Notes on the Winterton Bill

Luke Gormally

Mrs Ann Winterton, MP for Congleton, has introduced a private member's Bill "to prohibit the withdrawal or withholding of medical treatment, or the withdrawal or withholding of sustenance, with the intention of causing the death of a patient". The Bill was introduced to Parliament on the 15th December 1999 and was given its second reading (by a vote of 113 to 2) on 28 January 2000. The Bill has completed its Committee stages and the Report stage will be on Friday 14th April 2000.

The Bill is essentially a one-clause bill (clauses 2 and 3 are elucidatory). Clause 1 reads: "It shall be unlawful for any person responsible for the care of a patient to withdraw or withhold from the patient medical treatment or sustenance if his purpose or one of his purposes in doing so is to hasten or otherwise cause the death of the patient." The following briefing notes on the Bill were produced at the request of an MP.

These notes cover:

- the general legal and ethical background to the Bill;
- the need for the Bill, arising principally from the House of Lords' judgements in the Bland case [1993];
- some explanation of precisely what is unlawful and what is **not** unlawful under the terms of the Bill.
- an addendum on the BMA opposition to the Bill (written on receiving the text of Dr Ian Bogle's letter after the rest of the 'Notes' had been composed).

The general legal and ethical background to the Bill

This Bill is about restoring integrity and coherence to the law of homicide. Until 1993 the common law was clear and coherent in maintaining that it was **always** wrong to aim to bring about (that is, to have as the **purpose** of one's conduct to bring about) another person's death for any reason other than the requirements of justice. The common law upheld, in other words, the principle of the inviolability of innocent human life. This is a principle enshrined in Article 2 of The European Convention for the Protection of Human Rights and Fundamental Freedoms which provides that:

Everybody's right to life shall be protected by law. No one shall be deprived of his life intentionally save in the execution of the sentence of a court following his conviction for a crime for which this penalty is provided by law. [Article 2(1)]

It is the common law that to cause the death of an innocent person on purpose (or 'intentionally') is to commit the crime of murder. Until the House of Lords' judgements in the Bland case in 1993 it was a clearly understood part of the common law that murder can be committed not only by a positive act but also by omission in situations in which there is a duty to provide what is omitted. Certainly it was well understood that no one who has a duty of care, such as a parent or a doctor, could possibly be thought to be discharging that duty by aiming to cause the death of his or her child or patient. The reason why should be clear: every human being, simply

because he or she is human, possesses an inherent worth and dignity. Acknowledgement of this truth has two clear implications. Firstly, recognition of the inherent worth of a human being is incompatible with thinking that it is reasonable to end the life of a human being because you judge that life no longer worthwhile. When a doctor aims to end the life of a patient it is because for one reason or another he has come to think the continued existence of that patient no longer worthwhile. If he thought otherwise if he thought the life of the patient worthwhile he would not be aiming to end that patient's life. Secondly, esteem for the inherent worth of human beings is what underpins care for them, and that is why care characteristically finds expression in cherishing the person for whose care one is responsible. You cannot **care** for someone by putting an end to his or her life.

The need for the Bill

The ethical and legal positions just stated were fundamental to our common law until they were in part called into question by the judgements of the Law Lords in the Bland case. That case, as many will know, concerned a young man, Anthony Bland, who was a victim at the age of 17 of the Hillsborough football stadium disaster in 1989. The part of his brain necessary for thinking and feeling was extensively and permanently damaged due to lack of oxygen. However, he was not dying, still less dead. The most basic part of his brain, his brain stem, still functioned, and he breathed unassisted and digested food. He was supplied with nutrition and fluids through a tube. His excretory functions were regulated by a catheter and enemas. Infections were treated by antibiotics. His doctor and parents wanted to stop the feeding and medical care on the ground that it served no useful purpose. Airedale NHS Trust decided to ask the courts whether it would be lawful to do so. A declaration to that effect was given by the President of the Family Division of the High Court on 19 November 1992, and was upheld by the Court of Appeal on 9 December 1992 and by the House of Lords on 4 February 1993. Subsequently tube-feeding was withdrawn from Tony Bland, and he died of renal failure, consequent on dehydration, on 3 March 1993.

What subverted the law of homicide was the reasoning which led the Law Lords to uphold the declaration granted by the High Court. That reasoning in outline was as follows:

- that to stop feeding Tony Bland was an **omission;**
- that the doctor was under no duty to continue feeding, because
- the feeding was medical treatment, which
- was not **in the patient's best interests** as
- it was **futile**, because
- **a responsible body of medical opinion did not regard existence in Tony Bland's condition as a benefit.**

We should take careful note of the fact that Their Lordships' reasoning allows that tube-feeding of a patient may be judged futile on the grounds that the continued existence of a patient may be judged not worthwhile and that it may be left to doctors to reach such a judgement on the worthwhileness of a patient's life. Hence the approved purpose of stopping tube-feeding is so that doctors can put an end to the life of the patient.

Three of the five Law Lords (Lords Lowry, Browne-Wilkinson, and

Mustill) were quite explicit in saying that the purpose of stopping the tube-feeding of Tony Bland was to bring about his death. As Lord Browne-Wilkinson put it:

"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 or mens rea, in my judgement 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."

Their Lordships claimed that the conduct in question was not murder because it was an **omission**, while affirming that a positive act with the same intention would clearly be murder. It is evident, however, from their judgements that they found themselves unable to defend the distinction on which they relied between acts and omissions when both types of conduct have the same purpose of ending someone's life. As Lord Mustill put it in his judgement:

"The acute unease which I feel about adopting this way through the legal and ethical maze is I believe due in important part to the sensation that, however much the terminologies may differ, the ethical status of the two courses of action is for relevant purposes indistinguishable."

The common law as it has been determined by the judgements in the Bland case is inconsistent and indefensible. Moreover, it represents a growing threat to patients of a kind calculated seriously to undermine confidence in the medical profession. Prior to Bland conduct aimed at ending a patient's life was incompatible with the duty of care for a patient. Following Bland conduct aimed at ending a patient's life, providing it counts as an omission, may well be deemed an exercise of the duty of care for a patient if doctors judge that patient's life no longer worthwhile.

We should be clear that the implications of the Bland judgements are not confined to the care of patients in the severely damaged and permanently unconscious condition Tony Bland was in. Unsurprisingly, doctors have been quick to realise this. Hence, in June last year, the British Medical Association's Ethics Committee published guidance on Withholding and Withdrawing Life-prolonging Medical Treatment [London: BMA 1999] in which they considered it appropriate to withdraw tube-feeding not merely from patients in the kind of condition Tony Bland was in but also from "patients who have suffered a serious stroke or have severe dementia" (p.56). In so far as the purpose of withdrawing tube-feeding is to end the lives of these patients, as it was in the case of Tony Bland, we have reached a situation in which a body of doctors is seeking to extend the scope of what some of them now see as their duty (and hence right) to hasten the death of those of their patients whose lives they judge no longer worthwhile. It should be said that there are many other doctors in this country who deeply disapprove of the policy which the British Medical Association is promoting despite not having had a vote of its membership on that policy.[1]

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[1] Because the Bill does not reject another widely contested assumption made by the Law Lords in Bland, namely that tube-feeding is medical treatment, it does not prohibit the withdrawal of tube-feeding on the grounds that it is futile qua medical treatment, i.e. in so far as it cannot serve the purpose of restoring the patient to some measure of healthy functioning.

It would be quite naïve to think of the British Medical Association as a body disinterestedly dedicated to upholding a principled ethic of medical practice. The BMA is basically a doctors' trade union, concerned to protect its members, and so anxious to help shape a framework for professional practice which is least likely to place strain on its members. Doctors are under increasing pressure to economise on resources, and, among those resources, the use of hospital beds. Acceptance of the view that it is reasonable to starve certain classes of patients to death certainly offers one kind of solution to the competition for hospital beds. Even if the guidance on Withholding and Withdrawing Life-prolonging Medical Treatment is not **motivated** by any desire to offer a solution to the problem of scarcity of beds, it certainly can appear to offer a tempting solution to that problem. The dangers of that, in present circumstances, are very great.

In any case, to allow doctors the discretion to pass judgement on the worthwhileness of their patients' lives is wholly incompatible with that respect for the worth and dignity of every human being which is at the basis of our laws. To allow doctors to behave with the purpose of ending the lives of their patients subverts the law of murder, which is fundamental to the legal protection of every citizen. Hence the urgent need for this Bill. The Bill aims to reverse what was most clearly indefensible in the Bland judgements, and it aims to do that by declaring it unlawful "for any person responsible for the care of a patient to withdraw or withhold from the patient medical treatment or sustenance if his purpose or one of his purposes in doing so is to hasten or otherwise cause the death of the patient".

What is unlawful and what is not unlawful under the terms of the Bill

Accurate understanding of Clause 1 depends on a common sense understanding of the notion of 'purpose' which is important to ordinary ethical reflection and to the law. We easily distinguish someone's purpose in acting from other consequences, even foreseeable consequences, of what he does. Thus, for example, a foreseeable consequence of regular jogging is that I wear out my footwear. But wearing out my footwear is no part of my purpose in jogging; my purpose is to maintain my health. If I drive 200 miles across country to visit a sick friend, using up X gallons of petrol and causing some degree of wear and tear to the car's engine are no part of my purpose: they are not what I am aiming to achieve even though they are entirely foreseeable. My purpose is to cheer up my friend.

It makes an enormous difference both to the protection of patients and to the character of medical practice whether or not we allow doctors to aim at hastening the death of their patients. For if we think that **that** is an acceptable purpose for a doctor to have, we are in effect inviting doctors to decide if and when their patients no longer have worthwhile lives. But it is incompatible with a fundamental moral assumption of our law that people should be thought eligible to have their lives ended because someone has judged their lives no longer worthwhile. Hence the present Bill declares unlawful withholding or withdrawing medical treatment or sustenance if it is any part of one's purpose in doing so to end the life of a patient.

This does not make unlawful the withholding or withdrawing of medical

treatment if that treatment cannot or can no longer provide any therapeutic benefit or if, in one way or another, the treatment has become unduly burdensome to a patient. Thus, it is reasonable to discontinue artificial ventilation of a patient when all other therapeutic interventions have failed. For artificial ventilation is characteristically employed to keep a patient alive in order to provide doctors with the opportunity for therapeutic interventions designed to save a patient's life. That death immediately follows is no part of one's purpose in discontinuing artificial ventilation even though death is a foreseeable consequence of doing so. One's purpose in discontinuing ventilation is not to put an end to the life of the patient but to put an end to a form of treatment which can no longer help secure what it was intended to help secure, namely the recovery of the patient. It is no part of the purpose of medicine to seek to prolong life whatever the circumstances; so doctors are under no obligation to seek indefinitely to postpone death.

Nothing in this Bill obstructs good medical practice. Some may say that it will inspire fear in doctors of being accused of withholding or withdrawing treatment with the purpose of ending a patient's life when all they had in mind was to end futile treatment or treatment which was unduly burdensome to a patient. But the data about a patient's clinical condition and the observations of other carers will support doctors when they omit treatment for morally and legally acceptable reasons.

Addendum: the BMA's opposition to the Bill

The Chairman of Council of the BMA, Dr Ian Bogle, has written to MPs explaining BMA opposition to the Bill and urging them to vote against it,[2] but the reasons he invokes for the BMA's opposition are entirely spurious.

First he claims that the Bill shows no regard for patient autonomy in two ways, firstly in preventing respect for a competent patient's refusal of treatment, secondly in preventing due consideration of the 'best interests' of incompetent patients. But a doctor's respect for a competent patient's refusal of treatment need involve no intention on his part other than a concern not to commit the tort of battery, of which he would be guilty in imposing treatment contrary to a competent patient's wishes. Nothing in the Bill prevents extensive consideration of the 'best interests' and values of incompetent patients in so far as they can be ascertained. Indeed, doctors cannot reach reasonable decisions about whether treatment is likely to be excessively burdensome to an incompetent patient without careful consideration of the sensibility and sensitivities of the patient. But at the end of the day, the person responsible for making the decision to withdraw treatment from an incompetent patient is the doctor. Hence, the Bill quite properly focuses on what the doctor's purpose is in withdrawing treatment. And all the Bill excludes is that the doctor should withdraw treatment with the purpose of ending the patient's life.

Secondly, Dr Bogle claims that making it unlawful for doctors to aim at ending their patients lives is 'unhelpful and confusing' to doctors who must consider what is of benefit to their patients. This is a bit like saying that it is 'unhelpful and confusing' to investment managers to forbid them to go in for 'insider dealing'. On the contrary: it clarifies the situation and

[2] Dr Bogle's letter is dated 21 January.

helps them to concentrate on those activities they can properly engage in. Similarly, to forbid doctors to aim at ending their patients' lives helps them to focus on the issues that should really engage them if they have the true interests of patients at heart, namely, 'Is this treatment likely significantly to benefit the patient?' and 'Even if it is, will it nonetheless prove to be excessively burdensome to the patient either because of the pain and discomfort caused or because of the psychological stress occasioned by it or for some other type of reason?'

Thirdly, Dr Bogle claims that the Bill will cause poor quality patient care because it will inhibit doctors from withdrawing treatment when it is in the interests of patients to do so. But the scenarios Dr Bogle chooses to illustrate this contention are tendentiously described. Why say that the patient with chronic kidney disease who develops a rapidly progressive and terminal cancer and who for that reason wants to cease dialysis does so with the "purpose of hastening death"? We all know that dialysis can be very burdensome when the only condition affecting one is kidney disease. A patient who also has a rapidly progressive cancer in the terminal phase is most likely to feel that the burdens of dialysis are no longer worth struggling to bear when the overall benefits of total treatment are rapidly diminishing. And it is perfectly acceptable for a doctor to withdraw treatment on those grounds. Perhaps Dr Bogle's tendentious statement of the case is designed to stake out the claim that doctors should be allowed to aid and abet suicide, despite the fact that the law is quite clear in prohibiting assistance in suicide.

Dr Bogle's claim about his second scenario simply assumes what he needs to show holds good in regard to it. A patient with progressive cancer of the breast may indicate that she doesn't want certain kinds, or any kind, of treatment for secondary cancers for a number of reasons: it might be because she would think such treatment more than she can take, or because she would think it of too little benefit to warrant the suffering and strain it involves. Why, if these were her reasons, would a doctor's withholding of treatment **for those reasons** "be clearly open to interpretation as having the purpose of bringing about the patient's death"? Dr Bogle's claim is simply gratuitous.

The truth the BMA needs to face, and which it has been consistently evading for the past 12 years,[3] is the truth stated by Lord Mustill in the Bland case about the attempt to distinguish actions and omissions when both serve the **purpose** of ending a patient's life: "the ethical status of the two courses of action is for relevant purposes indistinguishable". The BMA claims to be opposed to euthanasia. But doctors who aim to end their patients' lives by withholding or withdrawing treatment or sustenance are in the business of

[3] The implicit reference here is to the BMA Working Party Report on Euthanasia of 1988, which evaded recognition of the moral reality of intentional killing by planned omission. To have done so would have involved an unwelcome judgement for the BMA on the widespread practice of sedation and starvation of handicapped newborn babies in paediatric units. For commentary on the inconsistency of BMA thinking as represented by the 1988 Report see my chapter 'The BMA Report on Euthanasia and the case against legalisation' in Luke Gormally (ed) Euthanasia, Clinical Practice and the Law [London: The Linacre Centre 1994], pp.177-192. The inconsistency of the BMA position opposing euthanasia by a positive act, while refusing to acknowledge that it may be carried out by intentional omissions has been exploited by euthanasiasts both within and without the BMA since 1988.

practising euthanasia by deliberate omission. Why, we must ask, is the BMA so anxious to have this as a protected option for doctors? For it serves neither the individual good of patients nor does it encourage confidence in the intentions of the medical profession, as recent cases have shown.

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38 Circus Road,
London NW8 9SE
England

Tel. +44 (0)20 7266 7410
Fax +44 (0)20 7266 5424
admin@linacre.org

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