Airedale NHS Trust (Respondents)

v.

Bland (acting by his Guardian *ad Litem)* (Appellant)

JUDGMENT

Die Jovis 4° Februarii 1993

Upon Report from the Appellate Committee to whom was referred the Cause Airedale NHS Trust against Bland (acting by his Guardian ad Litem), That the Committee had heard Counsel as well on Monday the 14th as on Tuesday the 15th and Wednesday the 16th days of December last upon the Petition and Appeal of Anthony Bland of Airedale General Hospital, Skipton Road, Steeton, Keighley, West Yorkshire (a patient acting by his Guardian *ad Litem* the Official Solicitor to the Supreme Court), praying that the matter of the Order set forth in the Schedule thereto, namely an Order of Her Majesty's Court of Appeal of the 3rd day of December 1992, might be reviewed before Her Majesty the Queen in Her Court of Parliament and that the said Order might be reversed, varied or altered or that the Petitioner might have such other relief in the premises as to Her Majesty the Queen in Her Court of Parliament might seem meet; as upon the case of Airedale NHS Trust lodged in answer to the said Appeal; and Counsel having been heard as amicus curiae instructed by the Treasury Solicitor; and due consideration had this day of what was offered on either side in this Cause:

It is Ordered and Adjudged, by the Lords Spiritual and Temporal in the Court of Parliament of Her Majesty the Queen assembled, That the said Order of the 3rd day of December 1992 complained of in the said Appeal be, and the same is hereby, **Affirmed** and that the said Petition and Appeal be, and the same is hereby, dismissed this House.

Cler: Parliamentor:

Judgment: 4 February 1993

HOUSE OF LORDS

AIREDALE NHS TRUST
(RESPONDENTS)

v.

BLAND

(ACTING BY HIS GUARDIAN *ad litem)*
(APPELLANT)

Lord Keith of Kinkel
Lord Goff of Chieveley
Lord Lowry
Lord Browne-Wilkinson
Lord Mustill

LORD KEITH OF KINKEL

My Lords,

As a result of injuries sustained in the Hillsborough disaster, Anthony Bland has for over three years been in the condition known as persistent vegetative state (P.V.S.). It is unnecessary to go into all the details about the manifestations of this state which are fully set out in the judgments of the courts below. It is sufficient to say that it arises from the destruction, through prolonged deprivation of oxygen, of the cerebral cortex, which has resolved into a watery mass. The cortex is that part of the brain which is the seat of cognitive function and sensory capacity. Anthony Bland cannot see, hear or feel anything. He cannot communicate in any way. The consciousness which is the essential feature of individual personality has departed for ever. On the other hand the brain stem, which controls the reflexive functions of the body, in particular heartbeat, breathing and digestion, continues to operate. In the eyes of the medical world and of the law a person is not clinically dead so

long as the brain stem retains its function. In order to maintain Anthony Bland in his present condition, feeding and hydration are achieved artificially by means of a nasogastric tube and excretionary functions are regulated by a catheter and by enemas. The catheter from time to time gives rise to infections which have to be dealt with by appropriate medical treatment. The undisputed consensus of eminent medical opinion is that there is no prospect whatever that Anthony Bland will ever make any recovery from his present condition, but that there is every likelihood that he will maintain his present state of existence for many years to come, provided that the medical care which he is now receiving is continued.

In that state of affairs the medical men in charge of Anthony Bland's case formed the view, which was supported by his parents, that no useful purpose was to be served by continuing that medical care and that it was appropriate to stop the artificial feeding and other measures aimed at prolonging his existence. Since, however, there were doubts as to whether this course might not constitute a criminal offence, the responsible hospital authority, the Airedale N.H.S. Trust, sought in the High Court of Justice declarations designed to resolve these doubts. In the result, declarations on the lines asked for were granted by judgment of the President of the Family Division on 19 November 1992. That judgment was affirmed by the Court of Appeal (Sir Thomas Bingham M.R., Butler-Sloss and Hoffman L.JJ.) on 9 December 1992. The declarations are in these terms:

> "that despite the inability of the defendant to consent thereto the plaintiff and the responsible attending physicians: -
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> 1. may lawfully discontinue all life-sustaining treatment and medical supportive measures designed to keep the defendant alive in his existing persistent vegetative state including the termination of ventilation nutrition and hydration by artificial means; and
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> 2. may lawfully discontinue and thereafter need not furnish medical treatment to the defendant except for the sole purpose of enabling him to end his life and die peacefully with the greatest dignity and the least of pain suffering and distress;"

Anthony Bland, by the Official Solicitor as his guardian ad litem, now appeals, with leave given in the Court of Appeal, to your Lordships' House.

At the hearing of the appeal your Lordships were assisted by submissions made by Mr. Anthony Lester Q.C., as amicus curiae instructed by the Treasury Solicitor.

The broad issue raised by the appeal is stated by the parties to be "In what circumstances, if ever, can those having a duty to feed an invalid lawfully stop doing so?" The immediate issue, however, is whether in the particular circumstances of Anthony Bland's case those in charge of it would be acting lawfully if they discontinued the particular measures, including feeding by nasogastric tube, which are now being used to maintain Anthony Bland in his existing condition.

The first point to make is that it is unlawful, so as to constitute both a tort and the crime of battery, to administer medical treatment to an adult, who is conscious and of sound mind, without his consent: In *In re F, (Mental Patient: Sterilisation)* [1990] 2 A.C. 1. Such a person is completely at liberty to decline to undergo treatment, even if the result of his doing so will be that he will die. This extends to the situation where the person, in anticipation of his, through one cause or another, entering into a condition such as P.V.S.,

gives clear instructions that in such event he is not to be given medical care, including artificial feeding, designed to keep him alive. The second point is that it very commonly occurs that a person, due to accident or some other cause, becomes unconscious and is thus not able to give or withhold consent to medical treatment. In that situation it is lawful, under the principle of necessity, for medical men to apply such treatment as in their informed opinion is in the best interests of the unconscious patient. That is what happened in the case of Anthony Bland when he was first dealt with by the emergency services and later taken to hospital.

The object of medical treatment and care is to benefit the patient. It may do so by taking steps to prevent the occurrence of illness, or, if an illness does occur, by taking steps towards curing it. Where an illness or the effects of an injury cannot be cured, then efforts are directed towards preventing deterioration or relieving pain and suffering. In Anthony Bland's case the first imperative was to prevent him from dying, as he would certainly have done in the absence of the steps that were taken. If he had died, there can be no doubt that the cause of this would have been the injuries which he had suffered. As it was, the steps taken prevented him from dying, and there was instituted the course of treatment and care which still continues. For a time, no doubt, there was some hope that he might recover sufficiently for him to

be able to live a life that had some meaning. Some patients who have suffered damage to the cerebral cortex have, indeed, made a complete recovery. It all depends on the degree of damage. But sound medical opinion takes the view that if a P.V.S. patient shows no signs of recovery after six months, or at most a year, then there is no prospect whatever of any recovery. There are techniques available which make it possible to ascertain the state of the cerebral cortex, and in Anthony Bland's case these indicate that, as mentioned above, it has degenerated into a mass of watery fluid. The 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. It is argued for the respondents, supported by the amicus curiae, that his best interests favour discontinuance. I feel some doubt about this way of putting the matter. In *In re. F. (Mental Patient: Sterilisation)* [1990] 2 A.C. 1 this House held that it would be lawful to sterilise a female mental patient who was incapable of giving consent to the procedure. The ground of the decision was that sterilisation would be in the patient's best interests because her life would be fuller and more agreeable if she were sterilised than if she were not. In *In re J. (A Minor) (Wardship: Medical Treatment)* [1991] Fam. 33 the Court of Appeal held it to be lawful to withhold life saving treatment from a very young child in circumstances where the child's life, if saved, would be one irredeemably racked by pain and agony. In both cases it was possible to make a value judgment as to the consequences to a sensate being of in the one case withholding and in the other case administering the treatment in question. In the case of a permanently insensate being, who if continuing to live would never experience the slightest actual discomfort, it is difficult, if not impossible, to make any relevant comparison between continued existence and

the absence of it. It is, however, perhaps permissible to say that to an individual with no cognitive capacity whatever, and no prospect of ever recovering any such capacity in this world, it must be a matter of complete indifference whether he lives or dies.

Where one individual has assumed responsibility for the care of another who cannot look after himself or herself, whether as a medical practitioner or otherwise, that responsibility cannot lawfully be shed unless arrangements are made for the responsibility to be taken over by someone else. Thus a person having charge of a baby who fails to feed it, so that it dies, will be guilty at least of manslaughter. The same is true of one having charge of an adult who is frail and cannot look after herself: *Reg. v. Stone* [1977] Q.B. 354. It was argued for the guardian ad litem, by analogy with

that case, that here the doctors in charge of Anthony Bland had a continuing duty to feed him by means of the nasogastric tube and that if they failed to carry out that duty they were guilty of manslaughter, if not murder. This was coupled with the argument that feeding by means of the nasogastric tube was not medical treatment at all, but simply feeding indistinguishable from feeding by normal means. As regards this latter argument, I am of opinion that regard should be had to the whole regime, including the artificial feeding, which at present keeps Anthony Bland alive. That regime amounts to medical treatment and care, and it is incorrect to direct attention exclusively to the fact that nourishment is being provided. In any event, the administration of nourishment by the means adopted involves the application of a medical technique. But it is, of course, true that in general it would not be lawful for a medical practitioner who assumed responsibility for the care of an unconscious patient simply to give up treatment in circumstances where continuance of it would confer some benefit on the patient. On the other hand 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 and care: *Bolam v. Friern Hospital Management Committee* [1957] 1 W.L.R. 582.

Given that existence in the persistent vegetative state is not a benefit to the patient, it remains to consider whether the principle of the sanctity of life, which it is the concern of the State, and the judiciary as one of the arms of the State, to maintain, requires this House to hold that the judgment of the Court of Appeal was incorrect. In my opinion it does not. The principle is not an absolute one. It does not compel a medical practitioner on pain of criminal sanctions to treat a patient, who will die if he does not, contrary to the express wishes of the patient. It does not authorise forcible feeding of prisoners on hunger strike. It does not compel the temporary keeping alive of patients who are terminally ill where to do so would merely prolong their suffering. On the other hand it forbids the taking of active measures to cut short the life of a terminally ill patient. In my judgment it does no violence

to the principle to hold that it is lawful to cease to give medical treatment and care to a P.V.S. patient who has been in that state for over three years, considering that to do so involves invasive manipulation of the patient's body to which he has not consented and which confers no benefit upon him.

Although this case falls to be decided by the law of England, it is of some comfort to observe that in other common law jurisdictions, particularly in the United States where there are many cases on the subject, the courts have with near unanimity concluded that it is not unlawful to discontinue medical treatment and care, including artificial feeding, of P.V.S. patients and others in similar conditions.

The decision whether or not the continued treatment and care of a P.V.S. patient confers any benefit on him is essentially one for the practitioners in charge of his case. The question is whether any decision that it does not and that the treatment and care should therefore be discontinued should as a matter of routine be brought before the Family Division for endorsement or the reverse. The view taken by the President of the Family Division and the Court of Appeal was that it should, at least for the time being and until a body of experience and practice has been built up which might obviate the need for application in every case. As the Master of the Rolls said, this would be in the interests of the protection of patients, the protection of doctors, the reassurance of the patients' families and the reassurance of the public. I respectfully agree that these considerations render desirable the practice of application.

My Lords, for these reasons, which are substantially the same as those set out in the speech to be delivered by my noble and learned friend Lord Goff of Chieveley, with which I agree, I would dismiss the appeal.

LORD GOFF OF CHIEVELEY

My Lords,

The facts of the present case are not in dispute. They are fully set out in the judgment of Sir Stephen Brown P at first instance; they have been admirably summarised in the judgment of Sir Thomas Bingham M.R. in the Court of Appeal; and they have been summarised yet again in the agreed statement of facts and issues prepared by counsel for the assistance of the Appellate Committee of your Lordships' House. They reveal a tragic state of affairs, which has evoked great sympathy both for Anthony Bland himself, and for his devoted family, and great respect for all those who have been responsible for his medical treatment and care since he was admitted to hospital following the terrible injuries which he suffered at Hillsborough in April 1989. For present purposes, I propose simply to adopt the sympathetic

and economical summary of the Master of the Rolls which, for convenience of reference, I will now incorporate into this opinion.

> "Mr Anthony David Bland, then aged 17 , went to the Hillsborough Ground on 15 April 1989 to support the Liverpool Football Club. In the course of the disaster which occurred on that day, his lungs were crushed and punctured and the supply of oxygen to his brain was interrupted. As a result, he suffered catastrophic and irreversible damage to the higher centres of the brain. The condition from which he suffers, and has suffered since April 1989, is known as a persistent vegetative state (abbreviated to P.V.S.).
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> "P.V.S. is a recognised medical condition quite distinct from other conditions sometimes known as "irreversible coma", "the Guillain-Barre syndrome", "the locked-in syndrome" and "brain death". Its distinguishing characteristics are that the brain stem remains alive and functioning while the cortex of the brain loses its function and activity. Thus the P.V.S. patient continues to breathe unaided and his digestion continues to function. But although his eyes are open, he cannot see. He cannot hear. Although capable of reflex movement, particularly in response to painful stimuli, the patient is incapable of voluntary movement and can feel no pain. He cannot taste or smell. He cannot speak or communicate in any way. He has no cognitive function and can thus feel no emotion, whether pleasure or distress. The absence of cerebral function is not a matter of surmise; it can be scientifically demonstrated. The space which the brain should occupy is full of watery fluid.
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> "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 describe Mr Bland as the worst P.V.S. case he had every seen.
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> "Mr Bland lies in bed in the Airedale General Hospital, his eyes open, his mind vacant, his limbs crooked and taut. He cannot swallow, and so cannot be spoon-fed without a high risk that food will be inhaled into the lung. He is fed by means of a tube, threaded through the nose and down into the stomach, through which liquified food is mechanically pumped. His bowels are evacuated by enema. His bladder is drained by catheter. He has been subject to repeated bouts

of infection affecting his urinary tract and chest, which have been treated with antibiotics. Drugs have also been administered to reduce salivation, to reduce muscle tone and severe sweating and to encourage gastric emptying. A tracheostomy tube has been inserted and removed. Urino-genitary problems have required surgical intervention.

"A patient in this condition requires very skilled nursing and close medical attention if he is to survive. The Airedale National Health Service Trust have, it is agreed, provided both to Mr Bland. Introduction of the nasogastric tube is itself a task of some delicacy even in an insensate patient. Thereafter it must be monitored to ensure it has not become dislodged and to control inflammation, irritation and infection to which it may give arise. The catheter must be monitored: it may cause infection (and has repeatedly done so); it has had to be re-sited, in an operation performed without anaesthetic. The mouth and other parts of the body must be constantly tended. The patient must be repeatedly moved to avoid pressure sores. Without skilled nursing and close medical attention a P.V.S. patient will quickly succumb to infection. With such care, a young and otherwise healthy patient may live for many years.

"At no time before the disaster did Mr Bland give any indication of his wishes should he find himself in such a condition. It is not a topic most adolescents address. After careful thought his family agreed that the feeding tube should be removed and felt that this was what Mr Bland would have wanted. His father said of his son in evidence: 'He certainly wouldn't want to be left like that'. He could see no advantage at all in continuation of the current treatment. He was not cross-examined. It was accordingly with the concurrence of Mr Bland's family, as well as the consultant in charge of his case and the support of two independent doctors, that the Airedale N.H.S. Trust as plaintiff in this action applied to the Family Division of the High Court for declarations that they might

'(1) . . . lawfully discontinue all life-sustaining treatment and medical support measures designed to keep AB [Mr Bland] alive in his existing persistent vegetative state including the termination of ventilation nutrition and hydration by artificial means; and

(2) ... lawfully discontinue and thereafter need not furnish medical treatment to AB except for the sole purpose of enabling AB to end his life and die peacefully with the greatest dignity and the least of pain suffering and distress.'

"After a hearing in which he was assisted by an amicus curiae instructed by the Attorney General, the President of the Family Division made these declarations (subject to a minor change of wording) on 19 November 1992. He declined to make further declarations which were also sought."

The Official Solicitor, acting on behalf of Anthony Bland, appealed against that decision to the Court of Appeal, who dismissed the appeal. Now,

with the leave of the Court of Appeal, the Official Solicitor has appealed to your Lordships' House.

In so acting, the Official Solicitor has ensured that all relevant matters of fact and law are properly investigated and scrutinised before any irrevocable decision is taken affecting Anthony Bland, for whom he acts as guardian ad litem. This function was performed by Mr James Munby, Q.C., who appeared before your Lordships as he did before the courts below; and he made submissions in the form of a series of propositions any of which, if accepted, would preclude the grant of the declarations granted by the learned President. Like the courts below, I have come to the conclusion that I am unable to accept Mr Munby's submissions; but I have nevertheless found them to be of great assistance in that they have compelled me to think more deeply about the applicable principles of law and, I hope, to formulate those principles more accurately. Your Lordships were also fortunate to have the assistance of Mr Anthony Lester, Q.C., appearing as amicus curiae, instructed by the Treasury Solicitor, and of the thoughtful argument of Mr Francis Q.C., for the respondents.

On one point there was no disagreement between counsel appearing before your Lordships. This was that proceedings for declaratory relief of the kind considered by this House in *In re F (Mental Patient: Sterilisation)* [1990] 2 A.C. I provided the most appropriate means by which authoritative guidance could be provided for the respondents to the appeal, the Airedale N.H.S. Trust, and for Dr. Howe who has Anthony Bland in his care, whose wish it is, in agreement with Anthony's parents, to discontinue the artificial

feeding of Anthony, with the inevitable result that, within one or two weeks, he will die. There has therefore been no contested argument about the appropriateness of the declaratory remedy in cases such as these, which are in fact concerned with the question whether in the particular circumstances those who discontinue life support (here artificial feeding) will commit a civil wrong or a criminal offence. In *In re F*, the question arose whether it would be lawful for doctors to sterilise an adult woman of unsound mind. In that case, this House was deeply concerned to discover that it was common ground between the parties that, in the case of adult persons of unsound mind, the parens patriae jurisdiction of the courts had been revoked with the effect that the courts could no longer exercise their jurisdiction to give consent on behalf of such persons. On that occasion Mr Munby, who there as here was instructed by the Official Solicitor, was invited to assist this House by advancing such arguments as could be advanced that the jurisdiction had not been abolished. At the end of the argument, your Lordships' House came reluctantly to the conclusion that the jurisdiction no longer existed; but, dismayed by the possibility that the courts might be powerless to provide the necessary guidance to the medical profession in that case, this House had recourse to declaratory relief for that purpose. Speaking for myself, I remain of the opinion that this conclusion was entirely justified. Of course, I recognise that strong warnings have been given against the civil courts usurping the function of the criminal courts, and it has been authoritatively

stated that a declaration as to the lawfulness or otherwise of future conduct is "no bar to a criminal prosecution, no matter the authority of the court which grants it": see *Imperial Tobacco Ltd. v. Attorney General* [1981] A.C.718, 741, per Viscount Dilhorne, and see also p. 752, per Lord Lane. But it is plain that the jurisdiction exists to grant such a declaration, and on occasion that jurisdiction has been exercised, as for example by your Lordships' House in *Royal College of Nursing of the United Kingdom v. Department of Health and Social Security* [1981] A.C. 800. It would, in my opinion, be a deplorable state of affairs if no authoritative guidance could be given to the medical profession in a case such as the present, so that a doctor would be compelled either to act contrary to the principles of medical ethics established by his professional body or to risk a prosecution for murder. As Compton J. said *in Barber v. Superior Court of State of California* (1983) 195 Cal. Rptr. 484, 486 (1983), ... "a murder prosecution is a poor way to design an ethical and moral code for doctors who are faced with decisions concerning the use of costly and extraordinary 'life support' equipment". In practice, authoritative guidance in circumstances such as these should in normal circumstances inhibit prosecution or, if (contrary to all expectation) criminal

proceedings were launched, justify the Attorney General in entering a nolle prosequi. In the present case, it is to be remembered that an amicus curiae has been instructed by the Treasury Solicitor; yet no representations have been made on behalf of the Attorney General that declaratory relief is here inappropriate. In expressing this opinion, I draw comfort from the fact that declaratory rulings have been employed for the same purpose in other common law jurisdictions, such as the United States of America (in a number of cases, of which the most recent appears to be *Re Gardner* 534 A 2d. 947, 949 (1987)); New Zealand *(Re J.H.L.* (unreported) 13 August, 1992 transcript pp. 10, 12, 16, 39-40, per Thomas J., to whom submissions had been addressed upon the point); and South Africa *(Clarke v. Hurst* (unreported), 30 July 1992, Supreme Court of South Africa, Durban and Coast Local Division, per Thirion J. transcript pp. 8-16, 86).

The central issue in the present case has been aptly stated by the Master of the Rolls to be whether artificial feeding and antibiotic drugs may lawfully be withheld from an insensate patient with no hope of recovery when it is known that if that is done the patient will shortly thereafter die. The Court of Appeal, like the President, answered this question generally in the affirmative, and (in the declarations made or approved by them) specifically also in the affirmative in relation to Anthony Bland. I find myself to be in agreement with the conclusions so reached by all the judges below, substantially for the reasons given by them. But the matter is of such importance that I propose to express my reasons in my own words.

I start with the simple fact that, in law, Anthony is still alive. It is true that his condition is such that it can be described as a living death; but he is nevertheless still alive. This is because, as a result of developments in modern medical technology, doctors no longer associate death exclusively with breathing and heart beat, and it has come to be accepted that death occurs

when the brain, and in particular the brain stem, has been destroyed (see Professor Ian Kennedy's Paper entitled *"Switching off Life Support Machines: The Legal Implications"* reprinted in *Treat Me Right, Essays in Medical Law and Ethics,* (1988)), especially at pp. 351-2, and the material there cited). There has been no dispute on this point in the present case, and it is unnecessary for me to consider it further. The evidence is that Anthony's brain stem is still alive and functioning and it follows that, in the present state of medical science, he is still alive and should be so regarded as a matter of law.

It is on this basis that I turn to the applicable principles of law. Here, the fundamental principle 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 of Human Rights, and in article 6 of the International Covenant of Civil and Political Rights.

But this principle, fundamental though it is, is not absolute. Indeed there are circumstances in which it is lawful to take another man's life, for example by a lawful act of self-defence, or (in the days when capital punishment was acceptable in our society) by lawful execution. We are not however concerned with cases such as these. We are concerned with circumstances in which it may be lawful to withhold from a patient medical treatment or care by means of which his life may be prolonged. But here too there is no absolute rule that the patient's life must be prolonged by such treatment or care, if available, regardless of the circumstances.

First, it is established that the principle of self-determination requires that respect must be given to the wishes of the patient, so that if 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 (see *Schloendorff v. Society of New York Hospital* 105 N.E. 92, 93, per Cardozo J. (1914); *S. v. McC. (Orse S.) and M (D.S. Intervene); W* v. *W* [1972] A.C. 24, 43, per Lord Reid; and *Sidaway v. Board of Governors of the Bethlem Royal Hospital and the Maudsley Hospital* [1985] A.C. 871, 882, per Lord Scarman). To this extent, the principle of the sanctity of human life must yield to the principle of self-determination (see Court of Appeal Transcript in the present case, at p. 38F per Hoffmann L.J.), and, for present purposes perhaps more important, the doctor's duty to act in the best interests of his patient must likewise be qualified. On this basis, it has been held that a patient of sound mind may, if properly informed, require that life support should be discontinued: see *Nancy B.* v. *Hotel Dieu de Quebec* (1992) 86 D.L.R. (4th) 385. Moreover the same principle applies where the patient's refusal to give his consent has been expressed at an earlier date, before he became unconscious or otherwise incapable of communicating it; though in such circumstances especial care

may be necessary to ensure that the prior refusal of consent is still properly to be regarded as applicable in the circumstances which have subsequently

occurred (see, e.g. *In re T. (Adult: Refusal of treatment)* [1992] 3 W.L.R. 782). I wish to add that, in cases of this kind, there is no question of the patient having committed suicide, nor therefore of the doctor having aided or abetted him in doing so. It is simply that the patient has, as he is entitled to do, declined to consent to treatment which might or would have the effect of prolonging his life, and the doctor has, in accordance with his duty, complied with his patient's wishes.

But in many cases not only may the patient be in no condition to be able to say whether or not he consents to the relevant treatment or care, but also he may have given no prior indication of his wishes with regard to it. In the case of a child who is a ward of court, the court itself will decide whether medical treatment should be provided in the child's best interests, taking into account medical opinion. But the court cannot give its consent on behalf of an adult patient who is incapable of himself deciding whether or not to consent to treatment. I am of the opinion that there is nevertheless no absolute obligation upon the doctor who has the patient in his care to prolong his life, regardless of the circumstances. Indeed, it would be most startling, and could lead to the most adverse and cruel effects upon the patient, if any such absolute rule were held to exist. It is scarcely consistent with the primacy given to the principle of self-determination in those cases in which the patient of sound mind has declined to give his consent, that the law should provide no means of enabling treatment to be withheld in appropriate circumstances where the patient is in no condition to indicate, if that was his wish, that he did not consent to it. The point was put forcibly in the judgment of the Supreme Judicial Court of Massachusetts in *Superintendent of Belchertown State School* v. *Saikewicz* (1977) 370 N.E. 2d. 417, 428, as follows:

> "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."

I must however stress, at this point, 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. As I have already indicated, the former may be lawful, either because the doctor is giving effect to his patient's wishes by withholding the treatment or care, or even in certain circumstances in which (on principles which I shall describe) the patient is incapacitated from stating whether or not he gives his consent. But it 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: see *Reg.* v. *Cox* (Unreported), Ognall J., Winchester Crown Court, 18 September 1992. 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. It is of course well known that there are many responsible members of our society who believe that euthanasia should be made lawful; but that result could, I believe, only be achieved by legislation which expresses the democratic will that so fundamental a change should be made in our law, and can, if enacted, ensure that such legalised killing can only be carried out subject to appropriate supervision and control. It is true that the drawing of this distinction may lead to a charge of hypocrisy; because it can be asked why, if the doctor, by discontinuing treatment, is entitled in consequence to let his patient die, it should not be lawful to put him out of his misery straight away, in a more humane manner, by a lethal injection, rather than let him linger on in pain until he dies. But the law does not feel able to authorise euthanasia, even in circumstances such as these; for once euthanasia is recognised as lawful in these circumstances, it is difficult to see any logical basis for excluding it in others.

At the heart of this distinction lies a theoretical question. Why is it that the doctor who gives his patient a lethal injection which kills him commits an unlawful act and indeed is guilty of murder, whereas a doctor who, by discontinuing life support, allows his patient to die, may not act unlawfully - and will not do so, if he commits no breach of duty to his patient? Professor Glanville Williams has suggested (see his *Textbook of Criminal Law,* 2nd ed., p. 282) that the reason is that what the doctor does when he switches off a life support machine 'is in substance not an act but an omission to struggle, and that 'the omission is not a breach of duty by the doctor because he is not obliged to continue in a hopeless case'.

I agree that the doctor's conduct in discontinuing life support can properly be categorised as an omission. It is true that it may be difficult to describe what the doctor actually does as an omission, for example where he takes some positive step to bring the life support to an end. But discontinuation of life support is, for present purposes, no different from not initiating life support in the first place. In each case, the doctor is simply allowing his patient to die in the sense that he is desisting from taking a step which might, in certain circumstances, prevent his patient from dying as a

result of his pre-existing condition; and as a matter of general principle an omission such as this will not be unlawful unless it constitutes a breach of duty to the patient. I also agree that the doctor's conduct is to be differentiated from that of, for example, an interloper who maliciously switches off a life support machine because, although the interloper may perform exactly the same act as the doctor who discontinues life support, his doing so constitutes interference with the life-prolonging treatment then being administered by the doctor. Accordingly, whereas the doctor, in discontinuing life support, is simply allowing his patient to die of his pre-existing condition, the interloper is actively intervening to stop the doctor from prolonging the patient's life, and such conduct cannot possibly be categorised as an omission.

The distinction appears, therefore, to be useful in the present context in that it can be invoked to explain how discontinuance of life support can be differentiated from ending a patient's life by a lethal injection. But in the end the reason for that difference is that, whereas the law considers that discontinuance of life support may be consistent with the doctor's duty to care for his patient, it does not, for reasons of policy, consider that it forms any part of his duty to give his patient a lethal injection to put him out of his agony.

I return to the patient who, because for example he is of unsound mind or has been rendered unconscious by accident or by illness, is incapable of stating whether or not he consents to treatment or care. In such circumstances, it is now established that a doctor may lawfully treat such a patient if he acts in his best interests, and indeed that, if the patient is already in his care, he is under a duty so to treat him: see *In re F* [1990] 2 A.C. 1, in which the legal principles governing treatment in such circumstances were stated by this House. For my part I can see no reason why, as a matter of principle, a decision by a doctor whether or not to initiate, or to continue to provide, treatment or care which could or might have the effect of prolonging such a patient's life, should not be governed by the same fundamental principle. Of course, in the great majority of cases, the best interests of the patient are likely to require that treatment of this kind, if available, should be given to a patient. But this may not always be so. To take a simple example given by Thomas J. in *Re J.H.L.* (Unreported) (High Court of New Zealand) 13 August 1992, at p. 35), to whose judgment in that case I wish to pay tribute, it 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. As I see it, the doctor's decision whether or not to take any such step must (subject to his patient's ability to give or withhold his consent) be made in the best interests of the patient. It is this principle too which, in my opinion, underlies 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 that he knows that an incidental effect of that application will be to abbreviate the patient's life. Such a decision may properly be made as part of the care of the living patient, in his best interests; and, on this basis, the treatment will be lawful. Moreover, where the doctor's treatment of his patient is lawful, the patient's death will be regarded in law as exclusively caused by the injury or disease to which his condition is attributable.

It is of course the development of modern medical technology, and in particular the development of life support systems, which has rendered cases such as the present so much more relevant than in the past. Even so, where (for example) a patient is brought into hospital in such a condition that, without the benefit of a life support system, he will not continue to live, the decision has to be made whether or not to give him that benefit, if available. That decision can only be made in the best interests of the patient. No doubt, his best interests will ordinarily require that he should be placed on a life support system as soon as necessary, if only to make an accurate assessment of his condition and a prognosis for the future. But if he neither recovers sufficiently to be taken off it nor dies, the question will ultimately arise whether he should be kept on it indefinitely. As I see it, that question (assuming the continued availability of the system) can only be answered by reference to the best interests of the patient himself, having regard to established medical practice. Indeed, if the justification for treating a patient who lacks the capacity to consent lies in the fact that the treatment is provided in his best interests, it must follow that the treatment may, and indeed ultimately should, be discontinued where it is no longer in his best interests to provide it. The question which lies at the heart of the present case is, as I see it, whether on that principle the doctors responsible for the treatment and

care of Anthony Bland can justifiably discontinue the process of artificial feeding upon which the prolongation of his life depends.

It is crucial for the understanding of this question that the question itself should be correctly formulated. The question is not whether the doctor should take a course which will kill his patient, or even take a course which has the effect of accelerating his death. The question is whether the doctor should or should not continue to provide his patient with medical treatment or care which, if continued, will prolong his patient's life. The question is sometimes put in striking or emotional terms, which can be misleading. For example, in the case of a life support system, it is sometimes asked: Should a doctor be entitled to switch it off, or to pull the plug? And then it is asked: Can it be in the best interests of the patient that a doctor should be able to switch the life support system off, when this will inevitably result in the patient's death? Such an approach has rightly been criticised as misleading, for example by Professor Ian Kennedy (in his paper in *Treat Me Right, Essays in Medical Law and Ethics* (1988), and by Thomas J. in *Re J.H.L.* at pp. 21-22. This is because the question is not whether it is in the best interests of the patient that he should die. The 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 medical treatment or care.

The correct formulation of the question is of particular importance in a case such as the present, where the patient is totally unconscious and where there is no hope whatsoever of any amelioration of his condition. In circumstances such as these, it may be difficult to say that it is in his best interests that the treatment should be ended. But if the question is asked, as in my opinion it should be, whether it is in his best interests that treatment

which has the effect of artificially prolonging his life should be continued, that question can sensibly be answered to the effect that it is not in his best interests to do so.

Even so, a distinction may be drawn between (1) cases in which, having regard to all the circumstances (including, for example, the intrusive nature of the treatment, the hazards involved in it, and the very poor quality of the life which may be prolonged for the patient if the treatment is successful), it may be judged not to be in the best interests of the patient to initiate or continue life-prolonging treatment, and (2) cases such as the present in which, so far as the living patient is concerned, the treatment is of no benefit to him because he is totally unconscious and there is no prospect of

any improvement in his condition. In both classes of case, the decision whether or not to withhold treatment must be made in the best interests of the patient. In the first class, however, the decision has to be made by weighing the relevant considerations. For example, in *In re J. (A Minor) (Wardship: Medical Treatment)* [1991] Fam. 33, the approach to be adopted in that case was stated, at p. 55, by Taylor L.J. as follows:

> "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."

With this class of case, however, your Lordships are not directly concerned in the present case; and though I do not wish to be understood to be casting any doubt upon any of the reported cases on the subject, nevertheless I must record that argument was not directed specifically towards these cases, and for that reason I do not intend to express any opinion about the precise principles applicable in relation to them.

By contrast, in the latter class of case, of which the present case provides an example, there is in reality no weighing operation to be performed. Here the condition of the patient, who is totally unconscious and in whose condition there is no prospect of any improvement, is such that life-prolonging treatment is properly regarded as being, in medical terms, useless. As the Master of the Rolls pointed out in the present case, medical treatment or care may be provided for a number of different purposes. It may be provided, for example, as an aid to diagnosis; for the treatment of physical or mental injury or illness; to alleviate pain or distress, or to make the patient's condition more tolerable. Such purposes may include prolonging the patient's life, for example to enable him to survive during diagnosis and treatment. But for my part I cannot see that medical treatment is appropriate or requisite simply to prolong a patient's life, when such treatment has no therapeutic purpose of any kind, as where it is futile because the patient is unconscious and there is no prospect of any improvement in his condition. It is reasonable also that account should be taken of the invasiveness of the treatment and of the indignity to which, as the present case shows, a person

has to be subjected if his life is prolonged by artificial means, which must cause considerable distress to his family - a distress which reflects not only their own feelings but their perception of the situation of their relative who is being kept alive. But in the end, in a case such as the present, it is the futility

of the treatment which justifies its termination. I do not consider that, in circumstances such as these, a doctor is required to initiate or to continue life-prolonging treatment or care in the best interests of his patient. It follows 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.

In the present case, it is proposed that the doctors should be entitled to discontinue both the artificial feeding of Anthony, and the use of antibiotics. It is plain from the evidence that Anthony, in his present condition, is very prone to infection and that, over some necessarily uncertain but not very long period of time, he will succumb to infection which, if unchecked, will spread and cause his death. But the effect of discontinuing the artificial feeding will be that he will inevitably die within one or two weeks.

Objection can be made to the latter course of action on the ground that Anthony will thereby be starved to death, and that this would constitute a breach of the duty to feed him which must form an essential part of the duty which every person owes to another in his care. But here again it is necessary to analyse precisely what this means in the case of Anthony. Anthony is not merely incapable of feeding himself. He is incapable of swallowing, and therefore of eating or drinking in the normal sense of those words. There is overwhelming evidence that, in the medical profession, artificial feeding is regarded as a form of medical treatment; and even if it is not strictly medical treatment, it must form part of the medical care of the patient. Indeed, the function of artificial feeding in the case of Anthony, by means of a nasogastric tube, is to provide a form of life support analogous to that provided by a ventilator which artificially breathes air in and out of the lungs of a patient incapable of breathing normally, thereby enabling oxygen to reach the bloodstream. The same principles must apply in either case when the question is asked whether the doctor in charge may lawfully discontinue the life-sustaining treatment or care; and if in either case the treatment is futile in the sense I have described, it can properly be concluded that it is no longer in the best interests of the patient to continue it. It is true that, in the case of discontinuance of artificial feeding, it can be said that the patient will as a result starve to death; and this may bring before our eyes the vision of an ordinary person slowly dying of hunger, and suffering all the pain and distress associated with such a death. But here it is clear from the evidence that no such pain or distress will be suffered by Anthony, who can feel nothing at all. Furthermore, we are told that the outward symptoms of dying in such a way, which might otherwise cause distress to the nurses who care for him or to

members of his family who visit him, can be suppressed by means of sedatives. In these circumstances, I can see no ground in the present case for

refusing the declarations applied for simply because the course of action proposed involves the discontinuance of artificial feeding.

In *In re F* [1990] 2 A.C. 1 it was stated that, where a doctor provides treatment for a person who is incapacitated from saying whether or not he consents to it, the doctor must, when deciding on the form of treatment, act in accordance with a responsible and competent body of relevant professional opinion, on the principles set down in *Bolam v. Friern Hospital Management Committee* [1957] 1 W.L.R. 582. In my opinion, this principle must equally be applicable to decisions to initiate, or to discontinue, life support, as it is to other forms of treatment. However, in a matter of such importance and sensitivity as discontinuance of life support, it is to be expected that guidance will be provided for the profession; and, on the evidence in the present case, such guidance is for a case such as the present to be found in a Discussion Paper on Treatment of Patients in Persistent Vegetative State, issued in September 1992 by the Medical Ethics Committee of the British Medical Association. Anybody reading this substantial paper will discover for himself the great care with which this topic is being considered by the profession. Mr Francis, for the respondents, drew to the attention of the Appellate Committee four safeguards in particular which, in the committee's opinion, should be observed before discontinuing life support for such patients. They are:

(1) Every effort should be made at rehabilitation for at least six months after the injury; (2) The diagnosis of irreversible PVS should not be considered confirmed until at least twelve months after the injury, with the effect that any decision to withhold life-prolonging treatment will be delayed for that period; (3) The diagnosis should be agreed by two other independent doctors; and (4) Generally, the wishes of the patient's immediate family will be given great weight.

In fact, the views expressed by the Committee on the subject of consultation with the relatives of PVS patients are consistent with the opinion expressed by your Lordships' House in *In re F* [1990] 2 A.C. 1 that it is good practice for the doctor to consult relatives. Indeed the committee recognises that, in the case of PVS patients, the relatives themselves will require a high degree of support and attention. But the committee is firmly of the opinion that the relatives' views cannot be determinative of the treatment. Indeed, if that were not so, the relatives would be able to dictate to the doctors what is

in the best interests of the patient, which cannot be right. Even so, a decision to withhold life-prolonging treatment, such as artificial feeding, must require close co-operation with those close to the patient; and it is recognised that, in practice, their views and the opinions of doctors will coincide in many cases.

Study of this document left me in no doubt that, if a doctor treating a PVS patient acts in accordance with the medical practice now being evolved by the Medical Ethics Committee of the B.M.A., he will be acting with the benefit of guidance from a responsible and competent body of relevant

professional opinion, as required by the *Bolam* test [1957] 1 W.L.R. 582. I also feel that those who are concerned that a matter of life and death, such as is involved in a decision to withhold life support in case of this kind, should be left to the doctors, would do well to study this paper. The truth is that, in the course of their work, doctors frequently have to make decisions which may affect the continued survival of their patients, and are in reality far more experienced in matters of this kind than are the judges. It is nevertheless the function of the judges to state the legal principles upon which the lawfulness of the actions of doctors depend; but in the end the decisions to be made in individual cases must rest with the doctors themselves. In these circumstances, what is required is a sensitive understanding by both the judges and the doctors of each other's respective functions, and in particular a determination by the judges not merely to understand the problems facing the medical profession in cases of this kind, but also to regard their professional standards with respect. Mutual understanding between the doctors and the judges is the best way to ensure the evolution of a sensitive and sensible legal framework for the treatment and care of patients, with a sound ethical base, in the interest of the patients themselves. This is a topic to which I will return at the end of this opinion, when I come to consider the extent to which the view of the court should be sought, as a matter of practice, in cases such as the present.

I wish however to refer at this stage to the approach adopted in most American courts, under which the court seeks, in a case in which the patient is incapacitated from expressing any view on the question whether life-prolonging treatment should be withheld in the relevant circumstances, to determine what decision the patient himself would have made had he been able to do so. This is called the substituted judgment test, and it generally involves a detailed inquiry into the patient's views and preferences: see, e.g., *Re Quintan* (1976) 355 A. 2d 647, and *Superintendent of Belchertown State*

School v. Saikewicz 370 N.E. 2d 417. In later cases concerned with PVS patients it has been held that, in the absence of clear and convincing evidence of the patient's wishes, the surrogate decision-maker has to implement as far as possible the decision which the incompetent patient would make if he was competent. However, accepting on this point the submission of Mr Lester, I do not consider that any such test forms part of English law in relation to incompetent adults, on whose behalf nobody has power to give consent to medical treatment. Certainly, in *In re F* [1990] 2 A.C. 1 your Lordships' House adopted a straightforward test based on the best interests of the patient; and I myself do not see why the same test should not be applied in the case of PVS patients, where the question is whether life-prolonging treatment should be withheld. This was also the opinion of Thomas J. in *Re J.H.L.*, a case concerned with the discontinuance of life support provided by ventilator to a patient suffering from the last stages of incurable Guillain-Barre syndrome. Of course, consistent with the best interests test, anything relevant to the application of the test may be taken into account; and if the personality of the patient is relevant to the application of the test (as it may be in cases where the various relevant factors have to be weighed), it may be

taken into account, as was done in *In re J (A Minor) (Wardship: Medical Treatment)* [1991] Fam. 33. But where the question is whether life support should be withheld from a PVS patient, it is difficult to see how the personality of the patient can be relevant, though it may be of comfort to his relatives if they believe, as in the present case, and indeed may well be so in many other cases, that the patient would not have wished his life to be artificially prolonged if he was totally unconscious and there was no hope of improvement in his condition.

I wish to add however that, like the courts below, I have derived assistance and support from decisions in a number of American jurisdictions to the effect that it is lawful to discontinue life-prolonging treatment hi the case of PVS patients where there is no prospect of improvement in their condition. Furthermore, I wish to refer to the section in Working Paper No. 28 (1982) on Euthanasia, Aiding Suicide and Cessation of Treatment published by the Law Reform Commission of Canada concerned with cessation of treatment, to which I also wish to express my indebtedness. I believe the legal principles as I have stated them to be broadly consistent with the conclusions summarised at pp. 65-66 of the Working Paper, which was substantially accepted in the Report of the Commission (1983), pp. 32-35. Indeed, I entertain a strong sense that a community of view on the legal

principles applicable in cases of discontinuing life support is in the course of development and acceptance throughout the common law world.

In setting out my understanding of the relevant principles, I have had very much in mind the submissions advanced by Mr Munby on behalf of the Official Solicitor, and I believe that I have answered, directly or indirectly, all his objections to the course now proposed. I do not, therefore, intend any disrespect to his argument if I do not answer each of his submissions seriatim. In summary, his two principal arguments were as follows. First, he submitted that the discontinuance of artificial feeding would constitute an act which would inevitably cause, and be intended to cause, Anthony's death; and as such, it would be unlawful, and indeed criminal. As will be plain from what I have already said, I cannot accept this proposition. In my opinion, for the reasons I have already given, there is no longer any duty upon the doctors to continue with this form of medical treatment or care in his case, and it follows that it cannot be unlawful to discontinue it. Second, he submitted that discontinuance of the artificial feeding of Anthony would be a breach of the doctor's duty to care for and feed him; and since it will (as it is intended to do) cause his death, it will necessarily be unlawful. I have considered this point earlier in this opinion, when I expressed my view that artificial feeding is, in a case such as the present, no different from life support by a ventilator, and as such can lawfully be discontinued when it no longer fulfils any therapeutic purpose. To me, the crucial point in which I found myself differing from Mr Munby was that I was unable to accept his treating the discontinuance of artificial feeding in the present case as equivalent to cutting a mountaineer's rope, or severing the air pipe of a deep sea diver. Once it is recognised, as I believe it must be, that the true question is not whether the

doctor should take a course in which he will actively kill his patient, but rather whether he should continue to provide his patient with medical treatment or care which, if continued, will prolong his life, then, as I see it, the essential basis of Mr Munby's submissions disappears. I wish to add that I was unable to accept his suggestion that recent decisions show that the law is proceeding down a "slippery slope", in the sense that the courts are becoming more and more ready to allow doctors to take steps which will result in the ending of life. On the contrary, as I have attempted to demonstrate, the courts are acting within a structure of legal principle, under which in particular they continue to draw a clear distinction between the bounds of lawful treatment of a living patient, and unlawful euthanasia.

I turn finally to the extent to which doctors should, as a matter of practice, seek the guidance of the court, by way of an application for declaratory relief, before withholding life-prolonging treatment from a PVS patient. The President considered that the opinion of the court should be sought in all cases similar to the present. In the Court of Appeal, the Master of the Rolls expressed his agreement with the President in the following words:

> "This was in my respectful view a wise ruling, directed to the protection of patients, the protection of doctors, the reassurance of patients' families and the reassurance of the public. The practice proposed seems to me desirable. It may very well be that with the passage of time a body of experience and practice will build up which will obviate the need for application in every case, but for the time being I am satisfied that the practice which the President described should be followed."

Before the Appellate Committee, this view was supported both by Mr Munby, for the Official Solicitor, and by Mr Lester, as amicus curiae. For the respondents, Mr Francis suggested that an adequate safeguard would be provided if reference to the court was required in certain specific cases, i.e. (1) where there was known to be a medical disagreement as to the diagnosis or prognosis, and (2) problems had arisen with the patient's relatives - disagreement by the next of kin with the medical recommendation; actual or apparent conflict of interest between the next of kin and the patient; dispute between members of the patient's family; or absence of any next of kin to give their consent. There is, I consider, much to be said for the view that an application to the court will not be needed in every case, but only in particular circumstances, such as those suggested by Mr Francis. In this connection I was impressed not only by the care being taken by the Medical Ethics Committee to provide guidance to the profession, but also by information given to the Appellate Committee about the substantial number of PVS patients in the country, and the very considerable cost of obtaining guidance from the court in cases such as the present. However, in my opinion this is a matter which would be better kept under review by the President of the Family Division than resolved now by your Lordships' House. I understand

that a similar review is being undertaken in cases concerned with the sterilisation of adult women of unsound mind, with a consequent relaxation of the practice relating to applications to the court in such cases. For my part, I would therefore leave the matter as proposed by the Master of the Rolls;

but I wish to express the hope that the President of the Family Division, who will no doubt be kept well informed about developments in this field, will soon feel able to relax the present requirement so as to limit applications for declarations to those cases in which there is a special need for the procedure to be invoked.

I wish to add one footnote. Since preparing this opinion, I have had the opportunity of reading in draft the speech of my noble and learned friend, Lord Browne Wilkinson, in which he has expressed the view that a doctor, in reaching a decision whether or not to continue, in the best interests of his patient, to prolong his life by artificial means, may well be influenced by his own attitude to the sanctity of human life. The point does not arise for decision in the present case. I only wish to observe that it has implications not only in the case of a patient who, like Anthony Bland, is totally unconscious, but also one who may be suffering from great physical pain or (as in the case of one suffering from Guillain-Barre syndrome) extreme mental distress; and it would in theory fall to be tested if the patient's relatives, dismayed by the artificial prolongation of the agony of their loved one, were to seek to restrain by injunction a doctor who was persisting in prolonging his life. I cannot help feeling, however, that such a situation is more theoretical than real. I suspect that it is unlikely to arise in practice, if only because the solution could be found in a change of medical practitioner. It is not to be forgotten, moreover, that doctors who for conscientious reasons would feel unable to discontinue life support in such circumstances can presumably, like those who have a conscientious objection to abortion, abstain from involvement in such work. For present purposes, however, it is enough to state that the best interests test is broad and flexible in the sense that room must be allowed for the exercise of judgment by the doctor as to whether the relevant conditions exist which justify the discontinuance of life support.

For these reasons, I would dismiss the appeal. Having read in draft the speech of my noble and learned friend Lord Keith of Kinkel, I can see no significant difference from the opinion which I have expressed.

LORD LOWRY

My Lords,

I have had the advantage of reading in draft the speeches of my noble and learned friends and, for the reasons given by my noble and learned friend Lord Goff of Chieveley, with which I understand the remainder of your

Lordships to be generally in agreement, I agree that this appeal should be dismissed.

I cannot usefully elaborate on your Lordships' careful analysis of the arguments. There are, however, four points in relation to your Lordships' reasoning and conclusions which it may be worth my while to make.

3. I do not believe that there is a valid legal distinction between the omission to treat a patient and the abandonment of treatment which has been commenced, since to recognise such a distinction could quite illogically confer on a doctor who had refrained from treatment an immunity which did not benefit a doctor who had embarked on treatment in order to see whether it might help the patient and had abandoned the treatment when it was seen not to do so.

4. As noted in *In re F (Mental Patient: Sterilisation)* [1990] 2 A.C. 1 and again in your Lordships' speeches, the parens patriae jurisdiction over adults who are for whatever reason mentally incompetent was abolished by statute. I have never heard a rational, or indeed any, explanation for this step, which has placed under a further disadvantage a class of adults who are already handicapped. Parliament has done nothing since *In re F* was decided, but I sincerely hope that the parens patriae jurisdiction over adults will soon be restored. The corresponding jurisdiction in wardship has continued to prove its value and it is most unfortunate that the court's armoury in relation to adults remains thus depleted. The prospect of restoration of this lost power is not controversial, since it does not conjure up the spectre of euthanasia; the decisions which can be made by the courts on behalf of incompetent persons would, as in wardship cases, be confined within lawful bounds.

5. Procedurally I can see no present alternative to an application to the court such as that made in the present case. This view is reinforced for me when I reflect, against the background of your Lordships' conclusions of law, that, in the absence of an application, the doctor who proposes the cessation of life-supporting care and treatment on the ground that their continuance would not be in the patient's best interests will have reached that conclusion himself and will be judge in his own cause unless and until his chosen course of action is challenged in criminal or civil proceedings. A practical alternative may, however, be evolved through the practice of the Family Division and with the help of the Medical Ethics Committee, which has already devoted so much thought to the problem, and possibly of Parliament through legislation, it will of course be understood that the court has no power to render lawful

something which without the court's sanction would have been unlawful. When I take into account that the case now before your Lordships could not be clearer on its facts, I have to say that I am left with the feeling that the general position is not satisfactory.

6. Although entirely satisfied with your Lordships' consensus, I ought finally to touch on the real point in the case. The strength of the Official

Solicitor's argument lies in its simplicity. In answer to the respondent's reliance on accepted medical opinion that feeding (nutrition and hydration), particularly by sophisticated artificial methods, is part of the life-supporting medical treatment, he says that the 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: to omit deliberately to perform this duty in the knowledge that the omission will lead to the death of the helpless one, and indeed with the intention, as in the present case, of conducing to that death, will render those in charge guilty of murder. One of the respondent's counter arguments, albeit not conclusive, is based on the overwhelming verdict of informed medical opinion worldwide, with particular reference to the common law jurisdictions, where the relevant law generally corresponds closely with our own, 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 contends. In this connection it may also be emphasised that an artificial feeding regime is inevitably associated with the continuous use of catheters and enemas and the sedulous avoidance and combatting of potentially deadly infection. I consider that the court, when intent on reaching a decision according to law, ought to give weight to informed medical opinion both on the point now under discussion and also on the question of what is in the best interests of a patient and I reject the idea, which is implicit in the appellant's argument, that informed medical opinion in these respects is merely a disguise for a philosophy which, if accepted, would legalise euthanasia.

The real answer to the Official Solicitor, as your Lordships are already agreed, is that his argument starts from the fallacious premiss, which can be taken as correct in ordinary doctor-patient relationships, namely, that feeding in order to sustain life is <u>necessarily</u> for the benefit of the patient. But in the prevailing circumstances the opposite view is overwhelmingly held by the

doctors and the validity of that view has been accepted by the courts below. The doctors consider that in the patient's best interests they ought not to feed him and the law, as applied by your Lordships, has gone further by saying that they are not entitled to feed him without his consent, which cannot be obtained. So the theory of the "duty to feed" is founded on a misapprehension and the Official Solicitor's argument leads to a legally erroneous conclusion. Even though the intention to bring about the patient's death is there, there is no proposed guilty act because, if 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 continued the care and treatment and would perform no guilty act by discontinuing.

I have no difficulty in accepting both this legal conclusion and its practical effect, but it is not hard to see how the case might appear to a non-lawyer, who might express himself on the following lines:

> "Yes, I understand the point, now that you have explained it to me. There is no duty, or indeed right to feed, when feeding is not in the best interests of the patient. But the real reason for withdrawing feeding is that the doctors consider that it would be in the patients best interests for him to be allowed to die. (I also know that the same result could be achieved, if not so quickly, by allowing the patient's next infection to go untreated, but that is not just the point which we have been discussing here.) The solution here seems to me to introduce what lawyers call a distinction without a difference: the intention is to terminate life, but the acceptable way of doing it is to discontinue a regime which the law has said that the doctors have no duty or even right to continue. And, incidentally, *In re F* (not that I would venture to query your reliance on that authority) was not concerned with matters of life and death at all. So might it not be suggested, no doubt quite wrongly, that this case is, in effect if not in law, an example of euthanasia in action? I can of course appreciate the arguments in a case like this, for indirectly terminating the patient's life and I believe that very many of my friends would be in favour of what is now proposed, but equally there must be many people who, from conviction or simply by virtue of their conventional

upbringing, are unconvinced that someone who can be kept alive should be allowed to die."

My Lords, I have used the homely expedient of attributing these words to my hypothetical non-lawyer in order to demonstrate the possible gap which my noble and learned friend Lord Mustill sees between old law and new medicine and perhaps also, I might add, new ethics. It is important, particularly in the area of criminal law which governs conduct, that society's notions of what is the law and what is right should coincide. One role of the legislator is to detect any disparity between these notions and to take appropriate action to close the gap.

At all events, for the reasons already relied on by your Lordships, I, too, would dismiss this appeal.

LORD BROWNE-WILKINSON

My Lords,

In this case the courts are asked to give the answer to two questions: whether the Airedale N.H.S. Trust and the physicians attending Anthony Bland may:

"(1) lawfully discontinue all life-sustaining treatment and medical support measures designed to keep [Mr. Bland] alive in his existing

persistent vegetative state including the termination of ventilation, nutrition and hydration by artificial means; and

"(2) lawfully discontinue and thereafter need not furnish medical treatment to [Mr. Bland] except for the sole purpose of enabling [Mr. Bland] to end his life and die peacefully with the greatest dignity and the least of pain, suffering and distress."

Those are questions of law. But behind the questions of law lie moral, ethical, medical and practical issues of fundamental importance to society. As Hoffman L.J. in the Court of Appeal emphasised, the law regulating the termination of artificial life support being given to patients must, to be acceptable, reflect a moral attitude which society accepts. This has led judges

into the consideration of the ethical and other non-legal problems raised by the ability to sustain life artificially which new medical technology has recently made possible. But in my judgment in giving the legal answer to these questions judges are faced with a dilemma. The ability to sustain life artificially is of relatively recent origin. Existing law may not provide an acceptable answer to the new legal questions which it raises. Should judges seek to develop new law to meet a wholly new situation? Or is this a matter which lies outside the area of legitimate development of the law by judges and requires society, through the democratic expression of its views in Parliament, to reach its decisions on the underlying moral and practical problems and then reflect those decisions in legislation?

I have no doubt that it is for Parliament, not the courts, to decide the broader issues which this case raises. Until recently there was no doubt what was life and what was death. A man was dead if he stopped breathing and his heart stopped beating. There was no artificial means of sustaining these indications of life for more than a short while. Death in the traditional sense was beyond human control. Apart from cases of unlawful homicide, death occurred automatically in the course of nature when the natural functions of the body failed to sustain the lungs and the heart.

Recent developments in medical science have fundamentally affected these previous certainties. In medicine, the cessation of breathing or of heartbeat is no longer death. By the use of a ventilator, lungs which in the unaided course of nature would have stopped breathing can be made to breathe, thereby sustaining the heartbeat. Those, like Anthony Bland, who would previously have died through inability to swallow food can be kept alive by artificial feeding. This has led the medical profession to redefine death in terms of brain stem death, i.e. the death of that part of the brain without which the body cannot function at all without assistance. In some cases it is now apparently possible, with the use of the ventilator, to sustain a beating heart even though the brain stem, and therefore in medical terms the patient, is dead; "the ventilated corpse".

I do not refer to these factors because Anthony Bland is already dead, either medically or legally. His brain stem is alive and so is he; provided that he is artificially fed and the waste products evacuated from his body by skilled medical care, his body sustains its own life. I refer to these factors in order to illustrate the scale of the problem which is presented by modern

technological developments, of which this case is merely one instance. The physical state known as death has changed. In many cases the time and manner of death is no longer dictated by nature but can be determined by human decision. The life of Anthony Bland, in the purely physical sense, has been and can be extended by skilled medical care for a period of years.

To my mind, these technical developments have raised a wholly new series of ethical and social problems. What is meant now by "life" in the moral precept which requires respect for the sanctity of human life? If the quality of life of a person such as Anthony Bland is non-existent since he is unaware of anything that happens to him, has he a right to be sustained in that state of living death and are his family and medical attendants under a duty to maintain it? If Anthony Bland has no such right and others no such duty, should society draw a distinction (which some would see as artificial) between adopting a course of action designed to produce certain death, on the one hand through the lack of food, and on the other from a fatal injection, the former being permissible and the latter (euthanasia) prohibited? If the withdrawal of life support is legitimate in the case of Anthony Bland, whose P.V.S. is very severe, what of others in this country also in P.V.S. (whom we were told numbered between 1,000 and 1,500) and others suffering from medical conditions having similar impact, e.g. the Guillain-Barre syndrome? Who is to decide, and according to what criteria, who is to live and who to die? What rights have the relatives of the patient in taking that decision?

In addition to these ethical questions, the new technology raises practical problems. Given that there are limited resources available for medical care, is it right to devote money to sustaining the lives of those who are, and always will be, unaware of their own existence rather than to treating those who, in a real sense, can be benefitted e.g. those deprived of dialysis for want of resources. Again, the timing of the patient's death may have a direct impact on the rights of other parties. In the case of a patient suffering from P.V.S. as a result of a road accident, the amount of damages recoverable will depend on whether the patient is kept alive or allowed to die. We were told by the Official Solicitor that there have already been cases in which this factor has been taken into account by relatives of the patient, though there is no question of that in the present case. Again, rights of succession to the estate of the patient may well depend on the timing of his death.

On the moral issues raised by this case, society is not all of one mind. Although it is probably true that the majority would favour the withdrawal of life support in the present case, there is undoubtedly a substantial body of opinion that is strongly opposed. The evidence shows that the Roman Catholic church and orthodox Jews are opposed. Within the medical

profession itself, there are those, including one of the very distinguished doctors who gave evidence in this case, who draw a distinction between withholding treatment on the one hand and withholding food and care on the other, the latter not being acceptable. The present case is an extreme one, since Anthony Bland can appreciate nothing whether he is alive or dead: but I have no doubt that less extreme cases will come before the courts on which public opinion may be more sharply divided.

The position therefore, in my view, is that if the judges seek to develop new law to regulate the new circumstances, the law so laid down will of necessity reflect judges' views on the underlying ethical questions, questions on which there is a legitimate division of opinion. By way of example, although the Court of Appeal in this case, in reaching the conclusion that the withdrawal of food and Anthony Bland's subsequent death would be for his benefit, attach importance to impalpable factors such as personal dignity and the way Anthony Bland would wish to be remembered but do not take into account spiritual values which, for example, a member of the Roman Catholic church would regard as relevant in assessing such benefit. Where a case raises wholly new moral and social issues, in my judgment it is not for the judges to seek to develop new, all embracing, principles of law in a way which reflects the individual judges' moral stance when society as a whole is substantially divided on the relevant moral issues. Moreover, it is not legitimate for a judge in reaching a view as to what is for the benefit of the one individual whose life is in issue to take into account the wider practical issues as to allocation of limited financial resources or the impact on third parties of altering the time at which death occurs.

For these reasons, it seems to me imperative that the moral, social and legal issues raised by this case should be considered by Parliament. The judges' function in this area of the law should be to apply the principles which society, through the democratic process, adopts, not to impose their standards on society. If Parliament fails to act, then judge-made law will of necessity through a gradual and uncertain process provide a legal answer to each new question as it arises. But in my judgment that is not the best way to proceed.

The function of the court in these circumstances is to determine this particular case in accordance with the existing law, and not seek to develop new law laying down a new regimen. The result of this limited approach may be unsatisfactory, both in moral and practical terms, but it is for Parliament to address the wider problems which the case raises and lay down principles of law generally applicable to the withdrawal of life support systems.

Before turning to the strict legality of what is proposed, I must say something about the procedure adopted in this case. The application asks the court to make declarations as to the legality of proposed future actions i.e. if granted, the declarations will purport to decide whether the proposed discontinuance of life support will constitute a crime. In general the court sets its face against making declarations as to the criminality of proposed future

actions. But I agree with my noble and learned friend Lord Goff of Chieveley that in this case it is absolutely necessary to do so. The doctors responsible for Anthony Bland's care have reached the view that it is for his benefit to withdraw life support but have been warned by the coroner that it may constitute a criminal offence if they do so. In the past, doctors exercised their own discretion, in accordance with medical ethics, in cases such as these. To the great advantage of society, they took the responsibility of deciding whether the perpetuation of life was pointless. But there are now present amongst the medical and nursing staff of hospitals those who genuinely believe in the sanctity of human life, no matter what the quality of that life, and report doctors who take such decisions to the authorities with a view to prosecution for a criminal offence. I am not criticising such people: they are acting in accordance with their own moral standards. But their actions have made it extremely risky for a doctor to take a decision of this kind when his action may lie on the borderline of legality. I have no doubt that the courts should, by declaration, provide to doctors faced with such decisions clear rulings whether the course they propose to adopt is or is not lawful.

I turn then to the question whether, under existing law, the proposed discontinuance of the artificial feeding of Anthony Bland would be lawful. Such discontinuance might be unlawful because (a) it would constitute a criminal offence or (b) it will give rise to civil liability to Anthony Bland or his personal representatives after his death.

A. Criminal Liability/Murder

It is the submission of the Official Solicitor that the withdrawal of artificial feeding would constitute murder. The Official Solicitor has been criticized for using emotive language in this case. In my judgment this criticism is misplaced: much the most difficult question is indeed whether the proposed course of action is, in law, murder notwithstanding the best motives from which everyone concerned is acting.

Murder consists of causing the death of another with intent so to do. What is proposed in the present case is to adopt a course with the intention of bringing about Anthony Bland's death. As to the element of intention or mens rea, in my 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.

As to the guilty act, or actus reus, the criminal law draws a distinction between the commission of a positive act which causes death and the omission to do an act which would have prevented death. In general an omission to prevent death is not an actus reus and cannot give rise to a conviction for murder. But where the accused was under a duty to the deceased to do the act which he omitted to do, such omission can constitute the actus reus of homicide, either murder *(Rex. v. Gibbins and Proctor* (1918) 13 Cr. App. Rep. 134) or manslaughter *(Reg. v. Stone* [1977] Q.B. 354) depending upon

the mens rea of the accused. The Official Solicitor submits that the actus reus of murder is present on two alternative grounds, viz.

7. The withdrawal of artificial feeding is a positive act of commission; or

8. If what is proposed is only an omission, the hospital and the doctors have assumed a duty to care for Anthony Bland (including feeding him) and therefore the omission to feed him would constitute the actus reus of murder.

1. Positive Act of Commission

Mr Munby, in his powerful but balanced argument for the Official Solicitor, submits that the removal of the nasogastric tube necessary to provide artificial feeding and the discontinuance of the existing regime of artificial feeding constitute positive acts of commission. I do not accept this. Apart from the act of removing the nasogastric tube, the mere failure to continue to do what you have previously done is not, in any ordinary sense, to do anything positive: on the contrary it is by definition an omission to do what you have previously done.

The positive act of removing the nasogastric tube presents more difficulty. It is undoubtedly a positive act, similar to switching off a ventilator in the case of a patient whose life is being sustained by artificial ventilation. But in my judgment in neither case should the act be classified as positive,

since to do so would be to introduce intolerably fine distinctions. If, instead of removing the nasogastric tube, it was left in place but no further nutrients were provided for the tube to convey to the patient's stomach, that would not be an act of commission. Again, as has been pointed out (Skegg, *Law, Ethics and Medicine,* (1984) p. 169 et seq.) if the switching off of a ventilator were to be classified as a positive act, exactly the same result can be achieved by installing a time-clock which requires to be re-set every 12 hours: the failure to re-set the machine could not be classified as a positive act. In my judgment, essentially what is being done is to omit to feed or to ventilate: the removal of the nasogastric tube or the switching off of a ventilator are merely incidents of that omission: see Glanville Williams, *Textbook of Criminal Law,* 2nd ed. (1983), p. 282, Skegg p. 169 et seq.

In my judgment, there is a further reason why the removal of the naso-gastric tube in the present case could not be regarded as a positive act causing the death. The tube itself, without the food being supplied through it, does nothing. The removal of the tube by itself does not cause the death since by itself it did not sustain life. Therefore even if, contrary to my view, the removal of the tube is to be classified as a positive act, it would not constitute the actus reus of murder since such positive act would not be the cause of death.

2. Omission: Duty to provide care

Mr Munby submits that by starting to treat Anthony Bland as a patient and instituting a regime of artificial feeding, the hospital and doctors have undertaken a duty to provide him with medical care and food for an indefinite period. That being their duty, the withdrawal of artificial feeding, even though a mere omission, will be a breach of that duty and therefore constitute murder.

The crux of this submission is the extent of the duty owed by the hospital and the doctors to Anthony Bland. In order to analyse the nature of that duty, it is necessary first to consider the relationship between a doctor and a patient who, through mental disability, is unable to consent to treatment. Any treatment given by a doctor to a patient which is invasive (i.e. involves any interference with the physical integrity of the patient) is unlawful unless done with the consent of the patient: it constitutes the crime of battery and the tort of trespass to the person. Thus, in the case of an adult who is mentally competent, the artificial feeding regime (and the attendant steps

necessary to evacuate the bowels and bladder) would be unlawful unless the patient consented to it. A mentally competent patient can at any time put an end to life support systems by refusing his consent to their continuation. In the ordinary case of murder by positive act of commission, the consent of the victim is no defence. But where the charge is one of murder by omission to do an act and the act omitted could only be done with the consent of the patient, refusal by the patient of consent to the doing of such act does, indirectly, provide a defence to the charge of murder. The doctor cannot owe to the patient any duty to maintain his life where that life can only be sustained by intrusive medical care to which the patient will not consent.

How then does the matter stand in the case of a patient who, by reason of his being under age or, like Anthony Bland, of full age but mentally disabled, is unable to give consent to treatment? So far as minors are concerned, the guardian of the child can consent, failing which the court, exercising the Crown's rights as parens patriae under the wardship jurisdiction, can consent on the child's behalf. Until 1960, the court had the same parens patriae jurisdiction over adults who were mentally incompetent. But by the joint effect of the Mental Health Act, 1959, and the revocation of the Warrant under the Signed Manual under which the jurisdiction of the Crown as parens patriae over those of unsound mind was conferred on the courts, the courts ceased to have any parens patriae jurisdiction over the person of a mentally incompetent adult, being left only with the statutory jurisdiction over his property (as opposed to his person) conferred by the Act of 1959: *In re F* [1990] 2 A.C. 1. Although no one has been able to explain why Parliament chose to take this course (indeed it has been suggested that it was an accident) no step has been taken to restore to the courts the parens patriae jurisdiction over the body of a mentally disabled adult. As a result the court, even if it thought fit, has no power on Anthony Bland's behalf either

to consent or refuse consent to the continuation of the invasive procedures involved in artificial feeding.

Faced with this lacuna in the law, this House in *In re F* developed and laid down a principle, based on concepts of necessity, under which a doctor

can lawfully treat a patient who cannot consent to such treatment if it is in the best interests of the patient to receive such treatment. In my view, the correct answer to the present case depends on the extent of the right to continue lawfully to invade the bodily integrity of Anthony Bland without his consent. If in the circumstances they have no right to continue artificial feeding, they cannot be in breach of any duty by ceasing to provide such feeding.

What then is the extent of the right to treat Anthony Bland which can be deduced from *In re F*? Both Lord Brandon of Oakbrook (p. 64) and Lord Goff (pp. 75 and 77) make it clear that the right to administer invasive medical care is wholly dependent upon such care being in the best interests of the patient. Moreover, a doctor's decision whether invasive care is in the best interests of the patient falls to be assessed by reference to the test laid down in *Bolam v. Friern Hospital Management Committee* [1957] 1 W.L.R. 582 viz. is the decision in accordance with a practice accepted at the time by a responsible body of medical opinion: see per Lord Brandon (pp. 66-67) Lord Goff (p. 78). In my judgment it must follow from this that if there comes a stage where the responsible doctor comes to the reasonable conclusion (which accords with the views of a responsible body of medical opinion) that further continuance of an intrusive life support system is not in the best interests of the patient, he can no longer lawfully continue that life support system: to do so would constitute the crime of battery and the tort of trespass to the person. Therefore he cannot be in breach of any duty to maintain the patient's life. Therefore he is not guilty of murder by omission.

3. What is the correct question?

If I am right so far in my analysis, 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. That question is not the same as, "Is it in Anthony Bland's best interests that he should die?" The latter question assumes that it is lawful to perpetuate the patient's life: but such perpetuation of life can only be achieved if it is lawful to continue to invade the bodily integrity of the patient by invasive medical care. Unless the doctor has reached the affirmative conclusion that it is in the patient's best interest to continue the invasive care, such care must cease.

The answer to the question must of course depend on the circumstances of each case and there will be no single "right" answer. Different doctors may take different views both on strictly medical issues and the broader ethical issues which the question raises. It follows that the legal question in this case (unlike the question which would arise if there were a parens patriae jurisdiction under which the court has to make the decision) is not whether the

court thinks it is in the best interests of Anthony Bland to continue to receive intrusive medical care but whether the responsible doctor has reached a reasonable and bona fide belief that it is not. The doctor's answer may well be influenced by his own attitude to the sanctity of human life. In cases where there is no strictly medical point in continuing care, if a doctor holds the view that the patient is entitled to stay alive, whatever the quality of such life, he can quite reasonably reach the view that the continuation of intrusive care, being the only way of preserving such life, is in the patient's best interests. But, in the same circumstances another doctor who sees no merit in perpetuating a life of which the patient is unaware can equally reasonably reach the view that the continuation of invasive treatment is not for the patient's benefit. Accordingly, on an application to the court for a declaration that the discontinuance of medical care will be lawful, the courts only concern will be to be satisfied that the doctor's decision to discontinue is in accordance with a respectable body of medical opinion and that it is reasonable.

4. The answer to the question

Anthony Bland has been irreversibly brain damaged: the most distinguished medical opinion is unanimous that there is no prospect at all that the condition will change for the better. He is not aware of anything. If artificial feeding is continued, he will feel nothing; if artificial feeding is discontinued and he dies he will feel nothing. Whether he lives or dies he will feel no pain or distress. All the purely physical considerations indicate that it is pointless to continue life support. Only if the doctors responsible for his care held the view that, though he is aware of nothing, there is some benefit to him in staying alive, would there be anything to indicate that it is for his benefit to continue the invasive medical care. In Anthony Bland's case, the doctors do not take that view. The discontinuance of life support would be in accordance with the proposals contained in the Discussion Paper on Treatment of Patients in Persistent Vegetative State issued in September 1992 by the Medical Ethics Committee of the British Medical Association. Therefore the *Bolam* requirement [1975] 1 W.L.R. 582 is satisfied.

In these circumstances, it is perfectly reasonable for the responsible doctors to conclude that there is no affirmative benefit to Anthony Bland in continuing the invasive medical procedures necessary to sustain his life. Having so concluded, they are neither entitled nor under a duty to continue such medical care. Therefore they will not be guilty of murder if they discontinue such care.

B. Civil Liability

The discontinuance of life support could expose the plaintiffs to a liability in tort to Anthony Bland or, more realistically, to his personal representatives. But such liability would have to be founded on a breach of some duty owed by them to Anthony Bland to maintain such life support. For the reasons which I have given in dealing with criminal liability, no such

breach of duty can exist in this case. Therefore the discontinuance of life support will also be lawful under civil law.

I am very conscious that I have reached my conclusions on narrow, legalistic, grounds which provide no satisfactory basis for the decision of cases which will arise in the future where the facts are not identical. I must again emphasise that this is an extreme case where it can be overwhelmingly proved that the patient is and will remain insensate: he neither feels pain from treatment nor will feel pain in dying and has no prospect of any medical care improving his condition. Unless, as I very much hope, Parliament reviews the law, the courts will be faced with cases where the chances of improvement are slight, or the patient has very slight sensate awareness. I express no view on what should be the answer in such circumstances: my decision does not cover such a case. I therefore consider that, for the foreseeable future, doctors would be well advised in each case to apply to the court for a declaration as to the legality of any proposed discontinuance of life support where there has been no valid consent by or on behalf of the patient to such discontinuance.

Finally, the conclusion I have reached will appear to some to be almost irrational. How can it be lawful to allow a patient to die slowly, though painlessly, over a period of weeks from lack of food but unlawful to produce his immediate death by a lethal injection, thereby saving his family from yet another ordeal to add to the tragedy that has already struck them? I find it difficult to find a moral answer to that question. But it is undoubtedly the law and nothing I have said casts doubt on the proposition that the doing of a positive act with the intention of ending life is and remains murder.

LORD MUSTILL

My Lords,

The pitiful state of Anthony Bland and the suffering of his devoted family must attract the sympathy of all. The devotion to duty of the medical staff, and the complete propriety of those who have faced up to the painful dilemma must equally attract the respect of all. This combination of sympathy and respect can but yield an urgent desire to take up the burden, to reach a conclusion on this deep moral issue of life and death, and to put that conclusion into effect as speedily and humanely as possible. The compelling nature of this task does however have its own risks, for it leads to an assumption that the central question of ethics is the only question, and that anything which stands in the way of a solution should be brushed aside as an empty technicality. However natural this impulse may be I believe that it must be resisted, for the authority of the state, through the medium of the court, is being invoked to permit one group of its citizens to terminate the life of another. Thus, although the issues spring from a private grief and the course

which is proposed is also private, in the sense that it will not be put into effect by the state, we are nevertheless here in the field of public law. The court must therefore be concerned not only to find a humane and morally justified solution to the problems of those directly involved, but also to examine rigorously both the process by which the solution is reached and the legal foundation on which it rests. Otherwise, the pressures created by this very extreme case may distort the law in a way which leads to false conclusions in situations where the issues are similar but more finely-balanced, and may in addition create unforeseen anomalies in criminal cases far-removed from the present. This appeal obviously raises acute problems of ethics, but this should not obscure the fact that it is also exceptionally difficult in point of law, and it is essential that these difficulties should be clearly recognised and objectively analyzed, not in a spirit of obstruction or pedantry, but because they are an inescapable part of any decision on whether the declarations made in the High Court should be allowed to stand.

Accordingly I shall concentrate in what follows on the legal rather than the ethical aspects of the appeal, although I have of course given the latter the most careful and anxious consideration. The moral issues have already been extensively discussed. I agree with the conclusion of all those who have delivered judgments in the case that the declarations ought to stand and I also agree broadly, although not necessarily in every detail, with the way hi which that conclusion has been reached. Rather than traverse the same ground again in different language I think it more useful to concentrate on two important matters which received comparatively little attention in the courts below. First, the role of the court; that is, the nature of the function which the court

is being called upon to perform, and the suitability of the court to perform it. Second, the consistency of the steps authorised by the two declarations now under appeal (which I will call "the proposed conduct") with the existing criminal law. In placing these matters firmly before the House the Official Solicitor, through the medium of Mr. Munby Q.C., has performed a most valuable service.

When performing this task it is essential to face up squarely to the true nature of what is proposed, and to have in mind what has been called "the distinction between the right to choose one's own death and the right to choose someone else's". *(103 (1989) Harv. Law Rev. Development in the Law; "Medical Technology and the Law"),* 519, 1665. Emollient expressions such as "letting nature take its course" and "easing the passing" may have their uses, but they are out of place here, for they conceal both the ethical and the legal issues, and I will try to avoid them. I will also abstain from debate about whether the proposed conduct will amount to euthanasia. The word is not a term of art, and what matters is not whether the declarations authorise euthanasia, but whether they authorise what would otherwise be murder. I will say only this. The conclusion that the declarations can be upheld depends crucially on a distinction drawn by the criminal law between acts and omissions, and carries with it inescapably a distinction between, on the one hand what is often called "mercy-killing", where active steps are taken in a

medical context to terminate the life of a suffering patient, and a situation such as the present where the proposed conduct has the aim for equally humane reasons of terminating the life of Anthony Bland by withholding from him the basic necessities of life. The acute unease which I feel about adopting this way through the legal and ethical maze is I believe due in an important part to the sensation that however much the terminologies may differ the ethical status of the two courses of action is for all relevant purposes indistinguishable. By dismissing this appeal I fear that your Lordships' House may only emphasise the distortions of a legal structure which is already both morally and intellectually misshapen. Still, the law is there and we must take it as it stands.

I. THE ROLE OF THE COURT

The issues now before the House fall into three groups-

9. Is it right, as a matter of general ethical principle, that the lives of persons in the position of Anthony Bland should be brought to

an end, and if so is it right that they should be brought to an end in the manner proposed?

10. Under the law as it now stands, can the proposed conduct be put into effect without committing a criminal offence, and particularly the offence of murder?

3. If the answer to the second question is "Yes, provided that certain conditions are shown to exist", do those conditions exist in the case of Anthony Bland?

What is the function of the courts in relation to these groups of issues? It is convenient to begin with the third. If the criteria for the legitimacy of the proposed conduct are essentially factual, a decision upon them is one which the court is well accustomed to perform, and may properly be obtained through the medium of an application for declaratory relief. If however they contain an element of ethical judgement, for example if the law requires the decision-maker to consider whether a certain course is "in the best interests" of the patient, the skill and experience of the judge will carry him only so far. They will help him to clear the ground by marshalling the considerations which are said to be relevant, eliminating errors of logic, and so on. But when the intellectual part of the task is complete and the decision-maker has to choose the factors which he will take into account, attach relevant weights to them and then strike a balance the judge is no better equipped, though no worse, than anyone else. In the end it is a matter of personal choice, dictated by his or her background, upbringing, education, convictions and temperament. Legal expertise gives no special advantage here.

Questions within the second group are entirely within the province of the courts. It is these questions which have exercised the family and all those

in the medical and nursing professions who have cared for Anthony Bland and given advice on his case. (For brevity, I will call these "the doctors"). As I understand the position they 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. But they wish to act within the law, and the very proper warning given by the coroner has been taken to heart. It is therefore natural that they should turn to the court for authority to do what they believe to be best. It is also natural that the court should wish to do everything proper to ensure that the doctors act, as they themselves wish to act, only in accordance with the law. No sensible

person could want the doctors to take the risk of having to validate their conduct after the event in the context of a trial for murder.

Because all this is perfectly natural, everyone concerned has pressed ahead without I believe having analyzed at all closely just what it is the court is being required to do. Very many applications to the Family Division raise issues of what is essentially social management, as for example where the court decides whether, in the light of guidance given by the appellate courts as to the correct general approach, it is better for a child to go to one parent rather than the other. The present case is quite different, for the declarations under appeal assume the answers to a set of hypothetical questions of criminal law. Not of course hypothetical through being divorced from real life, but hypothetical because they put in suit the criminal consequences of conduct which not only has not happened but never will happen, if the present appeal succeeds. We are thus embarked on a kind of proleptic criminal trial, without charge, jury or verdict.

My Lords, no procedure exists, nor so far as I am aware has ever been proposed, for conducting such an enquiry before the criminal courts. Not only would the notion that it is a proper function of the criminal courts to provide a decision, intended to be legally binding as to the future, on the criminality of acts or omissions as yet only in contemplation be rejected out of hand, but there exists no mechanism which would enable an application for this purpose even to be brought before the court. Yet we find that the present proceedings have been brought in the Family Division without demur, and that the extremely important questions of the criminal law to which they give rise have reached your Lordships' House not through the criminal appellate system but through the civil.

My Lords, by raising this point I am not of course suggesting that your Lordships should allow this appeal because the procedure adopted was impermissible. The appeal has reached this House, and your Lordships must decide it. Anything else would be unthinkable in human terms. Nor do I suggest that the grant of declarations as to criminality can never be granted in civil cases. The principle so strongly urged in *Imperial Tobacco v. Attorney General* [1981] A.C. 718 is, as was there acknowledged, subject to exception, and this is an exceptional case. Nor am I troubled by the fact that the decision in the present case does not create an issue estoppel in the criminal courts and

therefore does not form a conclusive bar to any future prosecution. I think it a great pity that the Attorney General did not appear in these proceedings

between private parties to represent the interests of the state in the maintenance of its citizens' lives and in the due enforcement of the criminal law, for although Mr. Munby Q.C. for the Official Solicitor and Mr. Lester Q.C. as Amicus Curiae have made invaluable submissions they were here in a different interest. Nevertheless it would be fanciful to suppose that if this appeal is dismissed and the proposed conduct goes ahead the prosecuting authorities would even think of starting proceedings against the doctors. What troubles me is very different.

In the first place, whilst the members of the House have all picked a way through the minefields of the existing law to the conclusion that the proposed conduct is lawful it would in my opinion be too optimistic to suppose that this is the end of the matter, and that in the future the doctors (or perhaps the judges of the High Court) will be able without difficulty to solve all future cases by ascertaining the facts and applying to them the precepts established in the speeches delivered today. The dozens of cases in the American courts have shown that the subject is too difficult, and the situations too diverse, for the law to be settled by a single appeal. I foresee that the appellate courts will be visited again, and that we shall find important areas of the criminal law in the course of elaboration through declaratory relief in the civil courts. Whilst I do not say that this is technically impossible it may not be the right way ahead. At all events I think it plain that the court is engaged on an unusual task and that it will be necessary to be sure, before this procedure becomes firmly established, just how it is that the civil courts can do in a criminal matter what the criminal courts themselves cannot do. The present appeal is not the right vehicle for this task, but since the House is invited to uphold the declarations granted in the High Court it is I believe necessary to consider what their effect will be. Three possibilities have been canvassed.

11. The effect of the declarations is to change the legal status of the proposed conduct <u>in this particular case.</u> On this view, even if the proposed conduct would have been unlawful without the decision of the court the declarations have made it lawful. This could be accomplished either by enlarging the category of proper medical treatment, which already stands outside the criminal law, so as to include a termination of life which the court has sanctioned in advance, or alternatively (and perhaps it comes to much the same) by altering the content of the doctors' duty to maintain life in cases where declarations such as the present have been made. This proposition would require a change in the law which I would hesitate long before endorsing, but the matter need not be further pursued, since it became plain during argument that none of the counsel were advocating this route.

12. The effect of the declaration, upheld by your Lordships' House, would be to create, through a binding precedent, a new common-law exception to the offence of murder, which in future would not only bind all

courts faced with criminal proceedings arising from the termination of life for medical reasons, but would also form a point of growth for the development of the criminal law in new and at present unforeseeable directions. This approach would have the great attraction of recognising that the law has been left behind by the rapid advances of medical technology. By starting with a clean slate the law would be freed from the piecemeal expedients to which courts throughout the common-law world have been driven when trying to fill the gap between old law and new medicine. It has however been rightly acknowledged by counsel that this is a step which the courts could not properly take. Any necessary changes would have to take account of the whole of this area of law and morals, including of course all the issues commonly grouped under the heading of euthanasia. The formulation of the necessary broad social and moral policy is an enterprise which the courts have neither the means nor in my opinion the right to perform. This can only be achieved by democratic process through the medium of Parliament.

3. The declarations will simply apply the law as it now stands to the undisputed facts of the present case. By upholding them the House will bind all courts charged in the future with a similar task to approach it in the same way. The declarations will not however alter the legal status of the proposed conduct from what it would have been even if no declarations had been sought, nor will it make any change in the existing criminal law. The declarations will therefore achieve no more in the present case than the useful but limited function of reassuring the doctors that what they wish to do was lawful when proposed and will be lawful when carried out, and will as a by-product ensure that in practice if the proposed conduct goes ahead no prosecution will ensue. I will not repeat what I have said about the unusual nature of this process, which must I believe be carried out by supposing that the doctors have already put into effect their proposals, have been charged with murder, and are now in the course of obtaining a ruling on whether on the undisputed facts they have a good defence.

My Lords, a little while ago I suggested that the present appeal raised three questions. Having discussed the nature of the second and third, I turn to the first which asks whether it is right to terminate the lives of persons in the position of Anthony Bland, and in particular whether it is right that this should be done in the manner proposed. (I mention the latter question because

it is a striking fact that in twenty out of the thirty nine American states which have legislated in favour of "living wills" the legislation specifically excludes termination of life by the withdrawal of nourishment and hydration) These are only fragments of a much wider nest of questions, all entirely ethical in content, beginning with the most general-" Is it ever right to terminate the life of a patient, with or without his consent?" I believe that adversarial proceedings, even with the help of an amicus curiae, are not the right vehicle for the discussion of this broad and highly contentious moral issue, nor do I believe that the judges are best fitted to carry it out. On the latter aspect I would adopt the very blunt words of Scalia J. in *Cruzan v. Director, Missouri Department of Health* (1990) 110 S.Ct. 2841, 2859, where a very similar

problem arose in a different constitutional and legal framework. These are problems properly decided by the citizens, through their elected representatives, not by the courts.

My Lords, I believe that I have said enough to explain why, from the outset, I have felt serious doubts about whether this question is justiciable, not in the technical sense, but in the sense of being a proper subject for legal adjudication. The whole matter cries out for exploration in depth by Parliament and then for the establishment by legislation not only of a new set of ethically and intellectually consistent rules, distinct from the general criminal law, but also of a sound procedural framework within which the rules can be applied to individual cases. The rapid advance of medical technology makes this an ever more urgent task, and I venture to hope that Parliament will soon take it in hand. Meanwhile, the present case cannot wait. We must ascertain the current state of the law and see whether it can be reconciled with the conduct which the doctors propose.

II THE LEGAL FRAMEWORK

Since it is common ground that the Function of the court on this appeal is to apply and if necessary develop the existing law, rather than create entirely new exceptions to the law of murder, it is convenient to begin by taking stock.

1. Consent to bodily invasion. Any invasion of the body of one person by another is potentially both a crime and a tort. At the bottom end of the scale consent is a defence both to a charge of common assault and to a claim in tort. The concentration in most discussions of this topic on this end of the scale has tended to divert attention from the fact that whatever the scope of

the civil defence of volenti non fit injuria there is a point higher up the scale than common assault at which consent in general ceases to form a defence to a criminal charge. The precise location of this point is at present under consideration by another Committee of your Lordships' House in *Reg. v. Laskey & Others*, and I need not explore it here, but that the point exists is beyond question. If one person cuts off the hand of another it is no answer to say that the amputee consented to what was done.

2. Proper medical treatment. How is it that, consistently with the proposition just stated, a doctor can with immunity perform on a consenting patient an act which would be a very serious crime if done by someone else? The answer must be that bodily invasions in the course of proper medical treatment stand completely outside the criminal law. The reason why the consent of the patient is so important is not that it furnishes a defence in itself, but because it is usually essential to the propriety of medical treatment. Thus, if the consent is absent, and is not dispensed with in special circumstances by operation of law, the acts of the doctor lose their immunity.

3. Paramountcy of the patient's choice. If the patient is capable of making a decision on whether to permit treatment and decides not to permit it his choice must be obeyed, even if on any objective view it is contrary to his best interests. A doctor has no right to proceed in the face of objection, even if it is plain to all, including the patient, that adverse consequences and even death will or may ensue.

4. Cessation of treatment. Thus it is that the patient who is undergoing life-maintaining treatment and decides that it would be preferable to die, must be allowed to die, provided that all necessary steps have been taken to be sure that this is what he or she really desires.

5. Emergencies. Although the consent of the patient is normally essential to the immunity of the doctor from criminal (and also from civil) process there are occasions when the law permits him to proceed without it. Notably, where urgent action is imperative in the interests of the patient, and because the patient is unconscious, or disorientated, or for some other reason the consent cannot be obtained until it is too late.

6. Necessity. In *In re F (Mental Patient: Sterilisation)* [1990] 2 A.C. 1 your Lordships' House has extended this general exception to the special

situation where the patient is permanently incapacitated from making any decision about treatment. In that case, the nature of the bodily invasion was such that unless the acts of the doctors fell into the special category of proper medical treatment they would have amounted to a most serious crime. If the patient had been capable of deciding whether or not she wished to be treated, and had either not been asked for her consent or had refused it, the doctors would have been criminally liable since consent is normally an essential element in proper medical treatment. As matters stood, however, the patient was incapable of making a decision, so that to abstain from proceeding without her consent would have meant that a decision adverse to treatment would mean that a decision against treatment would have been taken by default. The necessity for a decision to be made, one way or the other, coupled with her inability to make it enabled treatment to be made in what was considered her best interest.

7. Murder. It has been established for centuries that consent to the deliberate infliction of death is no defence to a charge of murder. Cases where the victim has urged the defendant to kill him and the defendant has complied are likely to be rare, but the proposition is established beyond doubt by the law on duelling, where even if the deceased was the challenger his consent to the risk of being deliberately killed by his opponent does not alter the case.

8. "Mercy killing." Prosecutions of doctors who are suspected of having killed their patients are extremely rare, and direct authority is in very short supply. Nevertheless, that "mercy killing" by active means is murder was taken for granted in the directions to the jury in *Adams, Arthur* (The Times 5 November 1981, Farquhason J.) and *Cox*, was the subject of direct decision

by an appellate court in *Barber* v. *Superior Court of State of California* (1983) 147 Cal. App. 3rd. 1032 and has never so far as I know been doubted. The fact that the doctor's motives are kindly will for some, although not for all, transform the moral quality of his act, but this makes no difference in law. It is intent to kill or cause grievous bodily harm which constitutes the mens rea of murder, and the reason why the intent was formed makes no difference at all.

9. Consent to "mercy killing". So far as I am aware no satisfactory reason has ever been advanced for suggesting that it makes the least difference in law, as distinct from morals, if the patient consents to or indeed urges the ending of his life by active means. The reason must be that, as in the other

cases of consent to being killed, the interest of the state in preserving life overrides the otherwise all-powerful interest of patient autonomy.

10. Acts and omissions. The English criminal law, and also it would appear from the cases cited, the law of transatlantic state jurisdictions, draws a sharp distinction between acts and omissions. If an act resulting in death is done without lawful excuse and with intent to kill it is murder. But an omission to act with the same result and with the same intent is in general no offence at all. So also with lesser crimes. To this general principle there are limited statutory exceptions, irrelevant here. There is also one important general exception at common law, namely that a person may be criminally liable for the consequences of an omission if he stands in such a relation to the victim that he is under a duty to act. Where the result is death the offence will usually be manslaughter, but if the necessary intent is proved it will be murder: see *Rex.* v. *Gibbins and Proctor,* (1918) 13 Cr. App. Rep. 134.

Precisely in what circumstances such a duty should be held to exist is at present quite unclear. No doubt it would be too stern a morality to place human beings on the same footing as regards criminal responsibility for allowing an undesirable state of affairs to continue as for bring that state of affairs into being, but even if there is sense in the distinction the current state of the law is unsatisfactory both morally and intellectually, as shown by the troubling case *of Reg. v. Stone* [1977] Q.B. 354. We cannot however try to put it in order here. For the time being all are agreed that the distinction between acts and omissions exists, and that we must give effect to it.

My Lords, this sketch of the law immediately brings forward two very difficult questions. The first is this. A doctor who kills his patient even with the consent of the patient is guilty of murder. Plainly a second doctor who kills his patient in circumstances where the obtaining of consent is impracticable cannot be in a better position than the first, even if the termination of life is in the best interests of the patient; for the combination of necessity and best interests is no more than a replacement for consent. How then can best interests legitimate the conduct proposed in the present case?

The second question requires a comparison between this case and *Gibbins and Proctor.* In the latter, the appellant had a helpless person in her care; because that person was helpless, she could not furnish herself with nourishment and was dependent for it on the appellant; the appellant intended

to bring about the death of the helpless person by withholding nourishment; she did so, and the helpless person died. Of course the cases are miles apart from an ethical standpoint, but where is the difference on the essential facts?

These and kindred questions have given rise to an extensive and understandably contentious literature, and to thoughtful discussions in the courts of the United States, Canada and New Zealand, and no doubt elsewhere. It is impossible to study it all, but the sources placed before the House, supplemented by a few others, have been sufficient to bring out the main lines of the possible arguments. I gratefully acknowledge the great help which this material has furnished, without thinking it necessary to give any but the barest of citation in what follows.

It is convenient now to discuss in turn the grounds upon which it might be held that under the existing law, and independently of the intervention of the court, the doctors may lawfully put the proposed conduct into effect.

III POTENTIAL DEFENCES

1. Attenuation of the interest in preserving life.

The interest of the state in preserving the lives of its citizens is very strong, but it is not absolute. There are contrary interests, and sometime these prevail; as witness the over-mastering effect of the patient's refusal of treatment, even where this makes death inevitable. It has been suggested, for example in *Re Quintan* (1976) 355 A 2d 647, that the balance may also be tipped, not by the weight of an opposing policy but by the attenuation of the interest in preserving life, where the "quality" of the life is diminished by disease or incapacity. My Lords, I would firmly reject this argument. If correct it would validate active as well as passive euthanasia, and thus require a change in the law of murder. In any event whilst the fact that a patient is in great pain may give him or her a powerful motive for wanting to end it, to which in certain circumstances it is proper to accede, is not at all the same as the proposition that because of incapacity or infirmity one life is intrinsically worth less than another. This is the first step on a very dangerous road indeed, and one which I am not willing to take.

2. The patient's choice.

In the majority of cases where the American courts have sanctioned the withdrawal of life-supporting medical care they have done so by developing

the rule that informed consent can release the doctor from his duty to treat. For this purpose they have founded upon the constitutional rights of the

patient, either the express right of due process or the still developing implied right of privacy. It is unnecessary to explore whether a similar approach would be appropriate in England, where constitutional rights play a much less theoretically important role, for I cannot see that the doctrine has anything to offer in the present case. It is perhaps sufficient to say that it takes two forms. In the first, the court looks for the making of an antecedent choice by a patient who can no longer make one, or communicate one, by the time that the question of termination has arisen. What is often called a "living will" has been held sufficient for this purpose. If no explicit choice has been made, the courts have on occasion felt able to infer from other evidence what they believe were the general feelings of the patient about termination of life in the case of incurable illness. In any event since there is no evidence that Anthony Bland ever thought or said anything on the subject the question of making an imputed choice does not arise. Whilst this course is in many ways attractive there are obvious dangers which may well be felt to justify the cautious attitude adopted by the courts of New York State in cases such as *Re Storar* (1981) 420 N.E. 2d. 64.

The second method, which is adopted if the evidence is insufficient to justify an inference of what the patient chose in the past so that it can be projected to the present, involves the appointment of a surrogate to make on behalf of the patient the choice which he believes the patient would now make if able to do so. For this purpose the surrogate builds up a picture of the patient's former character, feelings, convictions and so on from which the putative choice is deduced. This process may perhaps have some justification where the patient is sentient but unable to communicate a choice, but it breaks down totally in a case such as the present. To postulate a patient who is in such a condition that he cannot know that there is a choice to be made, or indeed know anything at all, and then ask whether he would have chosen to terminate his life because that condition made it no longer worth living is surely meaningless, as is very clearly shown by the lengths to which the court was driven in *Superintendent of Belchertown State School v. Saikewicz* (1977) 370 N.E. 2d 247. The idea is simply a fiction, which I would not be willing to adopt even if there were in the case of Anthony Bland any materials upon which a surrogate could act, which as far as I can see there are not.

3. Causation. One argument in support of the conclusion that if the proposed conduct is carried out and Anthony Bland then dies the doctors will

nevertheless be guilty of no offence depends upon a very special application of the doctrine of causation. This has powerful academic support: *P.D.G. Skegg, "Law, Ethics and Medicine",* Chapter 6, where it represents the author's chosen solution, and also *Glanville Williams, "Textbook of Criminal Law",* 2nd ed, pp. 282-283, and *I.M. Kennedy, "Treat me Right, Essays in Medical Law and Ethics",* (1988), at pp. 360-361, where it is offered by way of alternative. Nevertheless I find it hard to grasp. At several stages of his discussion Professor Skegg frankly accepts that some manipulation of the law of causation will be needed to produce the desired result. I am bound to say that the argument seems to me to require not manipulation of the law so much

as its application in an entirely new and illogical way. In one form the argument presented to the House asserts that for the purpose of both civil and criminal liability the cause of Anthony Bland's death, if and when it takes place, will be the Hillsborough disaster. As a matter of the criminal law of causation this may well be right, once it is assumed that the conduct is lawful. See *Reg. v. Blaue* [1975] 1 W.L.R. 1411; *Reg.* v. *Malcherek* [1981] 1 W.L.R. 690; *Finlayson* v. *H.M. Advocate* 1978 S.L.T. (Notes) 60. It does not perhaps follow that the conduct of the doctors is not also causative, but this is of no interest since if the conduct is lawful the doctors have nothing to worry about. If on the other hand the proposed conduct is unlawful, then it is in the same case as active euthanasia or any other unlawful act by doctors or laymen. In common sense they must all be causative or none; and it must be all, for otherwise euthanasia would never be murder.

A variant of the argument appears to put the ordinary law of causation into reverse. Normally, when faced with an act and a suggested consequence one begins by ascertaining the quality of the act and then, if it is found to be unlawful, one considers its connection to the consequence. This variant, by contrast, seems to begin the enquiry with the connection and then by applying a special rule of causation determine the character of the act. I confess that I cannot understand what mechanism enables this to be done. If the declarations are wrong and the proposed conduct is unlawful it is in my judgment perfectly obvious that the conduct will be, as it is intended to be, the cause of death, and nothing in the literature or the reported cases from other jurisdictions persuades me to any other conclusion. I should add that although part of the thoughtful judgment of Thomas J. in the High Court of New Zealand in *In re J.H.L.* (Unreported) 13 August 1992 discusses the question of causation, the main thrust of the reasoning was aimed elsewhere, towards a solution which is broadly in line with the one which all your Lordships have preferred.

4. Best interests of the community.

Threaded through the technical arguments addressed to the House were the strands of a much wider position, that it is in the best interests of the community at large that Anthony Bland's life should now end. The doctors have done all they can. Nothing will be gained by going on and much will be lost. The distress of the family will get steadily worse. The strain on the devotion of a medical staff charged with the care of a patient whose condition will never improve, who may live for years and who does not even recognise that he is being cared for, will continue to mount. The large resources of skill, labour and money now being devoted to Anthony Bland might in the opinion of many be more fruitfully employed in improving the condition of other patients, who if treated may have useful, healthy and enjoyable lives for years to come.

This argument was never squarely put, although hinted at from time to time. In social terms it has great force, and it will have to be faced in the end. But this is not a task which the courts can possibly undertake. A social

cost-benefit analysis of this kind, which would have to embrace "mercy-killing" to which exactly the same considerations apply, must be for Parliament alone, and the outcome of it is at present quite impossible to foresee. Until the nettle is grasped, we must struggle on with the existing law, imperfect as it is.

5. Best interests: the termination of life.

An alternative approach is to develop the reasoning of *In re F* [1990] 2 A.C. 1 by concentrating on the best interests, not of the community at large, but of Anthony Bland himself. Just as in *In re F*, so the argument runs, the best interests of the patient demand a course of action which would normally be unlawful without the patient's consent. Just as *in In re F* the patient is unable to decide for himself. In practice, to make no decision is to decide that the care and treatment shall continue. So that the decision shall not thus be made by default it is necessary that someone other than Anthony Bland should consider whether in his own best interests his life should now be brought to an end, and if the answer is affirmative the proposed conduct can be put into effect without risk of criminal responsibility.

I cannot accept this argument which, if sound, would serve to legitimate a termination by much more direct means than are now

contemplated. I can accept that a doctor in charge of a patient suffering the mental torture of Guillain-Barre syndrome, rational but trapped and mute in an unresponsive body, could well feel it imperative that a decision on whether to terminate life could wait no longer and that the only possible decision in the interests of the patient, even leaving out all the other interests involved, would be to end it here and now by a speedy and painless injection. Such a conclusion would attract much sympathy, but no doctrine of best interests could bring it within the law.

Quite apart from this the case of Anthony Bland seems to me quite different. He feels no pain and suffers no mental anguish. Stress was laid in argument on the damage to his personal dignity by the continuation of the present medical regime, and on the progressive erosion of the family's happy recollections by month after month of distressing and hopeless care. Considerations of this kind will no doubt carry great weight when Parliament comes to consider the whole question in the round. But it seems to me to be stretching the concept of personal rights beyond breaking point to say that Anthony Bland has an interest in ending these sources of others' distress. Unlike the conscious patient he does not know what is happening to his body, and cannot be affronted by it; he does not know of his family's continuing sorrow. By ending his life the doctors will not relieve him of a burden become intolerable, for others carry the burden and he has none. What other considerations could make it better for him to die now rather than later? None that we can measure, for of death we know nothing. The distressing

truth which must not be shirked is that is that the proposed conduct is not in the best interests of Anthony Bland, for he has no best interests of any kind.

6. Best interests: the termination of treatment

After much expression of negative opinions I turn to an argument which in my judgment is logically defensible and consistent with the existing law. In essence it turns the previous argument on its head by directing the enquiry to the interests of the patient, not in the termination of life but in the continuation of his treatment. It runs as follows-

(i). The cessation of nourishment and hydration is an omission not an act.

(ii). Accordingly, the cessation will not be a criminal act unless the doctors are under a present duty to continue the regime.

(iii) At the time when Anthony Bland came into the care of the doctors decisions had to be made about his care to which he was unable to make for himself. In accordance with *In re F,* [1990] 2 A.C. 1 these decisions were to be made in his best interests. Since the possibility that he might recover still existed his best interests required that he should be supported in the hope that this would happen. These best interests justified the application of the necessary regime without his consent.

(iv) All hope of recovery has now been abandoned. Thus, although the termination of his life is not in the best interests of Anthony Bland, 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.

(v). Since there is no longer a duty to provide nourishment and hydration a failure to do so cannot be a criminal offence.

My Lords, I must recognise at once that this chain of reasoning makes an unpromising start by transferring the morally and intellectually dubious distinction between acts and omissions into a context where the ethical foundations of the law are already open to question. The opportunity for anomaly and excessively fine distinctions, often depending more on the way in which the problem happens to be stated than on any real distinguishing features, has been exposed by many commentators, including in England the authors above-mentioned, together with *Smith and Hogan "Criminal Law"* 6th ed. (1988), p. 51, *H. Beynon* at [1982] Crim. L.R. 17 and *M.J. Gunn and J.C. Smith* at [1985] Crim. L.R. 705. All this being granted we are still forced to take the law as we find it and try to make it work. Moreover, although in cases near the borderline the categorisation of conduct will be

exceedingly hard, I believe that nearer the periphery there will be many instances which fall quite clearly into one category rather than the other. In my opinion the present is such a case, and in company with Compton J. in *Barber* 159 Cal. Rptr. 489, 490 amongst others I consider that the proposed conduct will fall into the category of omissions.

I therefore consider the argument to be soundly-based. Now that the time has come when 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 have also gone. Absent a duty, the omission to perform what had previously been a duty will no longer be a breach of the criminal law.

In reaching this conclusion I have taken into account the fact that whereas for almost all concerned the adoption of the proposed course will be a merciful relief, this will not be so for the nursing staff, who will be called on to act in a way which must be contrary to all their instincts, training and traditions. They will encounter the ethical problems, not in a court or in a lecture room, but face to face. As the United Kingdom Council for Nursing, Midwifery and Health Visiting has emphasised, for the nurses involved the interval between the initiation of the proposed conduct and the death of Anthony Bland will be a very stressful period. Acknowledging this I hope that the nurses will accept, as I believe, that sadly it is for the best.

For these reasons I would uphold the declarations. Whilst there is no need to go further it is better to mention one further point. The reasoning which I propose is, I believe, broadly in line with that of your Lordships. But I venture to feel some reservations about the application of the principle of civil liability in negligence laid down in *Bolam* v. *Friern Hospital Management Committee* [1957] 1 W.L.R.582 to decisions on "best interests" in a field dominated by the criminal law. I accept without difficulty that this principle applies to the ascertainment of the medical raw material such as diagnosis, prognosis and appraisal of the patient's cognitive functions. Beyond this point, however, it may be said that the decision is ethical, not medical, and that there is no reason in logic why on such a decision the opinions of doctors should be decisive. If there had been a possibility that this question might make a difference to the outcome of the appeal I would have wished to consider it further, but since it does not I prefer for the moment to express no opinion upon it.

IV. THE ETHICAL QUESTION

After discussing the legal issues at length I will deal only briefly with the ethical question which must be for most lay people what the case is really about. With the general tenor, if not with the details, of what was said in the courts below I respectfully agree. But I prefer to advance on a narrower front. In law, if my conclusion is right, the way is clear for the doctors to proceed as they and the family think best. If the principle of *Bolam* applies that is the

end of the matter, since nobody could doubt that a body of reasonable medical opinion would regard the proposed conduct as right. But even if *Bolam* is left aside, I still believe that the proposed conduct is ethically justified, since the continued treatment of Anthony Bland can no longer serve to maintain that combination of manifold characteristics which we call a personality. Some who have written on this subject maintain that this is too narrow a perspective, so I must make it clear that I do not assert that the human condition necessarily consists of nothing except a personality, or deny that it may also comprise a spiritual essence distinct from both body and personality. But of this we can know nothing, and in particular we cannot know whether it perishes with death or transcends it. Absent such knowledge we must measure up what we do know. So doing, I have no doubt that the best interests of Anthony Bland no longer demand the continuance of his present care and treatment. This is not at all to say that I would reach the same conclusion in less extreme cases, where the glimmerings of awareness may give the patient an interest which cannot be regarded as null. The issues, both legal and ethical, will then be altogether more difficult. As Mr. Munby has pointed out, in this part of the law the court has moved a long way in a short time. Every step forward requires the greatest caution. Here however I am satisfied that what is proposed, and what all those who have considered the matter believe to be right, is in accordance with the law.

My Lords, having said this I must admit to having felt profound misgivings about almost every aspect of this case. I will not rehearse them. I need only say that I entirely agree with and adopt everything said by my noble and learned friend Lord Browne-Wilkinson at the conclusion of his judgment.

I would dismiss this appeal.