terms that carry positive associations when describing the taking of one's own life are ones that have religious associations or the implication that the suicide serves the interest of some other person. These are terms such as *self-sacrifice* and *martyrdom*.

¹⁵ 'Voluntary Euthanasia (Legalisation) Bill', col.486.

¹⁶ *Ibid.*, col.488.

¹⁷ Earlier in 1936, Lord Dawson had allegedly 'performed' euthanasia on King George V, who at the time was dying of painful cancer. See F. Watson, 'The Death of King George', *History Today*, 12 (1986), 21-30. Lord Horder, at the time of the 1936 debate, was Physician in Ordinary to the King.

¹⁸ 'Voluntary Euthanasia (Legalisation) Bill', col.483. Interestingly, Lord Dawson referred in the debate to the example of abortion, which he maintained had also "evolved without intervention or change of Statute". Referring to the Offences against the Persons Act of 1861, the fundamental law in England and Wales which prohibited the procuring of miscarriages or supplying the means to so, Lord Dawson described the law as containing "no provision directly concerning medical abortion". Nevertheless, he argued that initially there had been an understanding that the procuring of abortion was only justifiable if the woman's life were in danger. Since then opinion had slowly changed, so that abortion was

"considered proper by most of the medical profession, if it be required in order to avoid injury to the health whether of mind or body, and whether actual or prospective." Lord Dawson did not mention that there had indeed been a change in the law subsequent to the 1861 Act, the Infant Life (Preservation) Act of 1929, which only then allowed legal concession for medical abortion for the purpose of saving the life of the mother. See J.K Mason and R.A McCall Smith, *Law and Medical Ethics* (London, Butterworths, 1999), pp.114-5.

¹⁹ 'Voluntary Euthanasia (Legalisation) Bill', col.483.

²⁰ As I argued earlier, the medical profession initially defended the use of the word 'euthanasia' in its classical form, meaning simply a calm and peaceful death. There was considerable resistance to the idea that 'euthanasia' should imply the hastening of death in any way.

²¹ 'Voluntary Euthanasia (Legalisation) Bill', col.485.

²² *Ibid.*, col.491.

²³ *Ibid.*, col.494.

²⁴ Christopher Lawrence, 'A Tale of Two Sciences: Bedside and Bench in Twentieth-Century Britain', *Medical History*, vol.43 (1999), 421-49, at p.433.

²⁵ *Ibid.*

²⁶ In his letter, Millard stated that deaths from cancer now numbered 600,000 a year in England and Wales and one in seven deaths over the age of 40. See C. Killick Millard, 'Euthanasia', *BMJ*, 21 December 1940, p.881.

²⁷ *Ibid.* Millard noted that subsequent to the 1936 Bill, the Voluntary Euthanasia Legalisation Society had compiled a list of more than 850 "distinguished supporters and sympathisers ... who have achieved distinction in their respective fields".

²⁸ Dr C.O. Hawthorne, 'Euthanasia', *BMJ*, 4 January 1941, p.32. For the objections to legalised euthanasia raised by Hawthorne at the inaugural meeting of the VELS, see also the *Lancet*, 'Voluntary Euthanasia', 14 December 1935, pp.1385-7

²⁹ See Killick Millard, *The Movement in Favour of Voluntary Euthanasia – An Historical Study*, p.3.

³⁰ Dr Harry Roberts, 'Euthanasia and Voluntary Death', in Harry Roberts (ed), *Euthanasia and Other Aspects of Life and Death* (London, Constable and Company Ltd, 1936), 3-16. As well as the essay on 'Euthanasia and Voluntary Death' the Voluntary Euthanasia (Legalisation) Bill of 1936 was published in full, along with essays on 'The Ethics of Suicide', 'Love and Sex', 'Crime and Punishment' and 'Education and the Child'. Excerpts from the book appeared in the *New Statesman*, *The Weekend Review*, *The Nation*, and the *Times Literary Supplement*. Roberts described the essays as an expression of opinion "based far more on personal experience, personal observation of ordinary people and ordinary world circumstances than on abstract theories or ethical conventions – orthodox or heterodox". For an earlier version of his essay on euthanasia, see Harry Roberts, 'May Doctors Kill?', *Living Age*, 347 (1934), 159-162.

³¹ Extract from the memoirs of Berlioz, cited by Harry Roberts in 'Euthanasia and Voluntary Death', at p.3. See *The Memoirs of Hector Berlioz*, edited and translated by David Cairns (London, Victor Gollancz, 1969).

³² Roberts, 'Euthanasia and Voluntary Death', p.4.

³³ 'Euthanasia and Voluntary Death', p.7. Roberts refers to the Inaugural Meeting of the Voluntary Euthanasia Society, 10 December 1935, BMA House, Tavistock-Square, London.

³⁴ For C.J. Bond's speech at the first meeting of the VELS see the *Lancet*, 'Voluntary Euthanasia', 14 December 1935, pp.1385-7. Also cited in Roberts, 'Euthanasia and Voluntary Death', p.7.

³⁵ Roberts, 'Euthanasia and Voluntary Death', p.15.

³⁶ *Ibid.*

³⁷ *Ibid.*, p.16.

³⁸ Harry Roberts co-authored a book with Lord Horder in which they argued for a religious view of the world, infused with humanity and compassion. See Thomas Horder and Harry Roberts, *The Philosophy of Jesus* (London, Dent, 1944).

³⁹ Dr Frederick Parkes Weber, M.D. F.R.C.P, 1883-1962. Obituaries for Parkes Weber can be found in the *BMJ*, 9 June 1962, pp.1630-1 and the *Lancet* 11 June 1962, pp.1308-9. For his letter supporting legalised euthanasia, see Frederick Parkes Weber, 'Euthanasia', *BMJ*, 30 November 1940, p.766. The papers and personal correspondence of Frederick Parkes

Weber are held at the Contemporary Medical Archives Centre (CMAC) of the Wellcome Institute for the History of Medicine, London. All references to his published writing and private correspondence are taken from archives held at CMAC, file number PP/FPW.

⁴⁰ Parkes Weber, *BMJ*, 30 November 1940, p.766. Parkes Weber's *Aspects of Death and Correlated Aspects of Life in Art, Epigram and Poetry* was first published in 1910, with subsequent editions published in 1914, 1918 and 1922. In this book he contested the idea that the experience of death was as agonising as it seemed to onlookers. In a letter to the editor of the *Lancet* in September 1926, Parkes Weber stated that "My *Aspects of Death* is as little a systematic study of actual death as Robert Burton's *Anatomy of Melancholy* is a study of real melancholic insanity". Rather, the book was about "mental reactions towards the idea of death". Parkes Weber pointed out that other physicians had also concerned themselves with attitudes to dying and drew attention to "a little book by Dr William Munk".

⁴¹ Parkes Weber, 'Euthanasia', *BMJ*, 30 November 1940, p.766. A similar letter by Parkes Weber can be found in the *Medical and Press Circular*, 29 December 1943, p.418.

⁴² *Ibid.*

⁴³ Julian Huxley, *News Chronicle*, 14 February 1941, p.4.

⁴⁴ *Ibid.* At a later date, Huxley expressed similar views in a collection of essays, arguing that "Man makes his concepts, he constructs them out of raw materials, of his experience, immediate and accumulated, with the aid of psychological reason and imagination. This is true not only of religious concepts, but also of scientific concepts." See Julian Huxley (ed), *The Humanist Frame* (London, George, Allen and Unwin Ltd, 1961), p.43.

⁴⁵ Julian Huxley is listed as a vice president of the VELS in the pamphlet produced by the organisation in 1940. See *Merciful Release – The Case for Voluntary Euthanasia*, (Leicester, CH Gee and Co Ltd, 1940).

⁴⁶ In this lecture Huxley stated: "in civilized communities of our present type the elimination of defect by natural selection is largely rendered inoperative by medicine, charity and the social services ... Humanity will gradually destroy itself from within, will decay in its core and essence, if this slow but relentless progress is not checked." See Julian Huxley, 'Galton Lecture: delivered before the Eugenics Society on 17 February 1936', *The Eugenics Review*, 28:1 (1936), 11-31, at p.30.

⁴⁷ John Ryle, M.D., F.R.C.P., 'Of Death and Dying', *Lancet*, 28 September 1940, pp.401-402. Whilst Parkes Weber commended Ryle's article as "a beautiful essay": *Lancet*, 2 November 1940, p.569, Sir Francis Freemantle dismissed the article and its criticism of religion as "dismal paganism", *Lancet*, 26 October 1940, p.533.

⁴⁸ As already discussed, the view that 'nature' prepared the dying person for a painless death was also held by nineteenth-century physicians such as Dr William Munk.

⁴⁹ *Lancet*, 28 September 1940, at p.401.

⁵⁰ Letter from John Ryle to Frederick Parkes Weber, 11 November 1940, Frederick Parkes Weber Papers, file PP/FPW/D/4/1, folder C.2, box 168, CMAC.

⁵² R.W. Cockshut, *BMJ*, 11 January 1941, p.65.

⁵² Hugh Barber, *Ibid.*

⁵³ Paper and records pertaining to the history of the Voluntary Euthanasia Society (from its foundation until the late 1970s) are held at CMAC. The archives include large scrapbooks with cuttings of press-coverage of euthanasia debates from the 1930s onwards. For the Edwin Barton case, see file SA/VES/B7.

⁵⁴ *Daily Mail*, 'Legalise "Easy Death" Demand', 23 May 1947, page unclear.

⁵⁵ *Ibid.*

⁵⁶ For details of the case of the American doctor, Herman Sander, see Peter Filene, *In the Arms of Others: A Cultural History of the Right-to-Die in America* (Chicago, Ivan Dee, 1998), pp.7-8.

⁵⁷ House of Lords, 'Voluntary Euthanasia', *Hansard*, 28 November 1950, cols.552-598.

⁵⁸ *Ibid.*, col.555.

⁵⁹ *Ibid.*, col.558.

⁶⁰ *Ibid.*

⁶¹ *Ibid.*, col.568.

⁶² The Very Reverend W. R. Matthews, Dean of St Paul's, *Address at the Annual Meeting of the VELS, 2 May 1950* (London, CH Gee and Co Ltd, 1950).

⁶³ *Ibid.*, p.3.

⁶⁴ Ibid.

⁶⁵ Ibid.

⁶⁶ (Josephine) Letitia Denny Fairfield, M.D, C.B.E, D.P.H, Barrister at Law, 1885-1978. During her career, Letitia Fairfield served as President Elect of the Medical Legal Society and was senior medical officer for London County Council for 37 years. An obituary for Letitia Fairfield can be found in the *Newsletter of the Medical Women's Federation*, no.10, April 1978. A selection of her papers is held at CMAC, which includes (alongside her consideration of euthanasia) writing on other medical-ethical subjects such as sterilisation, abortion, eugenics, marriage guidance and artificial donor insemination.

⁶⁷ Letitia Fairfield, 'What Mercy Killing Means', *The Sword*, 3 (1950), 167-8 at p.167. Letitia Fairfield papers, file GC/193, folder E.3, box 5, CMAC.

⁶⁸ Ibid.

⁶⁹ Ibid.

⁷⁰ Fairfield argued that legalised euthanasia would result in a rise of non-consensual killing by those professing to "act in the name of humanity" but who in reality were seeking to rid themselves of "a troublesome obligation". Interestingly, however, in an earlier section of her article Fairfield described how she witnessed an infant born with club-feet being deliberately allowed to die by a midwife who declared that "no one would want a thing like that". Fairfield condemned this, arguing that the infant's condition "would have been no barrier to a happy and useful life", but her anecdotal evidence is an example of a qualitative assessment of life being made regardless of the official legal position relating to euthanasia. Significantly, Fairfield described the infant as being "allowed to perish", which suggests lack of, as opposed to active, intervention on the part of the midwife.

⁷¹ The VELS changed its title to become the Euthanasia Society in 1955 then, in 1969, it changed its name again to become the Voluntary Euthanasia Society. See Jonathan Gould, *Your Death Warrant: The Implications of Euthanasia; a Medical, Legal and Ethical Study* (London, G. Chapman, 1971), p.24.

⁷² Annual Report of the Euthanasia Society, 1955, p.4. File SA/VES/A.11, CMAC.

⁷³ Nicholas Kemp, 'Merciful Release', *The History of the British Euthanasia Movement* (Manchester, Manchester University Press, 2002), p.154.

⁷⁴ House of Lords, 'Voluntary Euthanasia', col.564. Newspaper articles linking the Nazi euthanasia programme to the proposal for legalised euthanasia can be found in the VELS newspaper-cuttings archive, file SA/VES/B7, CMAC.

⁷⁵ Excerpt from Letitia Fairfield's script for the Granada Television Programme, *Thou Shalt Not Kill*, June 1957, Granada Television Studios, Manchester. The programme was broadcast on 25 June 1957 but rehearsals took place over three days prior to filming. The programme incorporated dramatic representations of hypothetical 'real-life' scenarios; featuring a doctor and a dying patient, the patient with family members, and finally the doctor being questioned by detectives. Interspersed amongst these scenes, was a discussion of euthanasia by a group of panellists, of which Fairfield was a member. Other panellists included Dr Stewart Noy, a general practitioner from Devon; Professor Glanville Williams, Fellow of Jesus College, Cambridge, and Honorary Vice President of the VELS; and Kingsley Martin, Editor of the *New Statesman*.

⁷⁶ Killick Millard, *The Movement in Favour of Voluntary Euthanasia – An Historical Study*, p.5.

⁷⁷ John McHugh and Charles Callan, *Moral Theology: A Complete Course*, vol.2 (New York, Joseph F. Wagner, 1930), p.715.

⁷⁸ Joseph Delany (ed.), *The Catholic Encyclopedia* (New York, Robert Appleton Company, 1909), p.102.

⁷⁹ H. Noldin, *Summa Theologiae Moralis, De Principiis*, 12th ed. (Barcelona, Herder, 1945), p.342-3.

⁸⁰ Joseph Fletcher, an American priest and professor of theology, quotes the writing of Catholic writer Koch Preuss, who argued that drugs should not be administered if the patient was deprived of consciousness but that 'artificial hastening of death may be permitted if this condition is observed'. See Joseph Fletcher, *Morals and Medicine* (New Jersey, Princeton University Press, 1954), p.182.

⁸¹ Henry Davis, S.J., *Moral and Pastoral Theology in Four Volumes*, vol.2, *Commandments of God, Precepts of the Church*, 2nd revised edition (London, Sheed and Ward, 1936), pp.167-8.

⁸² *Ibid.*, p.168.

⁸³ *Ibid.*

⁸⁴ *Ibid.*

⁸⁵ Joseph McAllister (ed.), *Ethics with Special Application to the Medical and Nursing Professions*, 2nd edition (Philadelphia, Saunders, 1955) at p.396.

⁸⁶ Fr. A. Bonnar, *The Catholic Doctor* (London, Burns Oates and Washourne Ltd, 1937), p.105.

⁸⁷ *Ibid.*

⁸⁸ Pope Pius XII, 'The Prolongation of Life', in Dennis Horan and David Mall (eds), *Death, Dying and Euthanasia* (Washington D.C., University Publications of America, 1977), 281-93. This is a reprint of the original papal declaration on pain relief, *Acta Apostolicae Sedis* (no.49, 1957). A report of the Pope's address was published in *The Times*, 25 February 1957.

⁸⁹ Script for *Thou Shalt Not Kill*, Granada Television, 25 June 1957. See earlier footnote, no.76, for details of the programme and its participants.

⁹⁰ *Ibid.*, at p.14.

⁹¹ *Ibid.*, at p.12.

⁹² See Glanville Williams, *The Sanctity of Life and the Criminal Law*, (London, Faber and Faber Ltd, 1958).

⁹³ *Ibid.*, at p.14.

⁹⁴ *Ibid.*

⁹⁵ *Ibid.*, at p.12.

⁹⁶ *Ibid.*

⁹⁷ Lord Patrick Devlin, *Easing the Passing. The Trial of John Bodkin Adams* (London, The Bodley Head, 1985), p.171.

Chapter 6

Euthanasia and the Hospice Movement

I. Hospice Care: An Institutional Response to 'Natural' Death

From the somewhat generalised and abstract debates of the first half of the twentieth century, I turn now to consider the impact that the ideas behind the establishment of the hospice movement had on the question of euthanasia. With the emergence of hospice provision for care of the dying, a subtle shift in the construction of arguments, both for and against euthanasia, can be detected. Up until now, this thesis has largely examined the ideological and practical problems faced by individual, often elite, medical practitioners when treating dying patients. Demarcating the acceptable range of responsibilities and powers when caring for the dying was a process that predominantly involved doctors sharing anecdotal accounts of encounters between individual clinicians and their patients, albeit filtered through wider sets of particular changing cultural, religious and medical concerns. With the entry of hospices as a new point of reference in euthanasia debates, on-going arguments were now re-located to an institutional setting – a setting that provided, at least in part, both rhetorical and material solutions to the problems of caring for the dying.

The development of ideas behind the modern hospice movement can be traced to the 1950s and 1960s when concern began to mount, initially amongst a small number of medical professionals, in relation to what were perceived as the inadequacies in provision of care for the dying. Arguments against legalised ending of life, already rehearsed at the end of the nineteenth century and throughout the early part of the twentieth century, were once again mobilised, but this time in the context of specific proposals for a practical, institutional response. In effect, the establishment of the hospices and the accompanying philosophy that underpinned their development moved euthanasia debates to new ground. With improved practical provision for care of the dying, opponents of euthanasia felt their position was strengthened, while supporters of euthanasia were forced, to some degree, to re-formulate and re-examine the basis of their continued calls for legalisation.

As with the contributions of William Munk in the late nineteenth century and Letitia Fairfield during the first half of the twentieth century, an emphasis on palliative care provided an alternative position for medical professionals who argued against calls for legalising euthanasia. By the late twentieth century, however, palliative care had emerged as a highly sophisticated and multidisciplinary field.¹ Those working in the hospice and palliative care setting developed an alternative discourse characterised by the concept of managing ‘total pain’: an all-embracing phrase referring to the physical symptoms, mental distress, social problems and emotional difficulties of the dying patient. In practice this meant offering support for the patient as a ‘whole person’ with not only doctors and nurses involved in providing care, but also the involvement of a team of other professionals such as chaplains, social workers, counsellors and occupational therapists.²

By offering this comprehensive network of not only medical but also social support for patients, proponents of hospice care argued that calls for legalised euthanasia (in their view a disturbing symptom of inadequate provision of care for the dying) were now rendered redundant. Also, those who opposed euthanasia sought to bring a new sense of clarity and definition to the term itself. No longer was the word ‘euthanasia’ cast in shades of grey. Distinctions, such as those discussed earlier in this thesis, between ‘real’ or ‘quick’ or ‘slow’ or ‘barbarous’ euthanasia were abandoned. Instead proponents of the hospice movement disassociated themselves from the term euthanasia in any form. Legalised or otherwise, euthanasia was viewed strictly in terms of requested ‘killing’ – a notion perceived to be outside the bounds of hospice or indeed any type of medical care.³

To a degree, the concerns of the hospice movement resonate with the bleak view of modern medicine offered by writers such as Ariès and Illich, who depict death in hospital as an isolating and de-humanising experience. Countering such alienation, proponents of the hospices claimed to place patients and their families at the centre of their focus of care, stressing the importance of listening to the dying patients, and rejecting the notion that patients be subjected to aggressive or intrusive treatment. To this extent the hospice movement could be construed as essentially ‘anti-modern’, embracing ‘traditional’ values and “striking a responsive chord in people who lament the gradual erosion of many modes of support once provided by family and community”.⁴ Nevertheless, the emergence of the hospices as an alternative form of terminal care cannot be neatly categorised simply in terms of a response to a perceived increase in the medicalisation of death. If ‘traditional’ values lay at the heart of hospice philosophy, then these values were ‘reinvented’ so as to accommodate

innovative and advanced pain-relieving techniques and, if required, sustained levels of medical intervention.

Jane Elizabeth Seymour has argued that the “persuasiveness of the hospice ‘way’ of death lies perhaps in its promise to bring to fruition an image of late modern ‘natural’ death”.⁵ Drawing on the work of Norbert Elias, she describes this particular vision of ‘natural’ death as taking place “in bed, at home if possible and under benign medical care in which interventions to ensure painlessness are balanced with the autonomous choices of the dying individual and their close companions”.⁶ It is indeed the case that the palliative care movement grew, at least in part, in response to what was seen as the failure of modern medicine to provide adequately for the dying, a point that I will elaborate on later in this chapter. However, the palliative care approach of hospice care should not be perceived (and Seymour, I suspect, would share this view) as inherently anti-medical. While the hospice movement did stress the importance of the patient as a ‘person’, it also harnessed the full powers of pain-relieving analgesics and narcotics, pioneering combination doses of different drugs and advocating that this pain relief be liberally administered.

The hospice movement may have provided surrogate familial and community support for the dying but this did not imply that an idealised ‘lost’ death was somehow also being reclaimed. Rather, hospice care incorporated the practical application of powerful pain relieving drugs and a commitment to finding new ways of minimising (even, it was claimed, eliminating) the pain of the terminally ill, into a particular, contextually specific view of ‘natural’ death that absorbed these changing practices. In addressing the question of how best to care for the dying, the hospice philosophy offered a set of social and technical practices tailored to meet the requirements of the terminally ill in a particular medical setting. It was from this fusion of medical and social ‘technologies’ that the proponents of hospice care supported their principled opposition to legalised euthanasia with a practical agenda for alleviating the suffering of the dying.

A central figure in the development of the philosophy behind the hospice movement was Dame Cicely Saunders, who from 1958 to 1965 conducted research on the control of pain in terminal cancer at St. Joseph’s Hospice in East Hackney.⁷ She was also to provide much of the impetus for the 1967 opening of St. Christopher’s Hospice in Sydenham, London, an event described by the medical sociologists Nicky James and David Field as “the symbolic reference of the ‘start’ of the modern hospice movement”.⁸ To date, Cicely

Saunders remains resolutely opposed to the legalisation of euthanasia. In one of her early papers on care of the dying, significantly titled 'The Problem of Euthanasia', she began by posing two rhetorical questions: "Is euthanasia morally right?" and "Is there really no other way of relieving the pain of a patient in the terminal stages of cancer?"⁹ Immediately, by raising these questions, the notions of principle and of practice, the first two analytical categories that I trace throughout my thesis, are brought sharply into focus.

As I will argue, principled and practical opposition to the legalisation of euthanasia plays a central role in the philosophy of hospice care. Indeed, Saunders' own biographical context, a strong personal religious faith coupled with professional training in nursing, social work and medicine, also brings principle and practice into the frame.¹⁰ To intentionally hasten the death of a patient would be, according to Saunders in her early paper on euthanasia, "to have assumed a responsibility which is not ours". She continued: "Many things we see are hard to reconcile with our faith in a loving and omnipotent God. There is no complete and easy explanation but we can see some clues to the full answer that we will only find in eternity. These are enough to give us confidence and to show us what we have to do in practice."¹¹ Saunders argued that this principled opposition would do little to sway those who held different views, since "the protagonists of euthanasia will not be moved by these arguments for these transcendental values have no reality for them".¹² However, she went on to defend her opposition on another level, namely, on the basis that euthanasia "can and should be unnecessary" if proper pain relief is administered.¹³

"It is my experience ... that we can relieve the suffering of 90 per cent of the patients," she wrote, adding that among the remaining 10 per cent, patients were occasionally heavily sedated but narcotics were never given in doses "which would be fatal in themselves." She concluded: "Those of us who think that euthanasia is wrong have the right to say so but also the responsibility to help to bring this relief of suffering about".¹⁴ I quote at some length from this first article written by Saunders on the subject of euthanasia – indeed, she has written many more over the course of her career. Her arguments are a vivid and important illustration of the way in which the principle – that the physician should not intentionally kill – has been defended on two fronts by the hospice movement. On the one hand, opposition to euthanasia often rests with spiritual, metaphysical faith – with the belief that to intentionally cut short the life of a patient would be to stray into territory that is God's alone. On the other hand, this opposition relies on a technical, medical argument that views legalised euthanasia as unnecessary once pain is properly controlled and managed.

The view that narcotics could be liberally administered in order to relieve pain but not in such quantities or strengths as to prove “fatal in themselves”, has already been discussed in the previous chapter of this thesis. This view, one that embraced medical power but simultaneously preserved a notion of death occurring at a ‘natural’ time, was a position that, as we have seen, involved negotiation and debate. In many ways, the advent of the philosophy of hospice care marked the consolidation of this position and its manifestation in institutional form. Dr Saunders did not explicitly use the term ‘natural’ death, this is my own analytical interpretation, but her religious references to an “omnipotent God” guiding her medical philosophy and practice, strongly suggests a view that places death, at least partially, outside of human control. I explore the way in which hospice philosophy upheld its own particular view of ‘natural’ death, and again trace the three categories of argument in rejection or support of euthanasia that run through this thesis: principled arguments, practical arguments relating to pain relief, and arguments surrounding ‘social’ death.

In this chapter I have drawn on documentary analysis of Cicely Saunders’ personal papers and correspondence, both published and unpublished, alongside supplementary analysis of background material that precedes and coincides with her writing. To begin with, I focus on what medical sociologist David Clark has highlighted as the movement from anecdotal to systematically gathered evidence on care of the dying that came to light during the 1950s. I also consider the specific institutional changes that revealed the shortcomings of provision of care for the elderly and terminally ill during this period. With regard to the papers of Cicely Saunders that I have consulted, I have paid particular attention to material that illustrates the ongoing tension between the question of euthanasia and the ideology and practice of palliative care. I focus on Dr Saunders’ correspondence with Dr Leonard Colebrook, a vocal and prominent member of the Euthanasia Society, who became the society’s chairman in 1961.

I present this correspondence, dating from August 1958 to February 1963, in the form of a detailed ‘case study’, illustrative of wider support for and opposition to euthanasia during the second half of the twentieth century and I consider the wider themes that resonate within this correspondence. My interest is primarily in arguments that pre-date the opening of the first modern hospice in the late 1960s. In this sense, the focus of this final chapter is not on the practicalities of the development and expansion of hospice care, but rather on the impact that hospice ‘ideology’ had on debates over euthanasia and pain-relief in the 1950s

and 1960s. The opening of St. Christopher's Hospice in 1967 may indeed have symbolically marked "the 'start' of the modern hospice movement", but the ideas that underpinned hospice care were being formulated and articulated some considerable time before the first patient was ever admitted to St. Christopher's. In concluding the chapter, I examine the final parliamentary attempt to legalise voluntary euthanasia in 1969 and consider the ways in which the idea of hospice care (now an institutional reality) filtered through into this debate. This new form of institutional care of the dying was offered as a practical alternative to legalised voluntary euthanasia. This, I argue, brought a degree of resolution to the question of pain relief for patients with incurable disease. At the very least, it had the effect of shifting debates over legalised euthanasia to new ground.

With principled opposition to euthanasia and the practice of pain relief at the heart of their philosophy, proponents of the hospice movement, by means of a sophisticated regime of relieving both physical and mental pain, aimed to render euthanasia both unethical and unnecessary. Despite this, the debate over euthanasia persisted, with voices both inside and outside of the medical profession arguing that the hospice position was neither strictly coherent nor honest. Other supporters of euthanasia, though acknowledging the significant impact made by the hospice movement, argued that this new provision of care for the dying did not fully resolve all the problems of the terminally ill. This chapter of this thesis examines the complex and at times fraught relationship between the issue of euthanasia and palliative care, a relationship that remains contested terrain to this day.

II. 'Natural' Death and New Evidence on Provision of Care for the Dying

Before Cicely Saunders wrote her first paper on caring for the dying cancer patient in 1958, interest was mounting with regard to the conditions and provision of care given to dying patients. It would be easy to characterise Saunders as an isolated figure who, in single-handedly recognising the shortcomings of mid-twentieth century medicine, went on to develop a new philosophy of care. This would be an over-simplification, however, as the decades preceding the publication of her article reveal that wider interest was being shown in the terminally ill and dying. Apart from discussion of explicit concerns relating to the possible legalisation of euthanasia, other writing considering the management of dying patients can be found in the medical journals during the 1940s and 1950s.

Material from this period has already been discussed in Chapter Five of this thesis. However, additional writing from the first half of the twentieth century suggests that discussion, not only on the issue of euthanasia but also on the more general subject of care of the dying, was becoming a growing source of anecdotal interest. In August 1948 *The Practitioner* published a collection of essays as part of its 'Symposium on Thanatology'. In his introductory paper, titled 'The Signs and Symptoms of Impending Death', Lord Horder wrote:

What is the relation between the doctor and a patient who is going to die? ... Nature will take its course, and doctors and patient should be their natural selves. To a direct question from an individual as to whether recovery is possible, the best answer is something rather evasive to the effect that there is no very special treatment, but we must rely on nature.¹⁵

The image of 'nature' as a third party, present alongside the physician at the bedside of the dying patient, was an image to which Lord Horder had appealed in the past.¹⁶ The term 'nature', according to Lord Horder's usage, was synonymous with the individual discretion of the elite practitioner who treated the dying patient in a largely private and unregulated setting. 'Natural' death was at the centre of this closed world, and was not a phrase that was viewed as requiring lengthy explanation or elaboration.¹⁷

Similarly, in his prize-winning essay of 1950 titled "The Management of the Hopeless Case", Dr C. J. Gavey commented that it "was for each practitioner to decide for himself carefully how far he can assist his desperate patient without transgressing the law".¹⁸ In Gavey's assessment, with regard to the relationship between doctor and patient it was "better" to "let nature decide who is to live".¹⁹ Such an emphasis on allowing 'nature' to "take its course" or "decide who is to live" might suggest a non-interventionist attitude to care of the dying. However, in another essay in the 'Symposium on Thanatology' edition of *The Practitioner*, Dr W. N. Leak counselled that the individual physician's discretion was the deciding factor when deliberating over the use of pain-relieving drugs. If the doctor considered death "the end of all things" then "obviously a few doses of morphine" would be an entirely acceptable course of action, Leak argued. If, however, the doctor thought "that kindness and goodness have absolute value" and believed in "existence beyond the grave", then, Leak stated, "his treatment will be more discriminating".²⁰

As David Clark comments in his analysis of journal writing on care of the dying from this period, "on questions of clinical care, the individual practitioner's personal beliefs,

attitudes and morality seem to be the chief elements in the armamentarium".²¹ However, Clark also highlights how this interest in care of the dying was also beginning to widen from a focus on the relationship between individual practitioner and patient, to an awareness that the overall provision of care was not of a sufficient standard. Clark quotes Leak's observation that, "a paradoxical and awkward situation" had arisen, whereby on the one hand life expectancy was rising and doctors were striving to prolong life, and on the other relatives were "not available or willing" to look after unwell family members at home.²²

In addition, in an article in *The Practitioner* directly addressing the question of legalised euthanasia, the Principal Medical Officer of Health, A. Leslie Banks appealed to a broader institutional answer to the problems of caring for the dying. "Improved hospital services, with facilities for early diagnosis and privacy for the advanced cases" were the solutions that he advocated. The legalisation of euthanasia was, he argued, a move that signalled "the final admission of failure" on the part of doctors and other medical professionals.²³ Though remaining anecdotal in tone, a shift was beginning to take place from an emphasis on the private bedside relationship between doctor and patient, to a view that was starting to take in a wider assessment of overall care for the dying. This shift may not have been detectable in the writing of elite practitioners such as Lord Horder, but for those such as A. Leslie Banks, with responsibility for standards of care on a national as opposed to individual level, it was becoming a growing concern. The very presence of a collection of articles on death and dying in a major medical journal and a prize-winning essay on the 'Management of the Hopeless Case' suggests that care of the dying was judged as meriting special attention – albeit that this attention was anecdotal in its basis.

If material in the British medical journals was predominantly anecdotal in tone, a number of reports published in the 1950s and early 1960s set out to provide comprehensive, evidence-based appraisals of the state of conditions for the dying. The first of these reports, compiled by the Marie Curie Foundation, surveyed patients suffering from cancer across the country. The report revealed disturbingly poor levels of care. Cancer patients often endured terrible conditions, short of the right food or warm clothes and bedding. The report also highlighted delays in treatment and called for an immediate response to the need for residential and convalescent homes.²⁴ Former army doctor, Dr H. L. Glyn Hughes, compiled a second report that examined the social conditions of the dying and considered the implications for subsequent health policy.²⁵ Pinpointing "a serious gap in the National Health Service", Glyn Hughes' analysis revealed a depressing picture of care for the terminally ill

who were not admitted to hospital but still required nursing care. In some cases the situation was so bad that Hughes concluded that such conditions “amounted to actual neglect when measured by standards that can be reasonably expected”²⁶

Additional alarming evidence on the state of care for the elderly and chronically ill emerged in the 1950s and early 1960s. In 1950 Dr John Sheldon conducted a study of the elderly and sick in Wolverhampton and found that many old people were confined to their homes, with a significant number confined to one room and with little outside support.²⁷ A later report, also written by Sheldon and published in 1961, revealed alarmingly poor standards of care for those who were admitted to hospital. This report to the Birmingham Regional Hospital Board contained highly emotive phrases, such as “human warehouses” and “storage space for patients”, to describe hospital geriatric units in this part of the country.²⁸

Sheldon’s studies and a further report commissioned by the Ministry of Health in 1954 that uncovered inadequate standards of care for the chronic sick and elderly, reinforced the earlier findings of Dr Marjorie Warren, the deputy superintendent of the West Middlesex County Hospital.²⁹ The hospital, and as a result, Dr Warren, took over a former Poor Law infirmary in 1935 as an outcome of the 1929 Local Government Act which had passed control of Poor Law institutions to local authorities in the hope of raising standards. Discovering that staff had neither the training nor the inclination to adequately support and care for the bedridden elderly, Dr Warren found that because elderly patients were viewed as beyond recovery they were often given little attention. In an article in the *Lancet* in June 1948, she described the condition of elderly, chronically ill patients, permanently confined to their beds: “in this miserable state, dull, apathetic and hopeless, life lingers on, sometimes for years, while those around them whisper arguments in favour of euthanasia”.³⁰

The concerns of Marjorie Warren and others, such as Lord Amulree, who shared a particular interest in the elderly, should, to an extent, be distinguished from the findings that came to light in the aftermath of the surveys of cancer patients in the 1950s.³¹ Concerns about the care, conditions and treatment of the elderly fed into a specific mid-twentieth century debate about how old age should itself be viewed. With this came the development of thinking that challenged the orthodoxy of confining elderly patients to bed – a practice that was increasingly seen as detrimental to the health of patients. Rather than focusing purely on care of the ‘dying’, the debate over geriatric provision centred on calls for a more

systematic and detailed classification of elderly patients. This, it was argued, would enable a distinction to be drawn between those classed as 'incurable' and those who could be rehabilitated by means of more 'active treatment.'³² As Moira Martin argues: "medical knowledge in the mid-twentieth century was finally challenging the view that ageing was in itself a disease and doctors were now willing to admit the elderly to the realm of curative medicine, from which they had long been excluded."³³

Nevertheless, the reports on the care of cancer patients and care of the elderly shared common ground in that both contributed to a picture of inadequate provision for the dying and incurable sick. As this bleak view came to light, argument against the legalisation of euthanasia took a different form. No longer was debate located purely on a philosophical, somewhat abstract level or restricted to anecdotal accounts of individual patients. As evidence gathered on the poor state of care of the dying, attention moved to the practical improvements that could be made. Illustrative of this was a *Lancet* editorial in 1961 that opposed legalised euthanasia and called for the collective efforts of the medical profession to be applied to "make death, when it comes, easy and happy".³⁴

A critique of medical care that emanated from within the profession was beginning to surface, but not to the extent that mercy killing was now endorsed as a legitimate position. According to this view the problem lay with deficiencies in *practice*, not in the overarching principle that the physician should not kill. The body of supporting evidence had now changed, moving from the anecdotal personal experiences of physicians to systematically gathered surveys and interview material. Death had been revealed as a grim and harrowing experience for many patients. Recourse to the maxim that 'nature should be allowed to take its course' was simply no longer adequate without improvements in standards of care.

In part, key institutional changes in the structure of medical care prompted this call for renewed attention to the care of the dying. The inadequacies of the newly formed NHS, with its emphasis on curative medical provision rather than support for the terminally ill, had been revealed. Yet even before the founding of the NHS in 1948, the transfer of Poor Law institutions to local authority responsibility had started to expose a growing number of doctors to the bleak realities of poor conditions, not only for the terminally ill, but also for the chronically sick and elderly. Changes in the demographic make-up of the population also meant that an ageing population was now increasingly affected by chronic as opposed to acute health problems. This experience was often marked by periods of lengthy and difficult

illness at home but with death itself occurring in a hospital setting where provision for the terminally or chronically ill was often poor.³⁵

Resolutely opposed to the legalisation of euthanasia but identifying that much more was required of the medical profession, Cicely Saunders entered the debate over how the dying should be cared for best. Hers was a style that drew both on the discourse of earlier writing on care of the dying and introduced a new set of vocabulary into the frame. Fusing 'traditional' values of community and family but simultaneously harnessing new types of medical power, her hospice philosophy sought to assuage fears of death and improve the lives of terminally ill patients. By offering a better standard of all-round care for the dying, improved practice would serve to reinforce the principle that the doctor should never kill. She was not to be without her opponents. If the hospice movement was one response to the poverty of care for the dying, those advocating the legalisation of euthanasia offered an alternative answer.

III. Justifying Pain Relief: A Twentieth-Century Ethical Debate

On 12 August 1958, Dr Leonard Colebrook of the Euthanasia Society wrote the first of many letters to Cicely Saunders, beginning a sustained period of personal correspondence.³⁶ The letters are of interest for a number of reasons, not least because they vividly illustrate the salient differences in medical opinion between those who opposed voluntary euthanasia and those who sought to have it formally legalised. Though the private correspondence of two individuals, written during a period which pre-dates the founding of the first modern hospice, the letters are in many ways representative of the ideas underpinning wider euthanasia debates that continued throughout the twentieth century. Challenges were made by each of the writers, both on a more abstract philosophical level and on a level that related directly to medical practice. Primarily, the correspondence was concerned with a debate about how the pain of dying patients should best be managed and, crucially, understood.

As discussed earlier in this thesis, during the early days of nineteenth-century use of pain-relieving drugs, the medical profession had to justify its position in certain hostile religious quarters. By the time of Dr Saunders' letters to Leonard Colebrook, the ability to offer comprehensive pain relief supported rather than undermined her own, keenly felt religious beliefs. "There are some who believe that the only right and dignified solution is to

make inevitable death as swift and as easy as possible, and that the responsibility of choosing release belongs to the individual”, wrote Cicely Saunders in an article published in 1961. This, she maintained, was “surely a flat denial of God’s power and wisdom, and above all his love”.³⁷ While euthanasia could not be contemplated on religious grounds, the need to find solutions to the problem of the patient in pain also carried a sense of moral urgency. The “deep concern” of those who advocated voluntary, legalised euthanasia was a “challenge” to the “indifference and consequent neglect of sufferers in this country today” but, she maintained, “the suffering that leads to such demands, can and should be alleviated”.³⁸

The practice of relieving pain was for Cicely Saunders, as it was for Dr William Munk in the late nineteenth century, wholly consistent with a view that gave religious meaning to death and dying. However, in the face of organised calls for legalised euthanasia, calls that now carried the support of medical as well as lay voices, the justification of pain relief was of central importance to those seeking to strengthen their rejection of euthanasia. Cicely Saunders’ justification of pain relief, so that no patient felt abandoned or left to suffer in isolation, was also the justification for those who rejected voluntary euthanasia. Pain relief by means of comprehensive physical and psychological palliative care was the key to vindicating the position of those who opposed euthanasia and to silencing what she considered to be the “deep” but misplaced “concern” of those in favour of euthanasia.

By drawing on documentary analysis of the correspondence between Saunders and Colebrook, I consider the three categories of argument that I identify in this thesis – principled opposition/support for euthanasia, arguments relating to the practice of pain relief, and the notion of ‘social’ death. Taking a thematic as opposed to strictly chronological approach to the material, I explore how these three categories relate to the overarching concept of ‘natural’ death. As well as writing to one another, the two doctors were also advancing their particular view of legalised euthanasia in a wider arena: publishing articles, corresponding with medical journals, and taking part in public debates. I use some of this literature to supplement the analysis of their correspondence, alongside additional relevant material concerning euthanasia and care of the dying taken from medical journals and from pamphlets produced by the Euthanasia Society.

i. Principled Opposition and Support for Euthanasia

During the years 1958-1963, the period of correspondence between Leonard Colebrook and Cicely Saunders on which I focus, Saunders was undertaking research on cancer pain at St Joseph's Hospice in East Hackney.³⁹ Alongside this work, she was simultaneously developing a programme of social, psychological and physical support for terminally ill patients. Colebrook was given Saunders' name by Brigadier Glyn Hughes after the two men met to discuss care of the dying. Colebrook's first approach to Dr Saunders was a formal letter in which he asked if she had any statistical data on the numbers of terminally ill patients in pain and the extent of their suffering.⁴⁰ From then on, their correspondence centred on the discussion and negotiation of their opposing positions on the issue of euthanasia.

Though supportive of Saunders' work, Colebrook's stance was diametrically opposed to her principled, religiously grounded objection to euthanasia. He supported the right to request a physician-assisted death from an alternative set of principles based on self-determination and choice, describing euthanasia as "the simplest of human rights to choose a quick and easy death in place of a horrible and slow one".⁴¹ This view, that euthanasia represented a positive exercise of individual choice, was echoed in a 1962 Euthanasia Society pamphlet. Criticising the earlier *Lancet* editorial of 1961 that had ruled out legalised euthanasia, the Euthanasia Society publication declared that the medical journal had failed to "directly pose the fundamental question of the patient's right to choose an easy death".⁴²

Claiming the right of the individual patient to a quick and painless death at a time of his or her own choosing, was a direct challenge to the religious meaning that Saunders ascribed to death. Colebrook's letters are littered with references that contrast his own belief system with that of Saunders.⁴³ Although he was assured by Saunders that the vast majority of her patients "would say to you at any time of night or day that they were pretty comfortable", he was not convinced.⁴⁴ Patients were bound to say that they were "pretty comfortable", when, he argued, they were unable to conceive that there "might be any better way than the endurance of pain ... anymore than in 1800 it would have occurred to any patient that he might have his leg amputated under anaesthesia".⁴⁵ Colebrook maintained that Saunders was "doing a most valuable thing" in alerting doctors and nurses to "the importance of kindness". However, her philosophy was not, he argued, "the whole answer", particularly for those "who cannot see pain and misery as the gifts of a benevolent Diety". If pain and misery were somehow part of a divine plan, asked Colebrook, then "why try to

relieve them?”⁴⁶ A pro-euthanasia publication of 1962 took up this same point, arguing that objections to euthanasia often rested on the belief that “suffering is the gift of God”. This, according to the publication, was a view that was “often linked with the contention, belief or superstition that it is wrong to interfere with nature.” However, if such ideas were extended to their “logical conclusion”, this would mean, “all alleviation of suffering, including the use of anaesthetics is wrong”.⁴⁷

In a letter to the *Lancet* in 1962, Colebrook made reference to the recent Suicide Act of 1961 which had ruled that the taking of one’s own life was no longer illegal (although to assist another person in taking their own life remained a criminal offence). According to Colebrook, the Suicide Act had profoundly altered the context of euthanasia debates, strengthening the position of those in the Euthanasia Society who argued for legalisation. The patient in pain was now, he argued, “at liberty to make the choice between waiting for death from so-called ‘natural causes’ or seeking relief from his or her suffering by an earlier, contrived death”. Often, however, patients were unable to act on this choice since “the means for ending their lives are not available to them”.⁴⁸

In another letter, again published in the *Lancet*, Colebrook questioned the journal’s conclusion that legalised euthanasia was “profoundly disturbing”.⁴⁹ The *Lancet*, argued Colebrook, was preoccupied with the position in which doctors would be placed were euthanasia to be legalised. How many doctors, he challenged, would “cut short their own lives” if they knew they were dying slowly and painfully from inoperable cancer? Doctors had the means to carry out such a decision; many patients, however, did not. He concluded: “If we conceded their right to be spared unnecessary suffering or distress, should we refuse to help them to achieve it when they asked for our help?”⁵⁰ As young man, he had cared for a number of patients “dying miserably from tuberculosis” and in more recent years had watched elderly friends and relatives die “sometimes in wards for the chronic sick, crowded with human wreckage – sometimes in more dismal still mental institutions”.⁵¹ Describing a visit to St. Joseph’s where he had observed care of the terminally ill, Colebrook acknowledged that he was “much impressed by the atmosphere of contentment, even of cheerfulness, that Dr Saunders and the devoted Roman Catholic staff have been able to create there”.⁵² The aim of the hospice was to “make the patients fairly comfortable rather than cure, and to that end they have relied not only on medical and nursing techniques, but also on high standard of kindness and the consolations of religion (when they are

acceptable)".⁵³ However, he questioned how far religion could be relied upon in general hospital wards where many patients did not share the same religious convictions.⁵⁴

Though keen to stress that her opposition to legalised euthanasia rested on technical arguments based on her research on cancer pain and her practical experience of treating patients, the influence of religious faith clearly filtered through into Cicely Saunders' letters to Leonard Colebrook. In a letter in December of 1959 she expressed the view that there was a desperate need for many more terminal-care homes such as St. Joseph's, and remarked that "there is much more to be done in this field generally". The relief of suffering in the dying could be achieved by "putting our hearts and minds to it", she argued, adding that, "it is because so few people do, that pathetic cases exist". However, she then remarked: "no experience of illness is ever wasted (but can always be transformed into something of eternal value and often something of joy here) and that is an infinitely worthwhile work."⁵⁵

In a later letter, recalling how she had nursed someone whom she had loved through a lengthy illness, Saunders returned to the theme of finding religious meaning in death. "The intangible things mean so much and are so hard to write", she commented, before describing how nursing her dying friend would not have been "so joyful and full of timeless tranquillity" if she and the dying man "had not left everything in God's hands all the way through".⁵⁶ Saunders wrote that she now had a "longing to help others to find that this hard, inevitable thing [death] can be completely transformed." This was not just for "the good of their own souls" but also "part of the working out of the world's redemption and just the bit entrusted to us". In her view, Colebrook sounded as if he "wanted to take away from life and death everything that we find hard to endure" so as to turn men and women into "a collection of Lotus Eaters". The answer was not, she argued, in "running away" or in "taking responsibility" as she believed Colebrook was proposing when he advocated legalised euthanasia. While she was not "unseeing of distress or complacent", the answer lay in "staying to fight until the fight finally changes into acceptance and love".⁵⁷

From these extracts from the correspondence between Saunders and Colebrook emerge two very different responses to the problem of suffering in the terminally ill and dying. On the one hand is a claim to self-determination and individual choice to enable the patient to be freed from pain by requesting death. On the other, is an emphasis on metaphysical faith that claims that only trust in God can 'transform' suffering and death from a positive to a negative experience. Cicely Saunders did not advance a philosophy in

which the “consolations of religion” were alone seen as sufficient when caring for the dying. She matched her spiritual belief with a commitment to finding new ways of alleviating and eliminating pain. However, such medical intervention in the form of administering pain relief did not disrupt her belief that, even in the light of such intervention, death continued to be left “in God’s hands”. Leonard Colebrook and The Euthanasia Society contested this position, arguing that by alleviating suffering (and not always sufficiently in the Society’s view), medical practice was already interfering with nature. To choose the timing and manner of one’s own death was purely an extension of this practice. This category of principled argument in many ways reiterates well-rehearsed arguments that centre on contesting or supporting metaphysical, religious objections to legalised euthanasia. It was in the area concerning the practical application of pain relief, the next category of arguments that I examine, that euthanasia debates entered new territory.

ii. The Practice of Pain Relief

As already illustrated, built into Saunders’ philosophy of care was the notion that the dying patient could be reconciled with his or her individual fate on a spiritual level. On a physical level, however, pain relief was the responsibility of the attending medical team. Saunders maintained that it was because so few medical minds had been devoted to the subject of comprehensively relieving pain that the number of cases of suffering remained unacceptably high. General and chronic wards, unable to offer what she described as “individual and careful” nursing, were falling short of providing the type of pain relief that could be offered by terminal care homes such as St. Joseph’s Hospice. Ultimately, euthanasia was to be opposed because, Saunders argued, the questions raised by the need to relieve the suffering of dying patients could and should be answered with a medical as well as religious response. In Colebrook’s view, Saunders’ means of assessing the pain of dying patients was inescapably linked to her own religious values. The description of a patient as “pretty comfortable” could only be achieved by ascribing one person’s religious values to another’s suffering. Though acknowledging that her work was underpinned by a firm religious belief, Saunders maintained that her concerns were of a practical nature, centring on deficiencies in mainstream provision of pain relief and on how she and her hospice offered a better alternative.

In a letter to the *Lancet*, Cicely Saunders responded to Leonard Colebrook’s call for legalised euthanasia by distancing herself from the view that “high standards of kindness” and the “consolations of religion” were all that were offered to relieve the pain of suffering

patients. She argued that St. Joseph's was not an isolated example of an institution developing new methods of caring for the dying. Other terminal care homes and hospitals were carrying out similar work, based on the findings of clinical research and observational studies of patients. She gave the example of the department of pharmacology at St. Mary's Medical School in London, where the records of several hundred terminally ill patients were being analysed. This research not only detailed the physical reactions of patients to analgesic drugs, but also recorded patient attitudes in order to gain an insight into mental as well as physical distress.⁵⁸

Since writing her earlier articles on care of the dying and euthanasia, Saunders believed that she had "learnt a great deal". The control of pain in terminal cancer was now a reality and "only rarely indeed" was it necessary to have the patient continually sedated. She added: "without going into the reasons why I personally believe that euthanasia is wrong, I would like to emphasise that it should be unnecessary and is an admission of defeat." Saunders assured her readers that the symptoms of dying patients, such as nausea or breathlessness, could be controlled and relieved. When administering drugs at St. Joseph's, the patients were not "troubled with tolerance or addiction". Indeed, they were "often on the same doses for weeks or months".⁵⁹ Addressing Colebrook's reference to the "consolations of religion", Saunders stated that neither she nor many of the patients at St. Joseph's were Roman Catholic. Depending on their particular religious orientation, patients were visited by "priests and ministers as they desire or by no-one if they so wish".⁶⁰

After Colebrook's visit to St. Joseph's, Saunders wrote to tell him that a patient whom he had met, a Mrs Vidler, had died. Suffering from "fungating cancer", this patient had been having regular morphine injections for almost a year and during the period of Colebrook's visit was administered the pain-relieving drug four times daily. Saunders wrote:

Later in the week in which you saw her, she suddenly went downhill for no very obvious reason. She once needed a slightly increased dose of morphine, but after that the pain receded. We never cut down morphine in these circumstances lest the patient should suffer withdrawal symptoms, but I am quite sure that the pain did what it so often does – disappears spontaneously for the last few days. She was very peaceful; I think she realised what was happening but was quite unafraid. She slipped away quietly into unconsciousness about twenty-four hours before she died. We miss her very much but remember her with nothing but admiration and gratitude.⁶¹

She then reported how another patient – Mr Morley, "the cheerful bus conductor who was short of breath, but otherwise looked fairly well" – had been mobile and active since

Colebrook's visit. "I am letting him go home this afternoon," she wrote; "he realises what is happening and he just badly wants to go and see his home again. We are very willing to do so as his wife is prepared to cope knowing that she can bring prepared to cope knowing that she can bring him back if there is any trouble."⁶² Thus, Saunders presented Colebrook with two patients, of whom he had direct personal knowledge, making clear that their pain had been comprehensively managed. Significantly, the first patient had suffered from "fungating cancer", which was the same disease that Colebrook had mentioned in an earlier letter in which he disputed that the terminally ill were at all times "pretty comfortable".⁶³ Implicit in this sharing of anecdotal case histories was the view that euthanasia was not only morally wrong but also a diversion from the effective, practical management of pain. Alongside principled opposition to legalised euthanasia, hospice care also offered a developing technical interest in pain relief and drug administration.

On request a list could be produced detailing the names of drugs and levels of dosage most commonly used at St. Joseph's.⁶⁴ For mild to moderate pain, soluble aspirin and paracetamol were administered. For moderate to severe pain, pethedine tablets were given or diamorphine by mouth in small doses. For severe pain, diamorphine was administered in larger doses until such a point when sedation was considered more appropriate than increased levels of analgesic. As well as detailing the possible combination of drugs to be given, the list also dealt with the treatment of common symptoms. Care of the mouth was of vital importance (as it was in William Munk's time) and for dysphagia iced drinks were to be given along with aspirin emulsion, or in the case of excessive salivation, small doses of atropine. Morphine could be given for discomfort as well as pain but opiate drugs were not to be used as sedatives to treat insomnia. However, it was noted that sleep often came after the administration of morphine to treat pain, due to the relief felt by the patient.⁶⁵

The St. Joseph's list, formulated by Saunders, also recommended an article on intractable pain that gave details of drugs that could be used as alternatives to morphine. This article presented the findings of general practitioners John Hunt and Michael Linnett, who concluded that, since GPs had close contact with their patients, often through long periods of illness, they were exposed to knowledge of pain-killing drugs "which is difficult to gain elsewhere".⁶⁶ In their article, Hunt and Linnett wrote that they were impressed "by the benefits that may be gained by mixing analgesics, by changing them from time to time to minimise sensitivity, tolerance or addiction".⁶⁷ Cicely Saunders also endorsed this practice of giving combinations of drugs administered at regular intervals.

Also in accordance with Saunders' thinking the article argued that "a patient should not have to watch the clock and count the minutes until his next injection is due." The distress of both patients and relatives could be avoided by preventing unnecessary delay in the administration of pain relief. The article elaborated:

They may be comforted [patients] by knowing that a tablet is put out, or a syringe loaded near by, ready to help at once should a spasm of pain come on. Special instruction of the nursing staff on these matters may be needed. A pain chart indicating the time, severity and duration of each attack, kept by a nurse and never mentioned or shown to the patient, is sometimes a help.⁶⁸

On the issue of morphine use, doctors Hunt and Linnett called into question the "popular misconception that the most powerful analgesics of the morphine group are so dangerous that they should only be given in the last resort". This, they argued, was "sometimes an unfortunate hindrance to the adequate relief of pain".⁶⁹ In their view, the objective of the doctor was to secure for the patient complete and continuing freedom from severe pain as opposed to temporary relief, where drugs would only be administered on the return of pain. When morphine was given in appropriate combinations with other drugs – drugs known as 'antagonists' – "comprehensive analgesia" was often "safe and pleasant ... and the patient can continue these mixtures for many months".⁷⁰

Cicely Saunders' opposition to Leonard Colebrook's advocacy of euthanasia should be viewed against a wider backdrop of growing clinical interest in the treatment of terminal pain, illustrated in the writing of Hunt and Linnett. Isabelle Basanger's work on the growth of what she terms "the medicine of pain" in the 1950s, explores how medical attitudes were changing during this period, particularly in relation to the patient suffering from chronic as opposed to acute pain.⁷¹ With the emergence of specialist pain clinics, employing multi-disciplinary teams that included psychiatrists or clinical psychologists, chronic pain was increasingly being seen as a psychological as well as physical phenomenon. Pain was perceived, not simply as a symptom of illness, but as Basanger describes "as an entirely separate problem requiring specific treatment".⁷²

The hospice commitment to finding new ways of relieving pain, combined with an emphasis on the psychological well-being of the patient, provided an important point of focus for the development of pain management as a clinical speciality. Beyond Saunders' unmoveable position that rejected any suggestion that the physician might intentionally bring

life to an end, lay a complex picture of the development of pain-relieving strategies where drugs were used in various combinations, with varying dosage levels and with varying aims in mind. This use of combinations of drugs allowed for control of a patient's physical pain and control of a patient's level of consciousness. Stimulants used to promote alertness could be reduced or withheld. Sedatives to promote drowsiness could also be administered as judged necessary.⁷³

Yet, as the article by Hunter and Linnett also revealed, the relief of pain brought about by morphine was often measured against the possible negative side effects of such drug use. For example, the article cautioned that the dangers of morphine addiction remained real, and counselled that "the old rule of thumb – that it is unwise to prescribe morphine for long unless the end of a painful illness can be foreseen either in recovery or death – still holds." Interestingly, the article then concluded that "many doctors would feel worse about being responsible for producing one addict than for failing to relieve pain entirely in a chronic condition."⁷⁴ This was a time of experimentation – a time when patients' reactions to pain relief were being observed and new regimes of treatment developed. Research on pain relief provided a body of new medical evidence that could be directly applied when discussing terminally ill patients, as typified by the cases of Mrs Vidler and Mr Morley. These cases stood not merely as isolated histories, but were instead presented as illustrative of growing medical knowledge and sensibility with regard to pain relief. In gaining support for her work and strengthening opposition to euthanasia, Saunders was effectively developing a number of different 'voices' in which she could propound her philosophy of hospice care. One voice operated on a religious level, stressing that life could only be taken when God determined. Another emphasised the technical, medical aspect of hospice provision for the dying, with its development of new pain relieving techniques and symptom control.

However, the type of pain relief administered depended on the type of illness in question and Saunders' work was largely based on her experiences with cancer patients. In the instance of non-fatal illnesses where patients might be expected to live for many years but without cure, morphine use was avoided for fear of addiction. In essence, if a causal link could be made between a patient's illness and his or her eventual death, then powerful pain relieving drugs could be legitimately given. If, however, no such link could be made, it was justifiable to avoid morphine use even if this implied, in Hunt and Linnett's words, "failing to relieve pain entirely". This conclusion reinforced Lord Patrick Devlin's 1957 legal summation in the Bodkin Adams trial, which, as discussed earlier in this thesis, endorsed the

use of pain relieving drugs even if this shortened life. Yet it also raised the question of the distinction between chronically ill and terminally ill patients and the manner in which, in the first case, pain relief was given with caution, whilst in the latter, it was judged appropriate to administer pain relief liberally.

The reluctance to administer pain relieving drugs to the chronically ill, for fear of establishing patient dependence or addiction, was an issue raised in a report on terminal illness in the elderly prepared by Dr A. N. Exton Smith, a physician at London's Whittington Hospital.⁷⁵ His report, published in a 1961 edition of the *Lancet*, concluded that while the control of pain was largely achievable in the case of patients suffering from malignant disease, in cases of chronic illness, in particular rheumatoid arthritis, the relief of pain was far more difficult.⁷⁶ Severe pain lasted for far longer periods, from months to years, and the suffering of patients in this group was magnified because their mental alertness allowed them to recognise their helplessness. While the pain of such patients might have responded to narcotics, "these had not been used for fear of habit-formation in an incurable but not directly fatal condition".⁷⁷

However, in cases of patients dying from malignant diseases such as cancer, Exton Smith concluded that less than a quarter of the patients in his study experienced moderate or severe pain. This pain was relatively limited in duration, and significantly, in all patients it could be controlled by powerful analgesics or narcotic drugs administered at intervals throughout the day under supervision as advocated by Cicely Saunders. Exton Smith considered that Saunders' regime of pain control was "a counsel of perfection to the busy general practitioner or district nurse", but it seems that in theory at least, he supported its powerful potential. Despite this largely positive assessment of the capacity to relieve pain in the dying, the study also revealed a small minority of patients who had lost all desire to live so that "their end was brought nearer by a refusal to eat or drink". Of the two hundred and twenty patients studied, eleven "repeatedly expressed a wish to die". One patient thought that too much was being done to help her, another asked "to be done away with", and some "prayed for death".⁷⁸

It is interesting that at the end of his *Lancet* article, Exton Smith thanked both Saunders and Colebrook for their "encouragement and assistance". In part, his report endorsed the developing philosophy of hospice care, reinforcing the view that pain in terminal illness could be controlled if drugs were administered at regular intervals and if

improved institutional provision was made for the dying. Drawing attention to the earlier findings of the Glyn Hughes report and the inadequacies of current standards of care for the dying, Exton Smith concluded, “constant medical care and a high standard of nursing are needed for patients whose illnesses have reached a terminal stage”.

Yet his report also found a minority of patients requesting that they wanted to die, a conclusion that was underlined when the research of Dr John Hinton was published in 1963. Hinton, who fostered a particular interest in the psychiatric difficulties faced by dying patients, found that doctors were unable to “control all physical discomfort” and that mental anxiety was “sufficiently common for a significant number of patients to consider suicide”.⁷⁹ This was a finding that could be interpreted in two ways. First, as evidence that legitimated the position of the pro-euthanasia lobby, or secondly, as an indication that even more needed to be done to relieve the pain and anxiety of the dying so that legalised euthanasia was no longer an issue.

Provided in the institutional setting of hospice care, the impact of developments in techniques of alleviating pain did not end disagreement over legalised euthanasia, but it did, to some degree at least, shift the debates to new ground. Despite maintaining his support for legalised euthanasia, after his visit to St. Joseph’s Leonard Colebrook expressed the opinion that “there would be little or no problem of euthanasia if all terminal care disease folks could end their lives in the atmosphere that you have done so much to create”.⁸⁰ In his letter to Cicely Saunders, he added: “alas that can hardly be for many a long year and meanwhile how many thousands end their lives in very different circumstances?”

However, he conceded that his visit to the hospice had helped to put the question of euthanasia “in perspective”.⁸¹ Similarly, the 1961 *Lancet* editorial on euthanasia acknowledged the “gross inadequacy” of current provision of care for the dying, but urged that “advocates of induced euthanasia should especially study and consider” the writing of Cicely Saunders. According to the journal, her articles on care of the dying showed “in detail and from experience what can be done ... to make a ‘good end’ is not an entirely outworn conception or accomplishment”.⁸² The development of hospice care of the dying gave opponents of legalised euthanasia a practical, institutional alternative to demands that the law should be changed to allow patient-requested death. The strength of this alternative was such that, even if proponents of legalised euthanasia did not accept principled, religious opposition to their arguments, they acknowledged that terminal care in a hospice setting did

go some way to address the practical inadequacies of care for suffering patients. Indeed, when writing her appeal to establish a new hospice in London, Saunders quoted Colebrook's comment that "there would be little or no problem of euthanasia" if the care offered by terminal homes such as St Joseph's was universally available.⁸³

The hospice philosophy offered a new regime of pain relief for dying patients, where drugs were administered liberally and, when needed, at regular intervals. Saunders argued that death was left in "God's hands" and yet at the same time, the introduction of a new regime of pain relief for the dying meant that a set of medical and technical practices had to be absorbed into this particular conception of 'natural' death. Interestingly, the *Lancet* article that rejected the legalisation of voluntary euthanasia argued that the term 'euthanasia' should itself be "reclaimed in its derivative sense", to imply simply "an easy happy death". The journal added: "if euthanasia in this sense was put on a par with childbirth ... could not all deaths be made very easy and, in our ageing population, even happy?"⁸⁴

Yet as I considered earlier, when the use of pain-relieving drugs in childbirth was first introduced in the nineteenth century, the medical profession faced opposition from those who argued, largely on religious grounds, that such intervention was 'unnatural'. The practice of pain relief in the hospice setting meant that treatment was uniquely tailored to patients who were terminally ill. As I have discussed, this implied a different set of medical practices than those employed when a patient was classed as chronically ill. For patients who were dying, morphine and other pain relieving drugs were administered without the fear of addiction or tolerance. This practice was then, I argue, absorbed into an idea of 'natural' death, preserving the view that death was not being artificially 'induced', and the view that medical intervention was not interfering with divine will.

iii. 'Social' Death and Hospice Care

In her 1961 letter to the *Lancet*, Cicely Saunders claimed that the greatest suffering that the terminally ill faced came in the form of "isolation". This isolation applied to the terminally ill as a group "left out of so much of our planning", and as individuals "who need a listener more than any other form of therapy."⁸⁵ The importance of relieving not only the physical but also the psychological pain of patients was an integral element of the philosophy of hospice care. Saunders argued that it was wrong to view patients simply in terms of a catalogue of medical symptoms. The key to effectively treating pain was to focus

on the patient as a 'whole' person, with individual needs and anxieties. In a letter to Colebrook, she explained:

In the old days we were taught in nursing pneumonia or typhoid patients, that one had to lift every effort off their shoulders and even think for them. I think care of the dying calls for something more individual. We have to try and watch what a patient's disease means to him, and never let him get overwhelmed by it. I do not claim that none of my patients suffer any pain or distress at all, but only that I try to keep it within their own personal limits of endurance.⁸⁶

The medical sociologists James and Field have argued that the response of the pro-euthanasia lobby to poor standards of terminal care was "to extend the individual's control over their own death", whilst the hospice answer "was to develop a community response which obviated the need for euthanasia".⁸⁷ I argue that the hospice 'solution' to euthanasia was an institutional response to the problem of caring for the dying – albeit rooted, as James and Field suggest, in what were viewed as the traditional values of community and family. Yet built into this institutional response, as the last excerpt from Cicely Saunders' letter illustrates, was an emphasis on not only the physical but also the social and psychological needs of the individual in pain. If the Euthanasia Society, as it was known in 1961, employed the language of individual agency in advancing its position, then so too did the hospice movement, albeit in a different manner.

By providing an institutionalised version of traditional sources of support such as family, community and religion, the hospice movement sought to challenge the idea that the incurable patient was no longer capable of engaging with others or participating fully in social interaction. However, in addition to these 'traditional' forms of social support, the hospice philosophy of care also included the notion that psychological pain could be clinically and systematically 'treated'. Addressing only physical pain was insufficient: the patient's psychological, spiritual and social needs also needed to be brought into focus. This, of course, was not a novel idea. In the nineteenth century, physicians such as William Munk and Benjamin Brodie had also been concerned with the mental state of dying patients. What was new, however, was the manner in which the hospice philosophy viewed physical and mental pain as inextricably linked in the all-encompassing concept of 'total pain'. If the right approach was taken, it was argued, this 'total' pain could be medically managed. Just as the hospices developed a routine of medical practices to deal with physical pain, psychological pain was also met with a regime of particular techniques.⁸⁸

When Saunders undertook her research in cancer pain at St. Joseph's, an important part of her work was to sit with patients and talk to them, recording these conversations so that they could be transcribed and analysed at a later date. Similar to the work of Elisabeth Kübler-Ross, a doctor at the Montefiore Hospital in New York, Saunders developed a practice of talking and listening to terminally ill patients.⁸⁹ Built into this practice was the notion that a patient, if socially supported and relieved of physical pain, could come to terms with his or her death and reach a sense of acceptance. This multi-layered concept of pain, understood in terms of both physical and mental suffering, meant that the concept of 'social' death was anathema to Saunders' philosophy of care for the dying. The terminally ill were never to be left with untreated physical pain or with feelings of isolation. With this approach, Saunders argued that at St. Joseph's "we try, and we believe often with success, to enable our patients to remain themselves throughout the illness ... They often make of it (consciously or unconsciously) not just a long defeat of living but a positive achievement of dying."⁹⁰

The notion of 'pain' as much more than a collection of physical symptoms can be found in the correspondence between Saunders and Colebrook. In a letter to Saunders of September 1961, Colebrook stated that he was puzzled by what he took to be her "categorical assertion in the *Lancet*" that the symptoms of terminal illness could always be relieved. Was it really possible, he asked, "to get rid of the severe breathlessness of a badly failing heart" or "the sense of suffocation and dysphagia of cancer of the throat?" In a letter that he had written to the *Lancet*, Colebrook had described St. Joseph's as enabling patients to be "pretty comfortable". Saunders had subsequently taken issue with his account and argued that the aim of the hospice "was something rather higher". Colebrook apologised if he had misquoted her. Yet he maintained that he believed his phrase was accurate, given that she had stated that pain-relieving drugs were often given for "weeks and months" and that she had conceded that hospice care could not "take away the hard thing that was happening".⁹¹ Colebrook "rejoiced" that she could do so much, but added that he "should feel grieved if you seemed to claim to be able to do all these things that make up the (very) hard way to death for a considerable minority".⁹²

Saunders replied by acknowledging that Colebrook was "speaking for a group that will not come my way". Although she considered that the campaign for legalised euthanasia would raise concern about the standards of care of the dying, and was grateful for Colebrook's support in raising the profile of her "plan for St. Christopher's", she maintained

that the Euthanasia Society's view was "a negative approach." Colebrook, however, was "a doughty opponent" for whom she had "a high personal regard".⁹³ Saunders then dealt with the physical symptoms of dying patients that had particularly concerned him in his letter. Suffocation could be treated by the "judicious use" of "ephedrine and heroine", whilst dysphagia, she claimed, responded "remarkably well to various measures", the first of which was get the patients hydrated.

She was neither claiming that she could remove a patient's symptoms altogether, nor that blindness and paraplegia could be alleviated. She remarked, "I do not think that people will think that I am doing anything so foolish".⁹⁴ Explaining her position further, she explored what was meant by the word 'relieve':

The derivation from the Latin 'to lift' means to me that we should take away the burden of these symptoms. Obviously this is easier with some than with others. 'The hard thing that is happening' is weakness, and approaching death means dependence and parting. That cannot be taken away but the physical distress can be relieved (in my sense) until the end comes within the individual patient's threshold so that he is able to 'make a good end'⁹⁵

Some of the "misunderstandings" between herself and Colebrook came about, she thought, because they did not mean the same thing when they used the word 'relieve'. "Of the two definitions in the dictionary", she stated, "you take 'remove' and I take 'alleviate', and I think that I use it in the medical sense. To 'relieve' pain does not mean to remove the cause but to take away the distressful feeling." Saunders wondered that it might be because she had read philosophy before medicine that this created another point of difference between them. "The intangible things mean so much and are so hard to write, or to get across to others," she commented.⁹⁶

Thus, Cicely Saunders' conception of 'pain', an idea that encompassed not only physical but also psycho-social elements to suffering, meant that the experience of dying was ascribed a particular meaning within the hospice setting. In part, death was a medically managed experience, characterised by a willingness to administer drugs whenever required, even to the point where physical pain was pre-empted and the patient did not have to ask for his or her next dose of pain relief. In addition, however, the hospice philosophy absorbed a particular set of religious and cultural beliefs so that dying was viewed as a process that could be "transformed" by means of the patient relinquishing his or her psychological fears and "weakness". Pain was an experience that could be shared. Dying was an experience that

meant dependence and acceptance, if not of God's will, then of the moral world of the hospice.

Saunders rejected the idea of 'social' death and in its place her hospice philosophy brought together a number of different elements, including an emphasis on the alleviation of physical suffering combined with therapeutic strategies that addressed the psychological state of the dying patient. Behind this approach, lay her firm commitment to a religious faith that infused her own understanding of the meaning of death. Ultimately, it was a combination of these values that permeated the hospice view of 'total' pain. If, after 1967, hospice care was to become a practical, institutional alternative to legalised euthanasia, in the late 1950s and early 1960s it was already offered as an ideological alternative. The ideas expressed by Cicely Saunders in the correspondence presented in this chapter were articulated when the practical plans for establishing modern hospices were still in a stage of infancy. Nevertheless, as I argued earlier, Saunders' letters to Leonard Colebrook offer a valuable insight into the core concepts that underpinned the establishment and subsequent expansion of this provision of care for the terminally ill.

It is possible to situate this embryonic discourse of hospice philosophy, as exemplified by Saunders' writing, as part of a wider literature concerned with death and dying produced in the 1960s and 1970s. This literature, that stressed the importance of "awareness of dying" and emphasised the psychological need for incurable patients to express their fears, has been portrayed by Ariès as a bold defiance of what was previously "the taboo" and "denial" of death.⁹⁷ More recent analysis is rather more sceptical. In an extremely thought-provoking study of the growth of literature on death and dying from the 1960s, medical sociologist David Armstrong argues that this discourse on death and dying subjects the patient to new methods of analysis and "interrogation".⁹⁸ The terminally ill patient is exposed to multiple levels of medical scrutiny, both physical and psychological, and is compelled to verbalise personal thoughts and feelings that are subject to the interpretation of medical professionals. Though fragmented into different parts, Armstrong contends that this discourse on death and dying still represents a manifestation of medical power.⁹⁹

It also is possible to apply some of Armstrong's thinking to the ideas behind hospice care. On the one hand, importance is placed on listening to the individual patient and tailoring treatment according to personal requirements, anxieties and feelings. On the other, the hospice arguably presents a prescriptive view that requires that the patient share in the

hospice values of acceptance and dependence during death. In addition, the hospice regime of pain relief as advocated by Cicely Saunders relies on pain being controlled and even pre-empted. Arguably, it might be suggested that this requires that the patient relinquish a certain amount of autonomy. At what point does the control of pain become the control of the patient? Saunders would no doubt strongly dispute this interpretation and point to the achievements of the hospice movement and the advancements that have been made, particularly in the area of caring for cancer patients. One need only read Susan Sontag's highly influential *Illness as Metaphor* to realise that taboo, secrecy and fear have often accompanied terminal illness and suffering.¹⁰⁰ Hospice care has done much to challenge this and to change, in innovative ways, the manner in which pain is medically treated and managed.

The development of the management of terminal pain as a specialist area of medicine has, I argue, had a significant impact on twentieth-century arguments over euthanasia. This does not mean that these debates have ended – indeed, regular press and media coverage of the question of legalised euthanasia suggests quite the contrary. However, I contend that the *content* of the arguments, both in favour of and against legalised euthanasia, has altered. An important contributing factor to this change has been the way in which the practice of pain relief and the management of pain began to be articulated by the medical profession in the latter half of the twentieth century. In stating that pain relief was *the* priority when caring for terminally ill patients (even if death was ‘unintentionally’ hastened as result of such intervention) and in offering hospice care as an institutional focal-point for refining pain-relieving practices, the medical profession moved opposition to legalised euthanasia to new ground. In turn, supporters of legalised euthanasia adapted and shaped their arguments in order to respond. By way of explaining and illustrating this point, I conclude this chapter by looking at the attempt to legalise voluntary euthanasia in 1969.

IV. Debating Euthanasia and Hospice Care

In March 1969, the House of Lords was presented for the third time with a bill that proposed the legalisation of voluntary euthanasia.¹⁰¹ Sponsored by Lord Raglan, the bill was ultimately defeated by sixty-one votes to forty, but of particular interest, given the focus of this thesis, was the manner in which the debate was framed from a medical perspective. In his opening address, Raglan immediately made direct reference to the positive contribution made by the hospice movement in improving standards of care for the terminally ill. He even

acknowledged that “it might be said that if everyone could spend his last days in such surroundings there would be no need for this bill”.¹⁰² However, since hospice provision was not available to the majority of patients who required such care, he argued, legalised euthanasia provided a guaranteed means of securing a humane and pain-free death. In addition, he maintained that even if with “money and education” hospice care was made more readily accessible, there would be those who chose not “to eke out their lives in this way”. Most people wished to die at home in familiar surroundings and not in an institution, he stated, adding, “I myself should like to die at home if I could.”¹⁰³

For those opposed to voluntary euthanasia, Raglan’s comments were seen as an open admission of the successes of hospice care in meeting the needs of those suffering from incurable and painful disease. If the real problem was simply the scarcity of hospice provision then surely the focus should be on increasing the number of hospices instead of permitting requested death, they questioned rhetorically. Lord Thurlow, who in 1969 was chairman of St. Christopher’s Hospice, argued that rather than legalising euthanasia greater financial support was needed for more hospice and geriatric care, and research into the management of pain. From his perspective, the debate had only served to highlight that these were the central issues at stake, rather than the need to change the law to allow doctors to end the lives of their patients. In Thurlow’s opinion, Raglan’s speech was “an appalling confession of failure” containing what he viewed as the admission that “we should legalise euthanasia because there are not enough places like St. Christopher’s.”¹⁰⁴

When contrasted with previous House of Lords debates on voluntary euthanasia, the 1969 debate differs in a number of respects. In the arguments conducted around the earlier bills of 1936 and 1950, the Lords who opposed any change in the law had tended to emphasise the relationship of trust between the doctor and the patient. In this latest debate, however, it was the existence of an institutionalised form of care for the terminally ill that provided rhetorical weight to arguments that opposed legislative change. Lord Horder’s reference in 1936 to the question of the patient asking ‘you will stand by me, won’t you?’ and the doctor answering ‘yes, I will’, was now supported by providing a practical example of a form of medical care in which the relief of pain made a priority. This priority was given, not with reference to the private realm of the relationship between elite physician and patient, but rather with reference to a specialist branch of medicine that was entirely devoted to caring for incurable patients.

Lord Raglan's insistence that most patients wished to die at home could also be addressed. By 1969, St. Christopher's had its own team of staff dedicated to home care. In addition, if the patient could not remain at home, one of the aims of St. Christopher's was to make the hospice less like other forms of institutionalised medicine by attempting to create an environment in which the patient could feel as comfortable as possible. With hospice care as a practical alternative that could be expanded if only sufficient funds were made available, legalised euthanasia was portrayed as a short-sighted and expedient means of 'solving' the problem of patients in pain. Although other arguments that had been rehearsed before were made in opposition to the bill, including, for example, references to the dangers of opening the way for non-voluntary euthanasia, the debate over pain relief was now cast in a different manner. Even if many patients were unable to access the type of care offered by the hospice, the 'ideal' model was now in place. This set the standard and this provided a new strand of argument in opposition to the legalisation of euthanasia.

Interestingly, the Voluntary Euthanasia Society (the word 'voluntary' was reinstated in the society's title in 1969) had also shifted its arguments, and in a significant fashion. The VES was responsible for drafting the bill presented to the House of Lords in 1969 and again, it was stipulated that the request for euthanasia had to be certified by two doctors. This time, however, the clauses that defined the grounds for euthanasia were altered. Whereas in previous bills the case for euthanasia was specified as one in which "fatal illness" was "accompanied by severe pain", in 1969 a patient said to be suffering from "irremediable conditions" was deemed an appropriate case for voluntary euthanasia.¹⁰⁵ These "irremediable conditions" were further defined as: "physical illness thought to be incurable and expected to cause distress; or a condition of grievous physical affliction occasioning serious injury or disability thought to be permanent and cause distress; or a condition of physical brain damage or deterioration such that normal mental faculties are irreparably impaired".¹⁰⁶ In addition, in the final draft of the bill a reference to "incapacity for rational existence" was added as a supplement to the phrase "expected to cause distress".

Clearly, this significantly widened the scope of the proposals for legalised euthanasia. No longer was the focus purely on the incurable patient in pain. Now a whole range of cases were brought into the frame – from those who were diagnosed with a degenerative mental illness, such as dementia, to those who were diagnosed with an illness that would lead to loss of physical control, such as Parkinson's disease. To retain the 'voluntary' element to the legislation, it was proposed that any individual would be free to draw up an advanced

declaration. This declaration would explicitly set out the wishes of the patient in the event, for example, of an accident that resulted in brain damage, or the diagnosis of an illness that might later effect the capacity to make decisions. It would come into force thirty days after being made and would remain in place (unless revoked) for three years.¹⁰⁷

The explanation for the Voluntary Euthanasia Society's apparent movement away from a concern that focused solely on "fatal illness and severe pain" so as to include an expanded range of cases and an advanced declarations can be explained, I suggest, in two ways. The first explanation relates directly to a subject that has been a theme throughout this thesis, namely, the practice of pain relief. When the first attempt was made to legalise euthanasia in 1936, the concern had been with incurable patients suffering from what was viewed as the widespread problem of unrelieved pain. By 1969, this situation had altered. There was now very little debate about the ethical permissibility of administering pain-relieving drugs in liberal doses. As long as the intention of the doctor was the alleviation of pain rather than the deliberate shortening of life, this practice was deemed not only acceptable but the mark of good practice. Combined with the impact of the emergence of hospice care that sought to tackle the problem of terminal pain in a comprehensive, multi-faceted manner, arguments in favour of the legalisation of euthanasia were gradually changing in relation to the perceived 'problem' of pain.

In many ways, the advent of modern hospice care was a manifestation (in institutional form) of principled opposition to legalised euthanasia accommodating changes in medical attitudes and practices that related to pain relief. To some extent, palliative care undermined the arguments for legalised euthanasia that were based on the need to relieve pain. Those campaigning for a change in the law did not fully accept this accommodation between principle and practice. Yet they did adjust their arguments to allow for the existence of hospice provision for the terminally ill and to allow for the revised medical, legal and religious position that is was now permissible to liberally use pain relief at the end of life.

That is not to argue that the relief of pain was no longer a contested issue. As Leonard Colebrook's letters to Cicely Saunders reveal, the degree to which pain could be fully managed and alleviated remained a point of dispute. Although recognising that improvements had been made in the management of pain, The Voluntary Euthanasia Society did not concede that hospice care could be offered as a direct substitute for legalised euthanasia. The shift in emphasis was far subtler. Those who campaigned for legalised

euthanasia appeared to acknowledge that pain and suffering could be medically controlled by the use of analgesic drugs in the final days and hours of the patient's life, but not over the course of a lengthy period of illness. By rendering the patient unconscious until death occurred, the VES conceded in 1971 that "most deaths may be peaceful".¹⁰⁸ However, it was the "process of dying" that "may go on for weeks and months, and even for years" with which the organisation now stated that it was concerned.

The second explanation for the shift in the focus of the VES is that throughout the 1960s concern had been growing about medical intervention that was perceived as sustaining life in 'artificially'. This was a perception held not only by the general public, but also within medical quarters. For example, the *British Medical Journal* of February 1968 carried an article describing how a doctor (suffering from stomach cancer) was repeatedly resuscitated against his wishes after his heart stopped beating on five occasions. Preparations were being made to intervene with an artificial respirator, but the doctor died before this could be achieved.¹⁰⁹ Related to fears of medical intervention of this kind, was the increasing use of life-support technology that sustained patients, though damage to the brain prevented consciousness or communication.¹¹⁰ Revealingly, Lord Raglan stated in Parliamentary Debate of 1969 that "the doctor's dilemma is principally where there is not the presence of pain to provide an obvious guide as to what to do."¹¹¹ His interest was more in the concern that medical intervention, of the highly technological kind, was sustaining lives when "bodies" and "personalities" had "disintegrated".¹¹² In effect, it was the introduction of more highly technological forms of medical intervention that opened a new front of debate over euthanasia, presenting medical professionals and wider society with a new set of questions in relation to defining the boundaries between life and death.

Euthanasia debates were entering a different phase. Just as the medical profession was finding a new rhetorical and practical 'solution' to the campaign for legalised euthanasia and the issue of pain relief, a different set of questions concerning the relationship between perceived 'quality' of life and life-sustaining medical intervention was becoming part of the debate over euthanasia. This was uncharted territory. As arguments over pain relief reached a tentative end-point, another front in the debate over legalised euthanasia was opened. Exploring this debate is the subject for another thesis, but as contend in the following conclusion the negotiation between principle and practice remains a central component of the ongoing construction of debates both in favour and against legalised euthanasia.

Notes

¹ Strictly speaking, palliative medicine only became an accredited speciality in Britain when it was recognised by the Royal College of Physicians in 1987. The term 'palliative care' was first used in 1974 by Canadian surgeon Balfour Mount to mean the application of pain-relieving practices (developed initially in hospices) to a wider arena, for example specialised hospital units or home care services. See Constance Putnam, *Hospice or Hemlock, Searching for Heroic Compassion* (Conneticut and London, Praeger), 2002, p.44. See also David Clark, 'Between Hope and Acceptance: the Medicalisation of Death', *British Medical Journal*, 13 April 2002, 905-7, at p.905.

² See David Clark, "'Total Pain", Disciplinary Power and the Body in the Work of Cicely Saunders, 1958-1967', *Social Science and Medicine*, 49 (1999), 727-736.

³ It should be stated that the term 'euthanasia' continues to be defined in different ways and that examples can be found in the medical journals where writers continue to distinguish 'active' from 'passive' euthanasia. See, for instance, Len Doyal and Lesley Doyal, 'Why Active Euthanasia and Physician Assisted Suicide Should Be Legalised', *British Medical Journal*, 10 November 2001, 1079-80.

⁴ Julia Lawton, *The Dying Process, Patients' Experiences of Palliative Care* (London, Routledge, 2000), p.12.

⁵ Jane Elizabeth Seymour, 'Revisiting Medicalisation and "Natural" Death', *Social Science and Medicine*, 49 (1999), 691-704, at p.693.

⁶ Ibid.

⁷ The Irish Sisters of Charity founded St. Joseph's Hospice in 1905. See Caroline C. S. Murphy, 'From Fredenheim to Hospice, a Century of Cancer Hospitals', in Lindsay Granshaw and Roy Porter (eds), *The Hospital in History* (London, Routledge, 1990), 221-39.

⁸ Nicky James and David Field, 'The Routinization of Hospice: Charisma and Bureaucratisation', *Social Science and Medicine*, 34 (1992), 1363-1375, at p.1363.

⁹ Cicely Saunders, *Care of the Dying: Nursing Times Reprint* (London, Macmillan, 1959), p.1. This *Nursing Times* booklet contains reprints of earlier articles written by Saunders for the journal and her essay on 'The Problem of Euthanasia' appears at pp.1-6. For a review of this collection of essays, see 'Care of the Dying', *Lancet*, 2 April 1960, 735-6. For Cicely Saunders' first published paper see 'Dying of Cancer', *St Thomas's Hospital Gazette*, 56 (1958), 37-47.

¹⁰ Cicely Saunders began her career as a doctor in mid-life, after initially working as a nurse and medical almoner. Her first degree was from Oxford University where she read politics and philosophy. See Shirley du Boulay, *Cicely Saunders: The Founder of the Modern Hospice Movement*, 2nd edition (London, Hodder and Stoughton, 1994).

¹¹ Saunders, *Care of the Dying*, p.1.

¹² In light of Cicely Saunders' comment, it is worth recalling from earlier discussion in this thesis that a significant number of leading religious figures, particularly from the Anglican clergy, supported legalised euthanasia and were active members of the VES. Interestingly, the last but one Primus of the Scottish Episcopal Church, Bishop Alastair Hoggart, became deeply involved in the work of the Voluntary Euthanasia Society Scotland (VESS) in the 1990s. He saw no conflict between this and his Christian faith.

¹³ Saunders, *Care of the Dying*, p.5.

¹⁴ Ibid.

¹⁵ Lord Horder, 'Signs and Symptoms of Impending Death', *The Practitioner*, 161 (1948), 77-79 at p.79.

¹⁶ As discussed in the previous chapter, Horder summoned the notion of 'nature' in his address to the House of Lords debate in euthanasia debate of 1936. Interestingly, he struck a rather different tone in this earlier speech, suggesting that physicians might "give assistance to a kindly Nature" as opposed to simply allowing nature to "take its course" as he suggests in this journal article.

¹⁷ In his essay in *The Practitioner*, Horder also warned against "prolonging the act of dying", a view that he would later echo in the House of Lords parliamentary debate on euthanasia in 1950.

In a quote that exemplifies the emphasis placed on the individual judgement of the doctor in tailoring appropriate treatment for the patient, Horder argued that, "A good doctor distinguishes between prolonging life and prolonging the act of dying." See 'Voluntary Euthanasia', *The Lancet*, 9 December 1950, p.775.

¹⁸ Dr C. J. Gavey, *The Management of the Hopeless Case*, Buckston Browne Prize Winning Essay, Harveian Society of London (London, H.K. Lewis, 1950), 1-41, at p.39. In the preface to his essay, Gavey describes how the Harveian Society chose the management of the dying patient as "a subject deserving of wider recognition".

¹⁹ *Ibid.*, p.38.

²⁰ W. N. Leak, 'Care of the Dying', *The Practitioner*, 161 (1948), 80-87, at p.82.

²¹ David Clark, 'Cradled to the Grave? Terminal care in the United Kingdom, 1948-1967', *Mortality*, 4:3 (1999), 225- 245, at p.231.

²² Leak, 'Care of the Dying', at p.80, quoted by Clark, 'Cradled to the Grave?', p.231.

²³ A. Leslie Banks, 'Euthanasia', *The Practitioner*, 161 (1948), 101-7, at p.107

²⁴ See Clark, 'Cradled to the Grave?', pp.227-231.

²⁵ See Clark, *ibid.* The Calouste Gulbenkian Foundation published Glyn Hughes' report, *Peace at Last*, in 1960. The foundation takes its name from its founder, the philanthropist and businessman Sarkis Calouste Gulbenkian who came to Britain in 1869 from Armenia. It continues to fund research today and also gives backing to projects in science and the arts. Interestingly, the foundation recently supported a study on the work of the Cumbrian Hospice at Home initiative. See Andrew Bibby, *Hospice Without Walls: The Story of West Cumbria's Remarkable Hospice at Home Service* (London, Calouste Gulbenkian Foundation, 1999).

²⁶ See Clark, 'Cradled to the Grave?', p.24.

²⁷ J. H. Sheldon, 'The Aged Sick and Infirm', *British Medical Journal*, 7 January 1954, pp.1425-1426.

²⁸ J. H. Sheldon, *Report to the Birmingham Regional Hospital Board on its Geriatric Services*, 1961, cited by James and Field, 'The Routinization of Hospice', p. 1364,

²⁹ The Ministry of Health Report concluded that geriatric units were frequently the responsibility of doctors who had little interest in or experience of caring for the chronically sick and elderly. There was also a shortage of nursing staff on what were considered low priority wards. See Moira Martin, 'Medical Knowledge and Medical Practice: Geriatric Medicine in the 1950s', *Social History of Medicine*, 8, (1995), 443-461, at p.451.

³⁰ Dr Marjorie Warren, 'Care of the Chronic Aged Sick', *Lancet*, 8 June 1948, pp. 841-2. See also Pat Thane, 'Inventing Geriatric Medicine', in Roger Cooter and John Pickstone (eds), *Medicine in the Twentieth Century* (Amsterdam, Harwood Academic Publishers, 2000), 436-61.

³¹ Lord Amulree, a physician at University College Hospital, London, fostered an interest in the care and conditions of the elderly and was a member of the British Medical Association committee established in the late 1940s that examined standards of care for the aged. Marjorie Warren was also a member of this committee. As discussed in the previous chapter of this thesis, Lord Amulree opposed the legalisation of euthanasia in the 1950 House of Lords debate.

³² Surveys of patients in hospitals during the Second World War revealed that many elderly patients were grouped together on the wards of Public Assistance Institutions (PAIs). Irrespective of their individual physical or mental conditions, these elderly patients were often confined to their beds. The Ministry of Health carried out these studies as part of an assessment programme to determine whether or not PAIs could accommodate war casualties. The surveys, conducted by senior consultants from voluntary hospitals, uncovered the extent of untreated sickness and unrelieved pain in PAI 'chronic' wards. Working at the Ministry of Health throughout the war, Lord Amulree was given responsibility for conditions in the PAIs. It was during this period that he gained much of his experience and knowledge in the problems of caring for the elderly. See Martin, 'Medical Knowledge and Medical Practice', pp.445-6.

³³ Martin, 'Medical Knowledge and Medical Practice', p.449.

³⁴ 'Euthanasia', *Lancet*, 12 August 1961, p.351.

³⁵ See James and Field, 'The Routinization of Hospice', p.1364.

³⁶ Leonard Colebrook (1883-1967) began his pre-medical studies in 1900 at the London Hospital Medical College, subsequently winning a scholarship to St. Mary's Hospital and graduating in 1906. Sir Almroth Wright of the Medical School at St. Mary's Hospital nurtured Colebrook's interest in pathology and bacteriology and a year after qualifying Colebrook was appointed as his assistant in the Inoculation Department of St. Mary's Hospital Medical School, remaining there until the outbreak of war in 1914. When 'treatment by vaccination' beds were allocated to Sir Almroth, Colebrook was the first resident medical officer appointed to these special wards. Colebrook's interest in vaccine therapy, tuberculosis and pneumonia continued throughout his career, combined with an interest in the treatment of burns and scalds. In his later years, he became an active supporter of the legalisation of euthanasia. See 'Leonard Colebrook 1883-1967', *Biographical Memoirs of the Fellows of the Royal Society*, 17 (1971), 91-138.

³⁷ Cicely Saunders, 'And From Sudden Death ...', *Nursing Times*, 17 August 1962, 1045-6, at p.1045. Reprint abridged from an article that originally appeared in the journal *Frontier*, Winter 1961.

³⁸ Saunders, 'And From Sudden Death', p.1045.

³⁹ The correspondence between Cicely Saunders and Leonard Colebrook can be found in the archive of Dame Cicely Saunders' papers, Trent Palliative Care Studies Centre, University of Sheffield. All references to this correspondence are from Box 15, File 1/2/96.

⁴⁰ In her article, 'The Problem of Euthanasia', Cicely Saunders argued that the members of the Euthanasia Society contended that euthanasia was "in accordance with both humanitarian and Christian concern for distress". However, she argued, they were "unable to produce any statistics for the proportion of these patients who suffer from intractable pain". Leonard Colebrook responded in a letter to Cicely Saunders in which he pointed out that he was surprised that she had reproached the Euthanasia Society for having produced no data about the numbers who were suffering. It was, he wrote, "precisely in the hope of getting such data that I got in touch with you". He added that he was still trying to collect evidence "as to the need for euthanasia", but that it was not easy since he had neither access to any "terminal homes" nor did he know anyone working in them. He did, however, congratulate Dr Saunders on her articles in the *Nursing Times* and commented that he had read them "with interest and profit." Leonard Colebrook (LC) to Cicely Saunders (CS), 30 August 1958. In her reply, Cicely Saunders conceded she only had the information that the Euthanasia Society had no data to substantiate its position as a result of her direct communication with Colebrook. It was, she concluded, "probably rather mean" to have used this in her article – nevertheless, she still felt that his position was "not the answer". CS to LC, 8 December 1959.

⁴¹ LC to CS, 10 December 1959.

⁴² *1962 Euthanasia Society Statement – Revised and Enlarged Edition of the 1961 Case for Voluntary Euthanasia* (Leicester, C. H. Gee and Co Ltd, 1962). In this publication the Euthanasia Society listed a number of prominent supporters of the organisation including Dame Peggy Ashcroft and Vera Brittain. Interestingly, the pain specialist Dr W. Ritchie Russell is also listed as a member. When in 1960 Leonard Colebrook's wife, Vera, contracted shingles, Colebrook wrote to Saunders to say that Vera's GP was "very reluctant to use morphine or opium" to control her pain. Saunders recommended that he contact Dr Russell to seek help. Colebrook later reported that his wife was "very much better" and that the experience had brought home to him "how many patients do not get opium derivatives for fear of addiction".

⁴³ At times in his correspondence with Cicely Saunders, Leonard Colebrook made light of his own religious scepticism. For example in a letter dated 26 February 1960 he described the nuns at St Joseph's as being "anxious about my poor soul" and concluded the letter by wishing Dr Saunders "pagan blessings". However, in other letters he was more critical of debating euthanasia from a religious perspective. In a letter discussing a forthcoming BBC radio broadcast in which both doctors were participating, Colebrook wrote: "I personally would be sorry if our conversation drifted into a more or less academic discussion about the relation of Mrs Brown's suffering to happenings in the Garden of Eden. If you feel strongly that such a discussion is fundamental to the whole problem then perhaps we had better abandon the project as unlikely to be useful." LC to CS, 13 August 1961.

- ⁴⁴ CS to LC, 8 December 1959.
- ⁴⁵ LC to CS, 10 December 1959.
- ⁴⁶ Ibid.
- ⁴⁷ C. Dennis Pegge, *Will Euthanasia Become Legal?* (London, CPU Ltd, 1962), p.10.
- ⁴⁸ Leonard Colebrook, 'The Liège Trial and the Problem of Voluntary Euthanasia', *Lancet*, 8 December 1962, p.1225.
- ⁴⁹ 'Euthanasia', *Lancet*, 12 August 1961, p.351. The *Lancet* editorial argued that campaigners for legalised euthanasia assumed that doctors would "do the painless killing" and that they suggested that "but for the law he [the doctor] would do it quite willingly". The journal challenged this position and added that it was tempted to ask whether all those who were willing to endorse the legalisation of euthanasia would also be willing to be put in the position of carrying out the task of administering a fatal injection. There was, the article argued, "for the agent if not for the subject, a very real difference between shortening life when this is a price that has to be paid for the relief of suffering, and deliberately, conclusively, killing with a lethal drug".
- ⁵⁰ Leonard Colebrook, 'Euthanasia', *Lancet*, 26 August 1961, p.485.
- ⁵¹ Ibid.
- ⁵² Ibid. After an invitation from Cicely Saunders to come to St Joseph's, Leonard Colebrook visited the hospice in early 1960. After his visit, Cicely Saunders wrote to Leonard Colebrook telling him, "we all very much enjoyed meeting you when you came to St Joseph's. I do hope that we did not bully you too much! We shall be very pleased for you to bring your wife at any time, or any other member of the Euthanasia Society who would like to come." CS to LC, 25 February 1960.
- ⁵³ Leonard Colebrook, 'Euthanasia', *Lancet*, 26 August 1961, p.485.
- ⁵⁴ Ibid.
- ⁵⁵ CS to LC, 8 December 1959.
- ⁵⁶ CS to LC, 7 September 1961.
- ⁵⁷ Ibid.
- ⁵⁸ Cicely Saunders, 'Euthanasia', *Lancet*, 2 September 1961, p.548.
- ⁵⁹ Ibid.
- ⁶⁰ Ibid. After the publication of her *Lancet* letter, Cicely Saunders wrote to Leonard Colebrook to thank him for mentioning St. Joseph's (in his own letter to the journal) "in such kind terms". However, she wanted to make clear in the *Lancet* that she was not alone in wishing to improve standards of care for the dying or that religion was the only comfort that was offered. She wrote: "I did not want the other homes to feel slighted or that everyone should have the picture of 'Dr Saunders and her band of holy women' ... people are so apt to think that one is a crank and I wanted them to see that this is something very worthwhile medically as well as otherwise." CS to LC, 7 September, 1961.
- ⁶¹ CS to LC, 25 February 1960.
- ⁶² Ibid.
- ⁶³ Leonard Colebrook to Cicely Saunders, 10 December 1959.
- ⁶⁴ *List produced on request of the drugs most commonly used at St Joseph's Hospice*, undated, Cicely Saunders Archive: Box 1, File 1/1/4.
- ⁶⁵ Ibid., p.1.
- ⁶⁶ Dr John H. Hunt and Dr Michael J. Linnett, 'Intractable Pain', *British Medical Journal*, 4 June 1960, 1723-9.
- ⁶⁷ Ibid., at p.1723.
- ⁶⁸ Ibid.
- ⁶⁹ Ibid., p.1725.
- ⁷⁰ Ibid.
- ⁷¹ Isabelle Basanger, 'Pain Physicians: All Alike, All Different', in Marc Berg and Annemarie Mol (eds), *Differences in Medicine: Unravelling Practices, Techniques and Bodies* (Durham and London, Duke University Press, 1998), 119-143, at p.124.
- ⁷² Ibid.

⁷³ Hunt and Linnett's article recommended that stimulants be used to counteract the side effects of morphine (often persistent drowsiness), thus keeping the patient "alert and co-operative with an interest in life", p.1725.

⁷⁴ Hunt and Linnett, 'Intractable Pain', p.1725.

⁷⁵ A. N. Exton Smith, 'Terminal Illness in the Aged', *Lancet*, 5 August 1961, 305-8. Exton Smith's study examined the pain and distress experienced by a group of 220 elderly patients during illness. As well as assessing physical pain and suffering, attention was also paid to the circumstances of death and each patient's mental state – especially awareness of conditions and surroundings. The study combined individual case descriptions with statistical analysis of the number of patients complaining of moderate or severe pain. Pain was judged to be severe or moderate when it did not respond to aspirin or other similar drugs but required more powerful analgesics such as morphine. Analysis was also made of the number of patients suffering other distressing symptoms (such as persistent nausea, vomiting, dysphagia and breathlessness) or experiencing mental deterioration. Interestingly, the report highlighted and went some way to explaining the wide variation in statistics on the prevalence of pain in cancer patients. While the Marie Curie Foundation findings of 1952 had concluded that 68% of a group of patients suffered moderate to severe pain, this figure was almost halved in Exton Smith's study. This was explained by the contrast in age ranges surveyed in the two studies. The Marie Curie report had looked at all ages of cancer sufferers, while Exton Smith had assessed patients where the average age was eighty. A "remarkable feature of old age," wrote Exton Smith, "is the poverty of constitutional reactions to infection and injury". Old age brought a blunting of sensibility to pain, he argued, adding, "it is generally accepted that malignant disease causes less pain and suffering in the elderly than in younger people."

⁷⁶ The work of Exton Smith also fed into the mid-twentieth century debate over the care of the elderly in general and the growth of geriatrics as a clinical speciality. In an earlier study published in 1952, Exton Smith found that the majority of elderly patients he surveyed were being cared for in hospital because their home conditions were unsatisfactory. Despite this, Exton Smith maintained that, ideally at least, "home was the best place for the elderly". See A. N. Exton Smith, 'Investigation of the Aged Sick in their Homes', *British Medical Journal*, 14 July 1952, 182-6.

⁷⁷ Exton Smith, 'Terminal Illness in the Aged', p.307.

⁷⁸ *Ibid.*, p.306.

⁷⁹ J. M. Hinton, 'The Physical and Mental Distress of the Dying', *Quarterly Journal of Medicine*, 32:125 (1963), 1-21, at p.15. See also John Hinton, *Dying*, 3rd edition (London, Penguin Books, 1991).

⁸⁰ LC to CS, 26 February 1960.

⁸¹ *Ibid.*

⁸² 'Euthanasia', *Lancet*, 12 August 1961, p.351.

⁸³ Cicely Saunders wrote to Leonard Colebrook to ask permission to use an extract from a section of his earlier correspondence. She wrote: "I am writing out an appeal and trying to get it into a form that is going to be telling and intelligible. While I was talking to Sir Kenneth Grubb about this I mentioned that you had been round St. Joseph's and what you had said about it and how it had helped you to 'get this difficult problem into perspective'. He thought that this was really good propoganda for us and I wondered whether you would allow me to quote from your letter to me in our appeal? In it you said that 'I still feel that there would be little or no problem of euthanasia if all terminal disease folks could end their lives in that atmosphere that you have done so much to create." Saunders added that Colebrook's interest was "a help in various ways, ... and would carry weight with other people." CS to LC, 12 December 1960. The "appeal" to which Saunders refers in this letter, relates to her plan to establish a new hospice for the care of the dying – which she achieved when St. Christopher's Hospice was opened in 1967. In preparing ground and seeking support for the opening of the hospice, Saunders enlisted the help of a number of figures with either religious or medical backgrounds. Sir Kenneth Grubb, whom she mentions in this letter, was then President of the Church Missionary Society. See David

Clark, 'Originating a Movement: Cicely Saunders and the Development of St Christopher's Hospice, 1957-1967', *Mortality* 3:1 (1998), 43-63.

⁸⁴ 'Euthanasia', *Lancet*, 12 August 1961, p.351.

⁸⁵ Ibid.

⁸⁶ CS to LC, 8 December 1959.

⁸⁷ James and Field, 'The Routinization of Hospice', at p.1365.

⁸⁸ The mid-twentieth century was a period when clinical interest was growing in the cultural and environmental influences on the experience of pain. In 1959 the physician Henry Beecher highlighted the impact of environmental factors on the sensation and perception of pain in his study of injured soldiers during the Second World War. The soldiers reported feeling little or no pain, despite having suffered serious injuries. After concluding that they were capable of feeling pain, Beecher argued that their perception had been altered by the knowledge that they were able to return home. H. Beecher, *Measurement and Subjective Responses*, (Oxford, Oxford University Press, 1959). See Gillian Bendelow and Simon Williams, 'Pain and the Mind-Body Dualism: A Sociological Approach', *Body and Society*, 1:2 (1995), 83-103, at p.95.

⁸⁹ Clark, "Total Pain", *Disciplinary Power and the Body*, at p.729. Elisabeth Kübler-Ross developed the influential theory of the "stages of dying" which considered psychological as well as physical dimensions to death. See Elisabeth Kübler Ross, *On Death and Dying* (New York, Macmillan, 1969).

⁹⁰ Cicely Saunders, 'Euthanasia', *Lancet*, 2 September 1961, p.548.

⁹¹ LC to CS, 3 September 1961. Colebrook quotes from Saunders' letter to the *Lancet* of 2 September 1962.

⁹² Ibid. Leonard Colebrook added that he felt that the proponents of legalised euthanasia would "perhaps get nowhere until a doctor had the courage to give relief to some case of unrelieved suffering – and to take the consequences of a court action".

⁹³ Ibid.

⁹⁴ CS to LC, 7 September 1961.

⁹⁵ Ibid.

⁹⁶ Ibid.

⁹⁷ For examples of the literature in question, see Barney Glaser and Anselm Strauss, *Awareness of Dying* (Chicago, Aldine, 1966) and Kübler Ross, *On Death and Dying*. For the comments made by Ariès, see *The Hour of Our Death* (London, Allen Lane, 1981), p.579.

⁹⁸ David Armstrong, 'Silence and Truth in Death and Dying', *Social Science and Medicine*, 24:8 (1987), 651-7.

⁹⁹ See also David Armstrong, *Political Anatomy of the Body: Medical Knowledge in Britain in the Twentieth Century* (Cambridge, Cambridge University Press, 1983), p.110.

¹⁰⁰ See Susan Sontag, *Illness as Metaphor and Aids and Its Metaphors* (London, Penguin, 2002).

¹⁰¹ House of Lords, 'Voluntary Euthanasia Bill', *Hansard*, 25 March 1969, cols 1143-1254. See also 'To Be or Not To Be?' *Nursing Times*, leading article, 20 March 1969, 382; 'Lords Reject Voluntary Euthanasia Bill', *Nursing Times*, leading article, 3 April 1969, 446, and 'Killing of Patients', *BMJ*, leading article, 5 April 1969, 4-5.

¹⁰² 'Voluntary Euthanasia Bill', 1969, col.1146.

¹⁰³ Ibid.

¹⁰⁴ Ibid., col.1201.

¹⁰⁵ A copy of the Voluntary Euthanasia Bill of 1969 can be found in Appendix C at the end of Hugh Trowell's *The Unfinished Debate on Euthanasia* (London, SCM Press, 1973), 172-6.

¹⁰⁶ Ibid., p.174.

¹⁰⁷ Ibid.

¹⁰⁸ See 'Doctors and Euthanasia: A Rejoinder to the British Medical Association's Report on Euthanasia, Voluntary Euthanasia Society, May 1971' in Trowell, *The Unfinished Debate*, Appendix B, 156-171, at p.161. For other examples of comment on euthanasia in 1971, see 'Easeful Death', *Nursing Times*, leading article, 28 January 1971, 97, and D. A. Roche, 'Suicide and Euthanasia', *British Medical Journal*, 3 July 1971, 50.

¹⁰⁹ W. St. C. Symmers, 'Not Allowed to Die', *British Medical Journal*, 17 February 1968, 442.

¹¹⁰ See 'When Do We Let the Patient Die?', *Annals of Internal Medicine*, editorial article, 68:3 (1968), 695-700.

¹¹¹ Voluntary Euthanasia Bill', 1969, col.1149.

¹¹² Ibid.

CONCLUSIONS

In July 2000, the Wellcome Wing at the Museum of Science in London put on public display a 'Euthanasia Machine' that had been used in the Northern Territories of Australia to allow a small number of terminally-ill patients to end their own lives.¹ The decision to exhibit the machine attracted a considerable amount of publicity and controversy. Yet it was remarkably mundane in appearance: a simple laptop computer attached to a battery, air pump and syringe driver, that functioned by running a software package with the emotive title 'The Deliverance Programme'. After a series of questions, the programme would ask the patient if he or she wished to die. If the 'yes' button was pressed three times the computer activated the pump and a lethal dose of drugs was injected through a needle strapped to the patient's arm.

In many senses, this computer that ends human life with the touch of a button appears to bring to fruition all the aspects of 'medicalised' death that so pre-occupied and concerned Philippe Ariès and Ivan Illich. Technical, efficient and managed by machine – even the role of the doctor is usurped in this twenty-first century version of requested death. At first glance, it seems that this confirms the commonly held perception that euthanasia debates are the product of a bio-technological age. Depending on the interpretative slant of the viewer, this machine might epitomise all that is 'artificial' with legalised requested death, or, alternatively, represent a defiant attempt to regain control at a time when medical intervention has already collapsed the 'natural' boundaries between life and death. However, what I have attempted to argue and illustrate in this thesis is that despite the immediate appeal of this view, debates over euthanasia have earlier historical origins that are rooted in nineteenth-century arguments about the meaning of pain and the practice of pain relief.

I began by considering how the idea of 'natural' death – the concept that death was a peaceful, gentle and painless transition from one world to the next – became established as the dominant paradigm of euthanasia (the 'good' death) in the nineteenth century. As orthodox theological interpretations of the 'value' of pain began to weaken, the ability of the doctor to intervene with powerful pain-relieving drugs allowed the patient's final days and hours to conform to the conventions of this ideal model of 'natural' death. The physician played an increasingly managerial role at the deathbed, administering drugs that secured

bodily calm and attending to psychological distress by offering the comforts of religious belief and a faith in his own professionalism.

It was not until the 1870s that the word 'euthanasia' began to be used to evoke the idea of the physician administering pain-relieving drugs so as to end life at the request of the patient. Earlier in the nineteenth century, the term was used in its classical form, implying a 'good' death that was calm and easy, rather than evoking any sense of mercy killing or requested death. Ending the life of the dying patient was expressly forbidden; indeed, a number of elite Victorian physicians expressed the view that it was the doctor's duty to prolong life, even if death appeared to be imminent. However, although the term 'euthanasia' would only begin to change in meaning towards the end of the nineteenth century, in the preceding years medical judgement and intervention were already an important part of the debate over how to achieve a 'good' death.

The mid-nineteenth century doctor was faced with a range of decisions when caring for the dying patient. Was curative treatment to be withheld or withdrawn? Was the patient to be informed of his or her prognosis? While the exact timing of death was judged to be the province of God and nature, this did not mean that the physician was passive. Clinical judgement played a crucial part in tailoring treatment to suit the individual requirements of the patient as the doctor strove to stage-manage the ideal form of 'natural' death. The image of the Victorian physician as a bearer of comfort and reassurance to the incurable patient is only part of the picture of nineteenth-century pain relief. While the medical profession maintained a united front in its commitment to anaesthesia, when discussing pain relief within the confines of the medical journals there was a more open acknowledgement of the potential risks and side effects of using drugs such as chloroform and morphine. This assessment of the risks and benefits of pain relief was rarely explicitly made when discussing the medical management of the dying patient. For example, while there was a vigorous debate about the dangers of chloroform precipitating death in surgical situations, this debate was not transferred to discussion of chloroform use in the care of the dying.

Nevertheless, the widespread use of analgesic drugs and the associated arguments that accompanied the new pain-relieving practices brought into focus two competing ethical models that would resonate in later debates over euthanasia. The first valued the preservation and 'sanctity' of life above all else, while the second considered the minimisation (and if possible the eradication) of pain to be of greater importance. As I argued in the early

chapters of this thesis, the introduction of anaesthesia signalled the growing legitimacy of renouncing pain even if this implied anxiety about exposing the patient to potential danger. Interestingly, however, when it came to care of the dying patient and the use of pain relief, the medical profession maintained that there was no disruption in the overarching principle of 'sanctity' of life. The new pain-relieving techniques were absorbed into a notion of a calm, peaceful and 'natural' death.

Medicine was portrayed as assisting rather than challenging the course of nature. Nineteenth-century doctors mobilised a number of arguments in order to support the idea that death was not to be feared. Death was depicted as an experience that was frequently painless (even in the absence of medical intervention); the importance of religious faith was underlined as a valuable source of psychological support; and medical intervention in order to relieve pain was promised. Yet, as I have argued, beyond the commitment to the principle that it was wrong for the physician to end life lay a more complex picture in which great weight was placed on the individual doctor's own clinical judgement when caring for the dying patient. The word 'euthanasia' may have remained faithful to its classical, etymological roots, but given that the doctor had now assumed a key role in securing the 'good' death, it was a term that implicitly referred to the importance of medical intervention, and, in particular, pain-relieving practices. In defining the role of the physician in the medical management of death, medical practice was translated into a shared form of language that could be employed when discussing care of the dying. This included defining justifiable and unjustifiable forms of medical intervention and drawing subtle distinctions between the 'preservation' and the 'prolongation' of life. Despite a collective insistence that life should not be shortened in any way, there were variations in the manner in which doctors articulated medical practice. While some referred to the duty of the physician to 'prolong' life, others rejected this view and stated that while life should not be shortened, equally, it should not be deliberately lengthened.

It was against this background of the negotiation between the principle that the physician was forbidden from ending life and the practice of pain relief, that non-medical writers began to use the term 'euthanasia' in a sense that implied the physician explicitly and deliberately ending life at the patient's request. The use of analgesic drugs was an integral part of this proposal. It provided the practical means of securing a quick and painless death and supported the argument, at least in the view of those who advanced the idea of requested death, that doctors were already interfering with nature when they sought to relieve pain. The

principle of the sanctity of human life was undermined by the medical profession's habitual recourse to pain relief, argued supporters of this version of euthanasia. Despite medical claims to the contrary, drugs such as chloroform and morphine *did* shorten life, they maintained, adding that their proposals were only a logical extension of the desire to alleviate pain. As I have considered, the relief of pain was not the only factor that appeared to motivate calls for physician-induced death. However, it was an important focal point for those who advocated requested death in the late nineteenth century and, indeed, would remain so during the campaign for legalised euthanasia in the first half of the twentieth century.

More than sixty years would elapse between Samuel D. Williams first using the term 'euthanasia' to evoke the idea of the physician ending life by means of administering a sufficiently strong dose of pain relief, and the first attempt to legalise voluntary euthanasia. Although in 1936 the collective position of the medical profession was one that remained opposed to any suggestion that the doctor should end life, there were subtle shifts in the way in which the practice of pain relief was articulated in relation to the care of the dying patient. Doctors began to concede that the use of pain-relieving drugs had the potential to hasten death. However, a distinction was drawn between what was seen to be the private, unscrutinised realm of the individual doctor easing the suffering of the incurable patient in pain, and the proposals for legalised euthanasia. The first was perceived to be based on a relationship of trust, a relationship that was cemented by the doctor's assurance to the patient that death would be made as easy and as painless as possible. The second was portrayed as the state endorsement of legalised killing, a move that threatened not only to impose intrusive bureaucracy in the final stages of a patient's life, but to also undermine the sense of faith that the patient placed in the doctor. Moreover, if the first image was compatible with the ideal of 'natural' death, the second was viewed as a direct challenge.

The process of accommodating pain-relieving practices that potentially hastened death to the principle that the physician should not end life culminated in the 1950s and 1960s. By emphasising that it was the intentions of the doctor administering pain relief, rather than the outcome of the use of analgesic drugs, provided the guide to acceptable and unacceptable forms of medical practice, the principle of 'double effect' was publicly acknowledged in religious, legal and medical circles. This signified the acceptance that the use of drugs, if given solely with the intention of relieving pain, was justifiable medical practice even if death was hastened as a result. In stressing the importance of the intentions of the doctor, the

liberal use of pain relief was now endorsed while preserving the principle that it was ethically wrong for the physician to intervene so as to precipitate the patient's death.

This view that embraced the use of pain relief that potentially hastened death yet simultaneously upheld the principle that the physician should not (deliberately) end life, was a position that, as I have explored in this thesis, evolved through a process of negotiation and debate. In many ways, the advent of the philosophy of the hospice movement marked the medical consolidation of this position and, with the opening of St. Christopher's Hospice in 1967, its manifestation in institutional form. Robust in her opposition to legalised euthanasia, Cicely Saunders argued that to intentionally cut short the life of a patient would mean doctors assuming a role that was, in her view, the province of a divine power. However, her opposition was also based on a practical argument. She maintained that legalised euthanasia was simply unnecessary once pain was properly controlled and medically managed.²

The concept of 'total pain', as developed by Saunders, was an innovative response to both the physical and psychological needs of the terminally ill. Physical pain was tackled with an array of therapeutic strategies that included drugs being used in different combinations and doses that were given, if required, at regular intervals. Once the patient was relieved of physical suffering, it was argued, the psychosocial dimensions to pain could then be addressed. The notion of 'total' pain was novel, but it is interesting to consider how the attitudes of nineteenth-century physicians in relation to care of the dying also appear to resonate in the approach of the hospice movement. Nineteenth-century doctors, such as Henry Halford, Benjamin Brodie and William Munk, also took the view that pain operated on a number of levels. They too made the connection between physical and psychological pain and argued that both had to be confronted in order for the patient to secure a 'good' death.

This similarity between the twentieth-century concept of 'total pain' and the approach of nineteenth-century physicians to the dying gives an insight, I argue, into some of the success of the ideas behind the hospice movement. Hospice care offered both medical and social support for the terminally ill. In seeking to distance itself from other forms of institutionalised medicine, the language of hospice philosophy, as illustrated by Cicely Saunders, spoke frequently of the need to treat the patient as an individual and to relax any strict adherence to general rules when it came to administering pain relief. Although, as I suggested, the argument could be made that the discourse of hospice care and 'total' pain is

'imposed' on the patient, it might also be argued that the hospice setting allowed for idiosyncrasies and differences in patients and tailored treatment accordingly. Certainly, there is a sense that when the ideas of the hospice movement were in their early stages, part of the hospice 'ideal' was to establish a relationship of intimacy and trust between the patients and medical professionals. In this sense, the discourse of the hospice resonates with the language of palliation used by elite nineteenth-century doctors when discussing care of the dying. The hospice movement's 'reinvention' of older medical attitudes to the management of death (that pre-date the growth of state-run institutionalised medicine), combined with a willingness to develop innovative pain-relieving techniques, had a significant impact on twentieth-century medical discourse on death and dying. It also, once hospice care was consolidated and expanded, had an important impact on way in which medical care was practically administered to patients who were terminally ill.

There are now more than two hundred hospices in Britain. Some are run by the National Health Service but the great majority are independent charities based in their own communities and reliant on locally donated funds.³ Given that only a small proportion of deaths occur in a hospice setting, the aim of medical professionals working in palliative care is to seek a greater transference of hospice practices to hospital wards and patient homes.⁴ There is also growing interest in the ways in which the principles of hospice and palliative care might be applied to older people in care homes or with mental illness.⁵ The concept of loss of sense 'self' and the notion of 'social' death are frequently referred to in academic literature that explores the experiences of patients with illnesses such as Alzheimer's disease or dementia.⁶ There is, therefore, the potential for hospice care, with its record of success in treating terminal illness, to be applied to the care of elderly patients with a very different set of needs.

At the end of the last substantive chapter of this thesis, I concluded that acceptance of the concept of 'double effect' and the emergence of hospice care provided the medical profession with both rhetorical and practical 'solutions' to the debate over legalised euthanasia and pain relief. I also argued that the Voluntary Euthanasia Society shifted its position somewhat in the late 1960s and conceded that there had been improvements in the medical management of pain. The Voluntary Euthanasia Bill of 1969 was the last attempt to seek a change in the law with a proposal that explicitly made reference to the word 'euthanasia. It is at this point that the main analysis of my thesis draws to a close. However, it must be said that there have since been efforts to formally alter the status of the law with

regard to the doctor-patient relationship. For example, in 1976 a bill was presented to the House of Lords in which one of the clauses stated that the patient should be entitled to complete relief from suffering. The clause stipulated that, if requested, the physician should render the patient unconscious in the event of other forms of pain-relief proving ineffective.⁷

The bill was easily defeated, not least because the majority of Lords considered there was no need for such legislation. Tellingly, the opinion was expressed that the alleviation of pain was already the duty of the doctor, even in situations where death might be hastened as a result.⁸ For those who opposed the bill, the accommodation between the principle that the doctor is prohibited from ending life and the practice of pain relief appeared to be comfortably established. However, the fact that a bill was even presented that included a clause pre-occupied with securing complete alleviation of suffering for the patient suggested that although improvements in pain-relief were recognised, there remained dispute about the degree to which pain was being successfully managed in all cases.

Yet, even after acknowledging this concern with the practice of pain-relief, this proposed legislation revealed the increasing shift from a concern with pain to issues related to perceptions of 'quality' of life – issues that were not necessarily tied to the patient experiencing physical pain, or for that matter, fatal illness. Other clauses in the bill stated that patients affected by degenerative illness or brain damage should not have their lives sustained by medical intervention if they had earlier expressed (in a written statement) a wish to die.⁹ This was the new element to the debate over euthanasia. Just as in the argument over pain-relief, the withholding or withdrawal of life-sustaining technology has also undergone negotiation and debate in the latter half of the twentieth century (indeed, it continues today) as part of an on-going process of accommodation between established principle and changing medical practice.

It is true that unlike other European countries, for example the Netherlands and Switzerland, Britain has resisted any moves to legalise patient-requested death.¹⁰ However, the British courts have displayed a degree of flexibility, making decisions on a case-by-case basis which in turn establish precedents that provide legal 'markers' when assessing medical-ethical dilemmas. The most recent case to attract attention was the case of Ms B, a paralysed patient whose life was being supported by a ventilator. She requested that her doctors turn off the ventilator and when they opposed, the court ruled that she was within her rights to refuse treatment, even if this resulted in her death.¹¹ The case of Ms B was

particularly important because it coincided with the failure of Diane Pretty's attempt to secure her 'right-to-die' at the European Court of Human Rights in Strasbourg. She had already lost her case in the British courts.¹² Mrs Pretty, a motor-neurone disease patient, subsequently died in hospice care. For euthanasia campaigners, the two cases represented the unfairness and hypocrisy that, in their view at least, characterises legal and medical definitions of 'acceptable and unacceptable' forms of medical intervention. Legally, however, distinctions have been drawn between what is judged to be the legitimate withdrawal or withholding of medical treatment that sustains life and the illegitimate intervention of medical treatment that ends life. The patient may request and consent to the former but not the latter.¹³

This is stating very simply what is a complicated area of medical-ethics. A fuller and more satisfactory explanation of the arguments and negotiations involved is the subject for another thesis. However, there is one point that I wish to make about the cases of Ms B and Mrs Pretty that is perhaps neglected in the medical-ethical literature that discusses the distinctions between the legal withdrawal and withholding of treatment and the illegal ending of life. Beyond the debate about 'acts' and 'omissions' lies an important point about the way in which medicine, the law, and indeed, wider society distinguishes between 'natural' and 'artificial' deaths. I suggest that the paralysed woman was perceived as being 'kept' alive and therefore prevented from dying a 'natural' death. Mrs Pretty was seen as wanting to die in a manner that used medical intervention to disrupt the 'natural' order to life and death. To consent to her death, therefore, would have been to allow a death that was wholly 'artificial'. Of course, this is not a view that is universally shared. So long as the distinction between 'natural' and 'artificial' death is contested, there will be support for and opposition to the concept of legalised euthanasia. The way in which medical practice is articulated and understood remains an integral part in this argument.

Ivan Illich's appeal to the image of Nemesis based on what he views as the all-encompassing stranglehold of medical power on Western life may indeed be overstated, but it is nonetheless powerful. He writes:

The Greeks saw gods in the forces of nature. For them, Nemesis represented divine vengeance visited upon mortals who infringe on those prerogatives the gods enviously guard for themselves. Nemesis was the inevitable punishment for the attempts to be a hero rather than a human being.¹⁴

Even though the subject of euthanasia was not Illich's particular target when he wrote these words, his reference to infringing "on those prerogatives the gods enviously guard for themselves" resonates with a certain view of euthanasia. Is euthanasia the desire to control and shape nature as this view suggests? Or is it merely the means by which the men and women can 'naturally' claim what it is to be "human" as opposed to being "heroes" in the face of either physical or psychological suffering?¹⁵ Across two centuries, the public position of the medical profession has been to reject the idea that legalised, physician-administered ending of life is in any sense a legitimate development of the medical practice. Yet the euthanasia debates examined in this thesis are about more than opposition to legislative change. They are also about the way in which changing practice was articulated and understood so as to preserve a concept of 'natural' death but at the same time embrace new medical techniques. This process continues today.

Notes

¹ In the summer of 1996, Australia's Northern Territories voted to legalise euthanasia for the terminally ill but the Federal Government soon repealed this legislation in 1997.

² For a recent example of the argument that the campaign for legalised euthanasia serves only as a diversion from improving standards of pain-relief and overall care for terminally-ill patients, see Ezekiel Emmanuel, 'Euthanasia: Where the Netherlands Leads Will the World Follow?', *British Medical Journal*, 9 June 2001, 1376-7.

³ Andrew Bibby, *Hospice Without Walls: The Story of West Cumbria's Remarkable Hospice at Home Service* (London, Calouste Gulbenkian Foundation, 1999), p.13.

⁴ See the recent clinical review in the *British Medical Journal*, John Ellershaw and Chris Ward, 'Care of the dying patient: The Last Hours or Days of Life', 4 January 2003, 30-4. This article states that 4.3% of all deaths are in hospice care.

⁵ Jo Hockley, a clinical nurse specialist at St. Columba's Hospice, Edinburgh, is currently conducting a research project that looks at extending the approaches of hospice and palliative care to older people in local nursing homes.

⁶ See, for example, Steven Sabat and Rom Harré, 'The Construction and Deconstruction of Self in Alzheimer's Disease', *Ageing and Society*, 12 (1992), 443-61, and Helen Sweeting and Mary Gilhooly, 'Dementia and the Phenomenon of Social Death', *Sociology of Health and Illness*, 19:1 (1997), 93-117.

⁷ For details of Baroness Wootton's Incurable Patients Bill of 1976, see Nicholas Kemp, 'Merciful Release', *The History of the British Euthanasia Movement* (Manchester, Manchester University Press, 2002), pp.214-5.

⁸ *Ibid.*, p.215.

⁹ Patients can now prepare anticipatory refusals of treatment in the form of 'living wills' or 'advanced directives'.

¹⁰ See Johan Legemaate, 'Twenty-Five Years of Dutch Experience and Policy on Euthanasia and Assisted Suicide', in David Thomasma, Thomasine Kimbrough-Kuscher, and Kisma Gerrit (eds), *Asking to Die: Inside the Dutch Debate on Euthanasia* (Dordrecht, Kluwer Academic Publishers, 1998), 19-34. See also Samia Hurst and Alex Mauron, 'Assisted Suicide and Euthanasia in Switzerland: Allowing a Role for Non-Physicians', *British Medical Journal*, 1 February 2003, 271-3. In the United States, only Oregon has legalised euthanasia, but other states are considering similar legislation.

¹¹ See John Keown, 'Medical murder by omission? The law and ethics of withholding medical treatment and withdrawing treatment and tube feeding', *Clinical Medicine*, 3:5 (2003), 460-3.

¹² See Kenneth Boyd, 'Mrs Pretty and Mrs B', *Journal of Medical Ethics*, 28 (2002), 211-2.

¹³ For the official medical view on such distinctions, see British Medical Association, *Euthanasia: Report of the Working Party to review the British Medical Association's guidance on Euthanasia* (London, BMA Publications, May 1988). General Medical Council, *Withholding and Withdrawing Life-prolonging Treatments: Good Practice in Decision-making* (London, General Medical Council Publications, 2002).

¹⁴ Ivan Illich, *Limits to Medicine. Medical Nemesis: The Expropriation of Health* (Harmondsworth, Penguin Books, 1976), p.43.

¹⁵ In a thought-provoking analysis similar in tone to that of Ivan Illich, the social anthropologist Tania Salem argues that euthanasia "translates one more sphere of intimate and personal meaning [death] into a medical event". See Tania Salem, 'Physician-Assisted Suicide: Promoting Autonomy or Medicalising Suicide', *Hastings Centre Report*, 29:3 (1999), 30-36 at p.35.

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