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THE HOUSE OF LORDS AND THE DISCONTINUATION OF ARTIFICIAL NUTRITION AND HYDRATION: AN ETHICAL ANALYSIS OF THE TONY BLAND CASE

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INTRODUCTION

On April 15, 1989, Tony Bland's ("Bland") lungs were crushed and punctured at the Hillsborough soccer disaster in Liverpool, England,¹ leaving him in a persistent vegetative state ("PVS").² Before incurring this injury, Bland did not indicate what treatment he should receive if left in such a condition. After medical diagnoses predicted he had no chance of recovery,³ Bland's family and doctors sought permission to dis-

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¹ See Steve Lohr, *93 Are Dead After a Crush at Soccer Game in England*, N.Y. TIMES, Apr. 16, 1989, at 12 (describing riot as worst tragedy in history of British soccer); *Soccer Game Stampede Kills 93, More than 200 Hurt at Match in England*, ST. PETERSBURG TIMES, Apr. 16, 1989, at 1A.

² See FRED PLUM & JEROME POSNER, *THE DIAGNOSIS OF STUPOR AND COMA* 6 (3d ed. 1980). The persistent vegetative state ("PVS") has been described as a return to wakefulness after a coma, but without any cognitive functioning whatsoever. *Id.* There is continued preservation of automatic or vegetative functioning (*i.e.*, heartbeat, digestion, and respiration) with a complete lack of higher thought processes. *Id.*

³ *Airedale N.H.S. Trust v. Bland*, 2 W.L.R. 316 (C.A. 1993). "There is no hope whatsoever of recovery of any kind. That is the unanimous opinion of all the distinguished doctors who have examined Anthony Bland [("Bland")]." *Id.* at 322.

continue his life-sustaining treatments, including his artificial nutrition and hydration.⁴

The public response to the decision by Bland's family and doctors was mixed. One editorial in a British religious journal, *The Tablet*, voiced concern over the withdrawal of all support from patients who were not dying.⁵ In addition, Archbishop Winning of Glasgow stated that the withdrawal of nutrition and hydration would be equivalent to the "intentional killing by starvation."⁶ Others viewed Bland's case as the first step toward an acceptance of euthanasia.⁷ Conversely, Bryan Jennett, a neurologist well-experienced in working with PVS patients, argued that such patients should be allowed to die.⁸

Three different courts held that the withdrawal of all life support from Bland was permissible.⁹ Thus, several weeks after *Airedale N.H.S. Trust v. Bland* was decided by the House of Lords, Bland died peacefully shortly after his life support was removed.¹⁰ R.I.P.

Part I of this Article analyzes the legal basis of the *Bland* decision. Part II explores the ethical issues arising from *Bland* and concludes that the legal basis used in situations similar to that of *Bland* should be altered to encompass the ethical distinction between "willing" that someone die and "intending" someone's death.

I. LEGAL AND ETHICAL PRINCIPLES USED BY THE *BLAND* COURTS

The law lords hearing *Bland* used three legal and ethical principles as a basis for their findings: (i) the sanctity of life; (ii) the autonomy of the patient; and (iii) the duty of care.

⁴ See *id.* at 321 (detailing Bland's treatment as including artificial mechanical feeding through nasogastric tube, four to five hours of care each day by two nurses, and assistance with all bodily functions).

⁵ THE TABLET, Nov. 28, 1992, at 1495-96, 1520.

⁶ *Id.*

⁷ See Jeremy Laurance, *Judgement Affects 1,000 Patients*, THE TIMES, Feb. 5, 1993, at 3. One doctor points out that the medical community may not have enough experience in this area, leading to negative evaluations of patient status. *Id.* He argues that patients should be given the chance to live before they are given the chance to die. *Id.*; see generally James Bopp, Jr. & Daniel Avila, *Perspectives on Cruzan: The Sirens Lure of Invented Consent: A Critique of Autonomy-Based Surrogate Decisionmaking for Legally-Incapacitated Older Persons*, 42 HASTINGS L.J. 779 (1991).

⁸ See Bryan Jennett, *Letting Vegetative Patients Die*, BRITISH MEDICAL JOURNAL 1305-06 (Nov. 28, 1992).

⁹ *Airedale N.H.S. Trust v. Bland*, 2 W.L.R. 322 (Fam.), *aff'd*, 2 W.L.R. 332 (C.A.), *aff'd*, 2 W.L.R. 359 (H.L.(E.) 1993).

¹⁰ See Richard Ford & Paul Wilkinson, *Tony Bland to Be Allowed to Die After Law Lords' Ruling*, THE TIMES, Feb. 5, 1993, at 1. Bland's father described the decision as a great relief and in everyone's best interest, including the family and nursing staff. *Id.*

A. *The Sanctity of Life*

Specific references to the sanctity of life were made by Lords Keith,¹¹ Goff,¹² and Browne-Wilkinson,¹³ stressing its importance but noting that the principle is not absolute. Lord Keith noted that, since being in a PVS is not beneficial to the patient, the sanctity of life principle is qualified by the medical treatment and care of a PVS patient which necessarily involves the "invasive manipulation" of the patient's body without the patient's consent.¹⁴ However, Lord Keith's conclusion that such treatment and care do not confer any benefit on a PVS patient is only an opinion and requires proof.

Lord Goff stated that the sanctity of life is the fundamental legal principle applicable to *Bland*.¹⁵ He emphasized the importance of this principle¹⁶ by citing its recognition in two places: (i) Article Two of the European Convention for the Protection of Human Rights and Fundamental Freedoms¹⁷ and (ii) Article Six of the International Covenant of Civil and Political Rights.¹⁸ However, Lord Goff contended that this principle is not absolute and must yield, to some extent, to the principle of self-determination.¹⁹ It should be noted that the principle of self-determination also overrides the third principle used in this case—the duty of care owed by a doctor to a patient. The Canadian case *Nancy B. v. Hotel-Dieu de Quebec*²⁰ is illustrative of this point. In *Nancy B.*, the court held that a patient of sound mind may, if properly informed, require that life support be discontinued.²¹

Lord Browne-Wilkinson expressed his concern that a doctor's attitude toward the sanctity of life may influence the doctor's decision regarding whether to continue treatment.²² Indeed, there are conflicting views of how to uphold the sanctity of life principle. Lord Goff suggested

¹¹ *Bland*, 2 W.L.R. at 362 (noting that sanctity of life principle is not absolute, while indicating maintenance of sanctity of life is a concern of both state and judiciary).

¹² *Id.* at 367 (positing that no absolute rule exists mandating prolongation of life of patient).

¹³ *Id.* at 381 (asking what is meant by "life" in principle of sanctity of life, especially in light of modern technological developments).

¹⁴ *Id.* at 362.

¹⁵ *Id.* at 367.

¹⁶ *Bland*, 2 W.L.R. at 367 (suggesting that medical science deemed Bland alive, providing application of sanctity of human life principle).

¹⁷ *Id.* (citing European Convention for Protection of Human Rights and Fundamental Freedoms, 1953, art. 2).

¹⁸ *Bland*, 2 W.L.R. at 367 (citing International Covenant of Civil and Political Rights, 1966, art. 6).

¹⁹ *Bland*, 2 W.L.R. at 367.

²⁰ 86 D.L.R.4th 385 (1992).

²¹ *Id.* at 395.

²² *Bland*, 2 W.L.R. at 386.

that when a family is dismayed by the artificial prolongation of a loved one's life they should seek a different medical practitioner.²³ Lord Goff indicated earlier that "it is crucial for the understanding of this question that the question itself should be correctly formulated."²⁴

The question which must be addressed concerns whether the doctor should continue to provide the patient with medical treatment or care which, if continued, would prolong the patient's life.²⁵ Yet, this is *not* a question of euthanasia. The crucial question is not whether it is in the best interest of the patient to die, since framing the issue in that manner directly challenges the sanctity of life principle.

It is apparent that this principle is not as clear as it may appear. Lord Browne-Wilkinson framed the issue by asking what "life" is in terms of the current evaluation of the moral precept.²⁶ Coupled with the consideration that the taking of life through an abortion is not illegal, it is suggested that the principle of the sanctity of life is in need of thorough re-evaluation.

B. *Principle of Autonomy*

The fact that the sanctity of life gives way to autonomy is evidence that, in today's world, the principle of self-determination is paramount. However, problems arise when people are incapable of communicating their wishes or consenting to treatment.²⁷ As previously mentioned, Bland had not expressed his wishes regarding treatment, and would be forever incapable of doing so. In order to address situations where such a problem exists, a combination of the principles of necessity and best interests has developed in English law.²⁸

Lord Goff pointed out that it is inconsistent with the primacy given to autonomy that the law should provide no means of enabling treatment

²³ *Id.* at 377; cf. *Brophy v. New England Sinai Hosp. Inc.*, 497 N.E.2d 626 (Mass. 1986) (finding hospital could not be forced to discontinue treatment of PVS patient, yet had duty to assist guardian of patient with transfer to facility where guardian's wishes would be carried out).

²⁴ *Bland*, 2 W.L.R. at 371.

²⁵ *Id.*

²⁶ *Id.* at 381. "The physical state known as death has changed." *Id.* Lord Browne-Wilkinson maintains that in light of today's technology, the time and manner of death can often be the product of human decisionmaking, resulting in new and more complex ethical and social issues. *Id.*

²⁷ See generally Jennifer E. Bennett Overton, Note, *Unanswered Implications—The Clouded Rights of the Incompetent Patient Under Cruzan v. Director, Missouri Department of Health*, 69 N.C. L. Rev. 1293 (1991); Steven M. Richard, Note, *Someone Make Up My Mind: The Troubling Right to Die Issues Presented by Incompetent Patients with No Prior Expression of a Treatment Preference*, 64 NOTRE DAME L. REV. 394 (1989).

²⁸ *Bland*, 2 W.L.R. at 370.

to be withheld if a person cannot consent.²⁹ It is established in English law that a doctor may lawfully treat a person unable to give consent if the doctor acts in the patient's best interests as judged by a reasonable portion of the body of medical opinion.³⁰ All counsel in *Bland* agreed that the case of *In re F*³¹ provided guidance for the resolution of the issues in *Bland*.³² The issue in *In re F* was whether it would be lawful for doctors to sterilize an adult woman who was of unsound mind.³³ The court's *parens patriae* jurisdiction³⁴ to give consent on such person's behalf no longer exists.³⁵ Lord Browne-Wilkinson noted that this jurisdiction was removed by the effect of the Mental Health Act of 1959 and by the revocation of the Warrant under the Sign Manual. Both actions left the courts with jurisdiction over the person's property but not over the person.³⁶ Rather than fail to provide the necessary guidance for the medical profession, the House made a declaratory ruling that it would be lawful for the doctors to proceed. The same type of declaratory ruling was sought in *Bland*.³⁷

The central issue surrounding *Bland* was whether doctors could justifiably discontinue the artificial feeding upon which Bland's life depended by relying on the principle of best interests.³⁸ The law lords stressed the importance of accurately framing the issues to be addressed.

Courts in the United States rely on the concept of substituted judgment when determining what choice a patient might have made under

²⁹ *Id.* at 368; see *Superintendent of Belchertown State Sch. v. Saikewicz*, 370 N.E.2d 417 (Mass. 1977). "To presume that the incompetent person must always be subjected to what many rational and intelligent persons may decline is to downgrade the status of the incompetent person by placing a lesser value on his intrinsic human worth and vitality." *Id.* at 428.

³⁰ See, e.g., *In re F* (Mental Patient: Sterilisation), 2 W.L.R. 1025 (1989); *T v. T and Another*, 2 W.L.R. 189 (1988) (indicating that, in exceptional circumstances where patient is suffering from such mental abnormality as never to be able to give consent, where no provision of law provides for consent to be given by another, medical advisor is justified in taking such steps as good medical practice demands).

³¹ 2 W.L.R. 1025.

³² *Bland*, 2 W.L.R. at 373.

³³ *In re F*, 2 W.L.R. at 1025.

³⁴ The *parens patriae* concept is an equitable doctrine which permits the state to make decisions to protect the welfare of persons unable to do so on their own. See Lawrence B. Custer, *The Origins of the Doctrine of Parens Patriae*, 27 Emory L. J. 195 (1978); see also Joanna K. Weinberg, *Whose Right Is It Anyway? Individualism, Community, and the Right to Die: A Commentary on the New Jersey Experience*, 40 HASTINGS L.J. 119, 125-30 (1988) (discussing principles of best interests, self-determination, and *parens patriae* doctrine).

³⁵ *Bland*, 2 W.L.R. at 365, 385.

³⁶ *Id.* at 385 (declaring that removal of *parens patriae* jurisdiction leaves court without power to give or refuse consent on Bland's behalf).

³⁷ *Bland*, 2 W.L.R. at 360 (giving terms of declaration).

³⁸ *Id.*

that patient's current condition.³⁹ Use of this concept may initially seem to enhance patient autonomy by attempting to focus on what the patient would have desired. However, critics of this approach claim it is open to abuse or, at least, manipulation of events to achieve a desired result.⁴⁰ The English law lords agree that the "best interests principle" is a broader and more viable principle on which to operate than the concept of substituted judgment. Lord Mustill went so far as to dismiss substituted judgment as "simply a fiction" (*not* to be confused with a legal fiction).⁴¹ He reasoned that use of this principle could in fact limit, rather than extend, patient autonomy by emphasizing one or two comments about future treatment, thus considering such statements out of context when viewed in the scope of a person's entire life.⁴²

The "substituted judgment" theory focuses disproportionately on the person's statements rather than on the person's overall best interests. The concept of "best interests," while not perfect, focuses on current and future interests and not on past events which may be misleading.

Doctors practicing under the concept of "best interests" consider an individual patient's best interests in accordance with a reasonable body of good medical practice. However, doctors may disagree over what is "reasonable" or what is "good." The "best interests" approach does have the advantage of considering usefulness or uselessness of treatment—a fact that presumably can be evaluated objectively. One is not left to guess what the patient would have wanted.

Lord Mustill's judgment best reflects the confusion over the questions to be asked concerning the principle of "best interests." He wrote, "As I understand the position [the doctors] have all, with heavy hearts, taken the ethical decision that since their efforts have run their course it is better from every point of view that Anthony Bland's life should be brought to an end."⁴³ This was the last judgment made, yet Lord Browne-Wilkinson had already noted that the correct question was not whether it was in Anthony Bland's best interests to die, but "whether it [was] in the best interests of Anthony Bland to continue the invasive medical care involved in artificial feeding."⁴⁴

³⁹ See *In re Estate of Longeway*, 549 N.E.2d 292 (Ill. 1989) (employing substituted judgment standard, rather than best interests standard, to determine when to exercise ward's rights).

⁴⁰ See generally Andrew Agrawal, *In Re Conroy: Forging a Path to Death With Dignity*, 67 B.U. L. REV. 365 (1987); Michael R. Flick, *The Due Process of Dying*, 79 CALIF. L. REV. 1121 (1991).

⁴¹ *Bland*, 2 W.L.R. at 396.

⁴² *Id.*

⁴³ *Id.* at 389.

⁴⁴ *Id.* at 385.

Lord Keith broadly stated that the issue is to determine "in what circumstances, if ever, can those having a duty to feed an invalid lawfully stop doing so."⁴⁵ Lord Lowry maintained that the necessity of feeding a PVS patient must be established through the best interests argument.⁴⁶

Lord Mustill moved through several arguments concerning the distinction between murder by way of an omission where a duty to act exists and an omission where a duty to act does not exist.⁴⁷ He noted that it can never be said that the termination of life is in the best interests of a person.⁴⁸ He eventually suggested that the focus of the inquiry should be the interests of the person in continuation of treatment.⁴⁹ While this is difficult to assess, it at least moves toward the position of the other judges by focusing on the obligation of doctors to continue life-prolonging treatment. The obligation to continue life-prolonging treatment is given even greater weight in the consideration of the third principle of *Bland*—the duty of care.

C. *The Duty of Care*

The principle of the duty of care is of great importance since breach of the duty leaves one liable in both civil and criminal cases. Lord Lowry noted that this is "the real point" in *Bland*.⁵⁰ The Official Solicitor argued that the duty to feed a helpless person is different from the duty to provide medical care.⁵¹ Although a debate exists regarding whether feeding is part of medical treatment for PVS patients, the majority of medical opinions conclude that it is. Lord Lowry maintained that the position that a helpless person must be fed falsely assumes that feeding in order to sustain life is necessarily for the benefit of the patient.⁵² This benefit must be established, and that is precisely where the best interests approach applies. If doctors advise that it is futile to continue treatment then it cannot be presumed that feeding is necessarily for the benefit of the patient.

⁴⁵ *Id.* at 360.

⁴⁶ *Bland*, 2 W.L.R. at 379.

⁴⁷ *Id.* at 394-95.

⁴⁸ *Id.* at 398. However, this seems to be at odds with his opinion at the beginning of his judgment.

⁴⁹ *Id.*

⁵⁰ *Id.* at 378.

⁵¹ *Bland*, 2 W.L.R. at 378 ("[T]he duty to feed a helpless person, such as a baby or an unconscious patient, is something different—an elementary duty to keep the patient alive which exists independently of all questions of treatment and which the person in charge cannot omit to perform. . . .") (emphasis added).

⁵² *Id.* at 379.

Lord Lowry's remarks do not entirely clarify this point. He stated that, "[e]ven though the intention to bring about the patient's death is there, there is no proposed guilty act because . . . the doctor would be acting unlawfully if he continued the care and treatment" where it is not in the patient's best interests.⁵³ Perhaps the wrong point is being considered here. Treatment is discontinued because it is futile; it is *not* terminated in order to cause the patient's death. This is a clear example of allowing a patient to die. There is a distinction between intending and willing for which the law does not provide. There is no intent to cause death, but there is a willingness to permit the person to die. Lord Goff made a point of highlighting the distinction between intending and allowing death, and it must be further emphasized so that the line between letting one die and euthanasia remains clear.⁵⁴

Lord Browne-Wilkinson's articulation of the doctors' duty to give or withhold treatment also provides reason for concern. He stated that "what is proposed in the present case is to adopt a course with the intention of bringing about Anthony Bland's death."⁵⁵ Thus, he argues that this is justifiable because the doctors are under no obligation or duty to continue feeding. If the obligation to feed remained, the doctors would be guilty of murder.

Lord Mustill's judgment posed the question of duty in the same manner. In his opinion, "the proposed conduct has the aim . . . of terminating the life of Anthony Bland by withholding from him the basic necessities of life."⁵⁶ A few paragraphs later, however, he states that cessation of treatment will be a criminal omission only if the doctors are still under a duty to continue treatment.⁵⁷

Lords Lowry, Browne-Wilkinson, and Mustill all agreed that the obligation to feed Bland had disappeared since there was no hope of his recovery. It is remarkable that, in light of this conclusion, they did not pursue the "letting die" approach but, rather, preferred to use the "intending death" approach which was not criminal since there was no further obligation to treat. They relied on the provisions of criminal law which draw no distinctions regarding the legality of causing death by act or omission except where there is no duty. It is not surprising that the lords urged the British Parliament to consider this matter and to issue clear laws and guidelines. They clearly did not feel that their judgments would be adequate guidance for what they consider an area of law rich with challenge.

⁵³ *Id.*

⁵⁴ *Id.* at 368-69.

⁵⁵ *Id.* at 383.

⁵⁶ *Bland*, 2 W.L.R. at 388.

⁵⁷ *Id.* at 389.

II. ETHICAL QUESTIONS ARISING FROM *BLAND*A. *Dualism*

Most of the descriptions of Bland that are dualistic in tone were made in the lower courts. For example, it was observed that "his spirit has left him and all that remains is the shell of his body,"⁵⁸ and "he has no life in the sense that even the most pitifully handicapped but conscious human being has a life."⁵⁹ A careful reading of the House of Lords judgment reveals little or nothing of dualism. Lord Mustill, however, noted that a person "may also comprise a spiritual essence distinct from both body and personality."⁶⁰ In addressing the spiritual essence, Lord Mustill stated that "of this we can know nothing and in particular we cannot know whether it perishes with death or transcends it."⁶¹ Although his wording at times seems dualistic, Lord Mustill at least attempted to recognize spiritual life and faith beliefs regarding the soul. This is a difficult area all the same. Even the Roman Catholic Church, which defines the human being as a person from conception, has difficulty explaining the concept of personhood.

B. *Quality of Life*

Not surprisingly, the concept of quality of life was considered at several points.⁶² If the best interests of a patient are going to be considered, it is almost inevitable that this be so. Lord Browne-Wilkinson questioned whether a person has the right to be sustained when one's quality of life is nonexistent.⁶³ This is an important point because it emphasizes that, not only was Bland's quality of life impaired, but his capacity for awareness and development had been totally destroyed. He could experience neither burdens nor benefits; he could experience nothing; he was insensate. Lord Mustill observed that any "glimmerings of awareness" shown by patients in damaged but less extreme situations establish a presumption of some kind of interest in life.⁶⁴ Bland did not even have a

⁵⁸ *Airedale N.H. Trust v. Bland*, 2 W.L.R. 322, 330 (Fam. 1993). "He has no feeling, no awareness, nor can he experience anything relating to his surroundings. To his parents and family he is 'dead.'" *Id.*

⁵⁹ *Id.*

⁶⁰ *Bland*, 2 W.L.R. at 400.

⁶¹ *Id.*

⁶² *Bland*, 2 W.L.R. at 371. Lord Goff noted that these types of cases can be grouped into two categories. *Id.* According to Lord Goff, in the first category of cases, in ascertaining the patient's best interests with regard to life sustaining treatment, the court will look to all circumstances, including the quality of life of the patient resulting from treatment. *Id.* In the second category of cases, which includes *Bland*, such a quality of life balancing is irrelevant because the patient is unconscious and there is no hope of improvement. *Id.*

⁶³ *Bland*, 2 W.L.R. at 381.

⁶⁴ *Id.* at 400.

"glimmering."⁶⁵ The law lords relied on this objective fact, rather than on the subjective quality of life assessments, when they considered the futility of his treatment.

Roman Catholic teaching does not steer away from "quality of life" arguments in every form. In addition to the "sanctity of the person" (a more nuanced position than the sanctity of life), the capacity to actually live one's life, and the way in which one lives one's life, are also important considerations. Physical life, however, is not an absolute value in the context of a belief in "eternal life." The Texas Bishops, for example, wrote that caregivers are not abandoning a PVS patient, as is sometimes claimed, by withdrawing nutrition and hydration.⁶⁶ They are accepting at some point (not hastily) that "the person has come to the end of his or her pilgrimage and should not be impeded from taking the final step."⁶⁷ This theory views death as a step in the journey to the future which we all eventually face, regardless of our individual beliefs.

Arguments about the quality of life were pointless in *Bland* since Bland could not in any way experience his life. However, such contentions are extremely important in other situations. Notwithstanding the sanctity of life considerations, the Roman Catholic Church teaches that there are limits on what must be done to prolong temporal life.⁶⁸ The human good of being alive is not an absolute value.⁶⁹ Death teaches us that lesson even if faith does not.

⁶⁵ *Id.* at 364. In his discussion of Bland's condition, Lord Goff noted:

The medical witnesses in this case include some of the outstanding authorities in the country on this condition. All are agreed on the diagnosis. All are agreed on the prognosis also: there is no hope of any improvement or recovery. One witness of great experience described Mr. Bland as the worst P.V.S. case he had ever seen.

Id.

⁶⁶ Texas Bishops, *On Withdrawing Artificial Nutrition and Hydration*, 20 ORIGINS 53, 54 (1990).

⁶⁷ *Id.*

⁶⁸ See *id.* at 53-54. (citing Pope Pius XII, *The Prolongation of Life* (Nov. 24, 1957), in 4 THE POPE SPEAKS, at 393-98 (1958)).

The Texas Bishops noted there are three basic moral principles: 1. Although life always is good, there are conditions which, if present, lessen or remove one's obligation to sustain life 2. If the reasonable foreseen benefits to the patient in the use of any means outweigh the burdens to the patient or others, then those means are morally obligatory. . . . 3. If the means used to prolong life are disproportionately burdensome compared with the benefits to the patient, then those means need not be used, they are morally optional.

Id.

⁶⁹ Texas Bishops, *supra* note 66, at 53-54 (stating that "the temporal concerns must always be subordinated to the patient's spiritual needs and obligations").

C. Nutrition and Hydration as Medical Treatment

There is a debate regarding whether the nutrition and hydration of a patient should be seen as medical treatment or, rather, whether, as claimed by the Official Solicitor, they are "something different—an elementary duty to keep the patient alive which exists independently of all questions of treatment and which the person in charge cannot omit to perform."⁷⁰ The latter view *presumes* that it is in the best interests of the patient to be kept alive but does not prove it. Although asking why the patient is being kept alive sounds like a "quality of life" question, we must determine for what purpose we are doing *any* particular act. We have to demonstrate a reason. Can keeping someone alive really "exist independently of all questions of treatment," as the Official Solicitor argued?⁷¹ This should then be balanced with the Roman Catholic position that there are limits on what must be done to prolong life.⁷²

In holding that nutrition and hydration are part of medical treatment, the lords relied on "the overwhelming verdict of informed medical opinion worldwide."⁷³ The lords acknowledged that the law of common law jurisdictions holds that "therapy and life-supporting care, including sophisticated methods of artificial feeding are components of medical treatment and cannot be separated" as the Official Solicitor contended.⁷⁴

The traditional Roman Catholic division of treatment into extraordinary and ordinary is significant in *Bland*. "Ordinary means" are those which are effective and can be employed without undue burden.⁷⁵ "Extraordinary means" are those which either are futile or whose use involves too grave a burden.⁷⁶ The distinction is sometimes made between artificial and natural means of life support. No one may reject natural means of life support, those necessary to sustain life in every situation—air, warmth, food, and water. Artificial means of providing support, however, have to be assessed. Artificial means are those employed because of some incapacity in the patient. They may be surgical, technical, or chemical, such as a catheter, ventilator, feeding tubes, or drugs. They, too, must be employed unless it is shown that they are useless or if the burden in using them or living with them is too great.⁷⁷ The case of

⁷⁰ *Bland*, 2 W.L.R. at 378.

⁷¹ *Id.*

⁷² See *supra* note 68 and accompanying text.

⁷³ *Bland*, 2 W.L.R. at 378.

⁷⁴ *Id.*

⁷⁵ See Texas Bishops, *supra* note 66, at 53, 55 n.2 (quoting Pope Pius XII, *supra* note 66, at 393-98).

⁷⁶ *Id.* at 54.

⁷⁷ *Id.* at 55 n.3 (citing Declaration on Euthanasia IV); see also *Nancy B. v. Hotel-Dieu de Quebec*, 86 D.L.R. 4th at 385 (holding that patient suffering from Guillain-Barre syndrome, an incurable neurological disorder leaving her incapable of movement, had the right to

Nancy B., discussed in subpart I(A), illustrates this latter point. She was not prepared to live her life totally dependent on a respirator and chose to forego use of it.

It has been found that, when people are extremely ill or dying, there is often a natural movement against food and drink—even in their ordinary forms. Mouth-moistening is all that is required for comfort. Therefore, to say that one must always provide food and drink is obviously incorrect. Accordingly, the provision of artificial nutrition and hydration is not an absolute value and can be rightly seen as medical treatment—or at least as part of medical care—which can be refused.

D. Continuation of Life-Sustaining Measures When the Underlying Pathology Cannot Be Cured

The lords noted that, “where the doctor’s treatment of his patient is lawful, then the patient’s death will be regarded in law as exclusively caused by the injury or disease to which his condition is attributable.”⁷⁸ Therefore, a question arises regarding whether the person should continue to be sustained indefinitely. In *Bland*, the lords relied on the principle of best interests.⁷⁹ If treatment is considered futile, then continuing treatment is not considered to be in the best interests of the patient. The doctors are then under no further legal obligation to provide treatment.⁸⁰ The nature of the question being asked at this stage is para-

have life support stopped). In *Nancy B.*, the court noted that a patient’s right to consent to or refuse treatment was limited only by the rights of others and applicable laws which sometimes prevents people from doing what they wish with their bodies. *Id.*

⁷⁸ *Bland*, 2 W.L.R. at 370.

⁷⁹ *Id.* at 361. Lord Keith stated that “[t]he fundamental question then comes to be whether continuance of the present regime of treatment and care, more than three years after the injuries that resulted in the P.V.S., would confer any benefit on Anthony Bland.” *Id.* Lord Goff placed great emphasis on the proper foundation of the issue at hand. According to Lord Goff, “[t]he question is whether it is in the best interests of the patient that his life should be prolonged by the continuance of this form of treatment or care.” *Id.* at 371. Lord Lowry argued that “the court . . . ought to give weight to informed medical opinion . . . on the question of what is in the best interests of a patient.” *Id.* at 378-79. Lord Browne-Wilkinson announced that “the critical decision to be made is whether it is in the best interests of Anthony Bland to continue the invasive medical care involved in artificial feeding.” *Id.* at 383. Finally, in upholding the declarations to cease treatment for Bland, Lord Mustill held that “his best interests in being kept alive have also disappeared, taking with them the justification for the non-consensual regime and the co-relative duty to keep it in being.” *Id.*

⁸⁰ See *Bland*, 2 W.L.R. at 362 (stating that “a medical practitioner is under no duty to continue to treat . . . 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”); see also *id.* at 370 (noting that a doctor caring for a terminally ill patient is not “under an absolute obligation to prolong his life by any means available to him, regardless of the quality of the patient’s life”); *id.* at 379 (“[I]f it is not in the interests of an insentient patient to continue the life-supporting care and treatment, the doctor would be acting unlawfully if he contin-

mount: whether it is in the best interests of the person that his or her life be prolonged by continuance of this form of medical treatment.⁸¹

Lord Goff noted that four major safeguards must be observed before discontinuing life support. These safeguards were recommended in *Discussion Paper on Treatment of Patients in Persistent Vegetative State*, a document issued in September 1992 by the Medical Ethics Committee of the British Medical Association.⁸² The guidelines provide that (i) every effort should be made at rehabilitation for at least six months; (ii) diagnosis of irreversible PVS should not be considered confirmed until at least twelve months after injury; (iii) the diagnosis should be agreed on by two other independent doctors; and (iv) the wishes of the patient's immediate family should generally be given some weight.⁸³

The law lords recognized help from decisions in a number of American jurisdictions addressing when it is lawful to discontinue life-prolonging treatment in the case of PVS patients, and in particular noted the publication *Euthanasia, Aiding Suicide and Cessation of Treatment*.⁸⁴ Their views add weight to what Lord Goff termed "a community of view on the legal principles applicable in cases of discontinuing life support . . . in the course of development and acceptance throughout the common law world."⁸⁵ This stress on legal principles shows that the decision to discontinue treatment cannot be made by the medical profession alone. When the doctors made a decision that treatment was futile, this involved the realization that they were no longer under any obligation to

ued the care and treatment and would perform no guilty act by discontinuing . . ."); *id.* at 385 (holding that there is no duty to maintain patient's life if such maintenance is no longer in best interests of patient. . .); *id.* at 398 (arguing that once patient's best interests of being kept alive are gone, there is no justification or duty to continue treatment).

⁸¹ See *supra* note 79 and accompanying text.

⁸² *Bland*, 2 W.L.R. at 373 (citing MEDICAL ETHICS COMMITTEE OF THE BRITISH MEDICAL ASSOCIATION, DISCUSSION PAPER ON TREATMENT OF PATIENTS IN PERSISTENT VEGETATIVE STATE (1992)).

⁸³ *Id.*

⁸⁴ *Id.* at 375 (citing Working Paper No. 28 of the Law of Reform Commission of Cases, *Euthanasia, Aiding Suicide and Cessation of Treatment* (1982)). Lord Goff cited *In re Gardner*, 534 A.2d 947, 949 (Me. 1987), for the proposition that declaratory judgments are appropriate for questions addressing whether "those who discontinue [artificial] life support . . . will commit a civil wrong or criminal offense." *Bland*, 2 W.L.R. at 366. *Schloendorff v. Society of N.Y. Hosp.*, 105 N.E. 92, 93 (N.Y. 1914), was referred to for its holding that when "an adult patient of sound mind refuses, however unreasonably, to consent to treatment or care by which his life would or might be prolonged, the doctors responsible for his care must give effect to his wishes, even though they do not consider it to be in his best interests to do so." *Bland*, 2 W.L.R. at 367. *In re Quinlan*, 355 A.2d 647, 664 (N.J. 1976), and *Superintendent of Belchertown State Sch. v. Saikewicz*, 370 N.E.2d 417, 431 (Mass. 1977), were utilized to provide support for the "substituted judgment test" in order to ascertain whether artificial life support may be ceased. *Bland*, 2 W.L.R. at 374.

⁸⁵ *Bland*, 2 W.L.R. at 375.

continue treatment. Their decision included the medical diagnosis, prognosis, and ethical concern that there would be no benefit to Bland in keeping him alive. The ethical component of their decision left the question of discontinuance open to the agreement of his family or to approval by the courts. This was necessary because of the ethical dimension of the question—whether the patient benefits simply in being kept alive. The medical profession had no special jurisdiction in this area. Taking the doctors' judgment of futility into account, the lords had to ask whether it was indeed in the best interests of Bland to continue such treatment. In the absence of even "glimmerings of awareness" on Bland's part, they came to the conclusion that there was no reason why he should be kept alive; his being kept alive would be forever unknown to him and would neither benefit nor burden him. Therefore, keeping Bland alive was futile, except as an exercise in prolonging biological life.

As outlined above, the wishes of the family must be taken into consideration, and all decisions must be taken within the recommended guidelines to ensure that the ethical decision is properly made. In this instance, Bland's family agreed with his doctors that treatment should be discontinued.⁸⁶

E. The Meaning of the "Omission" of Treatment & the "Intending" of Death

Most of the law lords referred to the distinction in criminal law between an act of commission and an act of omission.⁸⁷ Since intention is the main factor in establishing the *mens rea* for a criminal act, they noted that there is no difference between performing an act meant to kill or seriously harm and omitting to act with the same intention.⁸⁸

Some of the lords questioned the difference between allowing Bland to die and giving him a lethal injection to end his life quickly.⁸⁹ Lord Brown-Wilkinson also noted the distinction between the omission of an act and the omission of an act which the actor was duty-bound to provide. The failure to act is not considered an *actus reus* necessary for a

⁸⁶ *Id.* at 360.

⁸⁷ *Bland*, 2 W.L.R. at 368, 383, 394.

⁸⁸ *See id.* at 383 (stating that "[as] to the element of intention or *mens rea*, in my judgment there can be no real doubt that it is present in this case: the whole purpose of stopping artificial feeding is to bring about the death of Anthony Bland").

⁸⁹ Lord Goff stated "that the law draws a crucial distinction between cases in which a doctor decides not to provide . . . for his patient [sic] treatment . . . and those in which he decides, for example by administering a lethal drug, actively to bring his patient's life to an end." *Bland*, 2 W.L.R. at 368. Lord Lowry noted that, in withholding treatment, "the intention to bring about the patient's death is there." *Id.* at 37. Lord Browne-Wilkinson questioned whether the withdrawal of life support was murder, "notwithstanding the best motives from which everyone concerned is acting." *Id.* at 383.

homicide conviction.⁹⁰ Thus, the legal outcome turns on whether or not an obligation to the patient exists. If it does not exist, the doctor is not in breach of any obligation to maintain the person's life and, therefore, is not guilty of a criminal omission. In *Bland*, it was held that a duty did not extend to Bland because treatment was found to be futile.⁹¹

From a moral point of view, a distinction is also made between commission and omission. However, one can intend death equally through commission and omission. This would be true of omission in the case of not acting when there is a duty to act. When there is no duty to act (or, indeed, a duty not to act), then agents are not the cause of death and do not intend death because they did not employ means to bring death about even if they omitted to use means which could prolong life.

Some moral theologians distinguish between "intending" and "willing" death. Death may be "willed" when an agent views a patient's death as a positive event, such as a relief from suffering. How often has it been said that one is grateful that death came to a loved one suffering from great pain? That person's death was willed but certainly not intended. That is the difference.

In *Bland*, the law lords did not make use of this distinction. Intention in legal terms is determined by the agent's obligation to act in any given situation. If there is no obligation to act, then an agent is not guilty of criminal behavior. It is submitted that the intending-willing distinction could help clarify the commission-omission distinction. Some of the lords spoke of "the intention to kill" Bland by omission.⁹² The law lords could have held that the doctors in *Bland* were *not* the cause of Bland's death by omission since they were under no obligation to act and, therefore, they did not intend his death.⁹³ The application of the term "willing" death shows that the decision to allow Bland to die is very different from "intending" to end his life and is more than a matter of semantics. The distinction between willing death and intending death obviously needs serious reconsideration in law to avoid confusion about "intention."

In this case, the lords decided that Bland would not benefit from continued medical treatment and, therefore, withholding treatment was jus-

⁹⁰ *Bland*, 2 W.L.R. at 383 (citing *Rex v. Gibbons and Proctor*, 13 Cr. App. R. 134 (1918), and *Rey v. Stone*, (1977) Q.B. 354).

⁹¹ *Bland*, 2 W.L.R. at 364 (quoting Glanville Williams, *TEXTBOOK OF CRIMINAL LAW* 282 (2d ed. 1983) (arguing that, when a doctor turns off a life support machine, this is "not an act but an omission" . . . and . . . "the omission is not a breach of duty by the doctor, because he is not obliged to continue in a hopeless case.")).

⁹² See *supra* notes 87-88 and accompanying text.

⁹³ See *supra* note 91 and accompanying text.

tifiable.⁹⁴ Bland was to be *allowed to die*. Lord Goff captured this difference when he wrote that "the law draws a crucial distinction between cases in which a doctor decides not to provide, or to continue to provide, for his patient treatment or care which could or might prolong his life, and those in which he decides, for example by administering a lethal drug, actively to bring his patient's life to an end."⁹⁵ The difference is that, although doctors are not obliged to continue treatment in a hopeless case and may allow the patient to die, they are not allowed to terminate the patient's life out of pity. The latter is not part of a doctor's duty. Although the legal situation could change if the law changes, morally the distinction will remain.

CONCLUSION

Ethicists such as Anthony Fisher claim that the decision made in *Bland* is tantamount to "medically killing by judicial fiat."⁹⁶ An analysis of the case shows that the court did not condone euthanasia, but rather made a distinction between killing and allowing to die. Some of the judgments in the House of Lords indicate that euthanasia is likely to be one of the next challenges to the Courts of England.⁹⁷ The lords consider this to be a matter for Parliament and are divided in their approach to it.⁹⁸

If the House of Lords had paid more attention to the concept of "willing" rather than "intending" they would have made the "letting one die" approach clearer and would have made a useful contribution to the developing international body of law on this topic. The distinction between "killing" and "letting one die" must be honed so that it becomes the major

⁹⁴ See, e.g., *Bland*, 2 W.L.R. at 362 (holding that "a medical practitioner is under no duty to continue to treat such a patient when a large body of informed and responsible medical opinion is to the effect that no benefit at all would be conferred by continuance"); *id.* at 372 (stating "that no such duty rests upon the respondents, or upon Dr. Howe, in the case of Anthony Bland, whose condition is in reality no more than a living death, and for whom such treatment or care would, in medical terms be futile"); *id.* at 386 (concluding that, because there is no affirmative benefit to Anthony Bland in continued life support, the doctors are "neither entitled nor under a duty to continue such medical care"); *id.* at 389 (arguing that, because "Anthony Bland has no further interest in being kept alive, the necessity to do so, created by his inability to make a choice has gone and the justification for the invasive care and treatment, together with the duty to provide it has also gone").

⁹⁵ *Bland*, 2 W.L.R. at 368.

⁹⁶ Anthony Fisher OP, *On Not Starving the Unconscious*, 74 NEW BLACKFRIARS 130 (1993).

⁹⁷ See, e.g., *Bland*, 2 W.L.R. at 388 (noting similarity between euthanasia and cessation of life support).

⁹⁸ See, e.g., *id.* at 380 (stating that "it is for Parliament, not the courts, to decide the broader issues which this case raises"); *id.* at 382 ("For these reasons, it seems . . . imperative that the moral, social and legal issues raised by this case should be considered by Parliament."); *id.* at 392 ("The whole matter cries out for exploration in depth by Parliament . . .").

focal point in future cases. Lawyers, ethicists, theologians, and doctors must refine and redefine the concepts of intending, willing, and omitting in order that this distinction, already a part of established Roman Catholic medical ethics, might be further clarified.

