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INTRODUCTION

The Law and Ethics of Medicine seeks to clarify a fundamental legal principle, the "sanctity" or "inviolability" of human life, in the medical context. The book is aimed primarily at academic lawyers specializing in medical or health law and their students, though it should also be of use to legal practitioners who deal with medico-legal cases, and to judges who decide them. It is concerned mainly with the law in England and Wales but, as the inviolability of life is a foundational principle throughout the common law world (and beyond), lawyers in other jurisdictions may also find it of interest. The book may also appeal to legislators and policy makers, health care professionals, moral philosophers, and general readers interested in bioethical questions concerning the value of human life.

The book's focus is modest. It is not a textbook. It does not attempt a comprehensive analysis of the law concerning the inviolability of human life, even in the medical context. It deals only with selected medico-legal aspects of the principle. Still less does the book attempt a comprehensive moral-philosophical articulation and defense of the principle. There is already a rich and accessible literature which explores the principle and gives a thorough account of its application to vexed issues such as research on human embryos in vitro,[1] abortion,[2] and euthanasia.[3] Chapter 1 does, however, offer a basic outline of the principle and sketches the extent to which it has shaped aspects of the law in the medical context, particularly at the end of life. Some key concepts and distinctions are noted, which are revisited at various points in the book.

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[1] Eg RP George and C Tollefsen, *Embryo: A Defense of Human Life* (2nd edn, The Witherspoon Institute, 2011).

[2] Eg C Kazcor, *The Ethics of Abortion: Women's Rights, Human Life and the Question of Justice* (Routledge, 2010); P Lee, *Abortion and Unborn Human Life* (2nd edn, Catholic University of America Press, 2010); GG Grisez, *Abortion: The Myths, The Realities and the Arguments* (Corpus Books, 1970).

[3] Eg L Gormally (ed), *Euthanasia, Clinical Practice and the Law* (St Augustine Press, 1994); G Grisez and J Boyle, *Life and Death with Liberty and Justice* (University of Notre Dame Press, 1979): FJ Fitzpatrick, *Ethics in Nursing Practice* (The Linacre Centre, 1988). For a combined theological and philosophical discussion of the principle see A Fisher, *Catholic Bioethics for a New Millennium* (Cambridge University Press, 2011). For the case that the principle, outside the medical context, also prohibits the possession of nuclear weapons see J Finnis et al, *Nuclear Deterrence, Morality and Realism* (Clarendon Press, 1988).

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The central theme of the book is that, although the inviolability of life has long been a foundational principle of the law, it remains widely misunderstood by lawyers and judges and that, in no small measure as a result, the law has become, in several important respects, "morally and intellectually misshapen."[4] The book seeks to identify some of the main misunderstandings and thereby help restore the law's shape. For example, it points out that while the principle is opposed to intentionally taking the lives of patients, it does not require (as is often supposed) that their lives be preserved at all costs. The principle is not, then, "vitalist." Nor is it "religious" (by which its critics mean that it can only be defended as a matter of religious faith and not secular reason.) Nor is it "speciesist": it does not exclude rational beings with free will (if any) who are not members of our species.[5] In short, the main goal of *The Law and Ethics of Medicine* is elucidation of the fundamental legal principle of the inviolability of human life in the medical context. It should be of interest to any reader seeking a better understanding of the principle, whether or not he or she subscribes to its ethical basis.

The book is divided into three parts. Part I outlines the ethical principle and its influence on the law and illustrates the misunderstanding of the principle in the work of academic medical lawyers, incuding two of the founding figures of the discipline.

Part II addresses aspects of the beginning of life. It considers the instantiation of the principle by Anglo-American law in its historic prohibition of abortion, first by the common law, and then by nineteenth-century statutes. As we shall see, these statutes were passed at the instigation of physicians who pressed for their enactment to protect human life from conception and to prohibit what they openly called "murder." Chapter 5 contends that the decision of the United States Supreme Court in *Roe v Wade*, creating a constitutional right to abortion, was gravely flawed by its misreading of that history. Chapter 6 argues that the decision of the English High Court in *Smeaton*, that section 58 of the Offences against the Person Act 1861 does not prohibit the administration of the "morning after" pill with intent to prevent the implantation of an embryo, was another instance of judicial misreading of the nineteenth-century legislation's core purpose. Chapter 7 traces the tightening of the law by the Infant Life (Preservation) Act in 1929 to protect the

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[4] To borrow an apt phrase used by Lord Mustill in *Airedale NHS Trust v Bland* [1993] AC 789, 887.

[5] The book does not discuss the moral status of non-human life. Suffice it to say here that the principle of the inviolability of human life does not imply that human beings have no moral responsibilities in respect of animals.

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unborn "child capable of being born alive" and offers an interpretation of that phrase drawing largely on relevant historical materials. All three chapters show the extent to which an understanding of the law's historic purpose of protecting human life from its beginning can valuably inform our contemporary understanding and interpretation of the law. One contemporary issue concerns the legal status of the human embryo in vitro. Chapter 8 addresses the question whether the embryo in vitro should be classified in law as a person or as property. It contends that the case advanced by most commentators and courts for classifying the embryo outside the womb as property, a case based largely on the fact that the civil law does not regard the child in the womb as a person, is unconvincing, not least because it is again difficult to square with the criminal law's traditional goal of protecting all human beings from attack, before as well as after birth.

Part III deals with a number of issues at the end of life. Probably no legislative body worldwide has done more to contribute to the ongoing debate about the decriminalization of euthanasia than the House of Lords. The focus of Chapter 9 is the evidence it has gathered about the practice of euthanasia in the Netherlands and physician-assisted suicide in Oregon. Chapter 10 turns to the euthanasia debate in Europe. It critically analyzes a report of a committee of the Council of Europe which unsuccessfully argued for reversal of the Council's opposition to euthanasia; the decision of the European Court of Human Rights in the *Pretty* case, affirming English law's blanket ban on assisting suicide; and the decision of the Law Lords in the *Purdy* case which, remarkably, undermined that ban. Chapter 11 argues that the euthanasia debate has proved a regrettable distraction from the pressing need to improve the availability of palliative care, and considers whether there is not both an ethical and legal duty to provide such care. It shows that, the inviolability of life not being "vitalistic," both sound ethics and good law permit palliative care even in the unlikely event of death being hastened as an unintended side-effect of such care. Chapter 12 analyzes the landmark *Bland* case, concerning the lawfulness of withdrawing tube-feeding from a patient in PVS. *Bland*, in reaffirming the law's prohibition on intentionally killing the patient by an act, but in allowing him or her to be intentionally killed by dehydration, is the paradigm example of a misunderstanding of the inviolability of life leaving the law in a "morally and intellectually misshapen" state. The chapter replies to an academic defense of the decision, a defense which illustrates some of misunderstandings of the inviolability of life encountered in Part I.

In sum, although the inviolability of life is a historic and foundational principle of the law, *The Law and Ethics of Medicine* will contend that its

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meaning and application in the medical context have been, and remain, seriously misunderstood in the legal academy, at the Bar, on the Bench, and beyond. If this volume provides some measure of clarification, it will have served its purpose.

The views expressed in this book are those of the author and do not necessarily reflect those of Georgetown University.

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Part One

(Mis)understanding the Inviolability of Life

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CHAPTER 1

THE "SANCTITY OF LIFE," "BEST INTERESTS," AND "AUTONOMY": AN OVERVIEW

I INTRODUCTION

The "sanctity" or "inviolability of life" is, as has been repeatedly judicially affirmed,[1] a fundamental principle of the common law. Since the phrase "sanctity of life," though judicially hallowed, may have distracting theological connotations, "inviolability of life" (IOL) will be used hereafter. The doctrine and the principle of the IOL were originally formulated by theologians, but can stand on purely philosophical grounds. In *Re A*, the "Conjoined Twins" case, Brooke LJ referred to a brief the court had received from the Archbishop of Westminster. The brief referred to a number of "overarching moral considerations," the first of which was: "Human life is sacred, that is inviolable, so one should never aim to cause an innocent person's death by act or omission."[2] Brooke LJ observed:

> There can, of course, be no doubt that our common law judges were steeped in the Judaeo-Christian tradition and in the moral principles identified by the Archbishop when they were developing our criminal law over the centuries up to the time when Parliament took over the task. There can also be no doubt that it was these principles, shared as they were by the other founder members of the Council of Europe 50 years ago, which underlay the formulation of article 2 of the European Convention on Human Rights.[3]

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[1] See text at n 11.

[2] *Re A* [2001] Fam 147, 211. The IOL has historically been formulated in terms of the wrongness of intentionally taking "innocent" life. "Innocent" excludes anyone actively contributing to unjust aggression. The principle has, therefore, traditionally allowed the use of lethal force in self-defense, the prosecution of a just war, and the execution of capital offenders. This has little relevance to doctor-patient context, which is the concern of this book.

[3] Ibid 212.

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The principle appears, accordingly, in declarations on human rights as the "right to life." Indeed, a prohibition on intentional killing is central to the pre-Christian fount of Western medical ethics, the Hippocratic Oath[4] (and the modern reaffirmation of that Oath by the Declaration of Geneva[5]), and many non-believers recognize the right of human beings not to be intentionally killed.[6]

Although foundational to the common law, the IOL has rarely if ever been accurately formulated—put in propositional form—either in judicial decisions or in textbooks on medical/health law. Precisely what it involves is, indeed, mired in confusion, in the academy, at the Bar, and on the Bench. This introductory chapter seeks to outline the principle, summarize its relevance to the law governing medical decision-making at the end of life, and sketch its implications for the important concepts of "best interests" and "autonomy."

II THREE COMPETING APPROACHES TO THE VALUATION OF HUMAN LIFE

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There are three main, competing approaches to the valuation of human life.

A Vitalism

Human life is the *supreme* good and one should do everything possible to preserve it. The core principle, therefore, is: "try to maintain the life of each patient at all costs." Whether the life be that of an anencephalic newborn (one lacking the cerebral hemispheres) or a dying centenarian, vitalism prohibits its shortening and requires its preservation. Regardless of the pain, suffering, or expense that life-prolonging treatment entails, it must be administered: human life is to be preserved at all costs. Vitalism is as ethically untenable as its attempt to maintain life indefinitely is physically impossible. Its error lies in isolating the genuine and basic good of human life, and the duty to respect and promote that good, from the network of standards and responsibilities which make up our ethics and

[4] "To please no-one will I prescribe a deadly drug, nor give advice which may cause his death. Nor will I give a woman a pessary to procure abortion.": JK Mason and RA McCall Smith, *Law and Medical Ethics* (4th edn, Oxford University Press, 1994) 429.

[5] "I will maintain the utmost respect for human life from the time of conception; even under threat, I will not use my medical knowledge contrary to the laws of humanity.": ibid 430.

[6] A prohibition on killing is not, of course, exclusive to Western ethics. See D Keown, *Buddhism and Bioethics* (Macmillan/St Martins Press, 1995).

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law as a whole; and its neglect of concepts and distinctions (such as between intention and foresight) vital to that network.

B "Quality of life" (QOL)

On this approach, there is nothing supremely or even inherently valuable about the life of a human being. The dignity of human life, such as it is, is only as an *instrumental* good, a vehicle or platform for a "worthwhile" life, a life whose value resides in meeting a particular "quality" threshold (howsoever defined). The lives of certain patients fall below this threshold, not least because of disease, injury, or disability. This valuation of human life grounds the principle that, because certain lives are not worth living, it is right intentionally to terminate them, whether by act or omission. A core principle, therefore, is: "one may try to extinguish the life of a patient which is of such poor quality as to be not worth living." (Many of those who adopt this approach also believe that only a sub-set of human beings, those who meet a criterion such as a particular level of intellectual ability, qualify as "persons.")

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C The inviolability of life

Human life is a *basic, intrinsic* good. All human beings possess, in virtue of their common humanity, an inherent, inalienable, and ineliminable dignity. The dignity of human beings inheres because of the radical capacities, such as for understanding, rational choice, and free will, inherent in human nature. Some human beings, such as infants, may not yet possess the ability to exercise these radical capacities. But radical capacities must not be confused with abilities. We may have the radical capacity to speak Swahili but not the ability to do so. All human beings possess the capacities inherent in their nature even though, because of infancy, disability, or senility, they may not yet, not now, or no longer have the ability to exercise them.[7]

The right not to be killed is enjoyed regardless of inability or disability. Our dignity does not depend on our having a particular intellectual ability or having it to a particular degree. Any such distinctions are fundamentally arbitrary and inconsistent with a sound concept of justice:

> [E]very human being, however immature or mentally impaired, possesses a fundamental worth and dignity which are not lost as long as he or she is alive. Contrary to the view of some, human worth and dignity do not depend on acquiring and retaining some particular level of intellectual ability or capacity

[7] L Gormally (ed.), *Euthanasia, Clinical Practice and the Law* (St Augustine Press, 1994) 118–19.

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for choice or for communication. On that view of human worth and dignity, it turns out that the relevant level of intellectual ability (or whatever other characteristic is asserted to be morally decisive) always requires to be determined in an arbitrary fashion. In making the possession of human worth and dignity depend on an arbitrary discrimination between individuals, this view destroys the indispensable foundation of justice in society. For basic human rights belong to us precisely because of our worth and dignity, and if our possession of the latter is to be determined arbitrarily so will be our possession of the former. But there cannot be a framework conducive to just relationships in a society if *who are to count as the subjects of justice* is determined in an arbitrary fashion. That is why recognition of the fundamental worth and dignity of *every* human being is the indispensable foundation of justice in society.[8]

Human life is not, then, only an instrumental good, a necessary precondition of thinking or choosing or doing, but a basic good, a fundamental constituent of human flourishing. It is, in other words, not merely good as a means to an end but is, like other integral aspects of a flourishing human life, like friendship and the appreciation of beauty, something worthwhile in itself. Of course some people, like those who are pictures of health in the prime of life, participate in the good of life and health to a greater extent than others, such as the terminally ill, but even the sick and the dying participate in the good to the extent that they are able.

Although life is a basic good it is not an absolute good, a good to which all the other basic goods must be sacrificed in order to ensure its preservation. The IOL doctrine is not vitalistic. The core of the doctrine is the principle prohibiting intentional killing, not an injunction requiring the preservation of life at all costs. The core principle is: "it is always wrong to try to extinguish a patient's life." Although the doctrine denies that human life is an absolute good, the principle that it may never intentionally be taken is an absolute principle, that is, one which has no acceptable exceptions. Although the value of human life is not absolute, the prohibition on taking it is. The core principle prohibits trying to kill, but the IOL also prohibits exposing life to unreasonable risk. It is wrong to take life not only intentionally but also recklessly or negligently.

To sum up, the doctrine of the IOL holds that we all share, in virtue of our common humanity, an ineliminable dignity. This dignity grounds our "right to life." The principle of the IOL holds in essence that it is wrong to try to extinguish life.

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[8] J Keown and L Gormally, "Human Dignity, Autonomy and Mentally-Incapacitated Patients: A Critique of *Who Decides?*" (1999) 4 Web Journal of Current Legal Issues Part II (emphasis in original) <http://www.wjcli.ncl.ac.uk>.

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III MAIN FEATURES OF THE IOL AND THEIR INFLUENCE ON THE COMMON LAW

A Ineliminable dignity

The ineliminable equality-in-dignity of human beings has long been recognized by the common law and by international declarations on human rights. As the Preamble to the Universal Declaration of Human Rights proclaims: "recognition of the inherent dignity and of the equal and inalienable rights of all members of the human family is the foundation of freedom, justice and peace in the world."[9] Inherent human dignity is a core value of English law:

> The recognition and protection of human dignity is one of the core values—in truth *the* core value—of our society and, indeed, of all the societies which are part of the European family of nations and which have embraced the principles of the Convention. It is a core value of the common law, long pre-dating the Convention and the Charter [of Fundamental Rights of the European Union]. The invocation of the dignity of the patient in the form of declaration habitually used when the court is exercising its inherent declaratory jurisdiction in relation to the gravely ill or dying is not some meaningless incantation designed to comfort the living or to assuage the consciences of those involved in making life and death decisions: it is a solemn affirmation of the law's and of society's recognition of our humanity and of human dignity as something fundamental.[10]

Just as inherent dignity is a core value of English law, so is the principle of the IOL which is grounded in it. As Lord Goff observed in *Airedale NHS Trust v Bland*:

> [T]he fundamental principle [in this case] is the principle of the sanctity of human life—a principle long recognised not only in our own society but also in most, if not all, civilised societies throughout the modern world, as is indeed evidenced by its recognition both in article 2 of the European Convention for the Protection of Human Rights and Fundamental Freedoms 1953 . . . and in article 6 of the International Covenant of Civil and Political Rights 1966.[11]

Article 2(1) of the European Convention on Human Rights provides:

> Everyone's right to life shall be protected by law. No one shall be deprived of his life intentionally save in the execution of a sentence of a court following his conviction of a crime for which this penalty is provided by law.

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[9] See <http://www.un.org/en/documents/udhr/>.

[10] *R (A) v East Sussex County Council (No 2)* [2003] EWHC 167 (Admin) para 86, per Munby J (as he then was) (emphasis in original).

[11] [1993] AC 789, 863–4.

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The prohibition on intentional killing was aptly described by the House of Lords Select Committee on Medical Ethics in 1994 ("the Walton Committee") as "the cornerstone of law and of social relationships" which "protects each one of us impartially, embodying the belief that all are equal."[12] The prohibition applies even if a patient is suffering, even if the doctor's motive is compassionate, even if the patient is close to death, and even if the patient autonomously requests a lethal injection. In *Bland* Lord Goff observed:

> [I]t is not lawful for a doctor to administer a drug to his patient to bring about his death, even though that course is prompted by a humanitarian desire to end his suffering, however great that suffering may be... So to act is to cross the Rubicon which runs between on the one hand the care of the living patient and on the other hand euthanasia—actively causing his death to avoid or to end his suffering. Euthanasia is not lawful at common law.[13]

Nor is the law concerned to prohibit only active intentional killing. Although there is generally no liability for an omission to preserve life, it is well established that it is murder to omit to discharge a duty to preserve life with intent to kill, as by deliberately starving to death a child in one's care.[14] Also reflecting the IOL, the law punishes assisting or encouraging another to commit suicide. Section 2(1) of the Suicide Act 1961 provides a maximum penalty of 14 years' imprisonment for aiding, abetting, counseling, or procuring suicide or an attempt to commit suicide. The prohibition has been updated by section 59(2) of the Coroners and Justice Act 2009 which, replacing section 2(1), provides that a person commits an offence if he does an act capable of encouraging or assisting the suicide or attempted suicide of another person and the act was intended to encourage or assist suicide or an attempt to commit suicide.

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B Intention and foresight

The IOL draws an important distinction between intending death and merely foreseeing death as a side-effect of one's conduct. It adopts the principle of "double effect," according to which it is permissible to bring about a foreseen bad consequence if the bad effect is not intended, whether as an end or as a means, and the foreseen or foreseeable causing of the side-effect does not violate other moral norms, especially fairness. It is

[12] 'Report of the Select Committee on Medical Ethics' (HL Paper 21-I of 1993–4) para 237.
[13] *Bland* (n 11) 865.
[14] *R v Gibbins and Proctor* (1919) 13 Cr App R 134.

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therefore ethical and lawful to, for example, administer palliative drugs to the dying even if they will shorten life.

Foreseen causation should not be conflated with intention.[15] Intention, properly understood, always means purpose, not merely foresight plus causality and, despite occasional digression, the law (like common sense) always returns to this truth. One may intend and foresee a consequence of one's action (as when one deliberately decapitates another person). But one may intend a consequence without foreseeing that it will occur (as when one buys a lottery ticket to win a million-to-one jackpot). Conversely, one may not intend a consequence even though one foresees it as certain to occur (like the hangover after a bottle of port). As Lord Goff helpfully put it:

> [T]here can be intention without foresight that the relevant consequence was likely to occur. Conversely, there can be foresight of consequences without intention. [W]hen Field Marshal Montgomery invaded France on D-Day, he foresaw that many of the troops under his command would be killed on that very day. Obviously, however, he did not intend that any of them should be killed. [I] cannot emphasise too strongly that, because foresight of the consequence of death resulting from your act does not necessarily connote an intention on your part to kill, it cannot, in my opinion, be right for a jury to be told that the former will, as a matter of law, *of itself establish* the necessary intent, however overwhelming the probability of the consequence may be—as witness the example of Field Marshal Montgomery and D-Day.[16]

Some jurists, like Professor Glanville Williams, have proposed that "intention" should be stretched to include "oblique" intent (as Bentham called it) so that killers who foresee death as virtually certain but who do not intend it can nevertheless be convicted of murder. Williams instanced the villain who places a bomb on a plane in order to claim the insurance on a parcel but not to kill the pilot. Lord Goff rejected this proposed extension of intention:

> Now I have to confess that, as soon as somebody starts using an expression like "oblique intention," I become suspicious; because I suspect that it is only

[15] See generally J Finnis, *Intention and Identity* (Oxford University Press, 2011) Part Three.

[16] R Goff, "The Mental Element in the Crime of Murder" (1988) 104 LQR 30, 45 (emphasis in original). The same example, with Eisenhower substituted for Montgomery, was later used by the judgment of the court in the leading US Supreme Court decision on physician-assisted suicide: *Vacco v Quill* 521 US 793 at 802–3 (1997), per Rehnquist CJ: "The law has long used actors' intent or purpose to distinguish between two acts that may have the same result .... Put differently, the law distinguishes actions taken "because of" a given end from actions taken "in spite of" their unintended but foreseen consequences ... ('When General Eisenhower ordered American soldiers onto the beaches of Normandy, he knew that he was sending many American soldiers to certain death .... His purpose, though, was to ... liberate Europe from the Nazis')."

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necessary to use the rather mysterious adjective "oblique" to bring within "intention" something which is not intention at all. And that is exactly what is happening here. For the trouble with this kind of approach is that it has distorted the plain meaning of the word. To the question—did the defendant mean to destroy the parcel? The answer is, of course, yes, he did. But to the question—did the defendant mean to kill the pilot? The answer is, no, he didn't. Indeed, if he saw the pilot safely descending by parachute, he would no doubt be delighted; and so it is absurd to say that he meant to kill him. Of course, if the pilot is killed by the explosion, I share Professor Glanville Williams' *feeling* that the defendant can properly be called a murderer; but I do not think that that result can be achieved by artificially expanding the meaning of the word "intention." Quite apart from anything else, it can only lead to difficulties in directing juries. In a jury system, it is far better, if you can, to use a word in its plain and ordinary meaning. And you do not intend something merely because you know that it is virtually certain to happen; see the example of Field Marshal Montgomery and D-Day.[17]

His Lordship added that the parcel bomber should be convicted of murder not by way of artificially stretching the ordinary meaning of intention but by expanding the *mens rea* of murder to include "indifference to death":

[T]he jurists have become imprisoned within their own favourite concept of intention, to such an extent that they have tried, illegitimately, to expand it to include other cases. By adopting the solution that the mental element of murder consists of either (1) an intention to kill, or (2) indifference to death, we can, I suggest, both satisfy the general sense of justice as evidenced in the cases, and avoid the trap of using words otherwise than in their ordinary meaning—a trap which it is especially important to avoid in systems in which judges have to direct juries.[18]

English law appears to agree with Lord Goff in thus rejecting "oblique intent". As Professor Peter Skegg has observed, English courts have "tended to say that foresight of virtual certainty is something from which intention may be found or inferred, and . . . have stopped short of saying that such foresight is itself a form of intent. . . ."[19]

Consistent with the law's rejection of oblique intent is its endorsement of double effect. Lord Goff has referred to:

the established rule that a doctor may, when caring for a patient who is, for example, dying of cancer, lawfully administer painkilling drugs despite the fact

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[17] R Goff, "The Mental Element in the Crime of Murder" (1988) 104 LQR 30, 46 (emphasis in original).

[18] Ibid 45.

[19] PDG Skegg, "Medical Acts Hastening Death" in PDG Skegg et al (eds), *Medical Law in New Zealand* (Thomson Brookers, 2006) 505, 524.

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that he knows that an incidental effect of that application will be to abbreviate the patient's life.[20]

Unfortunately, the law's rejection of oblique intent is by no means as clear as it could and should be. The reasoning or dicta of the single judgment in the House of Lords in *R v Woollin*[21] is ambiguous enough to be read as holding not only that foresight of virtual certainty can be *evidence of* intention but that it *is* intention. It was, indeed, so interpreted by the majority of the Court of Appeal in *Re A*, the "Conjoined Twins" case, where the question was whether it would be lawful to separate the weaker twin (Mary) to save the stronger one (Jodie), even though it was foreseen that Mary would die. The presiding judge stated: "Unpalatable though it may be . . . to stigmatise the doctors with 'murderous intent', that is what in law they will have if they perform the operation and Mary dies as a result."[22] The majority's adoption of "oblique intention," though understandable in view of the ambiguity in *Woollin*, deprived them of the most cogent and coherent way of resolving the tragic dilemma before them: the principle of double effect. According to that principle, the separation of conjoined twins is justified where the death of the doomed twin is not intended and is merely foreseen as a side-effect, and the foreseeable causing of that side-effect does not violate the norm of fairness. Given that both Mary and Jodie would have died without separation, and that Mary was doomed with or without separation, it was not unfair to separate her from Jodie who could, and did, survive. The majority explicitly rejected double effect on the ground that the good and bad effects did not affect the same individual, as is the case with the administration of palliative drugs to a dying patient. However, this limitation has never been a requirement of double effect. The principle could, for example, justify the allied bombing of Nazi headquarters even if it were foreseen that innocent civilians nearby would be killed as a side-effect of the raid. Fortunately, the core common-sense meaning of intention asserts itself at points in the judgments of the Court of Appeal in the Conjoined Twins case where *Woollin*'s authority in relation to the crime of murder is no longer in issue, but rather the issue as framed in civil and human rights law. One such point is the following statement by Robert Walker LJ in relation to the "right to life" in Article 2 of the European Convention on Human Rights:

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[20] *Bland* (n 11) 867. See also *R v Cox* (1992) 12 BMLR 38, 41 (Ognall J).

[21] [1999] 1 AC 82.

[22] *Re A* [2001] Fam 147, 198–9, per Ward LJ. See also ibid 216, per Brooke LJ.

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> The Convention is to be construed as an autonomous text, without regard to any special rules of English law, and the word "intentionally" in article 2(1) must be given its natural and ordinary meaning. In my judgment the word, construed in that way, applies only to cases where the purpose of the prohibited action is to cause death.[23]

That is the position to which English law, too, gravitates, as many cases—including those discussed in *Woollin*—demonstrate when properly analyzed.

C Acts and omissions

The IOL prohibits intentional killing by act or omission. It therefore prohibits withholding/withdrawing treatment with intent to shorten life. But it permits withholding/withdrawing a life-prolonging treatment which is not worthwhile because it is futile or too burdensome. The IOL is, therefore, not vitalist: it does not require doctors to try to preserve life at all costs. Just as the IOL is not vitalist, neither is English law:

> [I]t cannot be right that a doctor, who has under his care a patient suffering painfully from terminal cancer, should be under an absolute obligation to perform upon him major surgery to abate another condition which, if unabated, would or might shorten his life still further. The doctor who is caring for such a patient cannot, in my opinion, be under an absolute obligation to prolong his life by any means available to him, regardless of the quality of the patient's life. Common humanity requires otherwise, as do medical ethics and good medical practice accepted in this country and overseas.[24]

D *Worth of treatment v worth of life: "quality of life benefits" v "beneficial Quality of life"*

It is always wrong to withhold/withdraw treatment because it is thought that the patient, rather than the treatment, is not worthwhile—because death is thought to be in the "best interests" of the patient. The IOL distinguishes what we may call "quality of life benefits" (used to judge whether a treatment would be worthwhile, comparing its benefits and burdens) from "beneficial Quality of life" (QOL) (used to judge whether the patient's life is or will be "worthwhile").

1 "quality of life benefits" v "beneficial Quality of life"

Given that the same phrase, "quality of life," is used to refer to these two very different concepts, it is not surprising that judges and academics have

[23] Ibid 256.
[24] *Bland* (n 11) 867, per Lord Goff.

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sometimes confused the question whether a *treatment* would be worthwhile with the question whether a patient's *life* would be worthwhile. Examples of its usage in the latter, QOL sense (but without advertence to its use in the alternative, former sense), can be found in leading cases on non-treatment of children (such as *Re J*) and of incompetent adults (most notably *Bland*). In *Re J*, where the question was whether it would be in the best interests of a disabled, premature baby with a short life-expectancy to be ventilated, Taylor LJ stated:

> I consider the correct approach is for the court to judge the quality of life the child would have to endure if given the treatment and decide whether in all the circumstances *such a life would be so afflicted as to be intolerable to that child*. I say "to that child" because the test should not be whether the life would be tolerable to the decider. The test must be whether the child in question, if capable of exercising sound judgment, would consider the life tolerable.[25]

Similarly, in *Bland* (a case about which we shall have much more to say in Chapter 12), where the question was whether it would be lawful to withdraw tube-feeding from a patient in a persistent vegetative state even though he would die as a result, Lord Keith ruled:

> [A] medical practitioner is under no duty to continue to treat such a patient where a large body of informed and responsible medical opinion is to the effect that no benefit at all would be conferred by continuance. *Existence in a vegetative state with no prospect of recovery is by that opinion regarded as not being a benefit*, and that, if not unarguably correct, at least forms a proper basis for the decision to discontinue treatment: *Bolam v. Friern Hospital Management Committee* [1957] 1 W.L.R. 582.[26]

To hold, as in *Re J*, that life-prolonging treatment may be withheld/withdrawn from a child because the child's life would be "intolerable" involves a judgment that the child no longer has a "beneficial Quality of life." This remains so irrespective of the rider that the judgment should be made from the child's perspective. Even if adopting such a perspective were feasible, the judgment of "intolerability" would remain a judgment that the child's life was no longer beneficial. Similarly, to judge that Tony Bland's existence was not beneficial (or, as one learned Lord Justice described it, a "humiliation")[27] is to judge that his life was no longer worth living. Indeed, a majority of the Law Lords judged that it would be lawful to withdraw his tube-feeding even though they thought that the

[25] [1991] FLR, 366, 383–4 (emphasis added). For the current status of the "intolerability" test see *W (by her litigation friend B) and M (by her litigation friend, the Official Solicitor) and S and A NHS Primary Care Trust* [2011] EWHC 2443 (Fam), discussed in the postscript to Chapter 12.

[26] *Bland* (n 11) 858–9 (emphasis added).

[27] *Bland* (n 11) 831, per Hoffmann LJ.

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doctor's intention was to kill.[28] Once the law endorses the judgment that certain patients have no "beneficial quality of life," and even that patients may lawfully be killed by deliberate withdrawal of treatment or tube-feeding, it forfeits any principled objection to the taking of positive steps to end their lives. Lord Mustill aptly observed that *Bland* left the law in a "morally and intellectually misshapen" state, prohibiting active intentional killing, but permitting intentional killing by omission.[29] The misshapenness resulted from the courts mistakenly thinking that the key moral distinction is between act and omission when, as the IOL holds, it is between intention and foresight.

Some judges appear to believe that the IOL is consistent with the QOL view that some lives are not beneficial. For example, Lord Keith said in *Bland* that although it was the duty of the state, and the judiciary as one of the arms of the state, to uphold the sanctity of life, the principle was not "absolute." While the principle forbade the taking of active measures to cut short life, it did not, for example, "compel the temporary keeping alive of patients who are terminally ill where to do so would merely prolong their suffering."[30] But once the principle is clarified, and clearly distinguished from vitalism, then we should say, with respect, that it *is* absolute. It endorses allowing terminally ill patients to die but never endorses judging that their lives lack worth, and treating oneself or anyone else as free to *try* to hasten their death. Allowing the terminally ill to die is not an exception to the principle but an application of it. In short, although the value of human life is not absolute, the prohibition on trying to extinguish it, by act or omission, is.

Bland raised ethical and legal issues scarcely less complex and profound than the Conjoined Twins case. But just as the principle of double effect offered a sound way through the thicket of questions raised by separating conjoined twins, it also offered a sound resolution to the question of withdrawing tube-feeding from a patient in a persistent vegetative state. Had their Lordships in *Bland* held that the tube-feeding could be withdrawn on the ground that it was a futile medical treatment, because it could do nothing to improve Tony Bland's medical condition (or quality of life), their reasoning would have left the law in much more reasonable moral and intellectual shape. As the IOL is not vitalist it does not require life to be preserved at all costs. It regards the core purposes of medicine as the restoration to health and well-functioning and, if that cannot be

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[28] Ibid 876 (Lord Browne-Wilkinson); 877 (Lord Lowry); 887 (Lord Mustill).
[29] Ibid 887.
[30] Ibid 859.

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achieved, the alleviation of symptoms. As Sir Thomas Bingham MR (as he then was) noted in the Court of Appeal in *Bland*, the objects of medical care have traditionally been understood as:

> (1) to prevent the occurrence of illness, injury or deformity . . . before they occur; (2) to cure illness when it does occur; (3) where illness cannot be cured, to prevent or retard deterioration of the patient's condition; (4) to relieve pain and suffering in body and mind.[31]

As the tube-feeding could do nothing to restore Tony Bland to health and well-functioning, its removal could (at least arguably) have been justified on the ground that it was a futile medical treatment. This was in essence the approach taken by Lord Goff, who drew an analogy between the tube-feeding and a ventilator.[32]

In the Conjoined Twins case, the presiding Lord Justice delivered a welcome reaffirmation of the key distinction between judging that a treatment is not worthwhile and that the patient's life is not worthwhile. His Lordship stated:

> Given the international conventions protecting "the right to life" . . . I conclude that it is impermissible to deny that every life has an equal inherent value. Life is worthwhile in itself whatever the diminution in one's capacity to enjoy it and however gravely impaired some of one's vital functions of speech, deliberation and choice may be.[33]

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Moreover, it appears that Parliament has restored the prohibition on intentionally withholding/withdrawing treatment or tube-feeding with intent to kill. In relation to the determination of the "best interests" of a mentally incapacitated adult, section 4(5) of the Mental Capacity Act 2005 provides that where the determination relates to life-sustaining treatment the person making the determination must not "be motivated by a desire to bring about his death." As Professor Finnis has pointed out, this should be interpreted as prohibiting any intent that death be brought about, either as an end or as a means:

> The phrase "motivated by a desire" has been used in the courts . . . as equivalent to the phrase "influenced by a desire", which is found in the Insolvency Act 1986, s 239(5). These judgments show that the courts treat the motivating desire . . . as including . . . all purposes which affect the decision-maker's deliberations and

[31] *Bland* (n 11) 809.

[32] Bland (n 11) 870. Whether tube-feeding *is* a medical treatment, as opposed to basic care which should be provided to all patients, is a matter for reasonable ethical debate, but at least an approach which considers whether a treatment is beneficial involves no judgment that the patient's life is no longer beneficial.

[33] *Re A* (n 2) 187–8, per Ward LJ.

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shape or enter into its conclusions—that is, all the kinds of purpose which are referred to when one says that in carrying out one's decision one has an intent to . . . or a purpose of. . . . And all this is reinforced by the way courts have spoken of intent and motivating desire in the context of Art.81 of the EC Treaty.[34]

Moreover, the alternative interpretation, which would allow a carer to withdraw treatment as a means of bringing about death provided he or she was motivated by a desire to achieve some other end, would gut the obvious protective function of the provision. Such an interpretation would allow a doctor to shorten life if motivated by a desire to get away early for the weekend.

2 "Best interests": subjective or objective?

Though section 4(5) of the Mental Capacity Act 2005 is welcome, the definition of "best interests" in section 4(6) and (7) is less so, for they define "best interests" largely in terms of subjective opinions rather than objective criteria. Section 4(6) provides that the person making the determination must take into account, so far as is reasonably ascertainable:

(a) the person's past and present *wishes and feelings* (and, in particular, any relevant written statement made by him when he had capacity),
(b) the *beliefs and values* that would be likely to influence his decision if he had capacity, and
(c) the *other factors that he would be likely to consider* if he were able to do so.[35]

Section 4(7) adds that the person making the determination must take into account, if it is practicable and appropriate to consult them, the *views* of:

(a) anyone named by the person as someone to be consulted on the matter in question or on matters of that kind,
(b) anyone engaged in caring for the person or interested in his welfare,
(c) any donee of a lasting power of attorney granted by the person, and
(d) any deputy appointed for the person by the court,
as to what would be in the person's best interests and, in particular, as to the matters mentioned in subsection (6).[36]

As Finnis comments:

This appearance of unrooted subjectivity remains a deep weakness in the Act's treatment of best interests, and it is important that commentaries on the Act

[34] J Finnis, "The Mental Capacity Act 2005: some ethical and legal issues" in H Watt (ed), *Incapacity and Care* (The Linacre Centre, 2009) 95, 101–2 (footnotes omitted), citing *Re MC Bacon Ltd* [1990] BCC 78, 86; *Re Hawkes Hill Publishing* [2007] BCC 937, para 33 and, in another context, *R v Greenwich LBC* [1991] 1 WLR 506, 508.
[35] Emphases added.
[36] Emphases added.

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encourage carers to feel confident that they have the right, indeed the duty, to consider the *real* true interests of the person and not *simply* the wishes and feelings of someone who may be incapable of sound judgment, or be in the grip of wrong-headed views about his or her own worth, or human worth in general; nor *simply* the views of others involved in the case.[37]

One way of denying worth to incompetent patients is to adopt the judgment that the value of life depends wholly on the value people *give* to their life through their choices, and that the loss of one's capacity to choose means that the only value in one's continued existence depends on the value one had chosen to attach to one's life when competent. Such an approach is inconsistent with the ineliminable dignity which we all share whether or not we are competent:

[E]xercises of autonomy . . . are *not* the fundamental source of worth and value in a person's life. Human beings possess an ineradicable value prior and subsequent to the possibility of exercising autonomy. Autonomy itself as a capacity is to be valued *precisely in so far as its exercise makes for the well-being and flourishing of the human beings who possess it.* But it is plain that many exercises of the capacity, that is, many self-determining choices, are destructive of human well-being—both in the life of the chooser and in the lives of others affected by his or her choices. The mere fact that someone has *chosen* to act or to be treated in a certain way establishes no title to moral respect for what has been chosen. The character of the choice must satisfy certain criteria in order to warrant our respect. The most basic criterion is that a choice should be consistent with respect for the fundamental dignity both of the chooser and of others.[38]

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In the leading case on the treatment of mentally incapacitated adults at common law, Lord Brandon observed: "The operation or other treatment will be in their best interests if, but only if, it is carried out in order either to save their lives, or to ensure improvement or prevent deterioration in their physical or mental health."[39] In relation to health care, "best interests" should be understood to include the standard objectives of health care practice:

the restoration and maintenance of health, or of whatever degree of well-functioning can be achieved; the prolongation of life; and the control of symptoms when cure cannot be achieved. It is in serving these ends that doctors serve the good—and, therefore, the best interests—of their patients. And, in the absence of these criteria, how can the courts hope to resolve disputes? If the understanding

[37] Finnis (n 34) 100 (emphases in original).

[38] J Keown and L Gormally, "Human Dignity, Autonomy and Mentally-Incapacitated Patients: A Critique of *Who Decides?*" (1999) 4 Web Journal of Current Legal Issues Part II (emphases in original).

[39] *Re F* [1990] 2 AC 1, 55.

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of "best interests" fails to include objective, substantive requirements there will be no non-arbitrary way of judging whether the testimony of relatives and others about a patient's "preferences" is self-serving; no non-arbitrary way of settling differences of opinion; and no objective criteria for determining whether a regulatory system is in fact operating to protect patients.[40]

In short, just as doctors and relatives can lose sight of the inherent dignity of a mentally incapacitated patient, so can the patient himself or herself. Misguided subjective views about the patient's worth should never be allowed to obscure what is truly and objectively in the best interests of the patient.

Further, section 4's vaguely defined criterion of "best interests," which guides those making decisions in relation to incompetent adults, does not apply to "advance decisions" made by adults themselves while still competent. There is a real risk, therefore, that some patients will make advance refusals of treatment based on a misguided opinion that in such-and-such a condition their life would not be worth living, and perhaps refuse treatment in advance of incompetence with intent to put an end to their life. It will now be suggested that the courts should make it clear that, while there is a right to refuse treatment, there is no right to commit suicide such as could impose a duty on others to facilitate death for that purpose, even by omission.

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E Autonomy

Autonomy is a valuable capacity, and part of human dignity, but its contribution to dignity is conditional, not absolute. Exercising one's autonomy to destroy one's (or another's) life is always wrong because it is always disrespectful of human dignity. So: it is always wrong intentionally to assist/encourage a patient to commit suicide and, equally, there is no "right to commit suicide," let alone a right to be assisted to commit suicide, either by act or omission.

The principle of "respect for autonomy" has in recent years become for many a core if not dominant principle of biomedical ethics and law. It is not, however, unproblematic. Its advocates often fail to agree on precisely what constitutes an "autonomous" choice or to offer any convincing account of why respect for someone else's choice as such should be regarded as a moral principle at all, let alone a core or dominant moral principle.[41] Our

[40] Keown and Gormally (n 38).

[41] For valuable contributions to the growing debate about the proper role of autonomy see A McCall Smith, "Beyond Autonomy" (1997) 14 Journal of Contemporary Health Law and Policy 23; O O'Neill, *Autonomy and Trust in Bioethics* (Cambridge University Press, 2002); C Foster, *Choosing Life, Choosing Death: The Tyranny of Autonomy in Medical Ethics and Law* (Hart Publishing, 2009).

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capacity for choice is undoubtedly very important, for it is through our choices that we shape our lives and influence the lives of those around us, for good or for ill. But we should exercise our autonomy responsibly, choosing for good, not ill. Neither the common law nor professional medical ethics has ever held that the mere fact *that* I have chosen justifies *what* I have chosen. Consequently, the law refuses to respect various choices, however autonomous. It disallows choices to be owned, eaten, or executed, to be the victim of actual bodily harm,[42] to possess illicit drugs, or to drive while not wearing a seatbelt. In the medical context patients have no right to demand whatever treatment or drugs they may want. A doctor may not amputate a healthy limb even on request, and female genital mutilation is prohibited by section 1 of the Female Genital Mutilation Act 2003, regardless of the woman's consent. The Mental Health Act 1983 allows treatment for mental disorder to be imposed on even a competent patient who chooses not to have it.[43] None of these autonomous choices need involve a risk of harm to anyone but the person making them but they are, nevertheless, disallowed by the law. Other autonomous choices do involve a risk of harm to others, which helps explain why they, too, are rejected by the law even when, as with duelling, the risk of harm may be entirely consensual. Choices which undermine human flourishing or well-being, such as choices to kill or mutilate (whether oneself or another), simply lack moral justification.

It is occasionally suggested that the decriminalization of suicide by the Suicide Act 1961 recognized a right to commit suicide.[44] However, the legislative history of the Suicide Act demonstrates that it was not the intention of Parliament to condone suicide, let alone establish a "right to suicide."[45] Far from it. The government made clear its hope that decriminalization would not give the impression that it regarded what it described as "self-murder" at all lightly.[46] As Lord Bingham explained in *R (Pretty) v Director of Public Prosecutions*:

> The law confers no right to commit suicide.... Suicide itself (and with it attempted suicide) was decriminalised because recognition of the common law offence was not thought to act as a deterrent, because it cast an unwarranted stigma on innocent members of the suicide's family and because it led to the distasteful result that patients recovering in hospital from a failed suicide attempt were prosecuted, in effect, for their lack of success. But while the 1961 Act

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[42] *R v Brown* [1994] 1 AC 212.
[43] Section 62.
[44] Eg *Bland* (n 11) 826–7, per Hoffmann LJ.
[45] *Hansard*, HC vol 645, cols 822–3 (1960–61).
[46] *Hansard*, HC vol 644, cols 1425–6 (1960–61).

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abrogated the rule of law whereby it was a crime for a person to commit (or attempt to commit) suicide, it conferred no right on anyone to do so. Had that been its object there would have been no justification for penalising by a potentially very long term of imprisonment one who aided, abetted, counselled or procured the exercise or attempted exercise by another of that right. The policy of the law remained firmly adverse to suicide, as section 2(1) makes clear.[47]

Further, as Professor Skegg has observed, even since the Suicide Act 1961 "it has continued to be accepted that doctors are sometimes free—sometimes, indeed, under a duty—to prevent patients from committing suicide."[48] In *Reeves v Commissioner of Police of the Metropolis*[49] the House of Lords held that police and prison authorities owe even competent prisoners a duty to take care to prevent them from committing suicide. Suicide may, moreover, be committed by omission, such as a refusal to eat, just as it may be committed by an act. In *R v Collins and Ashworth Hospital Authority, ex p Brady* Maurice Kay J (as he then was) observed that there should be circumstances in which public interests such as the preservation of life, the prevention of suicide, the maintenance of the integrity of the medical profession, and the preservation of institutional discipline "would properly prevail over a self-determined hunger strike so as to enable, even if not to require, intervention." His Lordship observed:

> It would be somewhat odd if there is a duty to prevent suicide by an act (for example, the use of a knife left in the cell) but not even a power to intervene to prevent self-destruction by starvation. I can see no moral justification for the law indulging its fascination with the difference between acts and omissions in a context such as this and no logical need for it to do so.[50]

In *Bland* Lord Goff said that when a patient refuses life-saving treatment "there is no question of the patient having committed suicide, nor therefore of the doctor having aided or abetted him in doing so": it was simply that the patient had declined to consent to treatment which might or would have the effect of prolonging his life, and the doctor had, in accordance with his duty, complied with his patient's wishes.[51] While this is no doubt generally the case, his Lordship did not appear to have considered the scenario where a patient's refusal of treatment is clearly designed to kill himself and where he demands that doctors assist him to

[47] *R v DPP* [2001] UKHL 61 at [35].

[48] PDG Skegg, *Law, Ethics and Medicine* (Clarendon Press, revised edn, 1988) 111 and authorities there cited.

[49] [2000] 1 AC 360.

[50] [2000] 8 Lloyd's Rep Med 355, 367.

[51] *Bland* (n 11) 864.

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carry out his suicidal enterprise. Imagine an otherwise healthy diabetic who refuses his regular insulin shot in order to end his life and who demands to be kept comfortable in hospital while he dies, perhaps as part of a campaign to undermine the law against assisting suicide. If the courts were to hold that doctors were under a duty to comply with his demands (and could not for example discharge him), then the law against assisted suicide would indeed be undermined. If the law were to require, or even permit, doctors *intentionally* to help him kill himself by withholding treatment, how could the law, without inconsistency, prohibit doctors from providing him with active assistance? The courts need to be wary of the right to refuse treatment being manipulated to undermine the law against assisting suicide. It is one thing for doctors to withhold/withdraw treatment with the intention of respecting the patient's legal right to refuse treatment (even if they feel sure that the patient's refusal is suicidal). It is quite another for doctors *intentionally to assist*—try to assist—suicidal refusals and for the courts to endorse such intentional assistance.

Surprisingly, the European Court indicated in *Pretty*,[52] albeit cryptically, that the United Kingdom's blanket ban on assisting suicide engaged the respect for "private and family life" guaranteed by Article 8(1) of the Convention, although the ban was saved by Article 8(2). The Court's interpretation of Article 8(1) was (as we shall suggest in Chapter 10) mistaken. The Court should have followed Lord Bingham's opinion in that case that Article 8(1) sought to protect certain choices while people are living their lives, not the choice to live no longer.

Unfortunately (as we shall also see in Chapter 10), the Law Lords in the *Purdy* case went even further than the European Court when they ordered the Director of Public Prosecutions (DPP) to issue guidance spelling out the factors he would take into account in deciding whether to prosecute Debbie Purdy's husband should he assist her to commit suicide.[53] As the Lord Chief Justice rightly observed in that case, delivering the judgment of the Court of Appeal, such an order would in effect create exceptions to the crime, exceptions which Parliament had not chosen to enact.

IV CONCLUSIONS

The IOL has long been a foundational principle of the common law. This has not saved it from being widely misunderstood, in the academy, at the Bar, and on the Bench. The root cause of the misunderstanding is the

[52] *Pretty v United Kingdom* (2002) 35 EHRR 1.
[53] *R (Purdy) v Director of Public Prosecutions* [2009] UKHL 45.

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tendency to confuse it with one (and sometimes both) of the two alternative approaches to the value of life: "vitalism" and "QOL." The confusion has, inevitably, impaired the law's moral and intellectual coherence. The law would regain its coherence if it:

- clearly denied that "oblique intent" is intent;
- clearly distinguished between "quality of life benefits" and "beneficial Quality of life";
- adopted a definition of "best interests" tied to the objective good of the patient, not least to the patient's life and health;
- clearly ruled out any intent to shorten life, whether by act or by omission, and as a means or as an end;
- recognized that the exercise of autonomy is to be valued to the extent that it serves the good of the patient, and that choices which are inconsistent with that good, not least choices to extinguish life, have no right to be endorsed;
- clearly denied that the right to refuse treatment involves a right to commit suicide and to be intentionally assisted to commit suicide.

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