

The BMA Report on Euthanasia and the Case ¹ Against Legalization*

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1. Introduction

The most important document on euthanasia to have appeared in the UK in the decade since *Euthanasia and Clinical Practice* was published in 1982 is the British Medical Association Working Party Report on *Euthanasia*.¹ This is a substantial document² which is more comprehensive in scope than *Euthanasia and Clinical Practice*, which concentrates almost exclusively on the *ethics* of clinical practice.

By contrast the BMA Report specifically discusses, among other questions, whether voluntary euthanasia should be *legalized*. Nonetheless, it is the view which the BMA Working Party took of the ethical considerations that should govern clinical practice which also determined the case they make against

legalization of euthanasia. Concern with the ethics of clinical practice is central to both documents. This chapter seeks to analyse and evaluate the case which the BMA Report makes against the legalization of voluntary euthanasia.

The Working Party which produced the Report was chaired by Sir Henry Yellowlees, a former Chief Medical Officer of The Department of Health and Social Security, and comprised two specialists in community medicine, a general practitioner, a consultant paediatrician, a professor of geriatric medicine, and the medical director of a hospice. It was served by officers of the British Medical Association, and there were three 'observers': one a solicitor who was a former chief nursing officer of a district health authority, one a barrister, and the third a professional philosopher who is also a neurosurgeon.³ The seven members of the Working Party were, then, all members of the medical profession and, apart from what came to them in the form of submissions and evidence, had access to advice on legal and philosophical questions from the 'observers'.

The Working Party was established early in 1987 in response to a resolution passed at the 1986 Annual Representative Meeting of the British Medical Association urging that the Association 'reconsider its policy on

* This paper is published in Luke Gormally (Ed), *Euthanasia, Clinical Practice and the Law*, The Linacre Centre, 1994, and all references to 'this volume' in the footnotes refer to this book.

¹ *Euthanasia, Report of the Working Party to review the British Medical Association's guidance on euthanasia*. London, British Medical Association, May 1988.

² The main part of the document is ordered consecutively in 271 paragraphs, organized into 14 chapters.

A final Chapter 15 contains 16 conclusions. References in the text of the present chapter to the BMA Report will be by paragraph number (e.g. para.16) or to a numbered conclusion (e.g. Conclusion 16).

There are frequent cross-references in the present chapter to the Linacre Centre's *Submission to the Select Committee of The House of Lords on Medical Ethics* (pp.111-165 of the present volume). Such references are indicated by the short title *Submission*, followed by the section number.

³ Dr Grant Gillett. For some evidence suggestive of his influence on the Working Party Report see footnote 9 to this chapter.

euthanasia'. To this end the Working Party held 15 meetings in a period of as many months, publishing the Report in May 1988.

The Working Party undertook to review a wide range of considerations with some bearing on the question of whether euthanasia should be legalized: ethical and legal considerations, the teaching of religious bodies, practices in other countries, as well as professional views about what is appropriate in those areas of clinical practice in which the issue of euthanasia can arise.

The primary objective of the Working Party was to define a general rule of appropriate professional conduct in regard both to voluntary and non-voluntary euthanasia. The position advanced is that euthanasia, whether voluntary or non-voluntary, is *generally* undesirable, and, accordingly, the Working Party concludes that killing patients for euthanasiast reasons should remain a criminal offence.

In section 2 of this Chapter I shall outline the main ethical considerations which lead the Working Party to conclude that euthanasia should not be legalised. In section 3 I shall identify what seem to be the weak points in that case. Those weaknesses are sufficiently grave to be damaging to a coherent professional ethic. The framework of principle required for a coherent ethic has been analysed in the *Submission* (Book II, Chapter 1 of the present volume), and in some respects is explored in greater depth in *Euthanasia and Clinical Practice: trends, principles and alternatives* (Book I).

2. The Working Party's case against legalizing voluntary euthanasia

2.1 Euthanasia and the value of the individual

The Working Party claim that a constant and core feature of the ethos of medicine is 'the conviction that human life is of inestimable value and ought to be protected and cherished' (para.72). An ethos dominated by that conviction leads one to embrace the arduous task of finding value in the lives of patients suffering pain and severe disability; to end those lives would be a comparatively easy option (para.62). The view that someone would be 'better off dead' is linked to being 'discriminatory about the kind of worth that attends a life' (para.56). In being asked to kill patients doctors are being asked to abandon the conviction that human life is of inestimable value and ought to be protected and cherished (para.72). The principal reason for rejecting 'a change in the law to permit doctors to intervene to end a person's life' derives from recognition 'of the supreme value of the individual, no matter how worthless and hopeless that individual may feel' (Conclusion 16).

One strand in the thinking of the Working Party involves distinguishing between the *objective* value of individual human beings, which remains 'inestimable', and the *subjective* sense of value an individual experiences, which may wax and wane. The 'inestimable' objective value does not permit us (it is at least suggested) to discriminate between the value of individual lives in such a way as to provide justification for ending some of those lives on the grounds that the individuals concerned would be 'better off' dead. To take that view of a human life would be to abandon the conviction that human lives are of 'inestimable value'.

Here we have the sketch of a line of reasoning for opposing euthanasiast killing. It needs a more developed and systematic statement, but seems clearly to represent one strand in the thinking of the Working Party. However, there are other elements in that thinking which are at odds with the reasoning sketched here and which tend to undermine the conclusion the Working Party seek to advance. It will be necessary to discuss those elements in the next section (see 3.1 below).

2.2 *The importance of an unambiguous rule against euthanasiast killing for maintaining the true character of the doctor's commitment to patient care.*

The second point presupposes and develops from the first. A sense of the inestimable value of individual human lives is essential if doctors are to 'maintain a dedication to care of patients and the preservation of life' (para.238). But if they do not have this dedication, 'if patients were to perceive that doctors were ready to kill where they cannot cure' (ibid.), then patients would cease to have confidence in the commitment of doctors. The destruction of trust in the character of doctors' commitment would undermine the doctor-patient relationship. To permit euthanasia would be to create a climate in which certain patients are perceived 'as lingering nuisances whose worth and well being are no longer significant' (ibid.) In so far as euthanasiast killing rests on the view that those to be killed would be better off dead because they no longer have lives worth living, it is premised on a valuation of human life incompatible with that valuation which is essential if doctors are to maintain a positive, creative commitment to the care of patients. For the sake of supporting that commitment doctors need to be forbidden to engage in

killing which rests on the assumption that the lives of some human beings are not of inestimable value. For in so far as they engaged in such killing they would have ceased to grasp the *practical import* of the belief that each human life is of inestimable value.

The reasoning of the Working Party here connects *practical* belief in the inestimable value of individual human lives with the *character* of doctors. 'If the profession is seen as sometimes curing and sometimes killing depending on a rather complex set of guidelines ... the patients may well have some apprehension *about the nature of the individuals* who are supposed to be jealously preserving their lives.' (para.77, emphasis added) For reasons explained in the *Submission* (section 1.2.2), the Working Party is right to see a close connection between euthanasiast killing and the valuation of human life. However, it is not clear that the Working Party's understanding of the kind of prohibition of euthanasiast killing they support will do the job they think required: the job of sustaining doctors in their commitment to the care of patients. For though the Working Party wish to see maintained a legal prohibition on euthanasiast killing they do not support their case by arguing for an *absolute* moral prohibition, i.e. a prohibition which does not allow of exceptions. The Working Party readily concede that a doctor may be confronted by cases in which, however rarely, he may justifiably kill a patient. It will be important to discuss the reason for allowing such exceptions and to ask whether the logic of doing so does not undermine a general prohibition (i.e. one which is meant to hold *for the most part*) and consequently the role of such a prohibition in protecting the character of doctors in their

commitment to the care of patients (see 3.4 below).

2.3 *The insensitivity of euthanasia*

In a number of places the Working Party Report advances the following consideration against permitting euthanasiast killing: euthanasia carried out as a solution to problems of pain and suffering is very often insensitive to the underlying significance of a plea to be killed and to the potentially transient character of the outlook which prompted the patient to make the plea (para.92.2; see para.61). Evidence for the frequently transient character of the desire that one's life be brought to an end is seen in the fact that 'failed suicides rarely repeat their attempts and that most are glad that their lives were saved' (para.42).

Considerations of this kind are not insignificant in considering the effect legalization of voluntary euthanasia would have on the practice of medicine. If it were legalized there should be little doubt that ostensible pleas to be killed which are covert pleas for considerate and committed care will be treated as providing sufficient justification for killing patients. The Netherlands has now provided us with ample evidence of how doctors are likely to behave when euthanasia is not in fact treated as a criminal offence.⁴

Nonetheless, someone might doubt whether a consideration of this kind provides sufficient reason for a blanket prohibition of euthanasia. In conjunction with the two other reasons offered it is indeed a powerful consideration. But those two reasons carry the main burden of the case for a

blanket prohibition and so it is important to examine how well-grounded and consistent is the Working Party's presentation of those reasons.

3. Weaknesses in the Working Party's case.

3.1 *Which human beings are of 'inestimable value' and why are they?*

The key assertion on which the Working Party's case against euthanasia hangs is that 'human life is of inestimable value'. At first sight this might be taken to mean that *any* human life is of inestimable value. But a reading of the sections of the Report on Brain Death (paras.29-33) and the Persistent Vegetative State (paras.34-39) undermines this interpretation.

The Working Party think that acceptance of 'brain death as a criterion for the end of life' indicates 'that it is the distinct functions provided by the human brain that make human life of unique ethical importance' (para.31). This confuses two questions which are quite distinct (though they may have a single correct answer): (1) When is X dead? and (2) When does X's life cease to have special moral significance?

A particular understanding of the meaning of death and certain physiological claims about the role of the brain stem in the human organism, together provide grounds for accepting that diagnosis of 'brain stem death' (which is what the UK protocol purports to establish)⁵ is an adequate

⁴ See the two chapters by John Keown in this volume.

⁵ The protocol is contained in Conference of Medical Royal Colleges and their Faculties in the UK. 'Diagnosis of Brain Death'. *British Medical Journal* 2(1976) 1187-1188. See further Conference of Medical Royal Colleges and their Faculties in the UK. 'Memorandum

basis for diagnosing death. The understanding of death referred to here is 'the cessation of the bodily life of the human individual'. By a living human individual is meant (given the falsehood of dualism)⁶ a living human organism. For something to cease to be an organism is for it to cease to be an integrated whole; death is loss of the capacity for integrated functioning. Given the truth of the physiological claim about the role of the brain stem as the key organ in the integration of the human organism, it is reasonable to hold that *total* destruction of the brain stem amounts to irreversible loss of the capacity for integrated organic functioning. On this account 'brain stem death' is a decisive indicator of death because in establishing the existence of 'brain stem death' one establishes that there no longer is a living organism.

The Working Party, however, speaking more broadly of 'brain death' (rather than 'brain stem death') think of its significance as lying not in the loss of integrated organic functioning but in the loss of the capacity for distinctively human experience (para.31). On this account of why someone may be dead, death is compatible with a functioning brain stem, for it could be declared on the basis of establishing irreversible destruction of the neocortex. It is indeed the view of the Working Party that all that stands in the way of declaring someone dead on the basis of establishing 'neocortical death' is the technical difficulty of establishing 'that irreversible and complete loss of all neocortical function has occurred' (para.34).

Discussing the case of a child with hydranencephaly, Dr. Christopher

on the diagnosis of death'. *British Medical Journal* 1(1979) 322.

⁶ See the *Submission*, section 1.1.5

Pallis has written: 'There is a spinal cord, a brain stem, and perhaps some diencephalic structures but certainly no cerebral hemispheres. The cranial cavity is full of cerebrospinal fluid and transilluminates when a light is applied to it. The child can breathe spontaneously, swallow, and grimace in response to painful stimuli. Its eyes are open. The heart can beat normally for months. No culture would declare that child dead.'⁷ That last observation does not appear to be one which the Working Party would dismiss as irrelevant since they state that'. . . it is important for doctors to be clear as to what they mean by death and to ask whether that is commensurate with what the community at large believes' (para.29).

Why did the Working Party come to think that the determination of an appropriate criterion of death should be based on an understanding of what is *valuable* in human life, as if loss of value were equivalent to death? Some indication of the source of this confusion may be found in the discussion of the Persistent Vegetative State (PVS): 'To be a human life of the type that we all regard as being of special ethical importance we require that there be a persisting capacity for sentience. Where we know that any such capacity has been irreversibly lost we conclude that there is no ethical reason to prolong the biological functions that remain ... ' (para.32) Here loss of the capacity which makes for 'ethical significance' is seen as a reason for not seeking to prolong 'biological functions'. Whatever the merits of this consideration as a reason

⁷ Christopher Pallis. *ABC of Brain Stem Death* London, British Medical Association 1983, 3. Dr Pallis, who has been the principal apologist for UK practice in the diagnosis of brain stem death, specifically repudiates neocortical death as an indicator of death; *ibid.*, 2.

for ceasing life-prolonging treatment it is not as such a reason for saying that the remaining 'biological functions' are not the functions of a living human organism.⁸ In one breath the Working Party recognises this (para.35) but in another they seek to justify the brain death criterion by reference to what functions are valuable to an individual⁹: 'Where an individual can no longer have the experiences of a human being and never will again we think that the functions that remain are of no further value to that individual. *That is why controversy over whether the brain stem is completely and in every part dead and whether the whole brain can be said not to be functioning just on the basis of the accepted battery of tests, are beside the point.*' (para.31; emphasis added)

In fact our sense of the 'unique ethical importance' of human beings is not based on their possession of 'sentience'. All forms of animal life possess sentience. It is the exercise of the capacities to understand and know the truth and to make free choices which *exhibit* the distinctive dignity and worth of human beings. But the BMA Working Party, along with most people, would be disinclined - for the present - to declare someone dead who,

through partial brain damage, had exclusively lost the material vehicles of just those capacities. So they retreat to the view that it is loss of sentience which renders someone dead. But in doing so they are not entitled to defend that claim by explaining that sentience is that distinct function provided by the human brain that makes human life of unique ethical importance. The dangers of conflating questions about whether or not a human being's life has lost its unique value or significance with the question about whether that human being is dead ought to be obvious. It is quite clear that there is a variety of conflicting views in our society about the conditions under which human beings may be said to have lost unique value or significance. If death is to be defined as the loss of such significance, then an adverse view about the value of a human being's life can find expression in the judgement that that human being is dead. Declarations of death would then be the expression of merely qualitative discriminations between human beings, that is discriminations based on the fact that a human being lacked some significant qualitative attribute.

One effect of acting in this way would be to disguise from people the extent to which they were involved in unjust discrimination between living human beings. It is clear that the Working Party is disposed to adopt this disguise in regard to PVS patients: as already noted, they consider the only obstacle to moving from 'brain death to neocortical death' is our technical inability 'to establish that irreversible and complete loss of all neocortical function has occurred' (para.34). Hence there is said to be a 'vast clinical and philosophical distinction' between terminating the life of a PVS patient and terminating 'the life of a sentient person'. While it is recognised that

⁸ The conflation of grounds for discontinuing treatment with grounds for declaring someone dead may be said to have occurred already in the change of position that occurred between the 1976 Report and the 1979 Memorandum of the Conference of Medical Royal Colleges and their Faculties in the UK.

⁹ There is reason to think that this strand in the Working Party's thought derives from one of its 'observers', Dr Grant Gillett. See Grant Gillett, 'Why let people die?' *Journal of Medical Ethics* 12 (1986), 83-86, and 'Euthanasia, letting die and the pause' *Journal of Medical Ethics* 14(1988), 61-68.

His position is stated more fully in Grant Gillett, *Reasonable Care*, Bristol: The Bristol Press 1989, especially pp.15-19, 56-68, 93-94, 99-105, and 145.

with PVS 'In one sense there is a human being still alive. . . in another the situation is often best described when a relative remarks that the person they love is no longer there.' The testimony of a distressed relative is invoked to give plausibility to the distinction advanced nowadays by certain philosophers between 'personal life' and 'mere biological life'. If one can be said to enjoy only the latter, then, these philosophers would say, one does not exist as a person.¹⁰

Philosophical thinking along these lines was undoubtedly influential in the composition of the Report. For when considering the case for killing a patient 'in a state that can no longer be called human life' (para.98), in which 'there is no prospect of restoring the patient to sentient life', the Report observes: 'The situation is not the same as one in which a sentient person is killed.' It immediately adds, however, that 'a patient in the UK who is in a persistent vegetative state, and, consequently, who is non-sentient, is not killed.' (para.101) This has somewhat the force of a detached ethnographic observation rather than a report on practice which the Working Party has given convincing reasons for maintaining. Indeed, when they say

....some patients have permanently lost all capacity for *the conscious quality of life that constitutes being fully human...* We have stopped short of saying that such a state ought to be terminated by a positive act. (para.131 .1; emphasis added)

¹⁰ Speaking of malformed babies held to be incapable of giving 'an appreciative response to care-giving', the Report says there is a 'threshold' below which 'there is only a biological vestige of life which it is pointless and cruel to preserve in its distorted state' (para.175).

the position stated sounds decidedly pragmatic, temporary and insecure. Two further points should be noted about this statement. First, many more patients than those in PVS have 'lost all capacity for the conscious quality of life that constitutes being fully human'. Certainly, on one interpretation of that formula (whether or not intended by the Working Party) patients with advanced senile dementia have lost the sort of 'conscious quality of life that constitutes being fully human'. Secondly, the Working Party merely stops short of recommending that these patients be killed by a *positive* act. But it does not oppose killing them by a planned course of omissions. That, however, is to raise another major point about the unsatisfactory character of the Working Party's case against legalizing euthanasia, a point to be considered more fully in the next section (3.2 below).

The *qualitative* discrimination between patients that the Working Party introduces in its discussion of patients in a PVS also plays an important role in its discussion of the treatment of 'severely malformed infants'. Some of these are clearly likened in status to PVS patients. The paediatrician's duty is said to be that of ascertaining 'whether there is any hope that the child will have a life that could reasonably be called the life of a person'. In regard to children with severe brain damage this is treated as equivalent to asking whether the child has 'the capacity to love and be loved. If this is not present and is never going to be then it is clear that the child lacks that crucial engagement with persons that constitutes a basis for ethically significant life. Where a child is responsive to human care and contact in some sentient way then the child must be treated as a person, however poorly developed.' (para. 132) Some

children, however, are said to lack 'the capacity for meaningful human life' (para 133)

Which human beings are, then, of inestimable value? Those with the distinctive brain-related capacities which confer 'unique ethical importance' on human beings. It is wholly implausible to suggest that sentience is the relevant capacity. Whatever developed level of ability is required for a 'meaningful human life' is also required if one is to be a human being of inestimable value.

Which abilities, and what degree of development of those abilities, are requisite will inevitably be contentious. In consequence the exercise of distinguishing between those who may not be intentionally killed (because they are of inestimable value) and those who may (because they lack that value) will unavoidably be arbitrary and therefore unjust.¹¹

3.2 What counts as intentional killing?

The Working Party are commendably clear in recognising the law's deep seated adherence to intent rather than consequences alone [as] an important reference point in the moral assessment of any action. A decision to withdraw treatment which has become a burden and is no longer of continuing benefit to a patient has a different intent to one which involves ending the life of a person. We accept drug treatment which may involve a risk to the patient's life if the sole intention is to relieve illness, pain, distress or suffering. [Conclusion 14]

Accepting the central importance of intention to the characterization and, therefore, the evaluation of chosen

actions, the Working Party reject the view that it is only outcomes or consequences which should count in the moral evaluation of actions. [see paras. 94-97] On this latter, characteristically utilitarian view there is no significant moral distinction between hastening death as a foreseeable consequence of the administration of drugs aimed at controlling pain, and bringing about death as a result of administering a lethal dose of drugs aimed precisely at bringing about death.

While the Working Party's insistence on the basic importance of intention is clear, their treatment of the important topic of intentional omissions is unsatisfactory. They tend to discuss decisions to terminate life as if they could be implemented only by positive acts. Thus at para.92 we read:

There is a distinction between a decision to terminate someone's life and a decision not to prolong a person's life. The former involves an act or intervention which causes death and the latter involves the cessation of life-prolonging treatment.

But a 'decision to terminate someone's life' may be carried out by a planned course of omissions as well as by a positive act. This fact is never sufficiently clearly recognised by the Working Party.¹² Indeed one of their conclusions explicitly contrasts non-treatment decisions with 'active interventions by a doctor to terminate life' as if the former were in all cases no more than decisions 'not to prolong life' [Conclusion 3].

Having recognised the centrality of intention to the law's characterization

¹¹ See further the *Submission*, section 1.1.4

¹² Paras. 261 and 262 do not provide clear evidence of such a recognition.

and assessment of action, the Working Party should have also taken account of the law's recognition of homicidal omissions.¹³

3.3 Limits of the duty to treat

Some decisions to omit life-prolonging treatment are morally acceptable and some are morally unacceptable for reasons other than that they are aimed at hastening a patient's death. While a comprehensive discussion of the limits of a doctor's duty to treat would be inappropriate here, it is necessary to give some consideration to the views of the Working Party about when omission of treatment is acceptable and to enquire whether those views are compatible with a principled opposition to euthanasia.

Under the general title 'Quality of life' the Working Party outline the kinds of situation in which differing quality of

life considerations provide reasons for withholding treatment. They are:

(1) When '... patients have permanently lost all capacity for the conscious quality of life that constitutes being fully human' (para. 131.1). The quality of life judgement made here to characterise the condition of the patient is one which determines in effect whether the kind of life someone has is worth preserving. The Working Party are disposed to ask whether a patient has 'the capacity for meaningful human life' (para. 133). If the answer is no, they clearly believe that life-prolonging measures should be withheld, though they stop 'short of saying that such a state ought to be terminated by a positive act' (para. 131.1)

(2) When the burdens consequent upon treatment greatly exceed the benefit secured by treatment, so that in effect the treatment is inflicting 'prolonged suffering then it is correct and wise to take the kinder course and settle for comfort and care rather than further intervention.' (para.131.2)

(3) When 'life as a whole' has become 'an intolerable burden' to a patient, it is not the treatment as such which is a burden but the medical prolongation of life; then 'the right thing to do is to agree not to take any measures which merely prolong life and cannot relieve the patient's condition'. (para. 131. 3)

Of these three kinds of reason for limiting treatment, (1) is clearly euthanasiast; for the reason offered purports to be a comprehensive judgement on the very value of a human being's existence such that, if the judgement is adverse, death may be

¹³ Perhaps the clearest direction, of obvious relevance to certain medical practices, is the one approved by the Court of Criminal Appeal in *R v Gibbins and Proctor*(1918) 13 Criminal Appeal Reports 134 at 137-8:

'...if you think that one or other of the prisoners wilfully and intentionally withheld food from that child so as to cause her to weaken and to cause her grievous bodily injury, as the result of which she died, it is not necessary for you to find that she intended or he intended to kill the child then and there. It is enough if you find that he or she intended to set up such a set of facts by withholding food or anything as would in the ordinary course of nature lead gradually but surely to her death.'

This direction was of the clearest relevance in *Regina v Arthur*, but the issue was regrettably obfuscated by the trial judge in his summing up in that case.

The court in *Gibbins and Proctor* was aware of many earlier directions to like effect, and specifically approved that given in *R v Bubb and Hook* (1850) 10 Cox CC. 455 at 459. The concept of murder by omission is fully confirmed by the Infanticide Act 1938, s.1(1), and the Homicide Act 1957, s.2(1).

presented as 'a good to be pursued by the doctor'.¹⁴

By contrast (2) offers a clearly non-euthanasiast reason for limiting treatment: treatment is limited precisely to avoid imposing unwarranted burdens consequent upon treatment and not with a view to hastening death.

The formulation of (3) as it stands is unsatisfactory, for two reasons: (a) because it does not distinguish between judgements made by a competent patient which give a doctor reason to limit treatment, and any parallel grounds there may be for limiting treatment of the incompetent; and (b) because it does not sufficiently distinguish between a construal of the suggested reason for limiting treatment which, in the mouth of a competent patient, would be clearly suicidal and any possible non-suicidal construal of the reason. [A clarification of these issues is offered in the Endnote to this chapter.]

The Working Party does briefly consider the question of cooperation with a patient's suicidal decisions when, in relation to high spinal injuries, they discuss what a doctor's response should be to a patient's refusal to consent to continuing respiratory support. At this point they show themselves aware of the fact that death may be intentionally hastened by deliberate omission, for they observe:

As the law stands it is impossible to maintain a hard and fast distinction between withdrawal of such support and assisted suicide. (para. 84)

¹⁴ See Linacre Centre Working Party Report in the present volume, Book I, chapter 3, sec.5, pp.43-5.

Accordingly, they hold that '... in this situation, doctors should make their position clear by both acting and being seen to act according to a court decision'. (ibid.,)

The Working Party's endorsement of comprehensive quality of life judgements in clinical practice along with their general reluctance to recognise the reality of intentional killing by planned omission, show most clearly their joint influence in what the Report is prepared to accommodate in the field of paediatric care. It will be evident to anyone familiar with the debate about management of handicapped newborns¹⁵ that para. 134 of the Report, in referring to 'a practical decision not to offer life-prolonging treatment', includes omission of adequate nutrition. It is made evident from what is specified as the appropriate treatment of children judged to be incapable of 'meaningful human lives': 'Hydration should be provided and the patient should not be deprived of the normal cuddling that expresses a fundamental human concern' (para. 134); in other words, it is hydration and cuddling which alone should be given. Of course the condition of some irreversibly dying infants may be such that attempts at feeding may be an unwarranted burden. But 'the practice of sedation and demand feeding' (para. 172) is applied to infants with malformations not because the provision of adequate nutrition would be burdensome but precisely as a method of bringing about the death by starvation.

The Working Party (at para. 135) seek to resist the logic of the position they

¹⁵ For some summary documentation of the debate as it had taken shape over a decade ago see the Linacre Centre Working Party Report, chapter 2, pp.15-22 in this volume.

have adopted in countenancing comprehensive quality of life judgements:

'The profession's moral stance ought to be that human life is generally worth saving and any slide toward the view that quality of life can be used to exercise "quality control" so that parents or society can opt to keep only "top quality" infants should be strongly resisted. If the medical profession was ever to allow such an attitude to influence our treatment of children then this would clearly undermine our commitment to preserve and enhance human life. The soundness of medical judgement is intimately dependent on a reverence for human life, and any erosion of our intuitive feelings for the young, the weak and the helpless carries great potential for making a fundamental difference to the ethos of medical practice.' (para. 136)

Much of this is well said, but unfortunately the Working Party have disabled their own case against these undesirable developments both by countenancing comprehensive quality of life judgements and by their intellectual evasiveness about the moral character of policies of sedation and starvation.

3.4 General Rules and Exceptions

It will be obvious enough from the points surveyed in 3.1-3.3 that the Working Party have not provided a case for an absolute *moral* prohibition on the practice of euthanasia. But this observation may be thought to be beside the point since the Working Party did not think of themselves as constructing such a case but rather of arriving at a clear general rule of conduct which would serve to sustain the character of the doctor's commitment to the well-being of

patients and thereby retain the trust of patients in doctors (see section 2.2 above). As the Report observes: 'If the profession is seen as sometimes curing and sometimes killing depending on a rather complex set of guidelines ... the patients may well have some apprehension about the nature of the individuals who are supposed to be jealously preserving their lives.' (para. 77) So what is at issue is the character of doctors as the necessary guarantor of the character of clinical practice.

The Working Party clearly does not think that an exceptionless (or absolute) moral rule is necessary to foster the kind of character they think desirable in doctors. Following the advice of Professor Hare, they seem to think that what is required is a fairly simple and clear general rule. Hare is quoted as saying:

Doctors would do well, having adopted some fairly simple set of principles which copes adequately with the cases they are likely to meet, to dismiss from their minds (at least when they are doctoring) the possibility of their being *further* exceptions to their principles. For doctors, like all of us, are human, and if once they start thinking, when engaged on a case, that this case might be one of the limitless and indeterminate set of exceptions to their principles, they will find such exceptions everywhere . . . The temptation to special pleading is too great. A doctor once said to me in connection with the proposal to allow euthanasia: 'We shall start by putting patients away because they are in intolerable pain and haven't long to live anyway; and we shall end up putting them away because it's Friday night and we want to get away for the weekend'. [Quoted in para. 12; emphasis added.]

So Hare's advice is that one formulate a clear moral rule which has built into it clear and unambiguous exceptions of a kind that do not require much on-the-job reflection about whether the case confronting one is covered by those exceptions. Clearly it is also required that the rule should draw the line about what is impermissible in a fashion sufficiently credible not to excite on-the-job doubts about its reasonableness.

The Working Party addresses the topic of exceptions to a general rule against euthanasia at two points. At para. 76 it is allowed that there may be 'highly unusual and circumscribed situations' in which 'it may well not be appropriate to regard a doctor's actions as totally and solely answerable to the general rule'; which seems to mean that it may be reasonable for a doctor to act on the basis of the judgement that the case he is dealing with is a justifiable exception to the rule. But the Working Party then go on to say that in such situations the doctor should 'seek a second opinion and explore one of the many other recourses we have suggested ... We believe that if the unusual problem is shared with a colleague the doctor will almost always find a way to deal with it which does not involve killing the patient'.

At paras. 115-120 the Working Party consider what they believe to be a circumscribed kind of situation in which 'mercy killing' is justifiable, and the practical implications such an exception may be thought to have for the practice of medicine. The situation they have in mind is one in which a person, usually not medically qualified, kills a companion in order to avoid inevitable suffering before an equally inevitable death. Such a situation could occur in wartime where one of two companions is wounded

and certain to be found by the enemy who will perpetrate acts of cruelty before death is inflicted. It is only the certain knowledge that a person will fall in the way of terrible and malicious suffering that can justify a 'mercy killing'. The Working Party did not feel that such an action could be justified when there was any chance of the suffering being averted in some other way or of some unpredictable 'good' befalling the victim. Such a mercy killing can be condoned only where the strongest humanitarian motives act in accord with *an uncontestable factual prediction*. (para. 115)

The Working Party believe that the situation which may arise in warfare provides no precedent for what a doctor should do in the face of situations in which euthanasia is demanded, both because there can be no certainty about what might eventuate before natural death and because terminally ill patients can normally expect to be well cared for. Others, however, may well think that the terms in which the Report expressed its justification of mercy killing in warfare also provide justification for killing in situations which may arise in clinical practice.¹⁶

¹⁶ The members of the BMA Working Party very clearly felt (as would a majority of people in our society) that it is intolerable to maintain an absolute prohibition on euthanasia in face of harrowing situations of the kind which are recorded as having arisen in the Burma campaign in the Second World War (para. 117 and reference). But we need to reflect on the terms in which the Working Party express their reason for making exceptions: it is the certain knowledge that suffering will be *terrible* that provides the purported justification of 'mercy killing'. Even if this were the only ground for mercy killing conceded by the Working Party (and it is not) many would think it a ground that in principle allowed extremely wide scope for euthanasia in clinical practice. For the logic of conceding the exception is to allow that there are circumstances in which it is

According to the Report: 'It is only the certain knowledge that a person will fall in the way of terrible and malicious suffering that can justify a "mercy killing".' That a person's suffering is inflicted from malice may indeed make it more terrible, but it is the certain knowledge that suffering will be *terrible* which provides the purported justification of 'mercy killing'. Many people think one can be as certain in clinical situations that terrible suffering will overtake people as one can be in military situations. So the Working Party is likely to seem unreasonable in resisting the logic of the justification of 'mercy killing' which it concedes at para. 115.

However, it should be clear from 3.1-3.3 that the Working Party has conceded much wider grounds for mercy killing than just the certain knowledge of terrible suffering. For they take no principled stand against killing by planned omission, and they allow that comprehensive and adverse quality of life judgements may provide grounds for making a patient's death the proper object of clinical management. Such judgements are inevitably arbitrary (see 3.1 above).

reasonable to treat the human dignity of the person to be killed as a value which can be nullified by the entirely predictable evils which are about to overtake a life (see *Submission*, section 1.2.2). But it is the standard case for euthanasia that incontestably predictable evils of suffering and loss of faculties rob so many lives of dignity and value that the ending of such a life is a benefit.

Absolute norms do confront us with hard cases where pressures of sympathy and compassion can make the norm seem intolerable. But the choice of euthanasia as the solution to intolerable suffering has implications that go far wider than the relief of hard cases and extends to the introduction, willy nilly, of very great evils. Among these evils is certainly to be included the corruption of the character of doctors in respects fundamentally subversive of the commitment to patient care that we require of them.

All this means that, despite their protestations to the contrary, the Working Party have conceded grounds on the basis of which doctors might well feel they are justified in carrying out euthanasia on an extensive scale. That being so, it is difficult to sustain the Working Party's opposition to the legalization of euthanasia, an opposition which assumes that the situations in which euthanasia may be called for are so circumscribed, marginal and infrequent that there is no case for legalizing it.

If the present reading of the Report is correct, then the intellectual concessions made by the Working Party would accommodate extensive euthanasiast practice, particularly of non-voluntary euthanasia. It is difficult, therefore, to see that they have provided a solid moral case for a legal prohibition of euthanasia. Moreover, in so far as the argument of the Working Party implies that a doctor may choose to kill patients on the grounds that they lack lives of value or that they lack 'the capacity for meaningful human life', they allow behaviour of a kind calculated to undermine precisely that disposition which we need doctors to have: the disposition to respect human beings simply because they are human. Lacking this fundamental requirement of justice, doctors will not 'stand by the commitment that leads us to preserve life and meet suffering creatively' (para. 75).

The reasoning of the Report fails, then, convincingly to articulate and defend the moral norms or rules which would support the cultivation of those dispositions which the Working Party recognise to be indispensable to the practice of good medicine. And that failure makes the Working Party's

insistence on a blanket legal prohibition seem ill-supported.

The dispositions we require in doctors cannot be cultivated without conformity to a different normative framework for clinical practice from that envisaged by the Report. The elements of the necessary framework are discussed and analysed in other parts of this volume.

Endnote: Euthanasia and the limits of the duty to treat

The case outlined in the *Submission* is both a case for an exceptionless (i.e. absolute) moral prohibition on the practice of euthanasia as well as a case for a blanket legal prohibition: the justification of euthanasia is too radically subversive of the foundations of just law to be legally accommodated in any form.

The absolute moral prohibition is implicit in what is called a sanctity of life ethic. Critics of a sanctity of life ethic are apt to caricature it by claiming that it requires a commitment to prolonging human lives whatever the circumstances.¹⁷ No such commitment is a requirement of traditional morality. Some of the limits, consistent with a sanctity of life

¹⁷ The caricature makes its most recent appearance in *Medical Ethics Today. Its Practice and Philosophy* London: British Medical Association, 1993. The volume, produced by the Medical Ethics Committee of the BMA, offers 'practical advice... in order to guide doctors in any aspects of their practice where ethical considerations arise'. (p. xxvi). At p.165 we read: 'The BMA does not espouse a strict vitalist "sanctity of life" approach although it recognises some of its members do.' This approach has been introduced in the text as requiring that 'life is... to be indefinitely sustained in all circumstances, for example, where its prolongation by artificial means would be regarded as inhumane and the treatment itself burdensome'.

ethic, to a doctor's duty to treat are discussed in chapters 5 and 6 of the Linacre Centre Working Party Report (Book I in this volume, pp.61-71). Here it will be useful to recall some of the clarifications established in those chapters which have a bearing on elements of the BMA Working Party's thinking which were surveyed earlier (at 3.3 above).

At that point it was noted that, whereas the first reason given for limiting treatment was euthanasiast (the judgement that someone lacks 'the capacity for meaningful human life'), and the second reason (that the burdens consequent on treatment greatly exceed the benefit secured by it) was consistent with opposition to euthanasia, the character of the third reason was in this respect not entirely clear.

The third reason envisaged by the BMA Working Party for limiting treatment is that 'life as a whole' may become 'an intolerable burden' to a patient, so that it is not treatment as such which is burdensome but rather the medical prolongation of life. In those circumstances the Working Party took the view that 'the right thing to do is to agree not to take any measures which merely prolong life and cannot relieve the patient's condition'. (para. 131.3)

A number of quite distinct lines of reasoning might be covered by what the Working Party has in mind at this point. In distinguishing them it would be useful, first of all, to separate the reasoning a *competent* patient might offer to a doctor as grounds for limiting treatment, from comparable reasoning about limiting treatment for an incompetent patient.

If patients are not in the ordinary sense of the term dying, the fact that they may be 'in pain, distressed, incontinent, upset at their insight into the fact that they are severely deformed or disabled, or becoming demented' (para. 131. 1) would not provide grounds for discontinuing a treatment for some other condition (such as insulin for diabetes) when the treatment does nothing to alleviate precisely what is burdensome in the patient's condition. For what could motivate discontinuing it other than the thought: My life is miserable and I can put an end to it by refusing insulin treatment? To proceed on that basis is to choose suicide by omission.

Similarly, when a patient who is dying and wretched decides to refuse treatment for some supervening condition which may hasten death precisely so that death will come sooner, it is clear that his attitude is suicidal.

But *Euthanasia and Clinical Practice* envisages the following scenario in which a patient who is dying is overcome by a supervening condition (e.g. pneumonia) which may hasten death. He reflects, after taking stock of the unalleviated wretchedness of his condition, on whether he has a duty to continue to strive to prolong his life and decides that he has not and for *that reason* declines treatment for the supervening condition. This line of reasoning is to be distinguished from the suicidally motivated reasoning of the previous patient.¹⁸

At one point *Euthanasia and Clinical Practice* seems firmly to rule out the possibility of a parallel judgement being made (by a doctor or others) in

¹⁸ See the careful analysis in sections 6 and 7 of chapter 5. [pp.64-66 in this volume]

respect of an incompetent patient.¹⁹ But this impression is belied a few pages later by what is implicit in the management of the patient with Parkinson's disease.²⁰ For what the doctor does implies that he has come to the decision that he does not *have* to keep on treating the repeated supervening bronchitis in a patient who is manifestly dying. Why? Not (as some have assumed)²¹ because he judges the patient no longer has a worthwhile life. Rather, what he judges is that curative treatment is no longer effectively securing some approximation to health in his patient. The recurrence of bronchitis is evidence in this case of the inexorable decline we call dying. It is not the purpose of medicine to seek to prolong life irrespective of whether it is possible to restore the patient to some approximation to health. (See *Submission 2.1*) And if that is so, one may judge, in respect of an incompetent patient, that one no longer has a duty to treat a life-threatening supervening condition (just because it is life-threatening)²² when the patient is already irreversibly dying.

These brief analyses of differing lines of reasoning which may determine clinical treatment are significant not because they always lead to obviously

¹⁹ See section 3 of chapter 6. [pp.69-70 in this volume]

²⁰ Chapter 7 [pp.77-78 in this volume]

²¹ Such as Helga Kuhse, who thinks that implicit in the Linacre Centre Working Party's description of this case is a comprehensive quality-of-life judgement on the life of the patient: treatment is discontinued allegedly because he is judged no longer to have a worthwhile life. See Helga Kuhse, *The Sanctity-of-Life Doctrine in Medicine. A Critique* Oxford: Clarendon Press 1987, pp.193-194.

²² Consideration of what is required for proper palliative care may of course suggest that one ought to treat the supervening life-threatening condition.

different overt behaviour but precisely because of the different character of the reasoning: some is compatible with recognition of human dignity, some is not. And the differences matter not only because of the large consequences they can have for the treatment of patients but also because of their significance for the moral integrity of doctors, which is undermined by choices to act for reasons incompatible with the recognition of human dignity.

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