Easing the Passing: R v Adams and Terminal Care in Postwar Britain

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Summary. This article examines the 1957 trial for murder of Dr John Bodkin Adams in the context of medical care of the dying in postwar Britain. R v Adams is significant because it is understood to have rendered lawful the medical administration of pain-relieving drugs to the dying even when it is known they will hasten death. I argue the legal sanction of this practice in the 1950s reflected and reinforced the rising authority and faith invested in physicians as specialists in terminal care. Specifically, the case highlights the role of the administration of potent narcotics in the establishment of care of the dying as a branch of medicine requiring specialised knowledge and skills. Finally, I argue that by drawing attention to a medical intervention intent on eliminating pain, the Adams case enables exploration of an aspect of the medicalisation of dying in the twentieth century that is rarely examined.

Keywords: history of dying; palliative care; R v Adams; postwar Britain; medico-legal history; pain

On the morning of 18 March 1957, John Bodkin Adams, a successful and prosperous middle-aged general practitioner from the picturesque English seaside town of Eastbourne, appeared in London’s Old Bailey charged with murdering an elderly patient, Mrs Edith Alice Morrell, with doses of heroin and morphine in the hope of pecuniary gain. So began a long and sensational trial: it ran for three weeks and, as one reporter put it, kept ‘the eyes of the whole newspaper-reading world focused in fascination’ until Dr Adams’ acquittal on 9 April.1

The Adams case has disappeared from the headlines, but it lives on in a less sensational manner in medico-legal literature dealing with end-of-life matters. Here it is understood to have rendered lawful the administration of pain-relieving drugs to the dying even when it is known they will accelerate death.2 Legal sanction of this practice is traced back

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2 For a succinct overview of the legal position on this practice, see Richard Ashcroft, ‘Death Policy in the United Kingdom’, in Robert H. Blank and Janna C. Merrick, eds, End-of-Life Decision Making (Cambridge, MA: MIT Press, 2005), 197–218, 205–6. On the medical position and contemporary palliative care practice, see British Medical Association Ethics Department, Medical Ethics Today: The BMA’s Handbook of Ethics and Law, 3rd edn (Chichester, West Sussex: Wiley-Blackwell, 2012), 434–9. While there is no doubt hastening death in the context of modern palliative care is considered lawful, it should be noted that there is considerable debate in contemporary medical circles regarding the extent to which this does, or needs to,
to a passage of Justice, later Lord, Devlin’s directions to the jury in R v Adams. Devlin directed that a doctor was entitled to relieve the pain and suffering of a dying patient even if the measures he took precipitated death.

Most scholarly discussion of this case has taken place in medico-legal and bioethical circles. Here scholars have sought to explain Devlin’s directions to the jury in terms of ethical and/or legal principles that obscure the historical context of the case. Meanwhile, other commentators appear unaware or uninterested in the novelty of Devlin’s direction and its implications for end-of-life care. Instead, they are engaged in what Kieran Dolin describes as an ‘historical contest over Adams’s guilt or innocence’; a debate over whether Adams was in fact a doctor who got away with serial murder. In the most sympathetic of these, by journalist Percy Hoskins, Adams emerges as the victim, albeit a roguish and avaricious one, of a scurrilous trial-by-newspaper. Pamela Cullen, the first writer to be granted official access to the police files, sees him as a more sinister figure. She argues that Dr Adams was a murderer who probably had more victims than Dr Harold Shipman, Britain’s most prolific serial killer.

This article approaches the Adams case from a different historical perspective, examining the case and trial in the context of a history of dying. It follows legal historian A. W. Simpson’s suggestion that Devlin’s comments to the jury might best be seen as a deferral to ‘current conventions in medical treatment’, bearing in mind that ‘practices in the care of the dying differ over time and between cultures’. My argument is also informed by Shai Lavi’s work on the history of dying in the United States, which has highlighted life-shortening palliative care and its legal sanction as historical (and not simply medico-legal or ethical) phenomena. Lavi points to these developments as indicative of the medicalisation of dying. The rise of this form of care reflects the transformation of dying from an experience governed by religion to one increasingly governed by modern medicine and the law. This is inextricably entwined with changing cultural conceptions of the ‘good death’—in particular the modern understanding that to die well one should be free of pain and suffering.


Due to remain closed until 2033, these were opened in 2003 at Cullen’s request. See Pamela Cullen, A Stranger in Blood: The Case Files on Dr John Bodkin Adams (London: Elliott & Thompson, 2004).


The analysis that follows draws on medical literature and the police files and trial transcript of the Adams case to offer a close reading of *R v Adams* in the context of medical care for the dying in postwar Britain.\(^\text{11}\) I argue that the medical evidence presented during the course of the Adams trial and Devlin’s unprecedented sanctioning of life-shortening terminal care should be understood as reflecting and reinforcing the rising authority and faith invested in physicians as scientific specialists in dying and its care, or ‘treatment’. In particular the case highlights the role of the administration of potent narcotics in the establishment of care for the dying as an exclusive medical activity requiring specialist knowledge and skills. This nascent specialisation is evident in the pivotal role medical experts played in the trial of Dr Adams. Specifically, it is evident in medical accounts of the care of the dying that were bound to arcane technical language and techniques that appeared beyond the assessment or judgment of the court.

This recasting of *R v Adams* builds on two bodies of scholarship. First, it engages with work on the history of the relationship between medicine and the law.\(^\text{12}\) As Catherine Crawford observes, influenced by Foucault, much modern scholarship in this area has illuminated the way “‘juridical power’ (that of a sovereign) has, during the past few centuries, been overtaken in significance by “biopower” (the power of the norm), a process that has tended to enhance the power and importance of medicine”.\(^\text{13}\) A substantial body of literature has explored aspects of this shifting balance of power through the changing conception, role and importance of medical experts and expertise in the Anglo-American legal enterprise.\(^\text{14}\) This is an evolution often examined in relation to the spectacular rise of forensic medicine and science in the nineteenth and twentieth centuries—a development heralded by the emergence of, and courts’ increasing dependence on, expert medical witnesses in two areas that began to appear ‘most difficult for the non-expert to penetrate: insanity and poisoning’.\(^\text{15}\)

This work demonstrates that the increasing value and authority accorded to expert medical testimony in the English courtroom corresponds with dramatic improvements in the efficacy of medical science and technology but also with processes of professionalization,
specialisation and medicalisation through which, writes Ian Burney, ‘social understandings and responses to such basic human experiences as pain, illness and death’ were ‘displaced by arrangements that produce and legitimate a narrower set of expert interventions’.¹⁶ As Joel Eigen points out, the very public nature of the courtroom provides historians with a particularly fruitful arena in which to examine wider acceptance of these emerging expert medical interventions, for here the budding medical expert has to assert their opinion not just before colleagues but the lay (and legal) public.¹⁷

Through the figure of the expert witness, *R v Adams* offers a rich as well as rare opportunity to study the expansion of medical expertise and authority into the realm of dying. In an era when the medical management of those close to death was rarely publically discussed, even within medical circles, physicians were required to testify as to the ethics and practice of terminal care in the midst of a sensational trial. The evident lay and legal deference to this medical testimony is indicative and constitutive of the extent to which dying was becoming an area of expert medical intervention by the 1950s. The following analysis draws attention to the enormous discretion thus afforded the medical profession at the deathbed, where the decision of whether, and in what circumstances, hastening death with pain-killers was justifiable was devolved to individual practitioners. In this way it seeks to underline the historical contingency of an aspect of contemporary medical ethics, reminding that ‘like “nature,” the “ethical” is what society and culture attribute to it at any particular historical moment’.¹⁸ *R v Adams* offers insight into the way modern notions of what might constitute ethical medical care of the terminally ill have evolved and, thus, this analysis also aims to contribute to the literature on the history of dying.

As Julie-Marie Strange observes, while in the wake of Philippe Ariès’s seminal scholarship death has become a major area of academic inquiry, investigation into the history of attitudes and practices specifically surrounding dying, as opposed to death and its aftermath (funeral rites, grief and mourning), is relatively new.¹⁹ This is particularly true of the early to mid-twentieth century where research into dying and its care remains limited, due at

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¹⁶Burney, * Bodies of Evidence*, 10. By way of contrast, earlier notions of ‘medical’ expertise in the English courtroom were not tied exclusively to professional credentials, encompassing, for example, all-female juries summoned as experts in cases that involved pregnancy, childbirth and sexual assault. See Golan, *Laws of Men and Laws of Nature*, 18–22; Crawford, ‘Medicine and the Law’, 1628.

¹⁷Joel Peter Eigen, ‘Not their Fathers’ Sons: The Changing Trajectory of Psychiatric Testimony, 1760–1900’, in Goold and Kelly, *Lawyers’ Medicine*, 79–98, 82. Of course, as Eigen and others have shown, the rise of the modern expert witness has not been without tension and controversy. Particularly in the nineteenth century, while medical expertise became an increasingly indispensable part of the legal process, the spectacle of experts contradicting each other on the witness stand roused great scepticism about scientists and their method. See also, for example, Golan, *Laws of Men*.


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least in part to a scarcity of relevant sources. The inter-and-early postwar years are largely bereft of the rich religious, fictional, personal and, in the nineteenth century, medical literature that historians such as Pat Jalland and Ralph Houlbrooke have employed to illuminate the attitudes and practices that shaped dying in England in earlier eras. This is also a time prior to the rise of a professional literature on dying and terminal care (in England associated with the pioneering work of Cicely Saunders) that historians and sociologists have drawn on to examine the rise of the modern hospice movement and, more broadly, what Tony Walter has described as the ‘revival’ of death from the 1960s.

However, while the picture of terminal care in early twentieth-century Britain remains sketchy, a broad outline of the history of dying in the modern Western world has become widely accepted. Most scholarship addressing the subject emphasises that dying, like many aspects of life, became increasingly medicalised in the twentieth century—a process often associated with the steady rise in the number of deaths taking place in hospitals from the 1930s. Strange notes that much of the relevant literature has focused on the way that in a climate where medicine had developed unprecedented means to cure the sick, death was often seen as a medical ‘failure’ in the twentieth century and dying patients were increasingly either subject to aggressive treatments intended to prolong life, or ignored and neglected by the medical profession. Milton Lewis argues that prior to the 1960s, in advanced Western societies such as Britain, twentieth-century medicine put the cure of the body before its care and that too often ‘medicine’s great concern with advancing scientific knowledge’ subordinated ‘the relief of suffering of the dying’. Caroline Murphy has documented how in the twentieth century cancer hospitals (established in the nineteenth century to care for the sick with little expectation of cure) shifted their focus towards research and ‘patients admitted for aggressive treatment aimed at cure’ replaced those who were dying. David Clark and Jalland have detailed the way in the postwar years a National...
Health Service intent on cure and rehabilitation failed to provide guidance on terminal care or systematic provision for the dying, condemning the poor and disadvantaged to inadequate, sometimes tragic, living conditions at home or under-resourced and under-staffed institutions.27

This study aims to further the discussion of the medicalisation of dying in the twentieth century by exploring an aspect of this history that remains less well examined. The two major postwar reports into terminal care in the United Kingdom, which provide central historical sources for this period, are, understandably, most concerned to document and detail the inadequate provision made for the poor and otherwise disadvantaged in the community.28 The Adams case, however, offers a rare glimpse of what dying might have looked like in the homes of England’s more comfortable classes. And it enables exploration of quite a different medical discourse on dying in postwar Britain, one that assumed physicians had a duty to provide care for those in the last stages of life and to relieve the pain associated with dying. Over a decade ago Clark looked at the emergence in postwar Britain of a medical discourse on dying that expressed active interest in terminal care and in which can be glimpsed the foundations of modern palliative medicine.29 More recently he has examined health professionals’ use of analgesics in institutions for the dying from the 1930s.30 This paper draws on Clark’s work to explore this aspect of the medicalisation of dying further, seeking to foreground the evolution and accommodation of a specialist form of medical treatment for terminal patients that was more intent on eliminating pain than staving-off death.

Easing the Passing in Postwar Britain

In her study of death in Victorian Britain, Jalland has documented the changing attitudes towards death and suffering in middle- and upper-class families.31 For much of the nineteenth century the pain associated with dying, like death itself, was a matter of divine providence and to be faced with faith and fortitude. For relatives and friends attending the dying, the focus was on the spiritual rather than the physical state of those close to death, and hope was invested above all in the prospect of salvation rather than the restoration of health or the elimination of pain.

However, in the latter part of the century, fear of death, which had once centred on the post-mortem horrors of eternal physical punishment, came to focus on the dying process itself. As fear of hell dimmed, even amongst the devout, there were ‘more accounts of death-bed scenes which described dreadful physical or mental suffering with little or no reference to spiritual and devotional consolation, and none at all to the state of the soul in the final hours’.32

29 Clark, ‘Cradled to the Grave?’.
31 Jalland, Death in the Victorian Family.
32 Ibid., 53.
This increasing anxiety about the physical suffering that might precede death was fostered in part by the rising prominence of the doctor at the bedside of the dying in middle- and upper-class families. Once attended by family and clergy, those near the end of their life became the subjects of medical care and attention, a fact reflected in the emergence of medical literature on the subject. Victorian doctors such as William Munk advised on the importance of spiritual reflection as well as the physical management of the death chamber (proper ventilation, bedding, nutrition). These medical practitioners also advocated the cautious use of opiates to treat pain. Caution was paramount. Concerned that pain-relief that precipitated death was illegal, violated the medical duty to preserve life and risked eroding the trust of patients and families, nineteenth-century physicians warned against the administration of such drugs in any situation where death might be hastened even accidently.

While in the first half of the following century there is a relative dearth of medical literature dedicated to detailing appropriate care for the terminally ill, it seems clear physicians did not desert the deathbed. In a major postwar report on terminal care in the United Kingdom prepared for the Calouste Gulbenkian Foundation, H. L. Hughes noted patients’ ‘touching’ reliance on their family doctor, observing that whether in hospital or at home, the patient ‘always felt better for a daily visit, and he often finds it easier to talk to his doctor than his relatives or a priest’. What is less clear is what medical management of the dying actually involved. Jalland observes that a lack of contemporaneous documentation means little has been written ‘about the actual care of the dying’ in England in the immediate postwar years. It is particularly difficult to discern what terminal care consisted of in the significant proportion of situations where death took place in the privacy of the home and the dying were attended by their general practitioner and professional nursing staff. As Irvine Loudon and Mark Drury write, ‘we know very little about the care of the dying in general practice before the 1960s, except that it was shrouded in silence. Few talked about it, wrote about it, or were taught anything about it as students’.

Clark has begun to shed light on this period by pointing to the emergence from the 1930s of a medical discourse that not only cautioned against the heroic prolongation of life, but also expressed an active interest in terminal care. It is evident in the limited and fragmentary material that emanated from terminal care homes and associated charities as well as interested clinicians. This is a literature that drew on physicians’ personal experience and observations and lay the foundations for the development, under the auspices of Cicely Saunders,
of the modern palliative care movement in the coming decades—a movement which would make dying and the relief of associated pain the subject of systematic scientific observation, research and clinical techniques. This published medical commentary on terminal care did not signal a new interest in the medical management of those at the end of life, so much as a new type of interest. This is a period that marks a transition in the history of the medicalisation of dying, not its emergence. It is a point where, as Clark observes, terminal care, ‘which had previously belonged to the realm of medical folklore’ was beginning to be seen as a branch of medicine that involved—and could be promoted as involving—specialist knowledge and skills. These would not begin to be consolidated into a professional literature until the 1960s, but the assumptions and priorities that underpinned this new medical specialisation are clearly evident in earlier medical writings and practices.

By the postwar years the most prominent aspect of specifically medical care for those at the end of their life (as opposed to more prosaic nursing and the provision of comfort and consolation) was the treatment of the pain associated with dying using the powerful narcotics that had become the exclusive province of medicine. Chief among these was opium and its derivatives. As Virginia Berridge and others have shown, for much of the nineteenth century opiates were widely available and used for recreational purposes as well as self-administered, or prescribed, as remedies for numerous common complaints (toothache, diarrhoea, chilblains). However, the emergence of medicine and pharmacy as powerful scientific specialities, coupled with growing medical and lay concerns about the dangers associated with consumption (addiction and poisoning but also deviance) led to the increasing regulation and restriction of such drugs in the twentieth century. The introduction of numerous milder forms of pain relief further curtailed the need for opiates and they were used increasingly conservatively within medicine. Marcia Meldrum suggests that by the 1920s one of the very few situations in which the prolonged medical administration of opiates was considered legitimate was in the context of the care of those deemed in the last stages of life.

In a 1948 article discussing care of the dying that appeared in *The Practitioner*, W. N. Leak observed that ‘purely medical treatment’ for the dying could ‘almost be written in one word—morphine’. At a meeting of the British Medical Association, Dr Ian Grant counselled that, while morphine should be withheld from terminal patients as long as possible to avoid problems of tolerance, it could sometimes be administered to ‘curative and

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40 Clark, ‘Cradled to the Grave?’, 243.


euphoric effect’. And in cases of desperate misery he advised his colleagues that it should not be spared, as ‘our first duty is to relieve pain and to induce merciful oblivion’. While acknowledging ‘the smoke of battle’ lingered over its use, another medical practitioner observed that regular injections of heroin, rather than morphine, were most effective ‘for bringing analgesia and peace of mind to those who have not long to live’.

Opiates were also administered to the dying orally, often in the form of what one physician described as ‘that famous Brompton requiem’. There was no standard composition of this mixture but, as formulas or recipes endorsed by clinicians and textbooks at the time indicate, it almost invariably included morphine or heroin and cocaine mixed with a sweetener (maybe honey) and alcohol (which might be adjusted to suit the individual taste of the patient). The doses of opiates recommended by physicians writing on the subject varied and were clearly intended as guides to be adjusted by individual doctors as they saw fit—presumably based on the assumption that the doctor at the bedside was best qualified to make judgements as to what sort of dosage was in the best interests of his patient. Authorities advised, for example, that Brompton cocktails be given ‘as often as required’ or that in the last stages of illness the dose of opiates would need to be increased ‘fairly rapidly’ at the discretion of the doctor.

The administration of opiates to the dying was not just advocated by individual physicians but as part of terminal care in the, albeit few, institutions that accommodated the dying in the first half of the twentieth century. Between the 1930s and 1950s ‘Brompton mixtures’, which were to become a central component in the work of the modern hospice movement, were widely prescribed to those deemed terminal in religious and charitable homes as well as in hospitals. Norman Sprott, Medical Superintendent at St Columba’s hospital in London, advised that these potent analgesic cocktails could be given freely to the dying and described the effect this way: ‘Large doses of narcotics will sometimes shorten a life—a result for which the patient might be profoundly thankful—but just as often, by bringing rest and sleep and comfort, they seem to prolong life, though even then the suffering is greatly lessened.

Sprott’s observations, as well as those of the other physicians quoted here, draw attention to the way powerful narcotics were administered to the dying, but also to the ambiguous clinical purpose and effect of the medical administration of such drugs. As Clark writes of the administration of the Brompton to the dying in various institutions: ‘Was it intended to induce euphoria? Did it potentiate moribundity? Most intriguing of all, was it originally intended to bring about an “easeful” death or even to hasten death?’

At the time what might constitute ‘proper’ medical treatment—as opposed to an unjustifiable hastening of death—for the terminally ill was not simply a matter of clinical propriety. In a very frank and widely circulated lecture, Clifford Hoyle, physician at King’s College Hospital, made it clear that any knowing ‘acceleration of death in the dying’ was illegal—from a

46Ibid.
conventional legal standpoint a doctor who deliberately hastened the death of a terminally ill patient opened himself/herself to a charge of homicide. Yet in Hoyle’s view the physician attending the deathbed was best placed to decide how far pain-relief for the dying should go—and in some instances this meant violating the law by hastening the death of a patient. Moreover, he assured colleagues, ‘the law forbids in theory but ignores in practice’. In practice, he advised, it was tacitly accepted that doctors ‘here, as in other spheres, should be protected from the consequences of steps honestly taken in the interests of patients’.  

There is no suggestion in Hoyle’s article—or, indeed, in any of the medical literature on care of the dying—that such decisions should be discussed with the patient, the patient’s family or even colleagues: quite the opposite. ‘If there are occasions when hastening death seems the most sensible and humane procedure the proper course then becomes a matter for one’s own conscience,’ instructed Hoyle, ‘the first essential on these occasions is to keep one’s own counsel’. He went on to suggest that one of the best ways to effect ‘such treatment’ was by administering quickly cumulative doses of morphine.

It was this ambiguous aspect of terminal care that Justice Devlin unexpectedly found himself navigating during the trial of Dr Adams in 1957. As he reflected some decades later, it became clear that he needed to clarify for the jury ‘how far the law allowed the orthodox doctor to go in easing the passing’. However, when the Adams story broke in 1956 quite different issues appeared at stake.

**The Strange Case of Dr Adams**

A series of lurid press articles first brought Dr John Bodkin Adams to the attention of the British public. ‘Seaside Mystery of 13 Rich Women’; ‘Yard Probe Mass Poisoning: 25 Deaths in the Great Mystery of Eastbourne’; ‘Mystery of the 300 Women: Yard Probes Hypnotic Killer Theory,’ screamed the headlines in August 1956. These stories were the result of leaks that a police investigation was underway into the apparently suspicious deaths, as well as the wills, of hundreds of Adams’ patients. The blaze of hostile publicity continued and was heightened by the rumour mill in the seaside resort where Dr Adams lived and worked. As one commentator insinuated, the case excited national and international attention because it appeared to have many of the hallmarks of a classic English murder mystery: this ‘strange case’ was like ‘a macabre story that Agatha Christie might have written’. Adams was an Irish-born general practitioner with diplomas in public health and anaesthetics who became a prosperous doctor in the English coastal town of Eastbourne. By the time of his arrest he had established a lucrative practice attending to many of the wealthy elderly who

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52 Hoyle, ‘The Care of the Dying’, 123.

53 Ibid.

54 Devlin, *Easing the Passing*, 124.

55 Daily Sketch, 20 August, 1956, 1; Daily Mail, 22 August, 1956, 1; Evening Standard, 22 August, 1956, 1.


retired to that fashionable part of the south coast. At least twenty years before his arrest for murder—at least twenty years before his arrest for murder—sometime in the 1930s—rumours had begun to spread that Dr Adams subjected his patients to drugs and sedatives to induce them to alter their wills to include him as legatee or to obtain powers of attorney and thus gain access to their finances. It was also rumoured that in some cases, once his purpose had been effected, he had precipitated the death of the person concerned or allowed them to die without proper medical treatment. According to the police, solicitors in the town began to shun any business in which Dr Adams was concerned and, when interviewed, some doctors indicated they regarded his activities as 'odd'.

An anonymous tip-off brought Dr Adams to the attention of Eastbourne police. Scotland Yard was called in on 17 August 1956 and a complex and wide-ranging investigation into Adams' activities and the death of numerous patients began. In November Adams was charged with a number of offences including the forging of National Health Service prescriptions and falsely stating on a number of cremation certificates that he had no pecuniary interest in the estates of those deceased. However, these charges were overshadowed when, on 19 December, Adams was arrested and charged with having murdered 81-year-old Edith Morrell six years earlier.

During the trial it was agreed that Morrell was a wealthy, autocratic widow who became an irritable patient after suffering a stroke in 1948 that left her partially paralysed, although not in significant physical pain. Dr Adams treated her with regular doses of opiates until her death at home on 13 November 1950. Her body was cremated. The prosecution alleged this course of drug administration was done in order to secure her dependency on him as he vigorously pursued some legacy under her will and culminated in Dr Adams prescribing and administering such huge quantities of heroin and morphine that he must have known the result would be to kill the elderly widow. According to the defence, the drug regime was medically justified to relieve discomfort, treat insomnia, alleviate restlessness and irritability and thus, ultimately, 'ease her passing'.

The prosecution's case was weak. At trial there was one case that was six years old, no body and no permission to use evidence that the police had gathered on the deaths of other patients attended by Adams. Further, although there was convincing evidence Adams had pursued a legacy under Mrs Morrell's will, in fact he ultimately received only an oak chest full of silver tableware. As the defence pointed out, this appeared a paltry legacy for which to murder an elderly lady who, the physicians agreed, looked likely to die in a matter of months, even weeks, with no intervention. Indeed, the prosecution failed to substantiate its case that Adams had murdered Mrs Morrell for money, Adams was acquitted and it was decided to pursue no further murder charges against him.

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60 The police limited their investigation to the years between 1946 and 1956. Nevertheless, this involved 312 separate investigations and the taking of over 900 witness statements. See Hannam to Chief Super., report, 19 August 1957, 1–2, MEPO 2/9784.
61 After his trial for murder, Adams pleaded guilty to almost all of the more minor charges. For details, see 'Dr J. B. Adams Fined on 14 Charges', BMJ, 1957, 2, 303.
62 This summary of the case and arguments is drawn from, R v John (Bodkin) Adams, transcript of the shorthand notes of Geo. Walpole & Co., MEPO 2/9790/1–2 (henceforth Trial Transcript).
63 Cullen offers a detailed account of the circumstances and witness statements related to many of these. See Cullen, A Stranger in Blood.
64 At committal the prosecution had alleged two further cases of murder. For a critical account of the prosecution's handling of the case, see Devlin, Easing the Passing.
As noted above, there are commentators who consider this to have been a miscarriage of justice. However, my interest lies elsewhere. One of the complicating factors in a labyrinthine trial was that the facts of the case and the evidence presented by medical witnesses raised the question of whether a medical practitioner was ever entitled to adopt a course of treatment which would have the effect of hastening a patient’s death. In this context, the salient question became not whether Dr Adams had murdered Mrs Morrell for money, but whether a murder could be said to have been committed at all.

Murder or Medicine?

According to the police, worried that similar charges might follow those of forgery that Adams was confronted with in November 1956, the doctor arranged a meeting with the head of the Scotland Yard investigation, Detective Superintendent Hannam.65 There he expressed his concerns to the detective who informed him that there were some other charges in the offing: investigations were underway into what appeared to be the unnatural deaths of some of his wealthy patients. The detective specified that one potential charge related to the death of Mrs Morrell. According to Hannam, Adams appeared shocked and responded: ‘Easing the passing of a dying person is not all that wicked. She wanted to die. That cannot be murder. It is impossible to accuse a doctor.’ A fortnight later, when Adams was arrested and charged with the murder at his residence, the arresting officers found his response equally bizarre. Apparently confused and bewildered he reportedly blurted, ‘Murder?’ paused and continued: Murder? Can you prove it was murder?’ And then: ‘I did not think you could prove murder. She was dying in any event’.66

The prosecution made much of these statements in court, arguing that they sounded like the responses of a ‘shaken man who had committed a murder which he thought could not be proved’.67 The defence did not deny Adams had made the statements. However, counsel argued that they did not constitute the confession of a guilty man, but the incredulous reaction of an innocent one ‘absolutely stunned by the monstrousness of the charge brought against him in his professional capacity as a doctor’.68 But from an historical vantage we might see the doctor’s bizarre statements slightly differently: less as evidence of his guilt or innocence and more as evidence of a disjunction between the medical and legal understandings of the right and proper way to care for the dying. There was virtually no dispute about the facts of the case. No one (from the above statements we might conclude least of all Adams) denied that, on the doctor’s orders large doses of heroin, morphine and paraldehyde had been administered to the ailing, 81-year-old widow during the long illness that preceded her death—or, indeed, that in the last days, Adams prescribed doses large enough to kill her.69 But did this, as the police and lawyers were trained to understand it, point to murder? Or, might it be medicine?

This question became increasingly salient during the trial as it became clear that Adams was not the only doctor who may have knowingly given a terminal patient drugs that would hasten death. Medical experts for both the defence and the prosecution indicated

66 Ibid., 2.
67 Trial Transcript, 8 April 1957, 17.
68 Trial Transcript, 5 April 1957, 39.
69 Playing the memory of the nurses against notebooks discovered at the last minute, the defence managed to raise some doubt as to whether all the drugs prescribed had been administered.
they believed that in some instances medical practitioners were entitled to administer drugs that would curtail life. As Devlin noted some time later, this is what Dr Adams’ statements and defence allusions to easing the passing implied, although, during the trial, Adams’ defence counsel and the medical witness for the defence, no doubt with a keen eye on the letter of the law, appeared vague on this point.70 The defence simply maintained that the manner in which Dr Adams ‘eased the passing’ was legitimate medical treatment.71 Neither the defence counsel nor his medical witness, Dr Harman, ever expanded on precisely what this might involve. But they did not need to. The disjuncture between the medical and legal perspectives on ‘easing the passing’ became startlingly obvious during the cross-examination of the chief medical witness for the prosecution, Dr Arthur Henry Douthwaite, a Harley Street specialist, senior physician at Guy’s Hospital and recognised authority on heroin and morphine.

Douthwaite explained that in his view the type and quantity of drugs given to Mrs Morrell in the last few days of her life indicated that Adams’ intention was to terminate her life. But, pressed under cross-examination, it appeared that while he believed this to be medically unjustifiable in the case of Mrs Morrell, who did not appear to have been in significant pain, in the case of a patient suffering severe physical pain, say in the case of inoperable cancer, it would be justifiable for a doctor to administer doses of pain-relieving drugs that he knew would cause death.72 At one point, when pressed for clarification, Douthwaite visibly startled the bench and counsel by confirming that such doses were indeed ‘intended to kill’.73 He elaborated: ‘I deliberately said my conclusions were that they [those amounts of drugs given by doctors] were given to terminate life. I said that deliberately because I don’t know, it is not my business to know, whether that is synonymous with murder’.74

Defence counsel immediately confirmed the law for the doctor: ‘Murder, Dr Douthwaite, is killing with intention of killing or terminating life.’ Or was it? Devlin intervened: ‘I think Mr Lawrence, I am very anxious there should not be introduced into this questions that may be partly questions of law. I don’t know, it may be a matter of medical practice that if a doctor gives drugs knowing that they will shorten life but gives them because they are necessary to relieve pain, he is not committing murder’.75

The trial moved on, but the judge returned to this point six days later during his summation. Here Devlin clarified what he saw as the relationship between the law and life-shortening terminal care in the following way. First, he pointed out that it did not matter whether Mrs Morrell’s death was inevitable and her days numbered. If her life was shortened by weeks or months it was just as much murder as if it was cut short by years. Nor did it matter whether she was in pain, for the law knows no special defence of preventing severe pain. However, then he added:

70Delvin, Easing the Passing, 124.
71See, for example, Trial Transcript, 5 April 1957, 39; Trial Transcript, 8 April, 22–3.
72Trial Transcript, 1 April 1957, 3–8.
73Ibid., 5. The observation regarding bench and counsel is drawn from Bedford, who noted that at this point of the examination, ‘Bench and counsel look at each other’. Bedford, The Best We Can Do, 134.
74Trial Transcript, 1 April 1957, 5. It became clear that the other medical expert for the prosecution, Dr Ashby, similarly believed that the deliberate medical acceleration of death did not necessarily constitute murder: While he observed ‘I am certain beyond a shred of doubt she could not have survived the doses prescribed’, under cross-examination he conceded: ‘I am not prepared to say whether [Dr Adams’] were instructions of a murderous nature’. Trial Transcript, 2 April 1957, 13, 24.
75Trial Transcript, 1 April 1957, 5.
But this does not mean that a doctor who is aiding the sick and the dying has to calculate in minutes, or even hours, and perhaps not in days or weeks, the effect upon a patient’s life of the medicines which he administers or else be in peril of a charge of murder. If the first purpose of medicine, the restoration of health, can no longer be achieved there is still much for a doctor to do, and he is entitled to do all that is proper and necessary to relieve pain and suffering, even if the measures he takes may incidentally shorten life.\textsuperscript{76}

It is easy to imagine the jury were sorely in need of such clarification at this stage of the trial, for, as Devlin pointed out, even the most basic facts of the Adams case appeared beyond the grasp of laypeople. It was ‘a most curious situation, perhaps unique in these courts’, the Judge mused during his summation, ‘that the act of murder has to be proved by expert evidence’.\textsuperscript{77} He went on to reflect that this was normally something any jury could understand, but in this case the court—judge and laymen—could not interpret the facts—or ‘data’—themselves, but were forced to rely on the complex, sometimes conflicting, interpretations of the medical witnesses. These began with recitals of detailed figures—of the number of grains of heroin, morphine and various other drugs prescribed for Mrs Morrell and given to her on particular days, at particular times, in particular combinations. It continued with debate on the probable effects these drugs would have had on this particular patient given her age, condition and estimates of the tolerance she had developed, complicated by broader discussion of how much of a particular drug could and should be given to whom, when and to what likely effect. It culminated in the confounding (at least for the lawyers present) revelation that within medical circles it might be considered justifiable to give those believed to be dying and in pain doses of drugs that shortened their life. But even here there was complexity. What type of pain justified this course of action? What level of pain? Was it, as the prosecution medical experts argued, only justifiable in cases of severe physical suffering, or, as the defence implied, also in cases of discomfort and mental distress? Or was the definition of pain so subjective, that, as counsel for the defence contended, it had to be left to the doctor ‘on the spot’ to assess whether the sort of pain being felt by the patient justified such treatment?\textsuperscript{78}

As a reporter for \textit{Time} magazine observed, ‘The more the experts talked, the less the laymen of the jury could be sure of anything’.\textsuperscript{79} It might have been hoped that the evidence of medical experts would help illuminate the distinction between a crime scene and a deathbed scene. But the more the medical witnesses spoke, the more inscrutable such distinctions became. The mysterious nature of the hours of technical testimony was, as the same reporter noted, compounded by the defence counsel’s skilled cross-examination, which managed—as was presumably its object—to shroud any sparks of certainty in ‘clouds of doubt’.\textsuperscript{80} Above all, the medical evidence suggested that the activities of the doctor at the deathbed were ultimately beyond the understanding of laypeople or the law. Devlin’s directions to the jury seemed to confirm this. He explained that there were no questions of ‘legal justification’ or ‘moral justification’ for them to consider in this case for, as he understood it, the word ‘justified’, that they had heard so often during the course of the trial, was ‘used in a

\textsuperscript{76}Trial Transcript, 8 April 1957, 21.  
\textsuperscript{77}Ibid., 72.  
\textsuperscript{78}Trial Transcript, 1 April 1957, 8.  
\textsuperscript{79}Not Guilty’, 33.  
purely medical sense’. This was a medical issue, not a legal or a moral one. ‘If the treatment given by Dr Adams was treatment designed to “promote comfort”, he summarised, “if it be right and proper treatment in the case, the fact—if it be the fact—that it incidentally shortened life does not give any grounds for convicting him of murder.’

After the Trial

Devlin’s directions to the jury quietly registered what one journalist attending the trial obliquely referred to as ‘one of the undercurrents of the case’. The trial and Devlin’s summation were reported in detail and its novelty swiftly noted in legal circles, but the idea that it was considered legitimate for a doctor to adopt a course of treatment that would hasten a patient’s death when it was deemed they were in the last stages of life provoked no medical or legal objections and little public comment, let alone controversy.

The most sustained medical response to the case did not seem to register the significance of Devlin’s directions to the jury. The writer of an editorial in the Medical Press was most concerned that the trial had thrown an unwelcome and intrusive spotlight on the sequestered world of end-of-life medical care. For him the Adams case drew attention to the way officious laymen threatened to circumscribe the discretion of doctors at the bedside and thus hamper what a physician deemed the best treatment for a dying patient in his care:

Any doctor with normal humanitarian impulses has always felt honour bound to reduce his patient’s sufferings to the minimum and, in cases where the prognosis was hopeless, has seldom stopped to count the cost as measured in the day-to-day duration of his patient’s life. Many and many a patient has been “kept under” at all costs to save him agony. This will, we imagine, scarcely be the case now, for every one of us will be looking over his shoulder for the smiler with the knife—somebody making notes to use against them later.

But no knives were drawn. The Lancet did note a brief exchange in the Lords that suggested the trial may have left some others less sanguine about the wide licence physicians appeared to have when it came to prescribing and administering narcotics to the dying. The Earl of Craven asked the government if, in the light of the Adams case, it considered it time for a review of the ‘laws relating to the use of drugs for medical purposes’. But any suggestion that the case had uncovered medical practices that might require oversight or regulation was quickly dismissed. Lord Strathclyde replied that the government did not consider it appropriate to further ‘circumscribe the clinical freedom of doctors to treat their patients in accordance with their individual judgement’.

And there the matter appeared to rest. Popular comment and debate focused not on what the trial had revealed generally of medical practice at the deathbed, but on whether or not Adams had got away with murder—a strand of thought evident in the trickle of libellous comment that preceded the doctor’s death in 1983 as well as the flood of speculation.
that followed it. The account offered at trial and in the press of Dr Adams’s activities provoked suspicion and criticism, but the same cannot be said of the revelation of the licence physicians had to administer life-shortening doses of opiates to the dying.

Conclusions
This paper has argued that Devlin’s direction to the jury in *R v Adams*, and what one legal scholar has described as the quite ‘remarkable exception to existing criminal law principles’ it represents, is best explained in the context of a history of dying. The court’s deference to expert medical opinion that viewed hastening death with narcotics as justifiable medical treatment registered the enormous power and authority invested in physicians as experts in terminal care by the mid-twentieth century. The trial also offers rare insight into evolving medical attitudes and practices regarding pain-relief for the dying, even within medical circles, were rarely the subject of open comment or discussion.

This history of the Adams case has thus sought to broaden discussion of the medicalisation of dying in twentieth-century Britain. The intensification of this process has often been associated with the steady rise in the proportion of hospital deaths from the 1930s. However, the Adams case suggests that the medicalisation of dying and its sequestration from laypeople is not just a result of its physical institutionalisation. It is also a product of the way care of the dying became the subject of specialist treatment, exemplified by the use of powerful narcotics to treat the pain associated with dying. These were drugs that could only be prescribed by a physician and demanded increasingly sophisticated pharmacological knowledge and skill to administer. This was a mode of care that appeared not just beyond the abilities of most laypeople, but beyond their comprehension.

The development of what has come to be known as palliative care is sometimes seen as a reaction against the medicalisation of death and a profession that was so intent on developing cures and treatments it had begun to neglect the dying and their pain. But this discussion of postwar ‘easing the passing’ has sought to draw attention to a co-existent medical discourse that prioritised the relief of pain, rather than the preservation of life, underscoring the continuity between the way physicians managed dying in the nineteenth century and the practices of doctors in the early twentieth century. This reinforces Clark’s point that the emergence of modern terminal care in Britain cannot be seen as an ‘anti-medical’ phenomenon. The rise of palliative care and its concern to eliminate the pain and suffering associated with dying suggests, rather, an extension of medical dominion.

This is not to imply that the professionalisation of care of the dying should be understood as a form of conspiratorial medical strategising. It is important to stress, as medical historians often observe, that the cultural norms and values of a society always underpin the nature of medical interventions and attitudes and shape the extent to which they are accepted as beneficial and desirable. In this sense the Adams case is part of broader historical contexts no more than gestured to here. The legal and lay deference to medical practice evident in this

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87 During his lifetime Adams accrued substantial libel damages. See Hoskins, ‘Adams, John Bodkin’.
88 Otlowski, *Voluntary Euthanasia and the Common Law*, 176.
89 See, for instance, Lewis, *Medicine and Care of the Dying*, 120.
case suggests that by the 1950s there was not only widespread acceptance that ‘doctor knew best’ when it came to care of the dying, but a deeply entrenched belief that to die well one should be free of pain.

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