

Submission to the Select Committee of the ¹ House of Lords on Medical Ethics

The Linacre Centre
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Introduction

This Submission has been prepared on behalf of The Linacre Centre for Health Care Ethics,¹ a national

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Catholic bioethics centre established in 1977 by the Roman Catholic Archbishops of England and Wales, who are its Trustees. The Centre has a record of academic research and publication in the field of health care ethics,² and an involvement in teaching and in consultancy work both for the Church, nationally and internationally, and for other bodies.

It is not the aim of this submission to make a documented presentation of the teaching of the Roman Catholic Church on the topics which concern the Select Committee.³ A simple statement of position is unlikely

John Finnis, 'Living Will Legislation' in Luke Gormally(ed) *Euthanasia, Clinical Practice and the Law* London: The Linacre Centre, 1994 pp.167-176

Luke Gormally, 'A Response [to Roy Fox, Palliative care and aggressive therapy]' in R J Elford (ed) *Medical Ethics and Elderly People* Edinburgh: Churchill Livingstone, 1987, pp.177-198.

Luke Gormally, 'Introduction' (pp.110) and 'The Living Will: the ethical framework of a recent Report' (pp.5369) in Luke Gormally (ed) *The Dependent Elderly. Autonomy, Justice and Quality of Care* Cambridge: Cambridge University Press, 1992.

Luke Gormally, 'Definitions of Personhood and Implications for the Care of PVS Patients', *Catholic Medical Quarterly* 44/4 (May 1993), pp.7-12

Luke Gormally, 'Against Voluntary Euthanasia' in Raanan Gillon (ed) *Principles of Health Care Ethics* Chichester: John Wiley, 1993 [forthcoming].

I J Keown, 'The Law and Practice of Euthanasia in The Netherlands', *Law Quarterly Review* 108 (1992), pp.5178.

² Noteworthy here is the Centre's Working Party Report, *Euthanasia and Clinical Practice: trends, principles and alternatives* first published in 1982. (See Book I of this volume.)

³ Some documentation may be found in *Euthanasia and Clinical Practice*, especially chapter 4, 'The Christian Tradition', and in an earlier publication by the Centre: [Luke Gormally] *Ordinary and extraordinary means of prolonging life* (Linacre Centre Paper 3) London: The Linacre Centre, 1979.

greatly to aid the Committee in its deliberations. The Centre has always sought to make intelligible to non-Catholics and non-Christians the Church's moral teaching in its bearings on the practice of medicine. Much of that teaching belongs to what has been called the tradition of *common morality*, whose central tenets belong to the moral patrimony of civilised societies.

Accordingly, the present submission is devoted to a broad exposition of that framework of moral understanding which has long shaped the traditional ethic of medical practice. Offering such an exposition seemed the most useful exercise we could undertake in relation to the deliberations of the Select Committee. For it is unlikely that the members of the Committee will find themselves disagreeing only about relatively derivative issues. Decisive disagreements are more likely to focus on the most fundamental issues: the value of human life, the moral significance of intention, the ethics of killing, the claims of autonomy, the purpose of medicine and its relation to duties of treatment and duties of care. Fundamental topics such as these are what the present submission seeks to illuminate, in a way accessible to those who do not share the religious faith of its authors.

Part One of this submission (Sections 14) is a sustained exposition which seeks to clear away some of those systematic misunderstandings of traditional moral principles which have obstructed a clear grasp of their continuing relevance to the practice of medicine and their implications for legislation and public policy. Without an accurate understanding of these principles it is not possible to appreciate what a traditional ethic requires of medical practice. Central to

that ethic has been the prohibition on intentionally killing patients, a prohibition respect for which has been a necessary foundation of the trust between doctor and patient which is so essential an ingredient of the therapeutic relationship.

Systematic misunderstandings of traditional moral principles, and false inferences from them, are nowadays offered to justify jettisoning a traditional ethic of medicine in the interests of having doctors kill patients. In some cases this change is supposed to be in the interests of patients. But often enough the change seems to be promoted in response to the concerns of those who want patients killed because they are perceived to be an unwelcome burden either to families or to the Health Service.

In Part Two of this Submission (Sections 56) the proper role of the Courts in interpreting the law is discussed along with general and specific proposals for change in the law.

In Part Three (Sections 78) the Submission comments on (a) the changed character of the apologetic for legalising euthanasia which has in part come about in response to the success of the Hospice Movement, and (b) the lessons to be learned from the permissive practice of euthanasia in Holland.⁴

Lord Justice Hoffmann rightly remarked in *Airedale NHS Trust v Bland*⁵: "This is not an area in which any difference can be allowed to exist between what is legal and what is

⁴ The organisation of topics in this submission follows the listing of topics in section 2 of the Special Report of The Select Committee (9 March 1993).

⁵ [1993] 2 *Weekly Law Reports* 316 at 350.

morally right.' There cannot be a true determination of what is morally right and legally appropriate if competing moral viewpoints on so fundamental a matter as killing are treated as having equivalent claims, and, in consequence, proposals for legislative change are designed as a pragmatic compromise between these viewpoints. The moral issues which confront the Select Committee are not radically new in character, though they may have been given new forms by advances in medical technology and clinical practice. Questions about when to withhold or withdraw treatment and whether it can ever be right for doctors to kill patients are questions with a long history. A carefully considered and elaborated set of answers to them has for centuries supported a humane practice of medicine, of which a shining example in our own age has been the development of palliative care in the Hospice Movement. Those carefully considered answers and their relevance to contemporary variations on old challenges deserve the attentive consideration and endorsement of the Select Committee. It is in the hope of promoting those ends that this Submission is respectfully offered.

Part 1

1. Sanctity of Life and Autonomy

Central to the concerns of the Select Committee are the questions: What may justify decisions and courses of conduct intended to bring about a person's death?⁶ and: Can such decisions and conduct be justified by

⁶ We shall call such decisions and courses of conduct 'intentional killing', and the phrases 'intentional killing' and 'intentionally kills' are to be understood throughout as having that precise sense (and not just as a way of signifying all non-accidental killing). Like several of the Law Lords in *Bland*, we use 'course of conduct' to include both 'positive actions' and deliberate 'omissions'.

either the wishes or the best interests of the person to be killed? These questions are nowadays apt to give rise to talk of a conflict between respect for the sanctity of human life and respect for autonomy (self-determination). Accordingly, it seems appropriate to begin with a consideration of the significance and grounding of these moral requirements and of their precise implications for certain central issues in medical practice.

1.1 Justice and the Sanctity of Life

1.1.1 The Sanctity of Life

In the Christian tradition the idea of the sanctity of life was employed exclusively of *human* life, to assert its inviolability, i.e. the entitlement of any human being to protection from unjust attack. So employed the idea connotes the specific grounds for such inviolability, namely that human life possesses an intrinsic dignity and value because created by God in his own image (Genesis 1:26) for the distinctive destiny of sharing in God's own life. A significant body of theological reflection on this revealed doctrine analysed the meaning of the image of God (*imago Dei*) in terms of the distinctive *capacity for rational existence* inherent in man's nature. It is in the nature of human beings to possess the capacity to develop both the ability to understand what is truly good and the ability to be moved by the desire for what is good. The authentic development of these abilities can lead us into a life of self-giving love which mirrors the very life of God: being made in the image (*imago*) of God, we are able to acquire his likeness (*similitudo*), an achievement which is the proper fulfilment of a human life.

Traditional understanding of the sanctity of human life, set in its original theological context, may be summarised in three points:

(1) The notion of the sanctity of life explained why certain reasons for killing human beings were inadmissible precisely because incompatible with the distinctive dignity human beings possess. Allowing for certain justifications of killing which were thought compatible with recognition of human dignity,⁷ the core of the principle of the sanctity of human life was formulated in the requirement that one ought never

intentionally to kill the innocent (that is, one ought never to adopt any course of action or omission intended to terminate the life of an innocent human being).

(2) The distinctive dignity of human beings belongs to them in virtue of a radical capacity inherent in their nature. Since it belongs to them in virtue of their *nature* it belongs to all human beings equally.

(3) The rational abilities that human beings characteristically develop (in virtue of the radical natural capacity for such development) may be exercised in ways which are consistent or inconsistent with the fulfilment which is proper to human beings. To choose and to act in ways which are inconsistent with our proper fulfilment is to choose and to act at variance with the *point* of the radical capacity in virtue of which we possess dignity. But to act in ways at variance with human dignity is not to lose human dignity: for there remains the ability to repent of bad choices and to give a right direction to a hitherto disordered life.

⁷ It was not thought incompatible with human dignity to execute a criminal found guilty of a capital crime insofar as what he received was considered *deserved punishment*; for the assumption behind the view that someone deserves death is that he knowingly chose to do what he did and so is answerable for it. The belief that human beings are answerable for what they do and can be found to deserve punishment implies a high conception of human dignity; we are not left to be pushed hither and thither by uncontrollable impulse and fate.

Similarly, the intentional killing of unjust aggressors in warfare has been justified on the grounds that they are answerable for actual (or threatened) violent and grave harm to the common good of a society.

Both justifications of capital punishment and of the killing of unjust aggressors in warfare yielded a common formula stating the basic norm in regard to killing: one ought never intentionally to kill the innocent, i.e. those not guilty of crime which it is one's task to punish or of unjustified violence which it is one's office to resist. This is what is identified in the main text as the core of the principle of the sanctity of life.

Failure to recognise the precise character of this principle led Lord Goff in *Airedale NHS Trust v Bland* to say that it is not absolute: [1993] 2 *WLR* at 367. Lord Goff's explanations for this observation seem to have in mind two quite distinct 'principles': (i) 'It is unlawful to kill (take another man's life)'; (ii) 'Human life should be preserved if at all possible, by any available means, regardless of circumstances'. Neither is the principle of the sanctity of life as traditionally understood.

1.1.2 Sanctity of Life, Human Dignity and Justice

In modern Western societies the theological understanding of human dignity has been transformed into secularised doctrines of the equal dignity of all citizens, doctrines which are the basis of what is sometimes called the 'politics of universalism', which insists on the *equal* basic rights and entitlements of citizens. Secularised doctrines of human dignity need to provide (a) some account of what underpins the claim that human beings possess dignity, and (b) some account of what is required if choice and action are to be consistent with human dignity. In what follows some of the accounts which are on offer in our society will be assessed with

particular reference to the adequacy of the answers they offer to the question of when killing is justified. A correct answer to this question is clearly fundamental to an understanding of justice in society, and to the criminal law, since protection from being unjustifiably killed is a precondition of enjoying whatever rights an individual may have.

1.1.3 Contemporary denials that human worth and dignity belong to all human beings.

The traditional belief in equal human dignity, both in its religious and secularised versions, is denied by a number of influential voices in our society. The understandings they offer of the basis for attributions of human dignity entail that dignity does not belong to all human beings. Broadly speaking, possession of human dignity is said by these thinkers to depend on two requirements: (a) on a human being having developed presently exercisable psychological abilities for understanding, choice and rational communication; and (b) on a human being actually exercising such abilities in the enjoyment of an acceptable quality of life. The precise relevance of the first requirement is variously explained.

1.1.3(i) A characteristic explanation of the unequal value of human lives.

A number of thinkers begin from the assertion that human beings are not equal in possessing basic dignity (and the value such dignity imports); they regard belief in the equal and distinctive dignity of human beings as a manifestation of an irrational prejudice (sometimes labelled

'speciesism'⁸). Rather, they say, a human life has value only in so far as the person whose life it is is in a position to value things and projects and activities and does value them. This means that if one does not possess the developed mental abilities to make it possible for things to seem valuable to one then there is no account one can give of one's life having value. Human beings who do not possess the mental capacities to make things matter *to them* do not *in themselves* matter.

On this account a human being can *give* worth and dignity to his life in so far as he is able to maintain a sense of things and projects being worthwhile and valuable. The corollary of this account of what it is for a human life to have value is that those lacking the mental abilities to confer value on their own lives must depend on others to attach value to their lives. This means, for example, that if those one would normally expect to value the life of an unborn child (the child's parents) or the life of a senile parent (his or her children) do not themselves account that life valuable, then not only is there unlikely to be a social basis for treating that life as valuable, but there is no account to be given of its value.

1.1.3 (ii) Warnock and Dworkin

The requirement that a human being possess presently exercisable abilities in order to possess dignity or distinctive value underlies the distinction Mary Warnock makes between 'simply being alive' and 'the specifically human consciousness of having a life to lead'. Only those enjoying such consciousness, and

⁸ Notably by Peter Singer. Singer's position is taken as a starting-point by Grant Gillett in developing his account of the value of human life. See Grant Gillett, *Reasonable Care*, Bristol: The Bristol Press 1989, p.14.

having the abilities responsibly to lead their lives, possess a distinctive value; and it is only the possession of that consciousness which explains the gravity of killing certain human beings. For humans with some idea of having lives of their own to live, for which they are responsible, 'dying, or being killed, is a different matter from the mere cessation of life'. Those, on the other hand, who are 'simply alive', who have merely 'biological life', cannot have lives with distinctive significance, value or dignity.⁹ Despite

⁹ Mary Warnock, *The Uses of Philosophy* (chapter 2: 'Man's Duties to his Own Species') Oxford: Blackwell Publishers 1992. at pp.2223. Baroness Warnock holds that we can be justified in killing human beings either for *their own sake* [about such justifications see 1.2.2, 1.3.2 and 1.3.3 of the main text] if we believe their lives are likely to be full of suffering and to deteriorate in misery, or for *the sake of others*, when those to be killed do not understand themselves to have lives for which they are responsible and when they are likely to impose what are perceived to be unacceptable burdens. The latter contention is straightforwardly an apologia for killing for the sake of convenience. Discussing the situation in which there is nothing about the prospective quality of life of the unborn child which might be invoked to justify abortion, Warnock considers the situation in which it is simply the case

`that the mother does not want it [the child] to be born ... Are we here justified in preferring to consider the quality of *her* life rather than that of the foetus? ... in the case of social abortion, it is the suffering of the mother if this child is born that is the decisive factor. And this... is consistent with the non-adoption of the principle of equal value to all lives.' (*ibid.*, pp.3435)

The general argument that we may justifiably kill those presently unable to think of themselves as responsible for their lives if and when they are perceived as diminishing the quality of life of others is a radical attack on the *moral* fabric of human solidarity and justice. Neither solidarity nor justice can be maintained by reliance on sentiments of affection uninformed by recognition of duties of care to those who in the course of nature (because of immaturity and decline) are necessarily dependent and without a sense of

immediate appearances, a similar distinction and a similar conclusion are also basic to Ronald Dworkin's more complex reflections on human worth and dignity and his explanation of why there should be extensive liberty for medicalised killing of innocent human beings. Professor Dworkin claims that almost all citizens have a shared ideal of wishing to honour the conviction that human life is sacred. He himself speaks of human life being intrinsically valuable and sacred, and formally rejects the view that nothing is valuable unless someone wants it or needs it to get what he wants.¹⁰ But he also considers that one reasonable 'interpretation' of this value and sacredness of human life is the 'liberal' view that 'life's inherent value ... depends on the intrinsic importance of human creative investment' in it; that is, on what people 'make of their own lives', so that the life which is sacred and inviolable is not 'biological life' but the 'human life ... created ... by personal choice, training, commitment and decision'.¹¹ So Dworkin's own (liberal) view is that a person suffering from Alzheimer's dementia

'is no longer capable of the acts or attachments that can give it [life]

responsibility for their own lives. The lives of many of us have depended at some stage on others recognising duties of care towards us, a recognition overriding any strong inclination to abandon care for us.

¹⁰ Ronald Dworkin, *Life's Dominion* London: Harper Collins 1993, p.69.

¹¹ Dworkin, *op.cit.*, pp.157, 93; Dworkin, 'When can a doctor kill?' *The Times* (London) 27 April 1993. So, for example: 'Recognising the sanctity of life... means... not frustrating investments in life that have already been made. For that reason liberal opinion cares more about the lives that people are now leading, lives in earnest, than about the possibility of other lives to come'; and the context shows that the lives which Dworkin here treats as mere 'possibilities' are the actual lives of healthy unborn children. See *Life's Dominion*, 99.

*value. Value cannot be poured into a life from the outside; it must be generated by the person whose life it is, and this is no longer possible for him.*¹²

On Dworkin's view, while some locate the 'transcendentally important source of ... sacred value' in 'biological life', others (like himself) think the source of that value lies in the exercisable abilities, especially for rational control of one's life, in virtue of which people can give the shape and significance they wish to their lives.

It is clear, then, that Dworkin's talk about the 'shared ideal of sanctity of life' is *practically empty*.¹³ The ideal

¹² *Life's Dominion*, p.230.

¹³ The claim that the idea of the sanctity of life is shared even by those who favour the most liberal regimes of abortion and euthanasia has three functions in Dworkin's argument.

(1) It gives him a premise for his claim (see e.g. *Life's Dominion*, pp.1645) that for purposes of U.S. constitutional law all questions about abortion and euthanasia are 'religious', so that choices to 'kill' the unborn or to commit or assist in suicide or to carry out euthanasia killing cannot be prohibited without violating the 'free exercise of religion' guaranteed by the First Amendment to the U.S. Constitution.

(2) It enables him to clothe the aspirations and choices of healthy adults (e.g. healthy pregnant women, and by implication the relatives of the demented) with the aura and the borrowed dignity of a sanctity heretofore reserved for the divinely bestowed being and status of the human subject who is always equal in dignity to his potential killer. The 'sanctity' appropriated by Dworkin is now remarketed as a self-assertive sanctity, bereft of awe, gratitude or humility, and parcelled out so as to ascribe to human beings a radical *inequality* of dignity. Consciously seeking argumentation 'likely to succeed in the political forum' (*ibid.*, p.29), Dworkin strives to deprive the common morality underlying our law about protection of life of its very vocabulary, press-ganging it into the service of the campaign to overthrow that law, a campaign more frankly and lucidly waged by others in the name of self-determination or autonomy.

can guide no one's deliberations until it is given content by 'interpretation'; the interpretations which ground competing claims about right conduct and just law are *contradictory*; and Dworkin's conclusions coincide with the position favoured by Warnock. The contest which he professed to expel with his talk of consensus about life's sacredness returns with undeniable vigour in the struggle between the thesis (which he dubs 'conservative' but which in many periods and cultures has been recognised as radical and transforming) that human life has dignity even in the most undeveloped human beings or in those severely disabled by disease or decrepitude, and the thesis (which he approvingly dubs 'liberal') which accords to the relatively powerful lethal dominion over the relatively weak. This is a struggle in which the law simply cannot be neutral without abdicating its claim to uphold basic justice, the state's most fundamental duty to protect the lives of innocent citizens against deliberate extinction at the hands of others.

One does not have to rely on religious premises to see that the understanding of human worth advocated by Baroness Warnock and Professor Dworkin, precisely because it is a direct attack on the principle of the basic equality-in-dignity of human beings, is radically subversive of justice. A secularised doctrine of human dignity needs to be consistent

(3) It enables him to launch a claim to be the moderate who reconciles two warring positions, while all the time he is siding definitively with the practical conclusions of one of those positions, pervasively misdescribing what the other position holds, and retailing unmeasured denunciations of what it promotes, e.g. nursing care of PVS patients ('the ultimate insult') or laws against assisting suicide or against voluntary euthanasia ('a devastating odious form of tyranny': p.217).

with our fundamental intuitions about justice.

1.1.4 The Basis of Human Dignity and Justice

What are the implications for justice of the kind of understanding of the worth and dignity of human life proposed by Warnock and Dworkin and similar thinkers who would like to see a radical revision of our homicide laws? Common to their positions is the requirement (explicit or implicit) that human beings possess *presently exercisable abilities* in order to be counted subjects of justice, and specifically to be counted among those entitled not to be killed intentionally without just reason. For such exercisable abilities are necessary if one is to find value in objects or projects, or to entertain some idea of having a life of one's own for which one is responsible (Warnock), or if one is to be well placed 'to make something' of one's life, thus having a 'life in earnest' whose 'sacredness' might count for something in any competition with the 'investments' which someone else has made in his own life (Dworkin).

The rational abilities necessary to these activities are various, and come in varying degrees in human beings. If actual possession of such abilities is a necessary condition of the claim to be treated justly, questions will have to be faced about precisely *which* abilities must be possessed, and how developed they must be before one enjoys this claim to be treated justly. And these questions could be answered only by *choosing* which to count as the relevant abilities and precisely how developed they must be to count. But any such line-drawing exercise is necessarily arbitrary. A distinction between A and B, where A and B fall

on either side of a line determining some minimal level of proximate capacity for the exercise of an ability, will not admit of reasoned defence when what is at issue is whether A and B are subjects of justice. If A qualifies for just treatment, B will fail to qualify even though there is very little difference in the degree to which he possesses the relevant abilities.¹⁴

Arbitrary choices may be reasonable and unavoidable in determining some entitlements (such as the requirement that one must have been a member of a club for three years in order to enjoy certain benefits). But if one's understanding of human worth and dignity commits one to being arbitrary about who are to be treated justly (*i.e.* about who are the very *subjects* of justice) it is clear that one lacks what is recognisable as a framework of justice. For it is incompatible with our fundamental intuitions about justice that we should determine who are the subjects of justice by arbitrary choice. The need for a non-arbitrary understanding of who are the subjects of justice requires us to *assume* that *just treatment is owing to all human beings in virtue of their humanity*.

¹⁴ Note that this is not a slippery slope argument, *i.e.* an argument from the alleged unacceptable consequences (logical or social) of an attempted discrimination between what is to be regarded as morally (or legally) acceptable and what unacceptable. [Some slippery slope arguments are cogent, others not: see Douglas Walton, *Slippery Slope Arguments* Clarendon Library of Logic and Philosophy, Oxford University Press, 1992] The argument here, however, is that the proposed discrimination under consideration is inherently unreasonable. It is no answer to this point to say that a distinction between the status in law of A and B can be made legally *effective*, by writing it into law and making it difficult to revise and by effectively policing its application so that departures from it are made difficult.

This indispensable assumption is also intrinsically reasonable. It is true that the distinctive dignity and value of human life are *manifested* in those specific exercises of developed rational abilities in which we achieve some share in such human goods as truth, beauty, justice, friendship and integrity. But the necessary rational abilities are acquired in virtue of an underlying or radical capacity, *given with our nature as human beings*, for developing precisely such abilities. Yet it should be clear that the dynamic development of this radical natural capacity¹⁵ is not directed to the acquisition of rational abilities for them to be exercised in just any fashion. Our abilities to know and choose are not properly exercised by, for example, believing falsehood or choosing to act unjustly, any more than our abilities to see and to walk are properly exercised in double-vision and tripping over obstacles. The nature in virtue of which we come to acquire rational abilities has its proper fulfilment, then, in exercises of rational abilities in which we recognise worth and dignity. But if it is characteristic of the nature of human beings to acquire abilities which are properly exercised in ways which are inherently valuable, then it is reasonable to hold that there is an inherent value or dignity in the nature we share in common, and

¹⁵ The radical dynamic capacity for rational life which normally results in the development of rational abilities may, of course, be *impeded* by failures of organic development, most importantly by failures of brain development. But whatever is conceived with the basic constitution necessary for human development should be recognised as possessing the radical capacity characteristic of human nature. Organic failures, either in development or decline, are failures in respect of the organic *vehicles* necessary for the exercise of rational abilities. But such failures in the life of a human being are not a reason for saying someone is not a human being, with the basic dignity which belongs to human beings.

seriously unreasonable (and radically subversive of justice) to judge that the lives of some human beings lack inherent value because those human beings lack certain presently exercisable psychological abilities.

1.1.5 Dualism and the false valuation of human life

It is clear enough from the brief descriptions offered above that Warnock's and Dworkin's accounts of which human lives possess worth rest on contrasting what they term the condition of 'simply being alive' or possessing mere 'biological life' with the condition involved in 'having a life' (on which worth depends). Discussing obligations to patients in a persistent vegetative state in his essay 'The Right to Death' Dworkin writes:

*'... nothing in the idea that life has intrinsic importance ... can justify a policy of keeping permanently comatose people alive. The worth of their lives - the character of the lives they have led - cannot be improved just by keeping the bodies they used to inhabit technically alive.'*¹⁶

Here we have a contrast between, on the one hand, a personal life (a life which a person has consciously led, to which value attaches), and, on the other, the ongoing biological life of a body which for some stretch of its existence may be inhabited by a person ('may be', because according to some of these thinkers some human bodies may never have truly 'personal' inhabitants).

This dualism left clear traces in the judgements in *Airedale NHS Trust v Bland*, in which a distinction was made between Tony Bland himself and his

¹⁶ 'The Right to Death', *The New York Review of Books*, 31 January, 1991, pp.14-17, at p.17c.

body; *e.g.* 'his spirit has left him and all that remains is the shell of his body' (Brown P); 'his body is alive, but he has no life... He is alive but has no life at all' (Hoffmann L J, consciously echoing Dworkin).

A dualism 'which thinks of the body as if it were some kind of habitation for and instrument of the real person, is defended by few philosophers... It renders inexplicable the unity in complexity which one experiences in everything one consciously does. It speaks as if there were two things ...: a non-bodily person and a non-personal living body. But neither of these can one recognise as oneself. One's living body is intrinsic, not merely instrumental, to one's 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.'¹⁷

Living human beings are organisms. On a non-dualistic view the unified life of the human organism is throughout *human*. There is not some separable organic substrate, the life of which is 'purely biological', and to which some personal subject, whose life is uniquely manifested in psychological activities, may be attached. The life that is exhibited in thinking is the *very same life* that is manifested in respiration and heartbeat. To cease to be able to

think is to lose an ability, not to lose one's life.'¹⁸

The rejection of (anthropological) dualism is important to recovering an appreciation of the inherent dignity of every human life. There is a fundamental conflict between the position of those who acknowledge a value and dignity in human beings *given with their humanity* and the position of those who think that value and dignity belong to a life *only* in so far as a person is in control of his life and can give it a valued meaning. The latter position is not reasonable. It fails to acknowledge the value of the radical natural *capacity to develop abilities* to find meaning in life, and the dignity of the nature in which that radical capacity inheres. And it fails to acknowledge that the developed abilities find their fulfilment not in just any way of life which one can be said to be in control of but in a way of life in which one submits, for example, to the claims of truth and justice. And one is not in control of what counts as true and just. To attach value and dignity exclusively to autonomous control is to

¹⁷ J M Finnis, 'Bland: Crossing the Rubicon?' (1993) 109 *Law Quarterly Review* 32937. See more fully *idem*, 'On the "value of Human Life" and "The Right to Death": Reflections on *Cruzan* and Dworkin' 17 *Southern Illinois University Law Journal* 1 at 911.

¹⁸ The movement to have irreversible destruction of the neocortex taken as the criterion of death rests on a dualism of biological life/personal life. This movement has clearly influenced official BMA positions (see especially paras. 32 and 34 of the 1988 BMA Working Party Report on *Euthanasia*). In the diagnosis of human death there is no alternative to employing criteria analogous to the criteria we employ in diagnosing death in other kinds of animals. Living human beings, like other animal organisms, die when they irreversibly lose the capacity for the integrated organic functioning characteristic of organisms. In the days before artificial ventilation, cessation of heart and lung function was an unambiguous indicator of the loss of the capacity for integrated organic functioning. If there is validity in taking 'brain stem death' as an indicator of death, it can only be because a functioning brain stem is a necessary condition of integrated organic functioning.

have blinded oneself to the true source of the basic value and dignity in a human life.

It is of considerable importance to note one implication of the inseparability of recognising someone's human dignity and recognising his status as a subject of justice. Since denial of the former entails denial of the latter, our practical reasoning should never involve us in judgements which amount to the denial of the inherent worth or dignity of a human being. The basic human dignity of the other is an *ineliminable* consideration when we deliberate about how we should treat him.

1.1.6 Justice and the Sanctity of Life Ethic Recovered

1.1.4 and 1.1.5 have argued for the necessity and reasonableness of attributing a fundamental worth and dignity to *every* living human being if we are to have a defensible understanding of justice. In so doing we have recovered from contemporary criticism, without benefit of religious premises, the basic truth about human worth and dignity which shapes the content of a sanctity of life ethic.

1.2 Justice and Killing

1.2.1 Killing for reasons incompatible with recognition of human dignity
Anyone who causes the death of another human being with intent to do so (i.e. who intentionally kills by 'act' or omission) acts on the basis that there is some reason for thinking that the person killed should have died. Quite generally what one does intentionally is identified by reference to one's *chosen purpose* in acting (under that description which makes clear its perceived desirability) and the *means* which are chosen (under that description which makes clear their

perceived relevance to the achievement of one's purpose). Both of these must feature in any adequate statement of why one is acting, *i.e.* in any adequate statement of one's *reasons* for doing precisely what one is doing.

It is clear that one can intentionally bring about someone's death by an omission which is intended to bring about death: one can want someone dead and one can bring it about that he dies precisely by choosing to omit to do what one *could* (and otherwise would) have done to keep him alive. When what one omits with such an intention to terminate life is not merely something one could have done but something one had a *duty* to do, then the law has rightly regarded such intentional omissions bringing about death as murder.¹⁹ There is no morally significant *general* distinction to be made between killing and letting die, and any attempt to rely on such a distinction is intellectually perilous.²⁰ One may let a patient die for perfectly sound reasons (see 2.2 below), but one may also 'let a patient die' for unacceptable reasons, including the absolutely unacceptable reason that one wants (however reluctantly) to hasten his death.

¹⁹ R. v. Gibbins and Proctor (1918) 13 *Criminal Appeal Reports* 134

²⁰ The Working Party of the British Medical Association which produced the 1988 Report on *Euthanasia* relies heavily on the distinction at crucial points throughout that document. (See below pp. 184-185.) Since the Report represents official BMA policy, this reliance on the distinction, together with unclarity about the scope of intention, influences the September 1992 *Discussion Paper on Treatment of Patients in Persistent Vegetative State* produced by the Medical Ethics Committee of the BMA. Even more regrettably, the Law Lords in *Bland*, following the lead of the doctors, also rely on the distinction, though clearly aware that it is untenable: see 6.2.1 below.

Both omissions contrary to duty which intentionally bring about someone's death and actions which intentionally cause death raise two questions which the person responsible should answer:

- Why was it that X should die?
- What entitled you to bring about the death?

Distinguishing between acceptable and unacceptable answers to the first question is the most fundamental task in determining what is justifiable killing.

Since it is in virtue of the worth and dignity which attaches to our humanity that we establish to *whom* justice is owing, recognition of that dignity is the precondition of human beings treating each other properly. That being so, any purported justification of killing must at the very least be *consistent* with recognising the dignity of every human being. What is *absolutely* excluded, therefore, is bringing about another's death for *reasons* incompatible with recognising the dignity of the person killed.

As we have already remarked, at the beginning of this subsection, the relevant reasons are identified in the description of one's intended course of action which identifies the perceived desirability of one's goal/purpose and the perceived relevance to one's goal of one's chosen means.

This general account of which causations of death are absolutely excluded by recognition of the basic worth and dignity of every human life (viz, those *intentional causations* decided upon for reasons incompatible with the recognition of human dignity) makes intelligible the *moral* significance of the distinction between intentional (intended) and (merely) foreseen causation of death. When death is merely foreseen, one's causing

it does not feature among the reasons one has for acting, and so is not chosen whether as end or as means (and thus is not intended). Many worthwhile activities, entirely consistent with recognition of human dignity, would be made impossible if all foreseeable causation of death were forbidden (examples would be: high-risk surgery, the giving of opiates for pain control in doses likely to hasten death, high-risk sports).

It is clear that one of the motives of those who seek to show that there is no morally significant difference between intention and foresight is to make a prohibition of the intentional causation of death seem as unreasonable as an absolute prohibition of foreseen causation of death would evidently be. It should now be clear why an absolute prohibition can justifiably cover at least some intentional causations of death, namely all those the reasons for which are incompatible with recognising the basic dignity of the persons to be killed. To allow such killings would be to grant that human beings may be treated as though their dignity were irrelevant to how one chose to act towards them.

1.2.2 Euthanasia: killing incompatible with recognition of human dignity

In this section it will be argued that the core reason a person proposing to carry out euthanasia would have to identify, to make intelligible what he sees to be the desirability of causing death, is a reason for action incompatible with recognising the dignity of the person to be killed.

It ought to be evident that the killing of a person for advantage or convenience is inconsistent with recognition of that person's dignity, for the person killed is certainly not treated as of equal

dignity with those advantaged by his death. Much advocacy of non-voluntary euthanasia is motivated by the thought that it is advantageous to others, in relieving them of the burdens of care for the handicapped and senile. Purported justifications for voluntary euthanasia, however, as also for much non-voluntary euthanasia, speak of it as a *benefit* or a *good* for the patient. If the reason for saying that death is desirable *qua* benefit to the patient is to be consistent with recognising the basic worth and dignity of the patient's life, then it cannot rest on tacitly assuming (or seeking to show) that no positive value attaches to that life. That assumption *would* be made if the reason for saying that death would benefit the patient were that it would terminate a condition of negative value, depriving the patient of nothing of positive value. Justifications of that type, if they have any place at all for recognising a value attaching to our humanity (and many do not), in effect treat it as a *commensurable* and therefore *eliminable* value in calculating the overall 'worth' of a life. But to treat the basic human dignity of some human beings as an eliminable value is to proceed by denying to those human beings their status as subjects of justice.

All standard justifications of voluntary euthanasia, in so far as they represent it as a benefit to the patient killed, do so in a way which is inconsistent with recognition of the basic dignity of every human being. Here are four standard patterns of justification:

(1) One justification²¹ represents human existence as no more than the possibility of enjoying goods. A human life is a benefit in so far as it comes up to a standard of normality in

²¹ Philippa Foot, 'Euthanasia', in her *Virtues and Vices*, Oxford: Basil Blackwell, 1978, pp.3361, at p.34.

the goods available in it. But if it sinks below that standard and is overtaken by evils it is overall an evil.²² Deliberately to end a life in that condition (if the patient asks to have it ended) is to benefit the patient.

Clearly this justification of voluntary euthanasia as a beneficial choice begins from the premise that our mere existence has no worth or value as such. So the justification is not consistent with recognising the dignity of every human being.

(2) Sometimes an attempted justification of voluntary euthanasia will concede that human life has value, but then argue that this value can be eliminated by the realities of suffering.²³ But if one treats the value attaching to our humanity as eliminable by countervailing disvalues one denies that basic dignity belongs to every human being whatever his or her condition.

(3) Some justifications of voluntary euthanasia start from the premise that human lives do not essentially possess a basic dignity and value. What gives a life value, it is claimed, is the ability of the person whose life it is to find value in projects, activities and relationships. Without a felt, *subjective* sense of worth and value a life lacks value. If a person is competent he is the only possible authority on whether he enjoys a subjective sense of value. If he soberly says he doesn't, his life lacks value. And those who lack presently exercisable abilities for finding value in their lives in consequence lack lives of value.

²² *Ibid.*, p.43.

²³ James Rachels, 'Euthanasia' in T. Regan (ed) *Matters of Life and Death*, New York: Random House, 1980, pp.2866, at p.46.

A justification of euthanasia which relies on the assumption that human lives do not *essentially* possess value straightforwardly denies the basic dignity of every human being.

(4) Some proponents of voluntary euthanasia speak of recognising the dignity of the person to be killed while asserting that continued life is not in the interests of that person. But this is mystificatory rhetoric. If one says that someone's continued existence is not in the interests of that person one means that person would be better off dead, that the nonexistence of that bodily person is of less disvalue than continued bodily existence. This could be true only if continued existence is reckoned to have a negative value, for death itself can hardly be thought to have positive value. So this form of justification is inconsistent with recognition of the basic dignity of every human being.

1.3 *Autonomy and Killing*

It will be said that the above argument against euthanasia, both voluntary and non-voluntary, is narrow-minded in basing itself exclusively on a doctrine of equal human dignity. It will be argued that at least in respect of voluntary euthanasia there is a case to be answered in its favour based on a right to personal autonomy. As already noted, there is much talk of 'conflicting moral principles of the sanctity of life and the right to personal autonomy'²⁴, and of the need to balance their differing claims. A reasoned assessment of such talk must depend on what kind of claims in the name of autonomy are well-grounded, and more particularly on whether 'a right to

personal autonomy' ever reasonably overrides what is required by recognition of human dignity. Something, therefore, needs to be said in general terms about autonomy and a 'right to personal autonomy', and about its relation to the normative constraints on killing imposed by recognition of human dignity.

1.3.1 Autonomy and a 'Right' to Personal Autonomy

The words 'autonomy' and 'autonomous' are used in respect of a capacity, a condition and a right.

To be autonomous, as the word implies, is to be self-governed or self-directed or self-determining in the conduct of one's life; that is the condition. 'Autonomy' is used of the capacity to be self-directed in the conduct of one's life. 'Respect for autonomy' involves respect at least for this capacity. 'A right to autonomy' must be a right to at least *some* exercise of the capacity for self-direction in one's life. But what exercise of that capacity? The answer we give to that question must surely depend on the understanding we have of the value of autonomy.

Some semi-popular talk about autonomy and the right to have one's autonomy respected seems to suggest that what people value is doing what they want (in the sense of acting on the wants, wishes and desires they *happen* to have) as distinct from having to do what someone else wants. But it seems fairly clear that the ability to do what one *happens* to want to do is not sufficient for self-government in the conduct of one's life. Someone whose condition is one of wanton self-indulgence does what he happens to want to do. What is valued in the capacity for self-government is at the

²⁴ See para.2 of the Special Report (9 March 1993) from the Select Committee of The House of Lords on Medical Ethics, echoing observations in the judgements in *Bland*.

very least our ability to evaluate our desires and to act selectively in accordance with our evaluations.

But will action in accordance with *any* kind of evaluation count as an exercise of autonomy? Our answer to this question will depend on what we think the point of self-government or self-direction is.

The capacity for self-government is properly exercised and developed with a view to the flourishing or well-being of the person who possesses it, and of the communities to which that person properly belongs in friendship and justice. If so exercised it is indeed an aspect of that flourishing. In what way is it an aspect?

Human happiness or well-being is not left to be wholly a matter of luck, or of grace which does not require willing cooperation; what we make of ourselves (our character) makes an important difference to whether or not we flourish as human beings. And our characters are decisively shaped by our chosen actions: these do not merely bring about effects external to us, they also serve to form our dispositions. A person's exercise of choice will in this way inescapably make for well-being or misery in his life.

So there is a clear case for valuing human choice, and hence for valuing the exercise of autonomy, precisely in so far as it serves to form in us those dispositions which are conducive to human flourishing.

People differ in their views on how wide an exercise of the capacity for self-direction should be respected. One very important factor in determining those differing views is whether or not one believes there is human knowledge of moral truths, that is, knowledge of the objective requirements we need to

meet if we are to flourish as human beings.

If there is such knowledge, then it is clear why we should value the exercise of choice in conformity with that knowledge: for evidently that would be an exercise of autonomy which makes for human flourishing. But it would not be obvious why we should value exercises of autonomy at variance with the objective requirements of human flourishing.

Still, if there is to be choice one has to allow not just for the possibility but also for the reality of erroneous choices. So, necessarily, respect for autonomy must leave scope for *some* erroneous choices. But it does not follow that any and every exercise of choice is to be respected. We need to bear in mind why this capacity is to be valued; and if our choices seriously undermine in us the capacity to flourish as human beings, and *a fortiori* if they aim to damage aspects of this capacity in others, there is no reason of moral principle why those choices should be respected.

1.3.2 Autonomy and the Justification of Voluntary Euthanasia

Can a right to autonomy be invoked to justify voluntary euthanasia? It is important to recognise how limited a role in justification the actual request to be killed can play. Certainly the mere fact of a request in itself provides little reason for a doctor to kill a patient. Can we envisage a doctor thinking it justifiable to kill a patient just because the patient has asked to be killed? Hardly. Indeed, we can envisage many circumstances in which doctors who are not opposed in principle to euthanasia would refuse requests; as when they think the request is prompted by an erroneous

view of the prognosis, or by some relievable depression, or by circumstances which can be readily changed. Any doctor who feels that a given patient still has a worthwhile life to live will not accede to a request for euthanasia from that patient. *By contrast, it is precisely the judgement that a patient no longer has a worthwhile life which will seem to justify euthanasia.* The role of this judgement in justifying euthanasia is not altered by the different grounds a doctor may have for arriving at it. Sometimes it will seem true on the basis of evidence which the doctor can independently take stock of: pain, degeneration, depression, wretched circumstances. At other times the judgement will be clinched in the doctor's mind only by what the patient asserts: that his life is no longer worth living.

A doctor, minded to think that at bottom a human life can have value only if the person whose life it is consciously finds value in it, may well accept, in the presence of some corroborative evidence, a patient's judgement that his life has irrevocably lost value and dignity. But that fact about the doctor's background reasoning is not a ground for thinking that the doctor is not himself responsible for the judgement that this patient no longer has a worthwhile life. For it is *this* judgement which will make it appear to *him* that a choice to bring about the patient's death is a beneficent choice.

Notwithstanding, then, that the killing which carries out voluntary euthanasia is requested, the justification of that killing rests centrally on the contention that the patient no longer has a worthwhile life. *But precisely that contention is inconsistent with*

recognising the continuing worth and dignity of the patient's life.

In any apparent conflict between, on the one hand, the requirement that we do not deny equal human dignity and respect for the sanctity of human life and, on the other, the putative claims of respect for autonomy, the principle of the sanctity of human life must always trump those claims. For recognition of equal human dignity is fundamental to recognition of all human beings as subjects of justice.

There is no authentic conflict between rightly respecting the sanctity of human life and rightly respecting autonomy. The exercise of human autonomy in giving shape, direction and character to a human life is not a source of value and dignity which is properly at *odds* with the fundamental source of human worth and dignity in human nature itself. For, as we saw (1.1.4), what makes it reasonable to recognise human nature as the source of our basic worth and dignity as human beings is the fact that our nature in its development is intrinsically directed to human fulfilment and human good. And what best makes sense of the ideal of respect for autonomy is the role played by free choice in the achievement of that fulfilment to which our nature is directed; for self-determining choice is integral to that achievement. But if the moral significance of autonomy is to be understood in that way, then the value of autonomy is derivative from, and reflective of, that which gives value to our humanity. So it should be clear that the claims of autonomy cannot properly extend to choices which are inconsistent with recognising the basic worth and dignity of every human being.

1.3.3 Autonomy and the Justification of Non-Voluntary Euthanasia

It is sometimes said²⁵ that debility, degeneration and dependency experienced by those who have become permanently incompetent, or the undignified way in which (sometimes unavoidably) they are treated, are inconsistent with the meaning and character they had given to their lives while competent. It is then claimed, or insinuated, that this meaning and character have been the exclusive source of dignity in the lives of many such people so that their present condition should be recognised as completely depriving them of dignity. For this reason, therefore, it would be beneficent to put an end to their lives.

Sufficient has already been said to show that such a line of reasoning provides no defensible ground for euthanasia of the incompetent who were formerly competent. As many of those nurses and others who care for such persons know, and testify to by their dispositions and acts of solidarity, communion or friendship with them, these people, though sadly weakened or wounded and scarcely or no longer able to exercise their autonomy, remain the very same persons they always were. Their state is in a sense undignified, but it is *not an indignity* (of the kind inflicted upon people by demeaning actions). Right down to their deaths they continue to share in the radical equality-in-dignity of all human beings.

1.4 Sanctity of Life and Autonomy: Conclusion

²⁵ For example by Ronald Dworkin, 'The Right to Death' at pp.1516; *Life's Dominion*, ch.7.

The teaching of Christian tradition about the sanctity of life can be recast in secular terms as a doctrine of equal basic worth and dignity. This doctrine has to be assumed if there is to be a non-arbitrary understanding of who are the subjects of justice, but the intrinsic reasonableness of the assumption can be defended.

Since we must hold all human beings to possess an ineliminable worth and dignity if they are to be recognised as subjects of justice, any justification for killing incompatible with recognising that worth and dignity is inadmissible. Justifications of voluntary and non-voluntary euthanasia as beneficent rely *essentially* on the judgement that, overall, the present life of the person to be killed is of negative value (not worthwhile). But such a judgement is incompatible with recognising the ineliminable worth and dignity of the person to be killed. Hence intentional killing (by act or omission) for euthanasiast reasons falls under the absolute prohibition of intentional killing of the innocent (itself the core requirement of respect for the sanctity of life).

2. The Duties of Doctors: Duties of Treatment and Duties of Care

2.1 *The Purpose of Medicine and Duties of Treatment*

Doctors are skilled practitioners of the art of medicine. The generic skills of diagnosis, prognosis and treatment draw on a basis of scientific knowledge, itself based on research.

It is of the first importance in seeking to define the duties of doctors in respect of treatment to be clear about the purpose of medicine. The purpose of medicine is the restoration and maintenance of health (or of some approximation to health) or the

palliation of symptoms. Traditionally, health has been understood as that condition of the body in virtue of which it functions well as an organic whole, so that the individual both enjoys physical vitality in itself and is well-placed to achieve some of the other goods intrinsic to human well-being.²⁶ Health is valued as inseparably an intrinsic and an instrumental good. The palliation of symptoms (when cure is not achievable) aims precisely to control those impediments to participation in other human goods which arise from organic malfunctioning; in other words, given that not even an approximation to health can be achieved, one aims to secure as *tolerable* a state of the organism as possible so that conscious living (with family and friends and others) may continue. Thus, palliative medicine, in deploying techniques of pain control, is focused, just like other forms of medicine, on the organic component of our aptitude to share in other human goods.²⁷

The prolongation of life has not traditionally been understood as an

²⁶ A clear exposition of this understanding may be found, for instance, in Leon R Kass, M. D., *Toward A More Natural Science. Biology and Human Affairs* (New York: The Free Press 1985), especially Chapter 6: 'The End of Medicine and the Pursuit of Health', pp.157 - 186.

²⁷ This is what symptom control is *aiming for*, except in the extreme situation - now, in principle, rare - in which acute pain is so intractable that the patient has to be rendered unconscious. What justifies doing that, given the rationale for palliative medicine offered in the text? It is the belief that for *this* patient *conscious* participation in other human goods has been rendered impossible by overwhelming pain so that there is nothing further to be achieved by maintaining a state of consciousness which is nothing other than consciousness of pain. But that understanding of the patient's situation does not amount to judging that the very existence of this patient is without value.

independent goal of medicine, without reference to the good of health. It has been considered a justifiable aim only in so far as a patient has had some continuing capacity for organic well-functioning sufficient to allow him to share in some of the goods of human life (e.g. contemplation, the exercise of choice, communication, or - and these are particularly relevant to babies - some form of play, the affection of others, the enjoyment of one's own vitality).

The recognition that prolongation of life has not been considered as *per se* an objective of medical practice should help to dispose of a radical misunderstanding of the requirements of respect for the sanctity of life which has been encouraged in recent years by those who wish to subvert the core requirement (that one ought never to kill the innocent intentionally). The misunderstanding has been to the effect that those who claim that a life has worth or value must mean that one should seek to prolong that life.²⁸

Section 1 has shown that recognition of human dignity would require that a doctor should never intentionally kill a patient. The fundamental worth and dignity of every human life has its source in the human nature each of us shares precisely in existing as a human being. A proposal to kill a patient is a proposal to put an end to that person's existence. But such a proposal cannot be justified for a reason compatible with recognising the worth and dignity of his very existence.

It is in the nature of human beings that they die. There is nothing that we have come to know in recent years which

²⁸ The misunderstanding features prominently in the writings of Helga Kuhse and Peter Singer. Its influence on the writings of Mary Warnock is also evident.

suggests that medicine should revise its traditional goals and seek to defy the inevitability of death. A doctor's decision not to seek to prolong a patient's life need not find its justification in reasons entailing any denial of the fundamental worth or dignity of that patient's life. There may be sound reasons for such a decision, compatible with respect for the fundamental dignity of the patient; these reasons are discussed in the next section.

It follows from the nature of the purpose which the institution of medicine exists to serve that the central duty of a doctor to an ill patient is that of competently employing those medical skills relevant either to aiding and abetting whatever capacity the patient may have for a return to health or to palliating those symptoms arising from disease or disability which impede a patient's remaining capacity to live well.

2.2 Limits on Duties of Treatment

2.2.1 Patient Consent and Duties of Treatment

Two statements by Pope Pius XII may usefully introduce the topic of patient consent in relation to a doctor's duties of treatment. In 1952 he said:

*'First of all, one must suppose that the doctor, as a private person, cannot take any measure or try any intervention without the consent of the patient. The doctor has only that power over the patient which the latter gives him, be it explicitly, or implicitly and tacitly. The patient for his part cannot confer rights which he does not possess'*²⁹

²⁹ Pope Pius XII. Address to the First International Congress of Histopathology, September 13, 1952. *Acta Apostolicae Sedis* 44 (1952), pp.779-89.

And in 1957 he made the same point in connection with restating the traditional norms on 'ordinary and extraordinary treatment':

*'The rights and duties of the doctor are correlative to those of the patient. The doctor, in fact, has no separate or independent right where the patient is concerned. In general he can take action only if the patient explicitly or implicitly, directly or indirectly, gives him permission.'*³⁰

These statements reflect a centuries-long tradition of theological thinking on the doctor-patient relationship, which offers no support for the unbridled paternalism which is sometimes said to have been accommodated by a traditional ethic of medical practice.

It is important to understand the underlying reasons for the place given to patient consent in the traditional thinking articulated by Pope Pius XII.

Medicine is a body of practices which are given their unity by the varied relations they have to the good of health. But the good of health as it is instantiated in the lives of individuals is an aspect of their personal well-being. Precisely as a personal good each person's health is primarily his responsibility. Once a person has reached that stage of physical development at which he is also able to exercise responsible choice, health is effectively promoted only through the choices and commitments of the person himself. For some the choices at a certain stage of their lives need be no more than moderation and good sense in regard to what they eat and drink; for others the required choices are much more exacting.

³⁰ Pope Pius XII, Address to Gregor Mendel Genetic Institute, November 24, 1957; *Acta Apostolicae Sedis* 49 (1957), pp.1027-1033.

The view that there is an intimate connection between health and personal responsibility implies that health cannot be viewed as a commodity which one can acquire by going to a doctor's surgery or to hospital. Health is effectively promoted only when a person takes responsibility for his health. The doctor's responsibility to aid and abet the restoration of health can best be discharged if the basic responsibility of the patient is recognised and respected. This means that the doctor must, within limits, respect the competent patient's choice.

There is a second important reason for insisting on respect for the competent patient's choice. Because health is a personal good it may be more or less intensively realised in one's life. The degree to which it is achieved depends in part upon the place other commitments occupy in one's life and the demands they make on one. What persons devote themselves to is a matter of choice influenced by aptitude, opportunity, inclination and inspiration. Sometimes it is a consequence of a serious and worthy choice of a way of life that health is impaired and one loses the opportunity to recover it. A doctor lacks the competence and so the authority to tell us to abandon the shaping commitments of our lives.

Because health is a personal good, an aspect of the flourishing of persons, it is wrong to neglect health problems simply because of laziness, it is wrong to damage health through self-indulgence, and it is wrong because of cowardice to avoid seeking the treatment one needs. While such behaviour is morally unreasonable, it is rarely the case that a uniform course of action is alone morally reasonable: the place one can give to fostering or

restoring the good of health in one's own life will depend upon the responsibilities which arise from one's other basic commitments. So for this reason, too, the choice of the patient must be respected.

Nothing in this way of explaining the significance and importance of patient consent suggests that the rationale for its true significance is the right of patients to construct (and deconstruct) their lives as they will, providing only that they do not damage the legitimate interests of non-consenting parties.

The second line of argument for the importance of patient consent suggests that a doctor has a duty to provide therapeutic or palliative treatment of a kind compatible with the reasonable commitments a person has undertaken, even if the 'compatible' treatment is not, in the doctor's view, the ideal therapy for the patient's condition. That kind of compromise is necessary and reasonable.

But there are patient wishes a doctor cannot justifiably accommodate. One such wish is the demand for euthanasia: the case against accommodating it has been fully explained in Section 1. At this point it would be appropriate to add consideration of the request for aid in suicide.

2.2.2 Duties of Treatment and Suicide

A request for euthanasia is not, of course, a request for assistance in suicide. A request for euthanasia from a patient to a doctor is a request that the doctor kill the patient. Suicide is the carrying out of a choice directly to kill oneself. One can carry out such a choice either by a positive course of action, *e.g.* by taking a lethal substance, or by deliberately omitting

life sustaining treatment or care (precisely in order to end one's life). Just as willingness to carry out euthanasiast killing rests on a false valuation of the life of another, so willingness to commit deliberately chosen suicide rests on a false valuation of one's own life (to the effect that it is no longer worthwhile). Since that valuation is incompatible with respect for one's own fundamental dignity, it is morally impermissible to aid a person to carry out an act of suicide.³¹

It is clear what this conclusion excludes when suicide is to be accomplished by an act such as taking a lethal dose of a drug: it excludes providing the necessary quantity of the drug with the intention of enabling the person to commit suicide.

³¹ The Voluntary Euthanasia Society falsely imply that the decriminalisation of suicide in 1961 involved recognition of 'the right of individuals to determine when their own life was insupportable' [*The Last Right. The Need for Voluntary Euthanasia* revised edition, London: The VES, 1989, p.4] Suicide was decriminalised because it was felt that prosecution of those who had attempted it could only make more difficult any attempt to help them retrieve a true sense of their worth and dignity. It remains that suicidal intentions rest on what the law *must* regard as a false valuation of one's own life (as of any other human life). And that is why aiding and abetting suicide rightly remains a crime. It is not perhaps surprising that an organisation such as the VES should misrepresent the implications of the decriminalisation of suicide, but it is surprising to find Hoffmann LJ and Lord Goff claim (in *Bland*[1993] 2 WLR at 351-2, 367) that decriminalisation of suicide 'was a recognition that the principle of self-determination should in that case [suicide] prevail over the sanctity of life'. The parliamentary debates on the Suicide Bill (see e.g. *House of Commons Debates*, 19 July 1961, col. 1425-6) make it clear that the Act's decriminalising of the act of the suicide himself had nothing to do with a 'principle of self-determination' which is in any case incompatible with the Act's prohibition of all forms of assistance in suicide.

When a competent person proposes to commit suicide by refusing necessary life-prolonging treatment (e.g. insulin for diabetes) or by refusing basic care (e.g. being fed) one does not collaborate by failing to override his proposal. The alternative to respecting the requirement of consent is to take a suicidal proposal as evidence that the person in question is incompetent and to force upon him the treatment or care which is in his best interests. But it is unreasonable to treat suicidal proposals as though they were always evidence of incompetence; that would be to act as if people could never be guilty of suicide.

Consideration will be given in Section 4 (Advance Directives) to what a doctor's moral responsibilities are towards an incompetent patient who while competent had left suicidally motivated instructions for his medical treatment in specified circumstances.

2.2.3 General Grounds for Limiting Treatment

There are two quite general grounds for limiting treatment: (i) one is that a particular treatment is failing to achieve its therapeutic or palliative goal (i.e. it is inefficacious treatment); (ii) the other is that it involves burdensome consequences which it is not reasonable to expect a patient to bear. When the patient is competent his own judgement of what is a tolerable burden must be decisive.

(i) *Inefficacious treatment*

Since prolongation of life is not an independent goal of medicine, the possibility of continuing to prolong life does not independently create an obligation to continue to provide life prolonging treatment. If a patient is in the terminal phase of dying it will normally be the case that it is clearly

inappropriate to persist with life-prolonging treatment unless that treatment has distinct palliative benefits.

More broadly, therapeutic treatment is to be judged inefficacious if the condition of the patient is such that it would be impossible to secure even an approximation to health in that patient, *i.e.* some desirable degree of well-functioning of the organism as a whole. It is on precisely this ground that it would be reasonable to withdraw specifically therapeutic treatment from a patient who has been securely diagnosed as irreversibly in a persistent vegetative state (PVS). For the organic condition of the patient has been rendered so seriously defective that it is impossible to achieve a desirable approximation to health (*viz.*, the well-functioning of the organism as a whole).

To say that it may be reasonable to withdraw *therapeutic treatment* (including, for example, antibiotics for recurrent infection) from PVS patients is not to say that it is reasonable to withdraw ordinary care from them. (For a discussion of what is required in this respect see 2.3.1 below.)

Doctors do not have a duty to provide inefficacious treatment, and patients (and families of patients) cannot reasonably require such treatment of doctors. But it is very important that in answering a question about the worthwhileness of a given treatment a doctor should focus very firmly on whether the treatment can deliver medical benefits (cure, mitigation of disability, palliation of symptoms) and should not allow the basis of his answer to shift to a judgement on the worthwhileness of the patient's life, so that the question he comes to answer is whether the patient is worth benefiting. For a negative answer to that question

would seem to justify not merely withholding a particular medical treatment but withholding all medical treatment and all basic care in order to end what is judged a worthless life.

(ii) Excessively burdensome treatment

Doctors do not have a duty to provide treatment which a competent patient would reasonably reject on the ground that it was in some respect excessively burdensome in its consequences. Typically treatment will hold out some prospects of benefit (specifically for prolonging a life) but will also involve burdensome consequences. There is no single right answer to the question of when those burdens become sufficiently burdensome to justify discontinuing a treatment. Providing a patient has discharged serious duties which he may have, such as duties to family, and providing he is not motivated by suicidal intentions, it may be reasonable for him to reject life-prolonging treatment because the burdens consequent upon it are more than he is disposed to put up with. Burdens may take the following forms:

(a) treatment may be excessively *costly*: the cost in question may be to an individual, to a family, or to a health service. A patient considering the financial consequences of treatment for different payers/providers may reasonably decide to forgo treatment even before a point is reached at which it would be obvious that acceptance of treatment would be unfair to others.

(b) Treatment may be excessively damaging to possibilities one cherishes. It may be reasonable to refuse chemotherapy for cancer because of its very likely effect on other bodily functions; *e.g.* that it renders one sterile and one is recently married and wanting a child.

(c) Treatment may be excessively painful: there will be limits to each individual's courage.

(d) Treatment may be excessively taxing psychologically: a broad species of burden, of particular relevance when considering treatment for the very elderly. When there is progressive failure of a number of systems of the body aggressive therapy can prove very oppressive.

(e) Treatment can be excessively restrictive on physical liberty: thus, doctors may promise an elderly patient a further year of life providing she remains under their constant care in hospital. She may reasonably want to spend the time remaining to her in visiting her children and grandchildren who are willing to give her ordinary nursing care.

(f) Finally, treatment may be excessively disruptive of one's inner life: thus thought, conversation, prayer may be most important to a patient, who therefore reasonably refuses the analgesia which dulls his mind.

These six categories of burden [a-f] are burdens consequent upon treatment.

They provide a fairly clear way of analysing the elements that can make for an acceptable or unacceptable *quality of life* when that phrase is used in a justifiable fashion to refer to the predictable consequences of treatment.³²

A competent patient who rejects *treatment* because of its excessively burdensome consequences rejects it because of a judgement on the treatment not because of a judgement

on the fundamental worth of his own continued existence. Such rejections may at times be faulted because they display a lack of prudence or courage, but they should not be faulted as euthanasiast.

2.2.4 Duties of Treatment to the Incompetent

Clearly doctors should not give inefficacious medical treatment to the incompetent. In this context a standard synonym for 'inefficacious' is 'futile'. Some judge treatment futile when they are inclined to think the life of the patient 'futile' (meaning 'no longer worthwhile'), and they think this judgement particularly well-founded if there is evidence for thinking that, in anticipation of his present condition, an incompetent patient took such a view of it while still competent. But any such judgement (and especially one invoked to justify the withholding of treatment with a view to ending the patient's life) is, for reasons already explained (see 1.3), an unacceptable basis for treatment decisions.

A doctor would be justified in withholding or withdrawing medical treatment the consequences of which a proxy decision-maker reasonably judged to be excessively burdensome. A proxy's decision would generally be reasonable if it was clear that a competent patient in similar circumstances would have good reason for refusing treatment. However, in assessing burdens a proxy needs to take account of the difference that incompetence itself may make to the burdensome character of treatment. Sometimes, sheer inability to understand what doctors are attempting and the painful, even though temporary, effects of treatment, may create considerable fear and repugnance, so that treatment which

³² The phrase is frequently used with unacceptably euthanasiast implications to refer to the very worthwhileness of a life.

would not be excessively burdensome for the competent may become so for the incompetent. Incomprehension can also limit the ability to cooperate with certain forms of treatment.

Both a proxy decision-maker for an incompetent patient and the doctor responsible for the care of that patient owe it to the patient to secure justice in his treatment. This means in summary that -

- (i) it is absolutely excluded that management of the patient should be directed to ending his life;
- (ii) where there is scope for securing through a course of treatment significant medical benefits, without excessive burdens in consequence, that course of treatment should be provided;
- (iii) if any suggested course of treatment which promises some medical benefits also carries with it some likelihood of unacceptably burdensome consequences then those responsible for treatment should be scrupulous in assessing the burdens of treatment. They should wish to ascertain that prospective burdens truly would be considerable before deciding that potentially beneficial treatment should be withheld.

2.3 *Doctors' duties of ordinary care towards hospitalised patients*

When a patient is admitted to hospital for treatment, responsibility is assumed not merely for providing him with beneficial medical treatment but also for providing him with what is ordinarily needed if the patient is to continue living: nourishment, shelter, warmth, hygiene. Dependence on a doctor in respect of such needs cannot be repudiated simply because distinctively medical goals are not achievable. No one would ordinarily doubt this. It is against this background

that we should consider the question of tube-feeding of those diagnosed as irreversibly in a 'persistent vegetative state'.

2.3.1 Feeding the P VS patient

In considering what a doctor's duties of ordinary care are towards a PVS patient certain propositions should not be in doubt:

- (i) PVS patients are living human beings, albeit gravely impaired. (See 1.1.5 above.) As living human beings they possess the ineliminable worth and dignity of our common humanity.
- (ii) Since they are living human beings it is incompatible with recognition of their dignity to judge their very existence to be without worth or value. If a PVS patient's life is judged to be without worth it will indeed seem reasonable to conclude that he would be better off dead, and, accordingly, reasonable to make his death the *object* of clinical management.
- (iii) If one aims to kill a patient by deliberate omission of treatment or care, (i.e. omission decided upon precisely to bring about death), one is intentionally killing. Such intentional killing of the innocent by planned omission is as gravely wrong³³ as intentional killing by positive act.³³

³³ A majority of the Law Lords in *Bland* accepted the proposition that those who have the care of patients in a condition such as the judges described in the case of Tony Bland may rightly adopt a pattern of care *with the intention, purpose or aim* of terminating the lives or bringing about the deaths of those patients. See: 'the proposed conduct has the aim . . . of terminating the life of Anthony Bland; . . . the conduct will be, as it is intended to be, the cause of death' (Lord Mustill, [1993] 2 WLR at 388, 397); 'the whole purpose of stopping artificial feeding is to bring about the death of Anthony Bland' (Lord Browne Wilkinson at 383); 'the intention to bring about the patient's death is there' (Lord Lowry at 379).

(iv) Death can occur as a foreseen consequence of omitting to do something one had good reason not to do. In such a case one cannot be held to be guilty of the death.

(v) PVS patients are entitled to the ordinary care to which any impaired and vulnerable person is normally entitled.

Given the exposition of the *limited* goals of *medical* treatment presented in this submission, one might argue that enteral feeding of a PVS patient (*i.e.* feeding by nasogastric tube or gastrostomy) is *medical* treatment, and since the limited goals of medical treatment are not achievable in a PVS patient (see 2.2.3 above) there can be no continuing obligation to supply enteral feeding once the irreversibility of the persistent vegetative state has been confirmed. Hence if one were to discontinue enteral feeding one might do so simply because there is no obligation to continue, and without entertaining any intention to cause the patient's death, even though foreseeing that discontinuance of feeding will cause his death.

The objection to this view is the weakness of the case for saying that enteral feeding is *medical treatment* rather than ordinary care. The definition of medical treatment should include *some* reference to the distinctive goals of medicine (the restoration and maintenance of health, or of some approximation to health, and the palliation of symptoms), so that medical treatment will have some identifiable therapeutic or palliative function. Enteral feeding serves neither such function but the ordinary function of nourishing the patient.

It can hardly be that just *anything* done by a doctor in the course of caring for patients is to count as medical treatment; if it were, then the

distinction between medical treatment and ordinary care would collapse. Nor will it do to say that the *intrusive* or 'invasive' character of what is done to the patient makes it medical treatment.³⁴ Any adult finding a choking child might reach to the back of the child's mouth to pull his tongue forward. Nor is it very convincing to suggest³⁵ that what makes enteral feeding medical treatment in the case of PVS patients is the fact that it substitutes for an ordinary bodily function. Many PVS patients retain some degree of swallowing reflex, and they standardly possess a capacity to digest food in the normal way. Enteral feeding is an expeditious way of delivering to the PVS patient the food any human being needs, and it serves the same purpose that eating and drinking do.

It is true that it normally requires a doctor's decision to first establish enteral feeding, though it will often not require specifically medical skills to maintain feeding by nasogastric tube. It is also true that the doctor's purpose in making such a decision will normally be to sustain the patient while diagnostic investigations are carried out and an attempt is made to establish an appropriate therapeutic regimen. But the tube feeding itself is not therapy and is not reasonably discontinued on the grounds that

³⁴ No member of the House of Lords in *Bland* questioned Lord Justice Butler-Sloss's remark that it is 'uncomfortable' to 'attempt to draw a line between different forms of feeding such as spoon-feeding a helpless patient or inserting a tube ...' ([1993] 2 WLR at 343).

³⁵ As Professor Jennett did as an expert witness before the Court in *Bland* (see [1993] 2 WLR at 325). Dr. Keith Andrews, who has very extensive experience in the management of PVS patients, maintained before the Court that enteral feeding is a part of ordinary care. His reason for doing so related to the function of enteral feeding.

therapeutic efforts have proved futile.³⁶

In *Bland* what the Law Lords approved was discontinuing tube-feeding on the basis of a medical judgement that tube-feeding had become futile because continued existence in Tony Bland's condition was not a benefit; in other words, Tony Bland's existence was without worth or value. In consequence, as Lord Browne-Wilkinson observed:

'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

³⁶ If it is morally acceptable to withdraw artificial ventilation from an irreversibly comatose patient why should it not be morally acceptable to withdraw artificial feeding? Artificial ventilation appears no more a therapeutic activity than artificial feeding. There is, however, a significant difference between the two activities relevant to determining whether they are properly classified as ordinary care. Feeding people (in a variety of ways, from setting dishes before them to spoon-feeding them) is part of our *ordinary care* of them. At various times in our lives, either because of underdevelopment or decline or accident, we can be helpless in regard to obtaining or ingesting food. If a mother fails to set dishes before her young children she will starve them. If she had failed to spoon-feed them when they were still younger she would have starved them. Tube-feeding (once one has embarked upon it) is most naturally understood as the *extension* of an ordinary pattern of care, and as owed to someone in the way of such care. By contrast, 'making people breathe' is not a part of our ordinary care of people; 'oxygenating' others is not a standard part of what we do for each other. And the reason is obvious: at any normal stage of extra-uterine life we can spontaneously breathe and the air is there to be inhaled. Consequently, supplying for the inability to breathe is *not* an extension of an activity of ordinary care. It is an intervention which is more reasonably interpreted as having its justification in the achievability of proper medical goals (the restoration of health, or of some approximation to health, or the palliation of symptoms). But if those goals are not achievable there can be no obligation to continue ventilation.

*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.*³⁷

There can certainly be a sound case for stopping tube-feeding if a patient is in the final phase of dying or if tube-feeding involves gross burdens for a patient (though the latter reason hardly applies to PVS patients who are supposed to be insensate). And in certain situations of extreme scarcity or disorder (which do not obtain in our society) doctors and nurses might reasonably neglect the permanently unconscious and other severely damaged patients because of overriding duties to others.

3. Withdrawing Treatment and Intentional Killing

This section simply draws together the relevant distinctions which have already been sufficiently explained in earlier sections.

3.1 It is certainly morally unacceptable to aim or intend to bring about someone's death for a reason or reasons incompatible with recognising the basic worth and dignity of that person as a human being, and incompatible, therefore, with justice. One's intent to bring about someone's death will be equally unacceptable whether it is achieved by

- (a) a positive act, such as a lethal injection;
- (b) the omission of treatment decided upon precisely to hasten death;
- (c) the omission of care decided upon precisely to hasten death.

3.2 It can be morally acceptable to withhold or withdraw treatment precisely because it is reasonably

³⁷ [1993] 2 WLR at 383.

judged inefficacious (futile) or excessively burdensome (2.2.3), even if one foresees that in consequence death will occur earlier than it might otherwise have done. One's *reason* for withholding treatment is not a judgement about the desirability of putting an end to the patient's life but a judgement about the desirability of putting an end to *treatment*, either because it is inefficacious or because it is imposing excessive burdens on the patient.

3.3 There are few circumstances (they are noted at the end of 2.3.1) in which it is reasonable to withdraw ordinary care, especially feeding, of a patient.

4. The Role of Advance Directives and Proxy Decision-makers

Here, as in previous sections, we consider the moral case for certain broad conceptions of what is desirable rather than the details of legislative proposals.³⁸

4.1 Advance Directives

4.1.1 The unilateral emphasis on autonomy

(a) Many proposals for advance directive legislation are vitiated by a unilateral emphasis on autonomy in their justification, with little or no recognition that the individual in his or her self-determination may rightly be expected to acknowledge a number of moral norms. Without recognition of norms about the wrongness of suicide and euthanasia (accomplished either by act or omission), apologies for advance directives articulated in terms of the claims of autonomy must seem to

³⁸ Some parts of this section draw verbatim on John Finnis, 'Living Will Legislation', other parts draw on Luke Gormally, 'The Living Will: the ethical framework of a recent Report' (for references see footnote 1).

justify the inclusion of euthanasia and assistance in suicide within the effective scope of advance directives.³⁹

(b) A strictly unilateral emphasis on autonomy leads to the view that the *sole* determinant of how one should be treated when incompetent is the anticipatory decision one made when competent. But the consequences of such a position are fairly obviously unacceptable. All advance directive legislation provides that, while competent, makers of declarations may readily revoke them. That provision acknowledges that for a variety of reasons one may come to recognise original directives as mistaken. But why should one's family or friends be prevented by *one's present incompetence* from making decisions on one's behalf on the basis of one's *best interests*?

(c) Some defend treating as immutable and effective an unrevoked anticipatory decision about treatment made by a person when competent.⁴⁰ They often base their defence on the claim that those acting on the now incompetent person's behalf are properly confined to the role of

³⁹ It cannot be true to say in general, as Lord Goff does say in *Airedale NHS Trust v Bland*[1993] 2 WLR at 367-8, that in the implementation of anticipatory refusals of 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'.

⁴⁰ For example, Dworkin, *Life's Dominion*, pp. 226-229. Dworkin believes a doctor would violate the autonomy of a manifestly happy patient with Alzheimer's disease if he refused to act on an advance directive made by the patient requiring that he be killed if he were to suffer Alzheimer's. Dworkin acknowledges, p.228, the shocking character of the conclusion towards which his argument drives him, but persists in his fictitious construct, so-called 'precedent autonomy', which (in tandem with the unbalanced primacy he here attributes to autonomy) impels him towards these conclusions.

exercising *his* right to self-determination.

The claim is based on a muddle. There are indeed rights protecting one's fundamental interests and well-being (life, privacy, reputation, bodily integrity, etc.) which can be vindicated and, in that sense, exercised on one's behalf while one is incompetent. But a right which is a right to form one's own intentions and make and execute one's own choices, simply cannot be exercised by the choices of another. Just as the refusal (which may but need not be unjustified) to carry out a dead man's last will and testament frustrates the intentions, purposes and will which he once had but does not and cannot violate his autonomy, so the refusal to carry out a now-incompetent person's unrevoked advance directive that he be killed if permanently incompetent frustrates his earlier intention but does not and cannot violate his autonomy; he no longer has any autonomy to be exercised, though he retains his ineliminable human dignity, and the rights and interests which should be respected in virtue of that dignity.⁴¹

(d) The radical incoherence of the notion that the incompetent have *autonomy rights* (as distinct from dignity and welfare rights) becomes more evident when those incompetent persons who have never made any advance healthcare directive are declared to have an autonomy right exercisable on their behalf, even by an agent or 'guardian' or other

'representative' whose decision is to refuse treatment on the ground that these patients, were they competent and reasonable, would choose to refuse treatment and accept death, perhaps not for their own supposed benefit but at any rate for the benefit of others liable to the costs and burdens of caring for them.

The unbalanced primacy of autonomy is thus tightly connected with the notion of *substituted judgement*. In turn, the widespread appeal to the 'standard' of substituted judgement, in preference to the alternative standard of the patient's best interests, sets all concerned on a royal road towards decisions to bring about the death of incompetent persons on the plea that if they were reasonable they would choose to seek death, if not by 'active' then by 'passive euthanasia'.

What is characteristically missing in much modern discussion of autonomy and self-determination is any strong sense that the most fundamental expression of respect for the dignity of human beings is not respect for autonomy but respect for the good of human beings. When persons have *exercisable capacities* for self-determination then respect for their self-determination is integral to respect for their good as persons: for it is in and through choice that they have the possibility of shaping their characters for good (or ill). But when persons do not yet, or no longer, possess presently exercisable capacities for self-determination, self-determination cannot be an essential ingredient, so to speak, in what one respects in respecting their good. Any exercise of self-determination which seeks to determine what should (or should not) happen to one, if and when one comes to be incompetent, should be respected only to the extent that doing so in

⁴¹ Writers who place a one-sided emphasis on autonomy in defending the claim that all advance directives should be respected will standardly admit, as does Dworkin, that even the (real) autonomy of the competent is often rightly overridden (see *Life's Dominion* pp. 192-3, 229-30). Dworkin, however, makes little or no effort to articulate a coherent account of when 'paternalism' is justified and when unjustified.

consistent with respecting the good of the now incompetent patient.

4.1.2 Advance declarations and the burdensomeness of treatment

It is certainly consistent with respecting the good of an incompetent patient to take account of the likely burdensome consequences of a course of treatment when considering it. [See 2.2.3(ii)] Now, whether certain consequences will amount to an undue burden of, say, pain or psychological stress for a patient will often depend upon the individual dispositions and circumstances of that patient. So there certainly is a role for advance *declarations* (rather than *directives*) in which a person, while competent, offers written advice on the sorts of consequence of treatment which he anticipates he would find oppressively hard to bear. That advice should then be taken carefully into account when doctors and others are deciding whether or not to proceed with a particular course of treatment which is likely to have significantly burdensome consequences.

However, the evidence supplied by the kind of advance declaration envisaged here could never be the sole determinant of the treatment decisions made. For in deciding treatment for the incompetent one would always have to make a judgement about whether it would be in the interests of the patient to bear with certain significant burdens in order to secure the benefits which treatment offered - benefits one could envisage the patient appreciating.

4.1.3 Advance directives and the refusal of ordinary care

Some patients who make advance directives, stipulating withdrawal of tube-feeding in certain conditions, do so

for suicidal reasons, believing that life in the anticipated conditions would not be worthwhile and choosing (prospectively) the withdrawal of tube-feeding precisely as a means of terminating their life. When it is plain to a doctor that the intentions of a patient who has made such a directive are of this sort, the doctor should certainly not put the directive into effect, for to do so would be to aid in the carrying out of a suicidal intention. However, it should also be recognised that an advance directive stipulating that in certain circumstances one would not want the continued provision of significantly expensive care, including tube-feeding, need not be suicidal. Persons making such directives may have in mind that even tube-feeding and nursing care, while not burdensome to them, could prove financially very burdensome to others. They might truly wish that the resources be used to meet other needs. This reason for rejecting such care is, then, not a false valuation of what their life might be at some future time. Rather it is a desire not to take up resources which they think disproportionate, to the detriment of others. That desire shows a sensitivity to the needs of others, and one would not be acting in a way contrary to a person's dignity if one honoured a directive which was prompted by what is generally agreed to be an admirable desire and involved an acceptance of death rather than the choice of death as a means or an end.⁴²

⁴² It should be noted that withholding tube-feeding in the circumstances envisaged in this paragraph is consistent not only with respect for human dignity but also with human solidarity with the deprived and the vulnerable. That is so because the reason for withholding tube-feeding is *the patient's own choice that this be an expression of solidarity* - of respect for the needs of others. But withholding tube-feeding can have this character only when the choice of the person who *suffers*

Many patients (perhaps a majority) who stipulate that in certain circumstances they should not receive tube-feeding will do so in terms which leave it unclear whether their intentions are suicidal or not. It seems to us that someone who has made an advance directive seeking to limit not care (or expensive care) in general but quite specifically the provision of nourishment probably has in mind that doctors should aim to bring about his death by means of this omission. And sometimes doctors will have reliable evidence from other sources that a patient's intentions were suicidal. In either kind of case, doctors should not withdraw or withhold tube-feeding. If the law as declared by the House of Lords in *Bland* is inconsistent with this, and imposes a legal duty to withhold tube-feeding in every case where consent has been withdrawn, the law should be amended by Parliament so as to restore its coherence with the principles of the Suicide Act 1961 concerning complicity in suicide (see further 6.2.2 below).

Sometimes a patient's intention in stipulating discontinuance of care, including tube-feeding, is left unclear not only by the advance directive but also by other available evidence. When that is the case, it seems to us not unreasonable for a doctor to assume

deprivation of tube-feeding gives it this character; what is involved is essentially an act of self-sacrifice. And that is the reason why withholding tube-feeding from those who have never made such a choice cannot be turned into an expression of human solidarity by the device of substituted judgement; we cannot make acts of self-sacrifice on behalf of others, and the pretension that we are doing so merely masks the reality that we are engaged in sacrificing them. In the absence of a prior choice of self-sacrifice on the part of a patient while competent, withdrawal of tube-feeding from that patient when incompetent must normally be accounted an offence against the requirements of human solidarity.

that what motivated the stipulation was a desire that others should cease to undertake the burdens and costs of burdensome and costly care, accepting death as an effect of such discontinuance but not choosing it as a means to relieving them of costs and burdens. Making that assumption, the doctor can reasonably respect the patient's declared wishes, treating the patient like the patient whose motives are known to be those of self-sacrifice and whose choice is known not to have been suicidal in intent.⁴³

4.1.4 Advance directives and the doctor-patient relationship

There is so much scope for doubt and conflict about whether the wording of an anticipatory decision is 'applicable in the circumstances' that it would be extremely imprudent to make advance directives enforceable by legislation. The proposal that doubt and conflict, where they arise, may be resolved by referring cases to a judicial forum⁴⁴ promises to introduce a degree of complexity to the decision-making process which will frequently be at odds with securing the interests of patients.

It would better accord with those interests and with sound doctor-patient relations if doctors were educated in a clear sense of those choices which are

⁴³ Some may think a benign interpretation of a patient's intentions when those intentions are opaque is not warranted. But the fact that there is a widespread tendency in our society to view the lives of many incompetent patients as without value should not be allowed to obscure the fact that many people have *independent* reasons for desiring to relieve others of burdens.

⁴⁴ The Law Commission, Consultation Paper No.129: *Mentally Incapacitated Adults and Decision Making. Medical Treatment and Research* London: HMSO, 1993, pp.41-42 (3.27-3.29).

inconsistent with recognition of the dignity of patients, together with a clear sense of their obligations to try to secure medical benefits for their patients while remaining sensitive to the burdensome costs which sometimes make a treatment option undesirable.

4.2 *The Proxy Decision Maker*

The spurious conception of the role of the proxy decision-maker as consisting in the exercise of the incompetent patient's right to self-determination was noted in section 4.1.1.

In considering the burdensome consequences of treatment, the proxy decision-maker does have a duty to consider available knowledge about the distinctive sensibility and circumstances of the patient whose interests he represents (2.2.3/ii; 4.1.2). What is involved in doing so is something of an exercise in trying to see through the patient's own eyes. But this limited exercise of imaginative identification with the patient is justified by the unavoidably subjective element in what is to count as unduly burdensome for a given patient. An exclusive invocation of the 'claims of autonomy', however, affords no general justification for giving or withholding treatment on the basis of substituted judgement (4.1.1/d).

A substitute decision-maker who represents the interests of a patient will be concerned to act as a friend intent at least on securing justice for the patient. Friends desire the good of the person whose friends they are. What is just to a patient and what is good for a patient can in fundamental respects be determined objectively. The traditional framework for making that determination is the framework

outlined and defended in this Submission.

Part 2

5. The Courts and 'Responsible Medical Opinion'

The responsibility for ensuring that every person within the jurisdiction is treated with fundamental justice belongs in a unique way (though not exclusively) to the courts. It is the courts that, on their own initiative, developed and upheld *habeas corpus* to prevent the injustice of false imprisonment. It is the courts that have defined and enforced the law against homicide, which underwrites justice's primary demand that one person must never impose on another innocent person the radical injustice of extinction. Even today the activities of the legislature have in no way superseded the role of the courts in identifying and upholding the demands of right.

The decision of the House of Lords in *Bland* involves an abdication of the courts' responsibility. This abdication is illustrated most vividly, but not unrepresentatively, in the following passage from the judgement of the senior Law Lord, Lord Keith of Kinkel:

'...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 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 WLR 582.

'Given that existence in the persistent vegetative state is not a benefit to the patient, it remains to consider whether the principle of sanctity of life, which it is the concern of the state, and the judiciary as one of the arms of the state, to maintain, requires this House to hold that the judgement of the Court of Appeal was incorrect.'

[1993] 2 WLR at 362 (emphasis added)

The significance of this judicial surrender of a vital premise (about the value of human existence) to the opinion of part of the medical profession is masked, in *Bland* itself, by the fact that the judges there seem likely to have reached the same decision even if they had not embraced the '*Bolam* principle' of deference to 'a body of responsible medical opinion'. But that principle of deference is unsound, as is stated plainly by Hoffmann L. J.⁴⁵ and noncommittally by Lord Mustill.⁴⁶

⁴⁵ [1993] 2 WLR 316 at 358-9: '... the medical profession can tell the court about the patient's condition and prognosis and about the probable consequences of giving or not giving certain kinds of treatment or care, including the provision of artificial feeding. But whether in those circumstances it would be lawful to provide or withhold the treatment or care is a matter for the law, and must be decided with regard to the general moral considerations of which I have spoken. As to these matters, the medical profession will no doubt have views which are entitled to great respect, but I would expect medical ethics to be formed by the law rather than the reverse. ... the plaintiff hospital trust ... has invited the court to decide whether, on medical facts which are not in dispute, the termination of life-support would be justified as being in the best interests of the patient. This is a purely legal (or moral) decision which does not require any medical expertise and is therefore appropriately made by the court.' This is a sound statement of principle. Hoffmann L. J. also, however, made an unexplained and highly questionable concession that 'the fact that the doctor has

Even in the area of medical negligence, there is reason to doubt the soundness of a legal rule that a doctor is not negligent if he acts in accordance with a practice accepted at the time as proper by a responsible body of medical opinion (even though other doctors adopt a different practice). That rule was disapproved by Lord Scarman, dissenting in *Sidaway v Governors of Bethlem Hospital* [1985] A. C. 871 at 876, where the issue was not one of competence in diagnostic or therapeutic procedures but involved the patient's right to be informed. In a case involving similar facts, the High Court of Australia has now unanimously disapproved the entire *Bolam* principle of determining the standard of medical care by deference to the standards of 'a responsible body of medical opinion': *Rogers v. Whitaker* (1992) 67 A. L. J. R. 47 at 50-51, a decision reached, ironically, on the same day as the President of the Family Division gave judgement in *Bland*. Where a medical decision involves a right even more fundamental than the patient's right to be informed, the right not to be intentionally killed, it cannot be appropriate for the courts to proceed on the basis that a death-dealing course of conduct (deliberate omissions) is lawful simply because a responsible and informed body of medical opinion judges that life is no benefit to this

acted in accordance with responsible medical opinion would usually be determinative' if the question related to 'some *past* act on the part of the doctor' and 'whether such an act had given rise to civil or criminal liability' (emphases added). As Lord Mustill implicitly indicates at p.391 H, there was no basis in the context of *Bland* for this distinction between a declaration of law in relation to prospective conduct and an application of the very same law to the same facts when they lie not in the future but in the past.

⁴⁶ [1993] 2 WLR 316 at 399.

patient, and/or that death and/or a course of conduct intended to terminate life is in this patient's best interests, and/or that tube-feeding is a medical treatment or form of 'medical care' and *therefore* may be terminated like any other medical treatment (as if it were not also an ordinary form of non-medical care). Each of these judgements is one which, though relating to the art of medicine, goes clearly beyond the expertise intrinsic and proper to that art. Each assumes a stance on the nature and meaning of human existence, the demands of justice, and/or the proper forms and limits of relationships between dependent people and those upon whom they depend.

6. Proposals to Change the Law

6.1 *Proposals which should not be adopted*

6.1.1 Medical Treatment (Advance Directives) Bill [H. L. Bill 73, 1993]

The wording of this Bill confirms what one would expect from a bill promoted by the Voluntary Euthanasia Society.

First, it must be observed that the form of advance directive scheduled to the Bill is purely optional (clause 1(3)) and cannot restrict the import of the Bill's own provisions for giving effect to advance directives of many kinds.

Secondly, it is clear from clause 9 of the Bill that it seeks to authorise conduct on the part of doctors intended to bring about the death of patients, the permissible conduct being limited to what is termed 'permitting the process of dying to take its course'.

Thirdly, vagueness about the definition of 'terminal condition' (clause 10) and, therefore, about 'the process of dying',

means that the advanced directives which the Bill would authorise and make binding on doctors would be effective in regard to a far wider range of patients than those in the terminal phase of dying. Indeed they would be effective in regard to patients who are not, in the normal sense of the term, dying. For 'terminal condition' is defined as 'an incurable or irreversible condition which, without the use of life-sustaining treatment, will ... soon result in death.' Diabetes, for example, seems to fall within the scope of this definition of a terminal condition: it is an incurable condition, for which insulin treatment is life-sustaining and without the insulin certain patients with diabetes will soon die.

Fourthly, 'life sustaining treatment' is defined (clause 10) to mean 'any medical procedure or intervention which, when administered to a qualified patient, has the effect only of prolonging the process of dying'. Because of the definition of 'terminal condition', the notion of prolonging the process of dying is made indistinguishable from the notion of 'delaying the moment of death'. (The word 'only' in the phrase 'effect only of prolonging' is so vague and elusive that it cannot provide any effective control on the meaning of the clause.) Since treatment for any life-threatening condition delays the moment of death (perhaps for decades!), a substitute (or proxy) decision-maker may, under clause 4(1) withhold *any* life-sustaining treatment, whatever its prospective benefits, providing only that the patient who appointed him is 'comatose, incompetent or otherwise mentally or physically incapable of communication'. This is a charter for the extensive practice of non-voluntary euthanasia.

Fifthly, the provision in clause 5(2) is designed to exempt doctors from prosecution for aiding and abetting suicide in circumstances in which the natural interpretation of their behaviour would be that they were doing precisely that. For it is certain that sometimes a patient aims to bring about his own death at some time in the future by a course of planned omissions to be carried out by others on his authority, and makes it clear that that is his intention; the implementation of such a course of planned omissions on the basis of that prior authorisation and in the knowledge of that intention is, morally speaking, aiding and abetting suicide.

Sixthly, clause 4(2), read in conjunction with direction 2 in the Schedule to the Bill, makes it clear both that provision of food and fluids may be classified as 'life-sustaining treatment' in relation to a broad range of conditions, and that withdrawing food and fluid is sanctioned *whatever* the intention of the patient may have been, or the intention of a substitute decision-maker is, in authorising such withdrawal.

We respectfully urge the Select Committee to recommend that the *Medical Treatment (Advance Directives) Bill* be rejected since it would very clearly legalise (and is no doubt intended to legalise) assisted suicide and non-voluntary euthanasia.

6.1.2 Termination of Medical Treatment Bill [H.L. Bill 70, 1993]

The Bill is simply a charter for non-voluntary euthanasia (clause 2) of the incompetent (clause 1a) and assisted suicide (clause 3) of the competent (clause 1b) by the withdrawal of medical treatment or food and fluids. Its brevity has the merit of making its

purpose eminently transparent. There is no need for legislation to cover the withdrawal of treatment on the grounds that it is medically otiose or unduly burdensome in its consequences.

We respectfully urge the Select Committee to recommend that any such Bill be rejected.

6.1.3 Legalising Euthanasia: General Observations

There are a number of general objections to all proposals for legalising euthanasia:

(1) Precisely in so far as euthanasia is considered *beneficent* to patients it involves killing on the basis of judgements about the value of their lives which are inconsistent with recognition of the dignity of the patients (1.2.2). Since recognition of the dignity of every human being is fundamental to justice, *and, therefore, to the law regulating our conduct towards each other* (1.1.4), it would be incompatible with what is basic to the law to allow euthanasiast killing.

(2) Killing the fundamental justification of which is that the patient would be better off dead (because of the disvalue of his continued existence) comprehends non-voluntary euthanasia. As clear-headed advocates of euthanasia recognise, if euthanasia is at all justified, there can be no good reason for denying the 'benefit' of killing to a patient because he is incapable of consent.⁴⁷ The evidence from the Netherlands is that doctors are *aiming* to bring about deaths in

⁴⁷ In relation to the withholding of treatment, Butler-Sloss LJ and Lord Goff both indicate that what is available as a benefit to the competent with their consent must be made available to the incompetent who cannot consent: *Bland* [1993] 2 WLR at 3470, 368D.

cases of incompetent patients much more frequently than in the case of competent patients (see Section 8 and references there).

(3) Propaganda for the legalisation of euthanasia in the past heavily emphasised its desirability to deal with intractable terminal pain. But developments in pain control associated with the Hospice Movement have provided a solution, at least in principle, to the large majority of cases of intolerable pain. In consequence, the case for legalising euthanasia has significantly shifted from drawing attention to intractable pain to emphasising 'intractable suffering'. But 'intractable suffering' is a very capacious reason for killing people, one possible effect of invoking which (see Section 7) is to encourage the cruellest pressures on those who are dependent.

(4) In so far as the legalisation of euthanasia made doctors the authorised agents of euthanasiast killing, such legislation would profoundly corrupt the practice of medicine by corrupting the character of doctors.

Quite generally, intentional acts (such as deliberate killing) do not merely bring about effects external to the agent, they also shape his dispositions. If a doctor kills a patient because he judges the patient no longer has a worthwhile life then in doing so he makes himself further disposed to kill patients for that reason (unless he repents of what he did). That is why a certain kind of argument for the legalisation of voluntary euthanasia is radically mistaken about what is at issue. The argument goes roughly as follows: a society should seek to prohibit only those practices which do harm to those who do not consent to the practices. But in voluntary

euthanasia no party who has not consented to the practice is harmed. It is a purely private transaction between consenting doctor and consenting patient, the effects of which are contained within the confines of that relationship.

One reason that picture is false is that a doctor's character is very significantly shaped by killing patients on the grounds that their lives are now without value. A doctor disposed to think that some of his patients may lack inherent worth, and that he may therefore be justified in killing them, has seriously undermined in himself a disposition indispensable to the practice of medicine: the willingness to give what is owing to patients just in virtue of their possession of basic human dignity. The absence of that willingness is likely to be fateful for other patients, including patients who never consented to be killed or to be denied what they are owed in virtue of their basic human dignity.

For the sake of all its citizens, who all at one time or another are likely to become patients, civil society has a basic interest in maintaining a legal framework for the practice of medicine which is conducive to respect on the part of doctors for the basic dignity of all their patients.

(5) Once legalised, euthanasia would become a quick and facile technical 'fix' to dispose of certain difficult patients (whether or not at their own request) in response to the heavy demands they made on care. Medicine would thereby be robbed of the incentive to find genuinely compassionate solutions to the difficulties presented by such patients. The kind of humane impulses which have sustained the development of hospice medicine and care would be

undermined, because too many would think euthanasia a cheaper and less personally demanding solution. It is widely recognised that the country in which the practice of euthanasia has become widespread is a country in which palliative care medicine is very inadequately developed.

Those who protest that they advocate no more than the legalisation of *voluntary* euthanasia are at best naive, though more often, it is to be feared, disingenuous. It is characteristic of certain advocates of legal reform to speak as if they could remain in control of the reform they propose once it is on the statute book. That is an illusion, as legalisation of abortion has shown. What legalisation of voluntary euthanasia would enshrine is the novel principle that one may be justified in killing people because, since they lack worthwhile lives, to do so is to benefit them. In enshrining such a principle in our laws we would have to contend with what Justice Cardozo described as 'the tendency of a principle to expand itself to the limit of its logic'.⁴⁸

6.2 Proposals which should be adopted

6.2.1 The Bland ruling on lawful intention to terminate life should be overturned

By far the most serious of the immediate legal implications of the *Bland* case is, we think, the ruling by a majority of the House of Lords (neither followed nor challenged by Lords Keith and Goff) that, provided it is not 'positive action' and is adopted because, in accordance with a body of responsible medical opinion, it is considered to be in the best interests of

the person whose life it terminates, it is *lawful* (and indeed may be legally required) to adopt a 'course of conduct' deliberately and precisely *with the intention, aim and purpose of terminating life*.

The basis on which Lords Lowry, Browne-Wilkinson and Mustill assumed such an intention in relation to Anthony Bland is legally obscure.⁴⁹ Be that as it may, there certainly are circumstances in which someone might decide to cease providing life support yet have no intention to terminate the life of the patient (though foreseeing and accepting that the death of the patient would be highly probable or even certain to follow in consequence of the cessation). For there can be circumstances in which those providing the support should or at least can give a higher priority to other responsibilities (e.g. to patients who can benefit more from the limited resources available).

But the tail must not be allowed to wag the dog. The fundamental and momentous issue whether intentional killing is to be allowed, ratified and indeed commanded in our society must not be determined by the topsy turvey process of first deciding against continued life support in hard cases such as *Bland*, then deciding that that solution involves an intent to terminate life, and accordingly abandoning the hitherto central principle of our common morality and our law: *no intentional killing of the innocent*.

We do not dispute the finding of all the judges in *Bland* that what was involved was legally an 'omission'. Nor do we question the general stance of English law that omissions are unlawful only if

⁴⁸ Quoted in Yale Kamisar, 'Some Non-Religious views against "Mercy-Killing" Legislation', *Minnesota Law Review* 42 (1958), 969-1042, at 1037.

⁴⁹ J M Finnis, 'Bland: Crossing the Rubicon?' in *Law Quarterly Review* 109 (1993), 329-37.

they involve the violation of a duty of care. We do not question even the more stringent position of English law, that X's omission (e.g. to warn Y of imminent danger) deliberately chosen with malicious intent to harm Y (e.g. so as to enjoy Y's suffering or death) is not unlawful if, independently of the intent, X owed no duty to protect Y from such harm or death. But the ruling of the majority in the House of Lords in *Bland* goes far beyond these positions. For it treats as lawful the omissions of persons who admittedly had a duty to care for Anthony Bland, and who were ready and willing to continue an extensive medical, nursing and general care for him right up to the moment of his death. It treats as lawful (and sometimes, indeed, compulsory) the proposal that terminating someone's life, i.e. the bringing about of his death (by deliberate omissions), be a part of carrying out their duty of care.

The judges in question all admit that the distinction they draw is morally indefensible and leaves the law 'misshapen' or 'almost irrational'.⁵⁰ They were right to do so. The law will indeed be misshapen and indefensible for so long as it treats as criminal a harmful 'act' while treating as lawful (and indeed compulsory) an 'omission', with the *very same intent, by one who has a duty to care for the person whose life is thereby terminated*. There is nothing misshapen about a law treating acts and omissions alike when deliberately adopted with the same

intention. And the settled legal (not moral) doctrine that harmful intent by itself does not make an omission criminal should not govern when the omission is by one who admittedly has a legal duty to protect the party harmed against that type of harm.

Neither in the judgements in *Bland* nor in any other legal source can we discover any reason for thinking that English law has ever, until 4 February 1993, accepted that someone who has a duty of care can carry it out by intending to terminate the life of the person in his care. We think that English law has in fact always rejected any such notion. We are surprised to note that the decided cases⁵¹ in which English law manifested its rejection of this notion were not even cited to the judge of first instance in *Bland*, went completely unmentioned in the oral argument and the judgements in the Court of Appeal, and received mention in only two of the judgements in the House of Lords. We accept that those previous cases did not concern doctors and did not have to confront the arguments raised in favour of terminating Anthony Bland's life. But we think that the rule articulated in those cases sets out a legal position of principle which could and should have been reaffirmed and developed by the judges in response to those arguments. The fundamental argument, which in fact the judges accepted, was that the doctors *et al.* owed no duty to Bland to keep him alive. The fundamental answer to that argument, an answer which the judges seem never to have clearly envisaged, is that *whatever the scope of the duty of care of those caring for Anthony Bland, they had a moral and legal duty not to exercise*

⁵⁰ Lord Mustill, at [1993] 2 WLR pp.388-9: 'the distortions of a legal structure which is already both morally and intellectually misshapen'; 'the morally and intellectually dubious distinction between acts and omissions' (p.399); Lord Browne-Wilkinson at p.387: the conclusion I have reached will appear to some to be almost irrational. . . . I find it difficult to find a moral answer . . .'; Lord Lowry at p.379: ' . . . a distinction without a difference...'

⁵¹ *R. v. Bubb* (1850) 4 Cox C.C. and *R. v. Gibbins and Proctor* (1918) 13 Cr. App. R. 134.

their care for him with intent to terminate his life.

In any event, it is now most urgently necessary, we suggest, to restore the integrity of the English law of homicide by rejecting the misshapen, almost irrational and wholly unnecessary rule or position adopted by the majority of the Lords in *Bland*. The necessary statute would not solve the problem of deciding whether and when life support can be withdrawn from incompetent patients. But it would restore one vital parameter or principle for any acceptable solution to that problem.

We respectfully ask the Select Committee to recommend the early enactment of a Bill along the following lines:

No person may in or in connection with providing to another person medical, nursing or other treatment, services or care do or omit anything with the intention⁵² of terminating that other person's life. A person who by any such act or omission with such intention causes the other's death shall be guilty of murder.

A provision of this kind would not purport to settle the debate about whether withdrawal of life support from PVS patients causes their death.

⁵² The concept of intention is central to the existing law of murder. A series of recent judicial decisions of the highest authority establish (in conformity with a sound philosophical understanding of intention) that there can be murder only if there is intention to kill (or cause grievous bodily harm); that there can be intention to kill without 'desire' to kill; and that one who foresees that his act will probably or even certainly cause death may, but need not, have the intention of killing. With these clarifications, the concept is to be left to the good sense of juries. See Lord Goff of Chieveley, 'The Mental Element in the Crime of Murder' (1988) 104 *Law Quarterly Review* 30.

It would not purport to settle the debate about the extent of the duty to maintain such support. It would simply restore the integrity of the fundamental principle of the law of murder, gravely impaired by the decision in *Bland*. That principle of the law of murder is an indispensable element in the recognition and protection of the basic rights of all members of our community, and an integral part of the state's fundamental duty of justice.

6.2.2 Unacceptable kinds of advance directive should be deprived of all legal effect

A majority at least of the House of Lords in *Bland* went out of their way to give a blanket and indeed indiscriminate approval to the idea that advance directives to discontinue treatment or care are of binding legal effect: see Lord Goff (Lords Keith and Lowry agreeing), [1993] 2 WLR at 367H. Quite mystifyingly, Lord Goff stated, in this connection, that 'in cases of this kind, there is no question of the patient having committed suicide ...' (p.367H). Unless he meant this, despite the syntax, to be a qualification on his ratification of advance directives, one must ask: Why is there 'no question' of suicide? Can it really be by sheer judicial fiat or stipulative definition? Suppose everyone knows that the patient's directive that on a certain date insulin (or food and water) be withdrawn was motivated simply by his intention of dying before the expiry of a term life insurance policy. On what legal principle is this not suicide? What should be Parliament's response to this remarkable and evidently unsolicited judicial development of the law? We think it should be to legislate at an early date so as to provide that where a patient is incompetent to give or withhold consent to medical treatment or care, the existence of a

declaration made by that patient at some earlier time purporting to give directions for the withdrawal of treatment or care (or of any specified form of treatment or care) shall not be taken to require those responsible for his treatment or care to follow any course of conduct (including omission) otherwise than in accordance with their judgement as to the best interests of the patient, and shall not be taken to require or authorise any person to give any assistance in suicide (including suicide by omission).

7. The Hospice Movement and Advances in Palliative Care

For many ordinary people the pain associated with terminal conditions still appears the most pressing reason for allowing euthanasia in certain types of case (witness expressions of sympathy for Dr. Cox). Those actively engaged in hospice care have documented its role in controlling the pain which is associated with a number of fatal conditions, and certain carcinomas in particular. In this connection, the very success of the development of palliative medicine within the context of hospice care has had a paradoxical effect. It is this paradoxical effect that is worth remarking on here.

In so far as satisfactory control of pain is achievable with the vast majority of patients⁵³, the common case for euthanasia would seem to have lost its force. Investment in extending the benefits of palliative care would seem a far more rational response to the incidence of severe pain than legalisation of euthanasia. And in so far as people come to know of the successes of contemporary palliative

⁵³ A repeated figure for satisfactory pain control is in 97% of cases in the hospice setting and in 90% of cases in domiciliary care.

care they generally acknowledge this truth.

The response of proponents of the legalisation of euthanasia, however, has been to shift from emphasising the problem of intractable pain to emphasising the problem of 'intractable suffering'. Intractable suffering, as we have already remarked, is a much more wide-ranging reason for killing patients, and covers experience that is not amenable to medical management in the way that pain has been.

It is worth remarking here on just how elastic the concept of 'intractable suffering' can be in rationalising the practice of euthanasia. An instructive case in point (referred to again in the following section) is provided by recent research on the practice of euthanasia in The Netherlands. One informant, a leading practitioner of euthanasia, said he would be put in a very difficult position if a patient told him that he really felt a nuisance to his relatives because they wanted to enjoy his estate. Asked whether he would rule out euthanasia in such a case, [he] replied: 'I think in the end I wouldn't, because that kind of influence - these children wanting the money now - is the same kind of power from the past that.., shaped us all. The same thing goes for religion ... education ... the kind of family he was raised in, all kinds of influences from the past that we can't put aside.'⁵⁴ If the misery provoked by the knowledge that one's children want one's estate is to count as a reason for euthanasia, then there will be an open invitation to children to make the lives of their dependent

⁵⁴ J Keown, 'Some reflections on euthanasia in The Netherlands' in Luke Gormally (ed) *The Dependent Elderly. Autonomy, Justice and Quality of Care* Cambridge: Cambridge University Press 1992, 70100, at 79. See Chapter 4 below, p.203.

parents such a misery that the 'burdensome' parents will be queuing up for euthanasia. If this were to happen then euthanasia by request would have become a facade covering a reality much closer to involuntary euthanasia.

In summary: one paradoxical consequence of the hospice movement's success in managing pain and making it seem a less pressing reason for euthanasia is that apologists for euthanasia's legalization have shifted to emphasising intractable suffering. And intractable suffering as a reason for euthanasia nominates a far wider range of candidates for euthanasia (voluntary and nonvoluntary) than intractable pain ever did.

8. The Dutch Experience⁵⁵

8.1 The Law

The intentional killing of a person at his 'express and serious' request is an offence contrary to Article 293 of the Dutch Penal Code, and assisting suicide is prohibited by the following Article. However, in a line of cases over the past twenty years, Dutch courts have held that a doctor charged with either offence can successfully avail himself of the defence of necessity (contained in Article 40) if he acted in accordance with 'responsible medical opinion' measured by the 'prevailing standards of medical ethics'.⁵⁶

When, according to 'responsible medical opinion', is it considered proper for a doctor to carry out euthanasia?

⁵⁵ This section draws on I J Keown, 'The Law and Practice of Euthanasia in The Netherlands' *Law Quarterly Review* 108 (1992), pp.51-78.

⁵⁶ *Ibid.*, 5155.

8.2 Medical Guidelines

In 1984 the Royal Dutch Medical Association published a report setting out conditions in which 'euthanasia' (a word which is used in Holland to mean 'voluntary euthanasia') accorded with medical ethics. It specified five:

1. The request must be made of the patient's free will, and not result from pressure by others.
2. The request must be 'well-considered', and not be based on a misunderstanding of diagnosis or prognosis.
3. The request must be 'durable', and not arise from impulse or temporary depression.
4. The patient must be experiencing 'unacceptable suffering'; he must feel the suffering to be 'persistent, unbearable and hopeless'.
5. The doctor must consult with a colleague before performing euthanasia, and report it to the legal authorities afterwards as a non-natural death.⁵⁷

A number of highly misleading claims have been made by proponents of legalised euthanasia about the Dutch experience. It has, for example, been asserted (by the Director of the Dutch Health Council) that the guidelines are 'precisely defined' and 'strict'.

First, it is not even possible to be confident about what the guidelines are: the above five have been laid down by the Dutch Medical Association, not the courts. As Professor Leenen, a leading Dutch health lawyer (and supporter of euthanasia) has observed, different courts have listed different criteria, which has created 'much uncertainty'. It has been held by the Supreme Court,

⁵⁷ *Ibid.*, 5760.

for example, that consultation is not essential for euthanasia to be lawful.

Secondly, even the five listed above are far from precise. What, for example, is meant by a 'free' request? Does it include a request made in response to a strong recommendation by a doctor or relatives? One of Holland's leading (and widely respected) practitioners of euthanasia was asked whether he would rule out euthanasia in the (hypothetical) case of a patient who asked for euthanasia because he felt a nuisance to his children who wanted him dead so that they could enjoy his estate. The doctor replied:

*'I ... think in the end I wouldn't, because that kind of influence - these children wanting the money now - is the same kind of power from the past that ... shaped us all.'*⁵⁸

This illustrates how subjective, elastic and inherently vague are the guidelines requiring a 'free' request and 'unbearable suffering'.

Thirdly, far from being 'strict', the guidelines could hardly be more lax. They assume rather than ensure the expertise and good faith of the individual doctor and are quite unenforceable.⁵⁹

8.3 Euthanasia in Practice

It comes as no surprise, therefore, that there is disturbing evidence not only of a high incidence of euthanasia in Holland but also of widespread breach of the guidelines.

In 1991 a Government Commission on Euthanasia, chaired by Attorney-

General Remmelink, published its report⁶⁰ and the results of a survey it had commissioned into the practice of euthanasia.⁶¹

The Survey shows that for the calendar year 1990, there were 2,300 cases of (voluntary) euthanasia and 400 cases of assisted suicide.⁶² There were, moreover, over 8,000 cases in which doctors administered morphine⁶³, and almost 8,000 cases in which they withheld or withdrew treatment⁶⁴ 'explicitly' or 'partly' *with intent to shorten life*.⁶⁵ Finally, the Survey

⁶⁰ *Medische beslissingen rond het levenseinde. Rapport van de Commissie onderzoek medische praktijk inzake euthanasie.* (S-Gravenhage: Sdu Uitgeverij Plantijnstraat, 1991).

⁶¹ *Medische beslissingen rond het levenseinde. Het onderzoek voor de commissie onderzoek medische praktijk inzake euthanasie.* (S-Gravenhage: Sdu Uitgeverij Plantijnstraat, 1991). An English translation has been published as P J van der Maas *et al.*, *Euthanasia and other Medical Decisions at the End of Life* (Elsevier 1992); also published in *Health Policy* 22/1-2 (1992). (Hereafter, 'Survey')

⁶² Survey, 178179.

⁶³ *Ibid.*, 183. See generally chapter 7.

⁶⁴ *Ibid.*, 184. See generally chapter 8.

⁶⁵ It should be noted that these cases are explicitly distinguished in the Report from cases in which morphine is administered or treatment withheld for reasons other than that of bringing about death while *foreseeing* that death may result from the decision. The latter kind of case does fall within the bounds of acceptable medical practice. But it is misleading of VES representatives to suggest that the 16,000 cases in which, in the terms of the Survey (see footnote 9 above), there was some 'intention' to shorten life (by administering opiates or withdrawing treatment) also fall within the bounds of acceptable medical practice. It is true that about 11,000 of these cases are described by the Survey as falling within the class of choices carried out 'partly with the intention to shorten life'. It seems not unlikely that that is an accurate description of a majority of those cases, though it should be recognised that the researchers made use of that description to cover certain cases for which it is inapplicable;

⁵⁸ *Ibid.*, 63.

⁵⁹ See Carlos F Gomez MD, *Regulating Death: Euthanasia and the Case of The Netherlands* New York: Free Press 1991, p.122.

revealed over 1,000 cases in which doctors stated that they had terminated life without the explicit request of the patient.⁶⁶ In short, the Survey, *in its own terms*, makes out that doctors admitted that it was their purpose to shorten their patients' lives in almost 20,000 cases.

Bearing in mind that there were only 49,000 deaths in 1990 in which a doctor's decision influenced the time of a patient's death⁶⁷ the finding that in over 40% the doctor purposely sought to shorten the patient's life suggests that intentional killing has become a regular feature of Dutch medical practice.

Moreover, in almost three-quarters of these cases the doctor is reported as having sought to hasten death without the explicit request of the patient.⁶⁸ The 1,000 cases in which doctors administered a lethal drug without explicit request provide particularly stark evidence of the widespread breach of the first three guidelines.

The fourth guideline, requiring that euthanasia be performed only when it is necessary, as a last resort, to end 'unbearable suffering', is also, as the remarkably high incidence itself indicates, widely ignored. Even 40% of the doctors surveyed agreed with the proposition that 'Adequate alleviation of pain and/or symptoms and personal care of the dying patient make euthanasia unnecessary'.⁶⁹ The inference from all the evidence that

namely, cases in which the only ground (mistakenly invoked) for attributing intention is that the hastening of death (resulting from the clinician's course of conduct) is regarded as 'not unwelcome' by the clinician.

⁶⁶ *Ibid.*, 182. See generally chapter 6.

⁶⁷ *Ibid.*, 187.

⁶⁸ John Keown, 'On Regulating Death', *Hastings Centre Report* 22/2 (1992), pp.39, 42.

⁶⁹ Survey, p.102, Table 9.7.

euthanasia is being used as an alternative to good palliative care is compelling.

Finally, the Survey also showed that of the 2,700 cases classified by the Survey as 'euthanasia' and assisted suicide, doctors certified death by natural causes in over 7 out of 10, thereby breaching the fifth guideline and committing the criminal offence of falsifying a death certificate.⁷⁰

In addition to the Survey, two independent academic studies of Dutch euthanasia have also served to establish the comprehensive failure of the guidelines. The first by Dr. Carlos Gomez, an American physician⁷¹, concludes that the Dutch attempt to control euthanasia and to provide for public accountability has failed and that attempts to protect vulnerable patients have proved 'half-hearted and ineffective at best'. The second by Dr. John Keown, lecturer in law in the University of Cambridge, concludes not only that the guidelines have been widely ignored, but that killing even without request now enjoys official approval. The evidence for this is to be found in recent publications of the Dutch Medical Association which approve in certain circumstances the killing of handicapped neonates and patients in coma, and, most recently⁷², those with severe dementia. Moreover, not only did the Rummelink survey find that over half of the doctors interviewed had either performed euthanasia without an explicit request or would be prepared to do so⁷³ but the Rummelink Commission condoned the

⁷⁰ *Ibid.*, 49, Table 5. 14.

⁷¹ *Op.cit.*, p.161, n.7 above.

⁷² See 'Dutch doctors support life termination in dementia', *British Medical Journal* 306(1993), p.1364.

⁷³ Survey p.58, Table 6.1.

vast majority of the 1,000 killings without explicit request.⁷⁴

Two main conclusions can be drawn from the Dutch experience. First, it vividly demonstrates how, when euthanasia is tolerated, it becomes practically impossible to keep it within defined limits. There is now overwhelming evidence, which has nowhere been seriously controverted, that the guidelines have proved wholly incapable of ensuring that euthanasia is confined to those who make a 'free, well-considered and durable request' and who are experiencing 'unbearable suffering'. Indeed, even Professor Leenen has observed that there is an 'almost total lack of control on the administration of euthanasia' in his country.⁷⁵

Some twenty years ago, the then Lord Bishop of Durham, The Right Reverend J S Habgood, cautioned that the consequences of legislation to permit euthanasia would, in the long run, be 'incalculable', not least because of the likely failure of any safeguards to prevent abuse.⁷⁶ The Dutch experience confirms the prescience of this warning and reveals the baleful effects, even in the short term, of tolerating euthanasia.

Secondly, the Dutch experience lends support to the argument developed in 1.2.2 and 1.3.2 above that the case for euthanasia rests fundamentally not on respect for autonomy but on a judgement that certain lives are not worth living and that it is right to terminate them. The Dutch, who only a few years ago were seeking to justify

euthanasiast killing in terms of the claims of autonomy, now accept that the absence of the ability to choose provides no reason against killing. The 1,000 cases of killing without explicit request; the approval of these killings by the R Emmelink Commission, and the growing categories of incompetent patients whose lives the Dutch Medical Association now regards it as permissible to terminate, lend empirical support to the proposition that the case for euthanasia rests not on respect for autonomy but on the acceptance of the concept of 'lives not worth living'. The potential of that concept both for rationalising grave injustice to patients and for corrupting the practice of medicine was sufficiently demonstrated in mid-century in Western Europe. Only the deepest complacency, hard to distinguish from a measure of sheer decadence, could willingly tolerate again medicalized killing, rationalised in terms fundamentally incompatible with justice, or contemplate accepting the grave damage that would be done to medicine by its involvement in such killing.⁷⁷

Concluding Observations

In conclusion, we respectfully submit that the recommendations of the Select

⁷⁴ *Op.cit.*, p.161, n.8 above: p.15.

⁷⁵ Quoted in I J Keown, *op.cit.*, p.160, n.3 above: p.78.

⁷⁶ J S Habgood, 'Euthanasia - A Christian View', *Journal of the Royal Society of Health* 3(1974)124,126.

⁷⁷ It is frequently said by contemporary proponents of euthanasia that what they seek to have legalised bears no comparison with medical involvement in euthanasia under the Nazis. The reasons advanced for the contention are weak. Some say that what they want legalised is killing justified in terms of the claims of autonomy. But no such simple justification is available (see 1.3.2). Others say that what they want justified would have a different 'motive' from medical euthanasia under the Nazis. But it is a commonplace observation, in law as in morals, that ostensibly worthy motives cannot independently render acceptable chosen behaviour which in its *intentional* character is objectionable.

Committee should be governed by two broad considerations.

First, the legalisation of medicalized killing, which some want the Select Committee to recommend, would necessarily find its justification in terms which are radically incompatible with recognising the equality-in-dignity of all human beings. Such killing could not be accommodated within a legal framework which recognised the basic requirements of justice. There is an urgent need, indeed, in consequence of certain judicial decisions, to introduce legislation which will restore the integrity of the law in regard to homicide (see 6.2.1 and 6.2.2).

Secondly, the traditional ethic of medicine, correctly understood, leaves very great scope for patients to refuse treatment which is likely to be found unduly burdensome, and scope for doctors to withdraw treatment on those grounds. Moreover, doctors have no moral duty to persist with *medical* treatment which is inefficacious in achieving the distinctive goals of medicine. On the other hand, a failure to achieve the therapeutic or palliative goals of medicine does not absolve doctors from the duties of ordinary care of patients.

What is to count as sound medical practice in regard to withholding and withdrawing treatment could never be exhaustively settled by legislation. But the citizens of our society, all of whom are potentially patients, do need to know that in making such decisions doctors are constrained by a framework of law which makes *absolutely* impermissible both intentional killing (by action or omission) and deliberate assistance in suicide (by action or omission). Within such a framework doctors can continue to seek to act in patients' best interests

while being responsive to the reasonable desires of patients to avoid unduly burdensome treatment and respectful of the primacy of the competent patient's own responsibility for his or her health. To seek to make enforceable some wider conception of the claims of patient autonomy would be both unreasonable in itself and ultimately destructive of good doctor-patient relationships.

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