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John Keown

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# ARTICLES

# THE LEGAL REVOLUTION: FROM "SANCTITY OF LIFE" TO "QUALITY OF LIFE" AND "AUTONOMY"

*John Keown**

> How can it be lawful to allow a patient to die slowly, though painlessly, over a period of weeks from lack of food but unlawful to produce his immediate death by a lethal injection, thereby saving his family from yet another ordeal to add to the tragedy that has already struck them? I find it difficult to find a moral answer to that question. But it is undoubtedly the law.[1]

## I. INTRODUCTION

The Western world is undergoing a legal revolution. For centuries, the law in both common law and civil law jurisdictions has stoutly upheld the principle of the "sanctity of life." Over the past thirty or so years, however, courts and legislatures across the Western world have seriously compromised that principle. Respect for life's inviolability has been eroded increasingly by efforts to promote largely unbridled individual autonomy and the notion that only some human lives, those which pass a certain "Quality" threshold, merit protection. To many, this revolution has been less obvious than other revolutions of the period. For unlike other revolutions promoted suddenly, violently, and outside the law by

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* Dr. Keown has an M.A. (Cantab) and D.Phil (Oxon). He is a Lecturer in the Law and Ethics of Medicine; on the Faculty of Law at the University of Cambridge; and a Fellow and Tutor at Queens' College in Cambridge. This Article retains British spelling and citation form in many places. It was previously published, in slightly different form, as "Restoring Moral and Intellectual Shape to the Law After *Bland*," in Volume 113 of the July 1997 issue of the *Law Quarterly Review*, pages 481-503. In addition, this Article is to appear in a forthcoming book by Luke Gormally, ed., *Issues for a Catholic Bioethic (The Linacre Centre)*.

1. Airedale N.H.S. Trust v. Bland [1993] A.C. 789 at p.885 *per* Lord Browne-Wilkinson.

social radicals, this revolution is being promoted gradually, without violence, and through the law by pillars of the legal establishment.

Examples of the abandonment of the principle by legislatures are not difficult to find. The United Kingdom has done more than most to promote this revolution. The Abortion Act of 1967, widely imitated around the globe, overturned the historic prohibition on abortion. Abortion was transformed from a serious criminal offense to a minor medical procedure, commonly performed for reasons of social convenience rather than medical necessity. The Human Fertilisation and Embryology Act of 1990, apart from further relaxing the law on abortion, also permitted destructive experimentation on human *in vitro* embryos until the start of the fifteenth day of development. Since its enactment, thousands of embryonic human beings have been created, frozen, stored, and discarded in the name of science and medicine.

But legislatures have not been alone in promoting the revolution. Judges have also played a major role. Again, examples are easy to find. In 1973, the United States Supreme Court, in judgments of breathtaking invention,[2] swept away that nation's longstanding laws against abortion, showing neither understanding nor respect for the traditions being trashed. In 1988, the Canadian Supreme Court followed suit.[3] Now, as the courts turn their attention to the other end of life, they continue to promote the revolution of death. In 1984, for example, the Dutch Supreme Court held that doctors could lawfully kill their patients in certain circumstances.[4]

This Article illustrates the ongoing legal revolution by examining in detail a landmark English case, decided in 1993 by the House of Lords. Arguably the most important case ever decided by that court, it illustrates well the extent to which even a conservative judiciary, without the latitude afforded by a written constitution or Charter or Rights, is furthering the legal revolution.

In *Airedale N.H.S. Trust v. Bland*,[5] the House of Lords held that it was lawful for a doctor to cease tube-feeding his patient who was in a "persistent vegetative state" (pvs) even though this would inevitably lead to the patient's death and even though, in the express opinion of a majority of their Lordships, the doctor's intent was to kill. The implications of the case are profound. A leading utilitarian bioethicist and advocate of eu-

2. Roe v. Wade, 410 U.S. 113 (1973).
3. R v. Morgentaler [1998] 1 S.C.R. 30.
4. Nederlands Jurisprudencie (1985) No. 106, 451.
5. [1993] A.C. 789 at p.885.

thanasia, Professor Peter Singer, has even commented that the case marks the collapse of the traditional Western ethic: the principle of the sanctity of human life.[6] There can be little doubt that the Law Lords dealt a blow to that principle and, although Singer's comment may be overstated, the blow may yet prove fatal. Whether it does so may well depend on the readiness of their Lordships to reconsider their reasoning in *Bland*.

This Article respectfully argues that the Law Lords should reconsider, not least because their reasoning leaves the law, as Lord Mustill commented, in a "morally and intellectually misshapen" state, prohibiting active but permitting passive medical killing. With few exceptions, notably Professor Finnis's acute commentary,[7] this cardinal case has inspired strikingly little academic analysis. This Article suggests that the doctrine of the sanctity of life was misrepresented, misunderstood, and mistakenly rejected, and argues that the courts should, by reinstating the law's consistent application of that doctrine, restore moral and intellectual consistency, coherence, and clarity to the law.

Part I outlines three alternative approaches to the valuation of human life: "vitalism;" "sanctity of life;" and "Quality of life" (the reason for the "Q" will appear later) and concludes that the sanctity of life offers a middle way between two unacceptable extremes. It also sketches how a proper understanding of the moral significance of individual autonomy—of autonomy as enabling us to make decisions that promote rather than frustrate human flourishing—dovetails with that middle way. Part I concludes by maintaining that the common law has historically followed this middle way in its rejection of "vitalism," "Quality of life," and unbridled autonomy.

Part II argues that the Law Lords in *Bland* swerved from the middle way towards the ethical extremes of "Quality of life" and unrestrained autonomy; observes that the case indeed leaves the law in a morally and

6. PETER SINGER, RETHINKING LIFE AND DEATH (1995) at p.1. I shall use the term "sanctity" throughout because the "sanctity of life" has consistently been stated by the courts to be a governing principle of English law. *See, e.g.*, text *infra* nn.52-53. However, the term runs the risk of seeming specifically religious and anyone who finds this possible connotation distracting could use the phrase "inviolability of human life." Again following judicial usage, I shall use "life" throughout as shorthand for "human life." This is not the place to canvass the important reasons for distinguishing human from other animal life.

7. J.M. Finnis, Bland: *Crossing the Rubicon?* (1993) 109 L.Q.R. 329. An overview of *Bland* and more recent cases on pvs is provided by J.K. Mason and G.T. Laurie, *The Management of the Persistent Vegetative State in the British Isles* (1996) 4 JURIDICAL REVIEW 263.

intellectually misshapen state; and suggests that the swerve may well have resulted from a confusion of the doctrine of the sanctity of life with vitalism.

Part III indicates how a coherent understanding of the principle of the sanctity of life—the principle at the heart of the doctrine of the sanctity of life—could have supplied a sound answer to the question raised in *Bland* and left the law in good shape.

## II. HUMAN LIFE AND THE LAW

### A. *Vitalism v. Sanctity of Life v. Quality of Life*

Before deciding which ethical approach the law ought to take to the valuation of human life, it is important to appreciate that there are at least three competing alternatives.

#### *i. Vitalism*

Vitalism holds that human life is an absolute moral value and that it is wrong either to shorten the life of an individual human being or to fail to strive to lengthen it. Whether the life be that of an anencephalic newborn (one lacking the cerebral hemispheres) or a dying centenarian, vitalism prohibits life's shortening and requires its preservation. Regardless of the pain, suffering, or expense that life-prolonging treatment entails, it must be administered because human life must be preserved at all costs. Vitalism is as ethically untenable as its attempt to maintain life indefinitely is physically impossible. Its error lies in isolating the genuine and basic good of human life, and the duty to respect and promote that good, from the network of standards and responsibilities that make up our ethics and law as a whole; and its neglect of concepts and distinctions (such as between intention and foresight) vital to that network.

#### *ii. The Sanctity of Life*

##### *a. The Prohibition of Intentional Killing*

The principle of the sanctity of life is often advocated but much less often understood. In Western thought, the development of the principle has owed much to the Judaeo-Christian tradition.[8] That tradition's doctrine of the sanctity of life holds that human life is created in the image of God and is, therefore, possessed of an intrinsic dignity that entitles it to

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8. Respect for life is, however, also deeply rooted in Eastern thought. *See* DAMIEN KEOWN, BUDDHISM AND BIOETHICS (1995) at pp.44-45.

protection from unjust attack. With or without the theological underpinning, the doctrine that human life possesses an intrinsic dignity grounds the principle that one must never intentionally kill an innocent human being.[9] The "right to life" is essentially a right not to be intentionally killed.

The dignity of human beings inheres because of that radical capacity, inherent in human nature, which normally results in the development of rational abilities such as understanding and choice. Some human beings, such as infants, may not yet possess the ability to exercise this radical capacity. But a radical capacity must not be confused with an exercisable ability: one may have, for example, the radical capacity but not the ability to speak Swahili. All human beings should be presumed to possess the radical capacity characteristic of their nature even though, because of infancy, disability, or senility, they may not yet, not now, or no longer have the abilities that characteristically issue from possession of that capacity.[10]

As this account of human dignity might suggest, the principle can also be articulated in non-religious terms, in which "inviolability" might be more apt than "sanctity." Indeed, a prohibition on killing is central to the pre-Christian fount of Western medical ethics—the Hippocratic oath[11]—and the modern reaffirmation of that Oath by the (arguably post-Christian) Declaration of Geneva,[12] and many non-believers recognise the right of human beings not to be intentionally killed. Lord Goff noted in *Bland* that the sanctity principle has long been recognised in most, if not all, civilized societies throughout the modern world, as is evidenced by its recognition by international conventions on human rights.[13] Article 2 of the European Convention, for example, provides: "Everyone's right to life shall be protected by law. *No one shall be deprived of his life intentionally* save in the execution of a sentence of a court following his con-

9. "Innocent" excludes anyone actively contributing to, or guilty of, unjust aggression and the principle has, therefore, traditionally allowed the use of lethal force in self defence, the prosecution of a just war and the execution of capital offenders. This has little relevance to doctors and patients.

10. *See* LUKE GORMALLY ED., EUTHANASIA, CLINICAL PRACTICE AND THE LAW (1994) at pp.118-119.

11. "To please no-one will I prescribe a deadly drug, nor give advice which may cause his death. Nor will I give a woman a pessary to procure abortion". J.K. MASON AND R.A. MCCALL SMITH, LAW AND MEDICAL ETHICS (4th ed. 1994) at p.429.

12. "I will maintain the utmost respect for human life from the time of conception; even under threat, I will not use my medical knowledge contrary to the laws of humanity." *Ibid.* at p.430.

13. [1993] A.C. 789 at pp.863-864.

viction of a crime for which this penalty is provided by law."[14]

The right not to be intentionally killed is enjoyed regardless of inability or disability. Rejecting any such distinctions as fundamentally arbitrary and inconsistent with a sound concept of justice, the principle (whether in its religious or secular forms) asserts that human life is not only an instrumental good, a necessary precondition of thinking or doing, but a basic good, a fundamental constituent of human flourishing. It is, in other words, not merely good as a means to an end but is, like other integral aspects of a flourishing human life, like friendship and knowledge, something worthwhile in itself. Of course some people, like those who are pictures of health in the prime of life, participate in the good of life and health to a greater extent than others, such as the terminally ill, but even the sick and the dying participate in the good to the extent they are able.

Human life is a basic good, but it is not the highest good, a good to which all the other basic goods must be sacrificed in order to ensure its preservation. The sanctity doctrine is not vitalistic. The core of the doctrine is the principle prohibiting intentional killing, not an injunction requiring the preservation of life at all costs.

*b. Intention and Foresight*

Sanctity prohibits *intentional* life-shortening. Conduct that is intended to shorten life—"intention" bearing its ordinary meaning of *purpose*—is always wrong. Conduct that may foreseeably shorten life is not always wrong. Whether it is wrong depends largely on whether there is a sufficient justification for taking the risk of shortening life.[15]

A doctor treating a terminally-ill cancer patient suffering pain clearly has a sufficient justification for administering palliative drugs with the intent to ease the pain, even though a foreseeable side-effect may, or will, be the shortening of life. Similarly, a doctor may properly withhold or

14. 1953 GR. BRIT. T.S. NO. 71 (CMD. 8969). Emphasis added.

15. The precise ethical criteria have traditionally been articulated in terms of the long-established principle of "double effect." This principle, recently endorsed by the House of Lords Select Committee on Medical Ethics (*Report of the Select Committee on Medical Ethics*, H.L. Paper 21-I of 1993-94, at para.242) holds that an act which produces a bad effect is morally permissible if the action is good in itself, the intention is solely to produce the good effect, the good effect is not achieved through the bad effect, and there is a sufficient reason to permit the bad effect. *See* Luke Gormally, *Prolongation of Life: the principle of respect for human life* (Linacre Centre Papers, Paper 1) (1978) at p.10. For a fuller discussion of the moral distinction between intended and foreseen consequences, *see* J.M. Finnis, *Intention and Side-Effects* in R.G. FREY AND CHRISTOPHER W. MORRIS, LIABILITY AND RESPONSIBILITY (1991) at p.32; and *Intention in Tort Law* in DAVID OWEN ED., PHILOSOPHICAL FOUNDATIONS OF TORT LAW (1995) 229 at pp.243-246.

withdraw a life-prolonging treatment that is futile (that is, cannot secure a significant therapeutic benefit) or that the patient would find too burdensome, even though the doctor foresees that non-treatment may or will result in the patient's life ending sooner than would otherwise be the case. Doctors may not, on the other hand, take unreasonable risks with patients' lives. It is one thing for a doctor to perform neurosurgery to remove a malignant tumour, even though the operation may prove fatal; quite another to perform it merely because the patient has a headache.

*c. Acts and Omissions*

In the medical context, there are no exceptions to sanctity's moral prohibition of intentional killing: the doctor who intentionally shortens the life of a patient, whether a terminally ill adult or a child with Down's syndrome, breaches the principle. It matters not, moreover, whether the shortening is brought about by an act or an omission. Intentionally shortening a patient's life by withholding treatment, food, water, or warmth, is no less wrong than injecting a lethal poison. Nor does a good motive, such as the alleviation of the patient's—or the relatives'—suffering, redeem a bad intent. In short, any conduct that is intended to shorten a patient's life, whether as an end or as a means to an end, and whatever the further motive, breaches the principle.

*d. The Worthwhileness of Treatment: Its Benefits and Burdens*

As the above distinction between intended and foreseen life-shortening indicates, the sanctity doctrine accepts that in many cases it is perfectly proper to withhold or withdraw life-preserving treatment. That one need not try to preserve life *at all costs* is sometimes amusingly expressed in terms of A. H. Clough's ironic poem, "The Latest Decalogue," that while one must not kill, one "needst not strive *officiously* to keep alive." More precisely, however, the sanctity principle holds that there can be no moral obligation to administer or undergo a treatment that is not worthwhile. A treatment may be not worthwhile either because it offers no reasonable hope of benefit or because, even though it does, the expected benefit would be outweighed by burdens which the treatment would impose, such as excessive pain. Notice, however, that the question is always whether the treatment would be worthwhile, not whether the patient's *life* would be worthwhile. Were one to engage in judgments of the latter sort, and to conclude that certain lives were not worth living, one would forfeit any principled basis for objecting to intentional killing.

Where the benefit of a proposed treatment is not outweighed by the burdens it would impose, it has traditionally been referred to as "ordinary" and, where the converse is the case, as "extraordinary." Problems associated with this terminology (not least the fact that "ordinary" was often mistakenly interpreted to mean "usual" and "extraordinary" to mean "unusual") have resulted in the increasing use of terms such as "proportionate" and "disproportionate." But whichever terms are used, the moral question is the same: whether a proposed treatment is worthwhile, that is, whether its benefits, if any, would outweigh its burdens, if any.

Take Angela, a baby born with Down's syndrome and an intestinal blockage. Her doctor informs her parents that the blockage can be removed by a straightforward surgical operation and that, if it is not so removed, Angela will die. The doctor and parents, judging that the treatment will clearly benefit Angela by saving her life while involving only minimal burdens, such as the usual discomfort associated with the operation, decide that the operation would be worthwhile or proportionate and should be performed.

Contrast Angela with Bertha, a baby born with a terminal illness that will inevitably lead to death in a matter of hours. Her doctor informs her parents that, due to respiratory difficulties, she may stop breathing at any time and asks whether they would like attempts at artificial ventilation to be made in the event that her breathing ceases. Given that such efforts could not reverse Bertha's inevitable decline, and might impose significant burdens on her, they decide against ventilation as it would be disproportionate. In short, they decide to allow Bertha to die in peace. Yet their judgment in no way contravenes the principle of the sanctity of life; it is, indeed, wholly consistent with it. But what if the decision in either case were made not on the basis of whether the proposed *treatment* was worthwhile, but on the basis that the child's *life* was not worthwhile? Here we encounter another extreme avoided by the sanctity doctrine: "Quality of life," the opposite pole to vitalism.

*iii. Quality of Life*

The doctrine of the Quality of life is not concerned with assessing the worthwhileness of treatment but with the worthwhileness of the patient's life. It holds that the lives of certain patients fall below a quality threshold, whether because of disease, injury, or disability. This valuation of human life grounds the principle that, because certain lives are not worth

living, it is right to intentionally terminate those lives, whether by act or omission. Some who subscribe to this philosophy would require the patient's request as a precondition of termination. Others would not. After all, they argue, if the life of an incompetent patient is of such low quality that it is no longer worth living, and death would be a benefit, what is wrong with terminating it?

### *B.* Quality v. Quality: A Crucial Distinction

#### *i. Patient's Condition v. Worth of Life*

"Quality of life" judgments purport to assess the worthwhileness of a patient's life. The sanctity doctrine opposes such attempts and merely takes the patient's condition into account in determining the worthwhileness of a proposed treatment. For, in order to decide whether a proposed treatment would be worthwhile, one must first ascertain the patient's present condition and consider whether, and to what extent, it would be improved by the proposed treatment. This exercise is often described as involving an assessment of the patient's "quality of life" now and as it would be after the treatment. At no point in the sanctity assessment is one purporting to pass judgment on the worthwhileness of the patient's life, but the use of the term "quality of life" clearly risks confusion with its use in that sense. Such confusion is, regrettably, rife in ethical and legal discourse. To avoid any confusion in this paper, "*q*uality of life" will hereinafter be used to refer to an assessment of the patient's condition as a preliminary to assessing the worthwhileness of a proposed treatment and "Quality of life" to refer to assessments of the worthwhileness of the patient's life.

#### *ii. Illustrating the Distinction*

To illustrate the differences between the two approaches, let us return to Angela. The sanctity approach concluded that the blockage should be removed because—on a fair measure, that is, one commonly used by people in relation to their *own* situation—the benefits promised by the treatment, the improvement the operation would make to her condition (or "quality of life"), would significantly outweigh any burdens. However, a Quality of life approach might well deny the operation on the ground *that life with Down's syndrome* is simply not worth living. The focus is not on the worthwhileness of the treatment: indeed, the problem is thought to arise by the Quality of life advocate precisely because the treatment would be entirely successful.

*iii. Sanctity v. Quality*

From the standpoint of the sanctity doctrine, a central objection to the Quality of life philosophy is that it denies the ineliminable value of each patient and engages in discriminatory judgments, posited on fundamentally arbitrary criteria such as physical or mental disability, to determine whose lives are "worthwhile" and whose are not. The arbitrariness is highlighted when it is asked *which* disabilities, and to which *degree*, are supposed to make life not worth living?[16] Such discrimination seems, moreover, inconsistent with national and international declarations of human rights, which recognise the inherent rights enjoyed by all human beings simply because of their common humanity, not because they pass some Quality threshold.

## *C. The Good of Autonomy*

In determining whether a proposed treatment would involve excessive burdens to a particular patient, the views of the patient are clearly crucial. Individuals differ, for example, in their ability to tolerate pain, and what may be excessively painful for one patient may not be so for another. Indeed, the distinctions between proportionate and disproportionate treatments were devised by moralists not primarily for the purposes of health care professionals faced with decisions about which treatments they were morally bound to offer, but for patients facing decisions about which treatments they were morally bound to accept.

Moreover, the responsibility for safeguarding and promoting the good of health lies primarily with the patient, not with the doctor, at least where the patient is competent. Choices by patients that promote the good of health therefore merit respect and it is reasonable to allow patients considerable leeway, given the considerable variation between patients, in deciding what treatments they would find excessively burdensome.

This does not mean that just *any* choice by the patient merits respect, such as a choice to refuse treatment as a means of committing suicide. The value of individual choice lies in the fact that it is through our choices that we are able to promote our own flourishing as human beings (and that of those around us). Such choices, moreover, serve to reinforce dispositions to act in ways conducive to our flourishing. For our choices have internal as well as external effects: they shape our character. A's

16. *See* GORMALLY, op. cit. *supra* n.10 at pp.123-124.

murder of B results not only in B being murdered but in making A a murderer. As the ancient adage attests, an act tends to form a habit, a habit tends to form a character, and a character tends to form a destiny.[17]

The capacity to choose brings with it the responsibility of making not just any old choice, but choices that do in fact promote, rather than undermine, human flourishing. Given the legitimate diversity of lifestyles and life choices that are consistent with human flourishing, many choices are consistent with human well-being. We should, therefore, think carefully before restricting another's autonomy. But it is difficult to see why patently immoral choices, choices clearly inconsistent with human well-being, such as my starving you to death or my starving myself to death, merit respect. An exercise of autonomy merits respect only when it is exercised in accordance with a framework of moral truths. For example, A's decision to murder B is an exercise of autonomy, but it hardly merits respect since it breaches a grave moral norm. This is particularly clear when the decision, such as a decision to murder, seriously harms another person. But it is also true when the decision is morally wrong, whether it "harms" another or not, such as a decision to buy and smoke crack cocaine, or to commit incest with a consenting relative, or to perform female circumcision on a consenting woman, or to commit suicide.

Autonomy is, in other words, like the pointer in a compass. The pointer itself is of little value; indeed, it makes little sense in the absence of the points of the compass. When the pointer indicates a morally valuable course—and there may be a number of morally valuable courses—the choice merits respect. But when the choice is immoral, whether because it would harm another, or oneself, or breach some other moral norm, what claim to moral respect can it have? This is not to say that all morally worthless choices should be overridden, merely that they lack moral force.

Much contemporary chatter about autonomy consists of little more than the bare, uncritical assertion that a person's choice merits respect simply because it is his or her choice, whatever the choice may be; that self-determination is a moral absolute. The focus is on a self-justifying "right to choose" rather than on what choice is right. The "right to choose x" often serves as a slogan with powerful emotional appeal. But crude slogans are no substitute for rational reflection, and one can hardly sensibly assert a right to choose "x" until one has considered whether it is right to choose "x." The right to choose only arguably makes any moral

17. *Ibid.* at pp.130-131.

sense in the context of a moral framework that enables us to discern what it is right to choose, what choices will in fact promote human flourishing. And not only our flourishing, but that of others. For we do not live as atomised individuals, as much loose talk about absolute respect for personal autonomy seems to assume, but rather in community, where our choices can have profound effects not only on ourselves but on others.

If the principle of the sanctity of life is accepted, and it has hitherto been a hallmark of civilised societies, its implications for the right to self-determination should be patent. If it is seriously immoral intentionally to kill an innocent person, it is difficult to see how a choice to kill, whether another or oneself, can command moral respect. As the Anglican and Catholic Bishops stated in their joint submission to the House of Lords Select Committee on Medical Ethics, autonomy is not absolute and is valid "only when it recognises other moral values, especially the respect due to human life as such, whether someone else's or one's own."[18]

Indeed, given the fundamental value of life, society is fully justified in using the criminal law to deter the implementation of such choices. This is not to say we must use the law against individuals who have attempted suicide (who typically need understanding and help rather than condemnation and punishment), though it remains reasonable to use it against those who would assist or encourage suicide.

To conclude, just as the patient's life is not the highest moral value requiring preservation at all costs, neither is the patient's self-determination a moral absolute requiring respect in all circumstances—certainly not when it involves a choice to kill, whether oneself or another.

### D. *The Law*

#### *i. Homicide*

The doctrine and principle of the sanctity of life have long informed the common law. The law prohibits, as murder, the intentional shortening of a patient's life, regardless of the motive of the doctor[19] or the age, medical condition, or wishes of the patient. Though the blameworthiness of the killer may of course be mitigated, it remains as much murder intentionally to shorten the life of an aged terminally ill cancer patient who

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18. EUTHANASIA—NO! (A Catholic Truth Society, 1993) at para.8.

19. As Lord Goff has pointed out "if I kill you from the motive of compassion (so-called mercy killing) I nevertheless intend to kill you and the crime is one of murder." Lord Goff, *The Mental Element in the Crime of Murder* (1988) 104 L.Q.R. 30 at p.42. Footnote omitted.

pleads for death as it is to kill a young person in the prime of life who strenuously objects to death.[20] It also remains murder regardless of "necessity"[21] or duress.[22]

*ii. Acts and Omissions*

The criminal law is likewise not concerned only with punishing active killing. Although there is, generally, no liability for an omission to preserve life, it is well-established that it is murder to omit to discharge a duty to preserve life if the omission is with intent to kill or cause serious harm. Examples would be a parent's omission to feed a child, as in *Gibbins* and *Proctor*,[23] or a doctor's failure to feed a patient, with like intent.

*iii. Intention and Foresight*

The important moral distinction between intention and foresight, which characterises the sanctity principle, has also, at least since the decision of the House of Lords in *R v Moloney*,[24] been more or less clearly incorporated into the English law of homicide. Murder requires proof of intention in its ordinary sense of *purpose*. Foresight, even of consequences that are certain, is not equivalent to intention and is, at most, evidence of intention.

20. At York Assizes in 1812, two women who drowned a dying and deformed newborn child were convicted of murder, even though they thought they were acting rightly and lawfully. The trial judge stated: "I think this prosecution may be of great use to the public, in removing an erroneous opinion, that the law allows the right of deliberately taking away the life of a human being under any circumstances whatever." *Woodger and Lyall* (1812) 54 ANNUAL REGISTER, CHRONICLE at p.97.

21. In Dudley and Stephens (1884-85) 14 Q.B.D. 273, Coleridge L.C.J., rejecting necessity as a defence to murder, observed (at p.287): "It is not needful to point out the awful danger of admitting the principle which has been contended for. Who is to be the judge of this sort of necessity? By what measure is the comparative value of lives to be measured? Is it to be strength, or intellect, or what?"

22. In Howe [1987] A.C. 417, Lord Mackay stated (at p. 456): "It seems to me plain that the reason that it was for so long stated by writers of authority that the defence of duress was not available in a charge of murder was because of the supreme importance that the law afforded to the protection of human life and that it seemed repugnant that the law should recognise in any individual in any circumstances, however extreme, the right to choose that one innocent person should be killed rather than another." He concluded that the law should continue to deny that right. *See also* McKay v. Essex A.H.A. [1982] Q.B. 1166.

23. [1918] 13 Cr. App. R. 134. In this Article, "his" includes "her" unless the contrary is apparent.

24. [1985] A.C. 905. *See also* Hancock and Shankland [1986] A.C. 455; Nedrick [1986] 1 W.L.R. 1025; Walker and Hayles [1990] 90 Cr. App. R.226; Fallon [1994] Crim. L.R. 509; Scalley [1995] Crim L.R. 504.

It will be recalled that the sanctity principle prohibits conduct intended to shorten life but that conduct which is foreseen to be certain or likely to shorten life may or may not be culpable, depending on the circumstances. So too with the criminal law. Intentional killing is punished as murder, but conduct that foreseeably shortens life is at most manslaughter and may be perfectly lawful, depending on the reasonableness of the doctor's conduct. For example, a doctor who follows reasonable medical practice in administering palliative drugs to a dying patient, intending thereby to alleviate suffering, acts lawfully, even if the drugs, as an unintended side-effect, hasten death.

In *R v Cox*, a physician who had administered a lethal drug to a dying patient at her request was convicted of attempted murder. In his summing-up, Mr. Justice Ognall said:

> It was plainly Dr. Cox's duty to do all that was medically possible to alleviate her pain and suffering, even if the course adopted carried with it an obvious risk that, as a side effect [note my emphasis, and I will repeat it—even if the course adopted carried with it an obvious risk that as a side effect] of that treatment, her death would be rendered likely or even certain.[25]

There was no doubt, he added, that the use of palliative drugs would often be fully justified even if they hastened death. What could never be lawful, however, was the use of drugs with the "primary purpose" of hastening death.[26]

*iv. Autonomy*

Historically, the law has adopted the traditional ethical understanding of the value of autonomy sketched above. Consequently, it has proscribed, and continues to proscribe, many exercises of autonomy on the ground that they are wrongful. Their wrongfulness often inheres in their infliction of harm upon others or in the exposure of others to the risk of harm, whether or not, as in duelling, the other consents to the risk of harm. But an exercise of autonomy may also be prohibited because it exposes oneself to harm, or to the risk of harm, such as buying and snorting cocaine or, less seriously, driving a vehicle without wearing a seatbelt.

25. [1992] 12 B.M.L.R. 38 at p.41. (The bracketed words appear in the extract from the summing up in IAN KENNEDY AND ANDREW GRUBB, MEDICAL LAW: TEXT WITH MATERIALS (2nd ed. 1994) at p.1309).) *See also* Adams [1957] Crim L.R. 365; Re J (A Minor)(Wardship: Medical Treatment) [1991] 1 F.L.R. 366 at pp.374-375 *per* Lord Donaldson M.R.

26. *Ibid.*

In short, the law has, historically, provided scant support for an absolutist understanding of individual autonomy.

## III. From Sanctity to Quality

### A. *The Facts*

Before his death on March 3, 1993, Tony Bland had lain in Airedale Hospital for over three years in pvs, a state in which, it was believed, he could neither see, hear, nor feel. The medical consensus was that he would never regain consciousness. Neither dead nor dying, his brain stem still functioned and he breathed and digested naturally. He was fed by nasogastric tube, his excretory functions regulated by catheter and enemas. Infections were treated with antibiotics. His doctor and parents wanted to stop the feeding and antibiotics on the ground that neither served any useful purpose. The hospital trust applied for a declaration that it would be lawful to do so.

The application, supported by an *amicus curiae* instructed by the Attorney-General, was opposed by the Official Solicitor, representing Bland. The declaration was granted by Sir Stephen Brown, President of the Family Division of the High Court, whose decision was unanimously affirmed by the Court of Appeal and the House of Lords.

### B. *The Ratio*

Counsel for the Official Solicitor, James Munby Q.C., argued that stopping treatment and feeding would be murder or at least manslaughter. Three of the Law Lords accepted his submission that the doctor's intention would be to kill Tony Bland, a submission that the remaining two neither rejected nor accepted. One of the three, Lord Browne-Wilkinson, said:[27]

> Murder consists of causing the death of another with intent to do so. What is proposed in the present case is to adopt a course with the intention of bringing about Anthony Bland's death. As to the element of intention. . ., in my judgment there can be no real doubt that it is present in this case: the whole purpose of stopping artificial feeding is to bring about the death of Anthony Bland.[28]

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27. [1993] A.C. 789 at p.881.

28. Why the majority assumed it was the doctor's intention to kill is unclear: it does not follow that because the doctor foresaw the patient's death as certain, he therefore intended it.

Why, then, would it not be murder? Because stopping treatment and feeding was not a positive act but an omission. Lord Goff stated that withdrawing life-support was no different from withholding it in the first place; the doctor was simply allowing the patient to die as a result of his preexisting condition.[29] Moreover, tube-feeding was medical treatment: there was, he said, "overwhelming evidence" that in the medical profession tube-feeding was so regarded and, even if it were not strictly treatment, it formed part of the patient's medical care. The provision of food by tube was, he added, analogous to the provision of air by a ventilator.

The House further held that the doctor was under no duty to continue tube-feeding. *Re F*[30] decided that a doctor could treat an incompetent patient only if it was in the patient's best interests; *Bland* held that the same criterion should govern the withdrawal of treatment. As continued feeding was no longer in the patient's interests, the doctor was under no duty to continue it. The tube-feeding was not in Bland's best interests because it was futile and it was futile because, in the words of Lord Goff,[31] "the patient is unconscious and there is no prospect of any improvement in his condition." In deciding whether treatment was futile, the doctor had to act in accordance with a responsible body of medical opinion and thereby satisfy the "*Bolam* test"—the test that determines whether, in an action for medical negligence, a doctor has fallen below the standard of care required by the law.[32]

### C. *Misunderstanding the Sanctity of Life*

#### *i. Tube-Feeding: Futile Treatment or Basic Care?*

Their Lordships' reasoning appears, with respect, vulnerable to several criticisms. Why was tube-feeding not basic care, which the hospital and its medical and nursing staff were under a duty to provide? The Law Lords held that tube-feeding was part of a regime of "medical treatment and care."[33] The insertion of a gastrostomy tube into the stomach requires a minor operation, which is clearly a medical procedure. But it is not at all clear that the insertion of a nasogastric tube is medical intervention. And, even if it were, the intervention had already been carried out

29. [1993] A.C. 789 at 866.
30. [1990] 2 A.C. 1.
31. [1993] A.C. 789 at 869.
32. Bolam v. Friern Hospital Management Committee [1957] 1 W.L.R. 582. Lord Mustill reserved judgement about the appropriateness of this test in this context. *See* text *infra* n.57.
33. *See, e.g.*, [1993] A.C. 789 at p.858 *per* Lord Keith.

in Tony Bland's case. The question in such a case is why the pouring of food down the tube constitutes medical treatment. What is it supposed to be treating? Nor does the difficulty evaporate by classifying it, as did the Law Lords, as medical treatment *or* medical care. As Professor Finnis observes:

> The judgments all seem to embrace a fallacious inference, that if tube-feeding *is* part of medical 'treatment or care,' tube-feeding is therefore *not* part of the non-medical (home or nursing) care which decent families and communities provide or arrange for their utterly dependent members. The non-sequitur is compounded by failure to note that although naso-gastric tube-feeding will not normally be established without a doctor's decision, no distinctively medical skills are needed to insert a naso-gastric tube or to maintain the supply of nutrients through it.[34]

Their Lordships placed great weight on the fact that the medical profession regards tube-feeding as medical treatment.[35] But whether an intervention is medical is not a matter to be determined by medical opinion, nor by the mere fact that it is an intervention typically performed by doctors. A doctor does many things in the course of his practice, such as reassuring patients or fitting catheters, which are not distinctively medical in nature. And, if it is opinion that is crucial, the answer one gets may well depend on whom one asks. Tube-feeding may be regarded as medical treatment by many doctors, but many nurses regard it as ordinary care.[36]

Lord Goff's analogy between tube-feeding and mechanical ventilation is, although accepted by Mr. Munby Q.C.[37], unpersuasive. Ventilation is a standard part of a therapeutic endeavour to stabilise, treat, and cure; tube-feeding is not. Moreover, ventilation replaces the patient's capacity to breathe, whereas a tube does not replace the capacity to digest; it merely delivers food to the stomach. Nor have all patients who are tube-fed, including, it appears, those in pvs, lost the capacity to swallow. Tube-feeding may be instituted solely to minimise the risk of the patient inhaling food and/or because spoon-feeding is thought to be too time-consuming. Even if the patient has lost the capacity to swallow, the tube would still not be treating anything. A feeding tube by which liquid is delivered

34. Op. cit. *supra* n.7 at p.335. Original emphasis.
35. *See, e.g.*, [1993] A.C. 789 at p.870 *per* Lord Goff.
36. *See, e.g.*, Nursing Times, Feb. 10, 1993, at p.7.
37. [1993] A.C. 789 at p.822.

to the patient's stomach is surely no more medical treatment than a catheter by which it is drained from the patient's bladder.

Even if tube-feeding were medical treatment, why was it futile? Was it because it would do nothing to restore Tony Bland to the condition towards which *medical* practice and procedures are directed, namely some level of health, an explanation consistent with the sanctity ethic?[38] Or was it rather because Bland's *life* was thought futile, an explanation inconsistent with it? Dr. Keith Andrews, Director of Medical Services at the Royal Hospital for Neurodisability and a leading authority on pvs, recently wrote:

> It is ironic that the only reason that tube feeding has been identified as 'treatment' has been so that it can be withdrawn . . . . I would argue that tube-feeding is extremely effective since it achieves all the things we intend it to. What is really being argued is whether the patient's life is futile—hence the need to find some way of ending that life.[39]

Are there, then, grounds for concluding that the judges in *Bland* condoned the withdrawal of tube-feeding because they felt the patient's life, rather than the "treatment," was futile?

*ii. Misunderstanding the Sanctity of Life*

Lord Mustill rejected the notion that the state's interest in preserving life was attenuated "where the 'quality' of the life is diminished by disease or incapacity." If correct, he added, that argument would justify active as well as passive euthanasia and thus require a change in the law of murder.[40] The proposition that because of incapacity or infirmity one life is intrinsically worth less than another was, he said, the first step on a "very dangerous road indeed" and one he was unwilling to take.[41] Yet even Lord Mustill held that Tony Bland had no interest in being kept alive[42] and no best interests of any kind.[43] How do these propositions differ from a judgment that the patient's life was no longer worthwhile?

The concept of the worthless life is even more pronounced in other judgments, particularly in those passages that espouse what one may call

38. *See* Luke Gormally, *Reflections on Horan and Boyle* in LUKE GORMALLY ED., THE DEPENDENT ELDERLY (1992) at p.47.
39. (1995) 311 B.M.J. 1437 (letters).
40. [1993] A.C. 789 at p.894.
41. *Ibid.*
42. *Ibid.* at p.898.
43. *Ibid.* at p.897.

"dualism," i.e., the notion that human beings comprise two separate entities: a "body" and a "person," the former being of merely instrumental value as a vehicle for the latter. Sir Stephen Brown, for example, described Tony Bland thus: "His spirit has left him and all that remains is the shell of his body . . . [which is] kept functioning as a biological unit."[44] Similarly, Lord Justice Hoffmann said: "His body is alive, but he has no life in the sense that even the most pitifully handicapped but conscious human being has a life."[45] Bland's existence was, he added, a "humiliation"; he was "grotesquely alive."[46]

Such judicial endorsement of dualism is both novel and surprising, not only because, as Finnis points out,[47] dualism enjoys little support among philosophers, but also because the law has hitherto rejected the notion of "biological units" that are "inhabited" by a non-bodily person and has, on the contrary, taken the traditional, common-sense view that human life is personal life, that living human beings are persons, and that persons are, applying standard biological criteria, either alive or dead. As the judges recognised, it would be murder actively to kill Bland, regardless of his permanent unconsciousness. The law does not deny personhood, and the rights it attracts, because the person has lost the ability to think. We are all "biological units," and our mental acts, far from being a separate form of life, are something "added to" our body (from where?), and intrinsically involve, like our physical acts, biological processes. They are an expression of our one life as a human being, a human person. For example, the judge who listens to and evaluates an argument from counsel is not a biological machine with a little mental person inside (reminiscent of "The Numskulls" in the children's comic) but an integrated, dynamic unity, a living human body exercising the capacities (intellectual and physical) that are inherent in his or her nature as a human being. It is because we are human beings, human "biological units," that we have the radical capacity for acts both physical and mental. The fact that a human being has lost the ability to think does not mean he or she has lost his or her life. As Finnis puts it:

> One's living body is intrinsic, not merely instrumental, to one's

44. *Ibid.* at p.804.

45. *Ibid.* at p.825. He admitted he had been influenced by reading the manuscript of Professor Dworkin's book, LIFE'S DOMINION, a book that espouses dualism and misrepresents the doctrine and the principle of the sanctity of life. *See* (1994) 110 L.Q.R. 671.

46. *See also* [1993] A.C. 789 at 863 *per* Lord Goff; at 879 *per* Lord Browne-Wilkinson; at 897 *per* Lord Mustill.

47. Op. cit. *supra* n.4 at p.334.

> personal life. Each of us has a human life (not a vegetable life plus an animal life plus a personal life); when it is flourishing that life includes all one's vital functions including speech, deliberation and choice; when gravely impaired it lacks some of those functions without ceasing to be the life of the person so impaired.[48]

And, he adds, the fact that one is in pvs, although a gravely impairing condition which may prevent participation in basic human goods apart from life such as friendship or aesthetic experience, does not mean that one is not participating in the good, the benefit, of life.

Could it have been beneficial to feed and care for Tony Bland even though he could not appreciate it? It is perfectly possible to benefit someone, even if they are unaware of it, as where A, unbeknown to B, deposits a large amount in B's bank account, or speaks well of him to C.[49] And to state, as did Lord Mustill,[50] that Bland had "no best interests of any kind" is surely false. Would it not have been contrary to his interests to use him as, for example, a sideboard?

Given the dualistic reasoning uncritically engaged in by the judges, their conclusion that Bland's life was of no benefit, indeed may even have been a harm, a humiliation, comes as little surprise. That it was Bland's life, and not his tube-feeding, that was adjudged worthless is clearly illustrated by the following passage from the speech of Lord Keith:

> [I]t is, of course, true that in general it would not be lawful for a medical practitioner who assumed responsibility for the care of an unconscious patient simply to give up treatment in circumstances where continuance of it would confer some benefit on the patient. On the other hand a medical practitioner is under no duty to continue to treat such a patient where a large body of informed and responsible medical opinion is to the effect that no benefit at all would be conferred by continuance. *Existence in a vegetative state with no prospect of recovery is by that opinion regarded as not being a benefit*, and that, if not unarguably correct, at least forms a proper basis for the decision to discontinue treatment and care: *Bolam v Friern Hospital Management Committee* [1957] 1 W.L.R. 582.[51]

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48. *Ibid.*

49. *See* Joseph Boyle, *A Case for Sometimes Tube-Feeding Patients in Persistent Vegetative State* in JOHN KEOWN, EUTHANASIA EXAMINED (1995) at ch.13.

50. [1993] A.C. 789 at p.897.

51. Bolam v Friern Hospital Management Committee [1957] 1 W.L.R. 582. *Ibid.* at pp.858-859. Emphasis added. *See also* p.857, where he implies that Bland's life was meaningless. *See also* pp.878-879 and pp.884-885 *per* Lord Browne-Wilkinson.

But why was discontinuance not a breach of the principle of the sanctity of life, a principle Lord Keith accepted[52] was the concern of the State, and the judiciary as an arm of the State was to uphold? What is remarkable is that, while their Lordships agreed with the fundamental importance of the principle, none of them accurately articulated it.

Lord Goff, for example, in setting out the fundamental principles of law relevant to the case, stated that the "fundamental principle is the principle of the sanctity of life."[53] But he then went on to claim that, although it is fundamental, the sanctity of life is "not absolute."[54] In support of this surprising claim, he made a number of observations which suggest that his Lordship misunderstood the principle.

He observed, first, that it is lawful to kill in self-defence and, secondly, that, in the medical context, there is no absolute rule that a patient's life must be prolonged by treatment or care regardless of the circumstances. Both statements are, as the discussion in Part I made clear, accurate. But they do not show that the principle of the sanctity of life is "not absolute," unless one thinks, as his Lordship appears to, that the principle prohibits all killings or requires the preservation of life at all costs. Neither proposition is, of course, consistent with the principle as traditionally formulated and understood. His Lordship observed, thirdly, that the fact that a doctor must respect a patient's refusal of life-prolonging treatment showed that the sanctity of life yielded to the right to self-determination. Again, his Lordship seems to think that the sanctity of life requires the preservation of life, even against the competent patient's contemporaneous wishes. Yet this is not the case. Fourthly, he distinguished between a doctor, on the one hand, omitting to provide life-prolonging treatment or care and, on the other, administering a lethal drug: "So to act is to cross the Rubicon which runs between on the one hand the care of the living patient and on the other hand euthanasia—actively causing his death to avoid or to end his suffering."[55] But, as we saw in Part I, the intentional killing by one person of another person in his care, even if effected by omission, breaches the principle.

*iii. The Bolam* Test

The Law Lords decided that Bland's doctor was under no duty to continue treatment and tube-feeding if he felt that continuation was no

52. *Ibid.* at p.859.
53. *Ibid.* at p.863.
54. *Ibid.* at p.864.
55. *Ibid.* at p.865.

longer in the patient's best interests and if his opinion was supported (as it was) by a responsible body of medical opinion. Indeed, as Lord Browne-Wilkinson pointed out, if the doctor decided that treatment was no longer in the patient's best interests, he was under a *duty* to withdraw it.[56] Since the doctor could only lawfully treat the patient if he believed it was in the patient's best interests, continuing treatment when he did not believe it to be so would constitute the crime and tort of battery.

But why should the judgment about which patients have lives worth living be delegated to a "responsible body" of medical opinion? Even assuming such a comprehensive judgment can be made about the worth of another (which the sanctity principle denies), what qualifies a *doctor* to make it? Lord Mustill aptly observed that the decision could be said to be ethical and that there was no logical reason why the opinions of doctors should be decisive.[57] His was, however, a lone voice among the Law Lords. Lord Browne-Wilkinson expressly stated that one doctor could decide, because of his ethical views about the sanctity of life, that his patient was "entitled to stay alive" whereas another doctor who saw "no merit in perpetuating a life of which the patient is unaware" could lawfully stop his patient's treatment.[58]

Their Lordships did observe that, for the present, all cases like Bland's should be brought before the High Court for a declaration. But what is the court's role? Is it, as it appears to be, essentially to confirm that the doctor's opinion is supported by a responsible body of medical opinion? Or is it to lay down judicial criteria for deciding which lives are worthwhile? If the latter, what are those criteria?[59]

### *iv. A "Slippery Slope"*

Lord Justice Hoffmann said that it was "absurd to conjure up the spectre of eugenics" as a reason against the decision in *Bland*.[60] However, once Quality supplants inviolability, there is no reason in principle why the Quality threshold should stop at pvs. Finnis has observed that it is one thing to say that one should not treat people in ways which affront their inalienable dignity, but quite another to say that, because of their physical or mental disability, they *have* no dignity—or worse, that they

56. *Ibid.* at p.883.
57. *Ibid.* at pp.898-899.
58. *Ibid.* at p.884.
59. *See* Frenchay N.H.S. Healthcare Trust v. S [1994] 1 W.L.R. 601; John Keown, *Applying Bland* (1994) 53 (3) C.L.J. 456.
60. [1993] A.C. 789 at p.831.

*are* an indignity. How can the latter judgment logically be limited to those in pvs? As he maintains, "Epithets of indignity and humiliation could easily be applied (as in recent history) to various classes of severely handicapped people, many of whom, moreover, cannot exercise the distinctively human or 'personal' forms of understanding and response."[61] Lord Mustill raised, without resolving, the case of the patient who has "glimmerings of awareness"[62] and Lord Browne-Wilkinson the patient with slight chances of improvement or with "very slight sensate awareness."[63]

In May 1995, the Irish Supreme Court, following *Bland*, permitted, by a 4-1 majority, the withdrawal of tube-feeding from a patient who was not in pvs and had retained some cognitive function.[64] It affirmed the decision of the trial judge, who stated that if the patient were aware of her condition "that would be a terrible torment to her and her situation would be *worse* than if she were fully P.V.S."[65]

Putting aside the reasoning of the judges who favoured withdrawal (which is more, rather than less, vulnerable to criticism than the reasoning in *Bland*), the Irish case illustrates the inherently arbitrary nature of Quality of life judgments. The criticism bites even more deeply when the judgment is, *via* the *Bolam* test, delegated to "responsible" opinion. The question then simply becomes whether there is a body of "responsible" medical opinion which supports the doctor's view that the patient's life is worthless, whether or not a larger body of medical opinion disagrees. The inherent arbitrariness of Quality of life judgments, particularly when delegated to doctors, is underlined when it is recalled that medical opinion is often divided and in flux. A patient may be treated by a doctor who thinks his life worthwhile, but that doctor's ethical views may change, or the patient may come under the care of a doctor with different ethical views. The upshot would appear to be that if a doctor responsible for a patient with advanced Alzheimer's disease thinks the patient's life is of no benefit, and the doctor's opinion coincides with that of a "responsible body" of medical opinion, the doctor may, indeed must, cease treating the patient.

A recent case concerning non-treatment of an incompetent adult in-

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61. Op. cit. *supra* n.7 at p.336.

62. [1993] A.C. 789 at p.899.

63. *Ibid.* at p.885.

64. In the Matter of a Ward of Court [1995] 2 I.L.R.M. 410; John Keown, *Life and Death in Dublin* (1996) 55 (1) C.L.J. 6.

65. Cited in [1995] 2 I.L.R.M. 401 at p.432 *per* O'Flaherty J. Emphasis added.

volved a twenty-three-year-old man ("R") with serious mental and physical disabilities.[66] Frail and weighing five stones, R operated cognitively and neurologically at the level of a newborn infant, responding to comfort, warmth, and a safe environment with an occasional smile; and to pain and to discomfort with distress and crying. After several hospital admissions in 1995, the consultant psychiatrist in learning disabilities who was responsible for his treatment agreed with R's parents that should R suffer a life-threatening condition involving a cardiac arrest he should not be given cardio-pulmonary resuscitation. As a result of concern expressed at this decision by staff at the day care centre R attended, the hospital trust applied for a declaration in the Family Division and the Official Solicitor was appointed to act as R's guardian *ad litem.*

Sir Stephen Brown granted a declaration in terms drafted by counsel for the Official Solicitor, James Munby Q.C., and approved by counsel for the plaintiffs and by R's parents. The declaration provided *inter alia* that it would be in R's best interests for the plaintiffs to perform a gastrostomy but to withhold cardio-pulmonary resuscitation and, provided R's general practitioner and consultant psychiatrist so advised and one or both of R's parents agreed, to withhold antibiotics in the event of a potentially life-threatening infection.[67]

*Re R* does little to assuage concerns about a slippery slope. Although Dr. Keith Andrews, medical expert for the Official Solicitor, opposed resuscitation on the ground that it would be a futile *treatment* (because of its very small prospect of success and its real risk of inflicting injuries on R), Sir Stephen Brown's judgment omits to distinguish between non-treatment on this ground and on the ground that the patient's *life* is thought futile. In fact, in a number of passages, the judge approves non-treatment on the latter ground.[68]

The risk of a slippery slope is heightened by the practical difficulties involved in accurately diagnosing a condition thought to justify non-treatment. Even pvs is not a clear-cut syndrome and misdiagnoses are not uncommon. A study carried out by Dr. Keith Andrews, published in July 1996, disclosed that of forty patients referred to the Royal Hospital for

66. *Re R* [1996] 2 F.L.R. 99.

67. *Ibid.* at p.110.

68. *See ibid.* at p.107 where he applied Re J (A Minor) [1991] 1 F.L.R. 366, in which the Court of Appeal adopted a Quality of life approach (*see* text *infra* nn.73-78). His reliance on *Re J* rather than *Bland* is puzzling as *Re J* involved a minor. Both cases, however, are at one in adopting a Quality of life approach. Another puzzling aspect of *Re R* is the doctors' willingness to perform a gastrostomy operation but not to administer antibiotics.

Neurodisability as vegetative between 1992 and 1995, no fewer than seventeen (forty-three percent) had been misdiagnosed. All but one of the seventeen had been referred by a hospital consultant, mostly by a neurologist, neurosurgeon or rehabilitation specialist. The study concluded that accurate diagnosis is possible but requires the skills of a multidisciplinary team experienced in the management of people with complex disabilities.[69]

The Practice Note governing applications for declarations in cases of pvs states that there should be two neurological reports on the patient, one commissioned by the Official Solicitor, but the involvement of such a team is not required.[70] Furthermore, the risks of misdiagnosis necessarily will increase if time is short. In one case where the Court of Appeal declared it lawful not to reinsert a feeding tube that had become disconnected, there had been insufficient time for the Official Solicitor to obtain an independent neurological opinion.[71] It seems doubtful whether the patient in that case was in fact vegetative.

*v. A Possible Explanation?*

What accounts for the judges' misunderstanding of the sanctity principle, a principle that has long been central to the law? A plausible explanation is that the principle does not appear to have been accurately set out before them by any of the counsel who appeared in the case. Even counsel for the Official Solicitor appears to have confused sanctity with vitalism. In the Court of Appeal, for example, he argued that if Tony Bland showed signs of life-threatening failure of, in succession, heart, lungs, liver, kidneys, spleen, bladder, and pancreas, the doctor would be under a duty to perform surgery to rectify the failure. Sir Thomas Bingham M.R. observed: "Such a suggestion is in my view so repugnant to one's sense of how one individual should behave towards another that I would reject it as possibly representing the law."[72] This observation is, with respect, entirely right since counsel's argument was surely vitalistic.

*Bland* was not the first time Mr. Munby Q.C. had, as counsel for the Official Solicitor, advanced a vitalistic understanding of the sanctity of life. In *Re J (A Minor)*,[73] the previous leading case on the withholding or

69. Keith Andrews et al., *Misdiagnosis of the vegetative state: retrospective study in a rehabilitation unit* (1996) 313 B.M.J. 13.
70. [1994] 2 All E.R. 413.
71. *Supra* n.59.
72. *Ibid.* at p.815. *See also* Butler-Sloss L.J. at pp.822-823.
73. Re J (A Minor)(Wardship: Medical Treatment) [1991] 1 F.L.R. 366.

withdrawal of medical treatment, the question was whether a disabled ward should be artificially ventilated. Mr. Munby Q.C. made two alternative submissions. The first, his "absolute" submission, was:

> That a court is never justified in withholding consent to treatment which could enable a child to survive a life-threatening condition, whatever the pain or other side-effects inherent in the treatment, and whatever the quality of life which it would experience thereafter.[74]

The alternative, "qualified" submission,[75] based on the reasoning of the Court of Appeal in the earlier case of *Re B*,[76] was that a court could withhold consent to treatment only if it was certain that the Quality of the child's life would be "intolerable" to the child. In *Re J*, then, the court was presented with only two alternatives: vitalism or Quality of life. It preferred the latter, with the rider that the Quality of life was to be judged from the perspective of the child. As Lord Justice Taylor expressed it:[77]

> The correct approach is for the court to judge the quality of life the child would have to endure if given the treatment and decide whether in all the circumstances such a life would be so afflicted as to be intolerable to that child. I say 'to that child' because the test should not be whether the life would be tolerable to the decider. The test must be whether the child in question, if capable of exercising sound judgment, would consider the life tolerable.[78]

It appears, then, that in *Bland*, as in *Re J* before it, the sanctity of life was not heard; that the choice as presented and perceived was between vitalism and Quality of life, and that the judges, unsurprisingly, opted for Quality of life. Despite the fundamental importance attached to the sanctity of life by the judges who sat in *Bland*, it is by no means clear that any had the benefit of an accurate appreciation of it.

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74. *Ibid.* at pp.370-371 *per* Lord Donaldson M.R.
75. *Ibid.* at p.373.
76. [1981] 1 W.L.R. 1421.
77. [1991] 1 F.L.R. 366 at pp.383-384.
78. Given that the child had never been capable of making any judgment, invoking the child's viewpoint is, with respect, a confused fiction. It is remarkable that the courts should import "substituted judgment" in the case of a child who has never been competent, yet reject it in the case of an adult like Tony Bland who once was. Yet even if substituted judgment had been applied in *Bland*, and the court had declared that the feeding should be stopped because he would have chosen to be killed rather than live in pvs, it would still amount to the making of a Quality of life judgment. A Quality of life judgment remains just that, whether made on the basis of best interests or substituted judgment.

### D. *Misunderstanding Autonomy*

The courts in *Bland* undervalued human life. But this was not their only error. For they also appeared to *over*value human autonomy, even to the extent of suggesting that the latter trumped the former. We noted above Lord Goff's statement that the patient's right to self-determination overrides the sanctity of life and observed that this statement is misleading if it suggests that the sanctity of life is breached when a doctor allows a patient to refuse a life-saving treatment. What *would* breach the principle, however, is a *suicidal* refusal of treatment by the patient and the intentional assistance or encouragement of that refusal by the doctor, whether by act or omission. Whether his Lordship was intending to condone such refusals and assistance in them is unclear. He said that where a patient refused life-prolonging treatment: "there is no question of the patient having committed suicide, nor therefore of the doctor having aided or abetted him in doing so."[79] If Lord Goff was referring to the refusal of a worthless treatment, this is uncontroversial. But if he included a refusal by which the patient intends to commit suicide, the statement indicates that patients may now lawfully commit suicide by refusals of treatment (or care?) and that doctors may assist or encourage such refusals, albeit by omission. In support of such a proposition could be cited the statement of Lord Justice Hoffmann in the Court of Appeal that the decriminalisation of suicide by the Suicide Act of 1961 "was a recognition that the principle of self-determination should in that case prevail over the sanctity of life."[80]

However, as the Parliamentary debates leading up to the enactment of the Suicide Act of 1961 confirm, the reason for decriminalisation was *not* respect for self-determination but a belief that the suicidal needed help rather than punishment. In other words, suicide was decriminalised not to help people to commit suicide, but to help them not to. The Government strenuously denied any intention to condone suicide, let alone establish a right to it. Moving the Suicide Bill's Third Reading, the Joint Under-Secretary of State for the Home Department issued the following warning:

> Because we have taken the view, as Parliament and the Government have taken, that the treatment of people who attempt to commit suicide should no longer be through the criminal courts,

79. [1993] A.C. 789 at p.864.

80. *Ibid.* at p.827. *See also* p.814 *per* Sir Thomas Bingham M.R., who assumed that a refusal of tube-feeding is not suicidal.

> it in no way lessens, nor should it lessen, the respect for the sanctity of human life which we all share. It must not be thought that because we are changing the method of treatment for those unfortunate people we seek to depreciate the gravity of the action of anyone who tries to commit suicide.[81]

Addressing fears that decriminalisation of suicides might give the impression that what the potential victims proposed was no longer regarded as wrong, he stated:

> I should like to state as solemnly as I can that that is certainly not the view of the Government, that we wish to give no encouragement whatever to suicide. . . .[82] I hope that nothing that I have said will give the impression that the act of self-murder, of self-destruction, is regarded at all lightly by the Home Office or the Government.[83]

The assertion that acceptance of a right to commit suicide was not the reason for decriminalisation is confirmed by the fact that assisted suicide was not decriminalised and remains a serious offence.

In *Secretary of State for the Home Department v Robb*, Mr. Justice Thorpe cited *Bland* as authority for the proposition that a patient who refuses life-prolonging treatment, which results in death, does not commit suicide and that the doctor who complies with the patient's wishes does not aid or abet suicide.[84] Granting a declaration that the Home Office and medical and nursing staff might lawfully abide by a prisoner's refusal to take food and water, he observed that "The principle of the sanctity of human life in this jurisdiction is seen to yield to the principle of self-determination" adding that, although the state interest in preventing suicide is recognisable, it had no application to a case such as the present where the refusal of food and treatment "in the exercise of the right of self-determination does not constitute an act of suicide."[85]

If Mr. Justice Thorpe is of the opinion that suicide may only be committed by an act, and not by a refusal of food and treatment, then he advances no argument or authority in support, beyond the *dicta* in *Bland*. But this is bootstrap authority: those *dicta* are themselves either ambiguous or bereft of authority and the point was simply not argued in that case. Moreover, his apparently unqualified proposition that the right to

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81. (1960-61) 645 PARL. DEB. H.C. cols.822-823. (Mr. Charles Fletcher-Cooke M.P.)
82. (1960-61) 644 PARL. DEB. H.C. cols.1425-26.
83. *Ibid.* col.1426.
84. [1995] 1 All ER 677.
85. *Ibid.* at p.682.

self-determination takes precedence over the sanctity of life is difficult to square with the prohibition on assisted suicide and murder on request.[86]

## IV. FROM QUALITY TO SANCTITY

What answer would the traditional ethic, accurately understood and applied, have yielded in the *Bland* case? Sanctity of life ethicists are agreed that since medical treatment, such as ventilation and probably also antibiotics, can do nothing to restore those in pvs to a state of health and well-functioning, it is futile and need not be provided. On the question whether tube-feeding is simply medical treatment or also basic care, there is no unanimity. Some classify tube-feeding as medical treatment that may, therefore, be withdrawn; others (probably advancing the more representative viewpoint) believe that it is basic care which ought, therefore, be provided.[87]

However, although the traditional ethic does not, as yet, unequivocally rule out the withdrawal of tube-feeding on the ground that it is futile medical treatment, it certainly rules out its withdrawal on the ground that the *patient* is futile. While the ethic may currently allow for a legitimate diversity of answers, it does insist on asking the right question: "Is tube-feeding 'treatment' and, if so, is it worthwhile?" and not "Is the patient's life worthwhile?"

How, then, could their Lordships have developed the law in accordance with the sanctity of life principle? As Finnis has pointed out, cases such as *Gibbins* and *Proctor* establish that one who undertakes the care of a dependent person and omits to provide necessary food or clothing with the intention of causing death (or serious harm) commits murder if death results. He adds that those cases do not confront the argument successfully raised in *Bland*—that one who has undertaken a duty of care may yet have no duty to exercise it so as to sustain life—but that "the proper application or extension of their rule to meet that argument was surely this: those who have a duty to care for someone may never exercise it in a manner intended to bring about that person's death."[88]

*Bland* holds the opposite. And it does so at the expense of radical in-

86. For an ethical and legal analysis of pre-incompetence refusals of treatment, *see* Stuart Hornett, *Advance Directives: A Legal and Ethical Analysis* in JOHN KEOWN ED., EUTHANASIA EXAMINED (1995) at ch.17.

87. *See, e.g.*, Luke Gormally, *Definitions of Personhood: Implications for the Care of PVS Patients* (1993) 9.3 ETHICS AND MEDICINE 44 at p.47. Joseph Boyle, op. cit. *supra* n.49.

88. Op. cit. *supra* n.7 at p.333.

consistency, prohibiting as murder intentional killing by an act, but permitting intentional killing by omission. Imagine the following scenario. X is a pvs patient who is free of any suffering and who has made no request to be killed. X's doctor decides that, because X's life is worthless, he would be better off dead, and stops his tube-feeding with intent to kill. In the next bed is Y, a patient dying in agony who, after serious reflection, begs the doctor to kill him by lethal injection. The doctor, fearful of prosecution, refuses. A third patient, Z, moved by Y's predicament, draws a pistol, holds it to the doctor's head and threatens "If you don't inject Y, I will shoot you dead." The doctor, to save his own life, administers a lethal drug to Y. The doctor's killing of X is lawful; his killing of Y is, at least in English law, murder.

Small wonder that Lord Mustill expressed his "acute unease" about resting his decision on a distinction between acts and omissions given that "however much the terminologies may differ the ethical status of the two courses of action is for all relevant purposes indistinguishable."[89] But it is the judges' reasoning in *Bland* that has distorted the legal structure, not vice versa. *Bland* is the culmination of a series of cases in which the courts have veered away from the traditional ethic, which coherently combines sanctity and quality in a consistent and principled legal opposition to intentional killing, toward a new ethic which incoherently combines sanctity and Quality and produces a misshapen opposition to active killing but not intentional killing by omission.

The Law Lords urged Parliament to consider the issues raised by *Bland*. A distinguished Select Committee of the House of Lords, chaired by Lord Walton and including Lord Mustill, was established by the House of Lords to consider the issues raised by the case. The Committee's report in February 1994 recommended that the law should not be relaxed to permit active intentional killing. Reaffirming the prohibition on intentional killing, the Committee observed: "That prohibition is the cornerstone of law and of social relationships. It protects each one of us impartially, embodying the belief that all are equal."[90]

On the question of tube-feeding patients in pvs, the Committee was divided between those who regarded it as basic care, which should be provided, and those who regarded it as medical treatment, which could properly be withdrawn. Nevertheless, the Committee was unanimous

89. [1993] A.C. 789 at p.887. *See also ibid.* at p.865 *per* Lord Goff; at p.877 *per* Lord Lowry; at p.885 *per* Lord Browne-Wilkinson.

90. Op. cit. *supra* n.15 at para.237.

that the question need not, indeed should not, usually arise since it was proper to withdraw medical treatment, including antibiotics, from such patients.[91]

However, by confining itself to considering active killing and ignoring intentional killing by omission the Committee did little to resolve the inconsistency in the law created by *Bland*.[92] Consequently, the law remains in the same misshapen state in which the Law Lords left it. And the question that the Committee said should not arise has continued to do so as hospitals and courts *hasten* to terminate the lives of those they consider to be in pvs.[93] Lord Lowry referred in *Bland* to a gap between "old law" and "new medicine" and observed that it was the role of the legislature to remedy any disparity between society's notions of what the law is and what is right.[94] But if their Lordships were looking to the legislature to render the law consistent by decriminalising active intentional killing, the legislature has declined the invitation and has bounced the misshapen ball back into the judicial forum.

## V. CONCLUSION

First, the ethical principle of the sanctity of life, which has long informed the common law, offers a middle way between the extremes of vitalism on the one hand and Quality of life on the other. *Bland* represented a swerve toward the Quality of life extreme, accepting that certain lives are of no benefit and may lawfully be intentionally terminated by omission.

Second, accentuating the swerve was a shift away from a traditional understanding of the value of autonomy, i.e., autonomy as enabling individuals to participate in the moral enterprise of making choiceworthy decisions, decisions that respect objective moral norms and promote the flourishing of the decision maker and others. That well-established understanding has been replaced largely by an essentially self-justificatory notion of autonomy, one in which choices merit respect simply by virtue of being choices.

Third, *Bland* has indeed left the law in a "morally and intellectually misshapen" state. The law prohibits doctors caring for patients in pvs

91. *Ibid.* at para.257.

92. The Committee gave no reason for limiting its definition of euthanasia to active killing (*ibid.* at para.20) nor did it rule out Quality of life judgments (*see, e.g.*, *ibid.* at para.255). It did not, therefore, advance a consistent sanctity ethic.

93. *See supra* n.55. *See also* Re D, THE TIMES, Mar. 22, 1997.

94. [1993] A.C. 789 at p.877.

from actively killing them but permits (if not requires) them to kill by omission. The case also suggests that while doctors may not actively assist competent patients to commit suicide, they may assist them to do so by omission—by intentionally assisting suicidal refusals of treatment. The significance of the decision is profound: although the House of Lords Select Committee reaffirmed that active killing, even on request, should remain unlawful, the Law Lords have decided that killing by omission, even without request, is already lawful. The making of such a fundamental change in the law seems difficult to reconcile with the guidelines for judicial development of the law laid down by Lord Lowry in *C. v. D.P.P.*[95]

Fourth, given that the Law Lords have embraced the Quality of life principle, and effectively delegated the judgment as to which lives are of no benefit to medical opinion, there is little reason to expect that judgment to be confined to patients in pvs. The ramifications of the courts' adoption of an individualist and amoral understanding of autonomy are likely to be profound, not least in its corrosive effect on the legal prohibition of assisted suicide and consensual murder.[96]

Fifth, the Law Lords' rejection of the sanctity principle and their adoption of an amoral concept of autonomy appear to have been based on a misunderstanding of the traditional ethic. As Lord Mustill rightly observed, it was a great pity that the Attorney-General had not appeared to represent the interests of the state in maintaining citizens' lives.[97] It is to be hoped that the Attorney will appear in an appropriate future case to represent, articulate, and defend the traditional ethic.

Finally, the decision whether to withdraw treatment and tube-feeding from a patient in pvs should be based on an evaluation of the worthwhileness of the treatment, not the supposed worthwhileness of the patient. While there appears to be a consensus that it is proper to withdraw treatment in such a case, there is a good argument that tube-feeding constitutes basic care and that it should, at least presumptively, be provided. Even if it were the better view that it may be withdrawn, this should be because it, and not the patient, is judged futile.

*Bland* indeed rendered the law morally and intellectually misshapen,

95. [1995] 2 All E.R. 43 at p.52. *See also* Airedale N.H.S. Trust v. Bland [1993] A.C. 789 at p.865 *per* Lord Goff; at p.880 *per* Lord Browne-Wilkinson; at p.890 *per* Lord Mustill.

96. *See also* Re MB [1997] 8 Med. L.R. 217, in which the Court of Appeal held that a competent pregnant woman has an absolute right to refuse medical treatment, even if she and the unborn child will die as a result.

97. [1993] A.C. 789 at p.889.

hypocritical rather than Hippocratic. But the Law Lords are not alone in promoting this legal revolution. For *Bland* is but one of several leading cases in common law jurisdictions that could have been used to illustrate the disturbing tendency of judges across the Western world to turn the traditional ethic on its head. Judges, often regarded as one of the most conservative arms of the state, have played a role no less significant than that of legislatures in subverting that ethic by converting a right *not* to be killed into a duty *to* kill and a right to self-determination into a right to self-termination. Unless the traditional ethic is restored by the courts or, failing the courts, by legislatures, one of the main pillars of Western civilisation, the sanctity of life, will have been fatally undermined.