[1993] 1 All ER 821

# Airedale NHS Trust v Bland

FAMILY DIVISION
SIR STEPHEN BROWN P

12, 13, 19 NOVEMBER 1992
COURT OF APPEAL, CIVIL DIVISION
SIR THOMAS BINGHAM MR, BUTLER-SLOSS AND HOFFMANN LJJ

1, 2, 3, 9 DECEMBER 1992

HOUSE OF LORDS
LORD KEITH OF KINKEL, LORD GOFF OF CHIEVELEY, LORD LOWRY, LORD BROWNE-WILKINSON AND LORD MUSTILL

Robert Francis QC and M R Taylor (instructed by Penningtons, agents for W J M Lovel, Harrogate) for the plaintiffs.
James Munby QC (instructed by the Official Solicitor) for the Official Solicitor as guardian ad litem.
Anthony Lester QC and Stephen Richards (instructed by the Treasury Solicitor) for the Attorney General as amicus curiae.

Cur adv vult

19 November 1992. The following judgment was delivered:

SIR STEPHEN BROWN P.

Anthony Bland became 21 on 21 September 1992 but for the past three and a half years he has been totally unaware of the world around him. As a keen supporter of Liverpool Football Club he was at the Hillsborough football ground on 15 April 1989. He was then 171/2. He was one of the victims of the disaster. He suffered a severe crushed chest injury which gave rise to hypoxic brain damage. His condition rapidly deteriorated and despite the intensive and heroic efforts of doctors and nurses he has remained ever since in a state of complete unawareness. This is known to the medical profession as a 'persistent vegetative state'. Although his brain stem is intact he suffered irreparable damage to the cortex. All the higher functions of Anthony Bland's brain have been destroyed. There is no hope whatsoever of recovery or improvement of any kind. That is the unanimous opinion of all the distinguished doctors who have examined Anthony Bland.

Since 12 May 1989 he has been under the care of Dr J G Howe FRCP, a consultant geriatrician at the Airedale General Hospital. Dr Howe has very considerable experience of patients suffering from what is described as persistent vegetative state. After his transfer to the Airedale General Hospital prolonged and persistent attempts were made to revive Anthony Bland. The skilled hospital staff including senior physiotherapists assisted by the parents and sister of Anthony Bland made exhaustive attempts to achieve some sign of revival. Although Anthony Bland's body breathes and reacts in a reflex manner to painful stimuli it

is quite clear that there is no awareness on his part of anything that is taking place around him. EEG and CT scans reveal no evidence of cortical activity. Indeed recent scans which have been photographed and produced to the court show that there is more space than substance in the relevant part of Anthony Bland's brain. There is simply no possibility whatsoever that he has any appreciation of anything that takes place around him. He is fed artificially and mechanically by a nasogastric tube which has been inserted through his nose and down into his stomach. All the natural bodily functions have to be operated with nursing intervention. He is fitted with a catheter which has given rise to infection necessitating surgical intervention. It is to be noted that the necessary surgical incision was made without any anaesthetic because Anthony Bland is utterly devoid of feeling of any kind. He requires four to five hours' nursing attention by two nurses every day. No complaint is made by the hospital authorities of the fact that they have to allocate substantial resources to this particular case—that is not a factor which has been prayed in aid of the course which the plaintiffs now seek to be allowed to follow. By August 1989, supported by the opinion of Dr Michael Johnson, a consultant neurologist of St James's University Hospital, Leeds, Dr Howe had reached the clear conclusion that there was absolutely no hope of any improvement. He felt that it would be appropriate to cease further treatment. This would involve withdrawing the artificial feeding through the nasogastric tube and declining antibiotic treatment if and when infection appeared. If this course were to be adopted then within some 10 to 14 days the lack of sustenance would bring an end to the physical functioning of the body of Anthony Bland and he would in terms 'die'. The process would be that of 'starvation'. This would be unpleasant for those who had to observe it but Anthony Bland himself would be totally unaware of what was taking place.

In August 1989 Dr Howe got into touch with the Sheffield coroner who was responsible for dealing with the fatal cases arising from the Hillsborough disaster. The coroner, who is both medically and legally qualified, alerted Dr Howe to the risks which he considered he might run if he took the proposed course of withdrawing treatment. The coroner pointed out that as the law stood it was his understanding that Dr Howe would run the risk of criminal proceedings if he took a course which brought to an end the existence of Anthony Bland, even though that existence could be regarded as being wholly pointless. He suggested that Dr Howe should consult his legal advisers. Heeding the warning of the coroner Dr Howe did indeed consult legal advisers and as a result the Airedale NHS Trust, which is responsible for administering the Airedale General Hospital, issued the originating summons which is now before the court. This seeks declarations that the trust and their responsible physicians may lawfully discontinue all life-sustaining treatment and medical support measures designed to keep Anthony Bland alive in his existing persistent vegetative state including the termination of ventilation, nutrition and hydration by artificial means and that they may lawfully discontinue and thereafter need not furnish medical treatment to Anthony Bland except for the sole purpose of enabling Anthony Bland to end his life and die peacefully with the greatest dignity and the least of pain, suffering and distress. The plaintiffs' action is fully supported by the parents and family of Anthony Bland. Because Anthony Bland himself is wholly incapable of taking any step with regard to this matter the Official Solicitor of the Supreme Court has been appointed to act as his guardian ad litem. He has instructed counsel to appear on the hearing of this summons. Whilst not disputing the completely insensate condition of Anthony Bland, he opposes the plaintiffs' application, contending that if the action

proposed by Dr Howe and the plaintiff hospital authority were to be implemented it would in terms amount in law to



the crime of murder. Because of the public importance of this case the court invited the assistance of the Attorney General and he has instructed counsel to appear as amicus curiae.

This case clearly raises serious moral, medical and ethical issues. However, none of the facts relating to the circumstances and the condition of Anthony Bland are in dispute. The court has been assisted by expert medical evidence from witnesses of the highest calibre and of the very greatest experience. All agree that Anthony Bland is now, and has been ever since the date of the Hillsborough disaster, in what is known to the medical profession now as a persistent vegetative state. The condition is irreversible and is not susceptible of any improvement. He is completely insensate and no medical procedure or treatment can bring about any beneficial change in his condition. All the witnesses have stated that the standard of care which has been afforded to Anthony Bland at the Airedale General Hospital is of the highest character. His parents have visited him daily and his sister has also been present frequently. The anguish which they continue to experience is self-evident. His father has given oral evidence before me and I also have a statement from Anthony Bland's mother. The father is a splendid straightforward Yorkshireman. He has faced the terrible tragedy which has befallen his family with remarkable realism and dignity. He has not allowed emotion to influence his judgment. He traced for me Anthony's brief life—explaining how he was a thoroughly normal boy. He described him as not a very clever boy but with a good personality—sensitive and willing. His great interest was football and Liverpool his chosen team. He said that he was not religious but that he had attended Sunday School in the Church of England. His assessment of Anthony Bland's situation was expressed in these clear terms:

> 'He certainly wouldn't want to be left like he is. I would feel that he should be removed and the family feel the same. I was angry when the advice from the coroner was received. I can see no point whatsoever in continuing treatment.'

Of course Anthony Bland is unable to express views of his own and there had been no occasion for him to express any view as to how he might view his situation if some terrible tragedy such as this befell him.

This case raises for the first time in the English courts the question in what circumstances, if any, can a doctor lawfully discontinue life-sustaining treatment (including nutrition and hydration) without which a patient in Anthony Bland's condition will die. Professor Bryan Jennett CBE, until recently Foundation Professor of Neurosurgery at the Institute of Neurological Science in the University of Glasgow and having the very widest experience as a neurosurgeon, was responsible together with Professor Plum of New York for coining the term 'persistent vegetative state' in 1972. It is intended to describe a syndrome that was being increasingly encountered as the life-saving and life-sustaining technologies of intensive care were securing the survival of some patients with brain damage of a severity that would previously have proved fatal. Professor Jennett told the court that until this descriptive term was proposed, and soon

widely adopted, such patients were often referred to as being in a prolonged or irreversible coma. However the word 'coma', he said, implies a continuing sleeplike state due to depression of the brain stem activating systems—whilst the hallmark of the vegetative patient is that after a variable time in coma wakefulness returns, with long periods of spontaneous eye opening. This period in coma commonly lasts 10 to 21 days after head injury which causes concussive depression of brain stem function, but after hypoxic insults patients often begin to open their eyes in two



to three days. Unlike less severely brain damaged patients emerging from coma, the vegetative patient fails to regain any cognitive behaviour that would indicate function in the cerebral cortex—the grey matter responsible for consciousness, thinking, feeling and responding in meaningful (as distinct from reflex) ways to stimuli from the surroundings. Because the brain stem and various other sub-cortical and more primitive parts of the brain are still functioning, the vegetative patient has a wide range of reflex activity, including breathing and, in some patients, a very limited capacity to swallow reflexly. Vegetative patients must be distinguished from patients in a 'locked in' syndrome—who, because of a focal lesion in the brain stem that does not affect consciousness, are totally paralysed in limbs and speech but may communicate by a yes/no code using eye or eyebrow movements. They are also quite different from patients who have suffered 'brain death'—whose brain stem has permanently ceased to function and who are dependent on a ventilator to maintain respiration, and whose heart always stops within a week or two at the most. By contrast, vegetative patients have suffered cognitive death, but can continue to breath for years because the brain stem is still functioning. The key to the diagnosis is that, on clinical observation over a prolonged period of time, there is no evidence of a working mind. EEG records show a range of abnormal activity with severe depression of cortical activity obvious only in a minority of cases. Professor Jennett referred to the very considerable research which has taken place internationally and the consideration of the problem by the medical ethics committee of the British Medical Association. He concluded from all the research material that only exceptional cases have been reported as showing recovery after a year, and none of those patients appear to have achieved independence. He gave it as his opinion that nasogastric feeding is a form of 'medical treatment' just as is a ventilator or a kidney machine. It is a means of substituting a function that has naturally failed. He said that tube feeding is accepted as 'medical treatment' in the United States of America and in Canada. He referred to the Appleton International Conference, which accepted that life-sustaining hydration and nutrition is a medical treatment which may justifiably be withdrawn from persistently vegetative patients for whom there are no patient-based reasons for continuing to treat. He expressed the opinion that it has become accepted good practice in this country as elsewhere to agree in consultation with the families of the vegetative patients to withhold antibiotics and cardiopulmonary resuscitation in the event of complications that would call for such measures in patients with a prospect of recovery. He expressed the very strong view that it would be in accordance with good medical practice in the case of Anthony Bland to withdraw the nasogastric artificial feeding. He stated that he considered there to be no benefit in maintaining life-sustaining treatment because he could see no prospect of recovery of cognitive function. He, like the other expert medical witnesses who gave evidence before me, had examined Anthony Bland. He stated that in his view this was an extreme and clear case of the persistent vegetative state. He could see no benefit to the patient in continuing the

treatment of feeding by means of a nasogastric tube. Dr Cartlidge FRCP is the consultant neurologist to the Newcastle Health Authority and senior lecturer in neurology at the University of Newcastle-upon-Tyne. He has very considerable experience of the so-called persistent vegetative state. He too examined Anthony Bland and expressed the firm opinion that he was showing all the signs of this extreme condition. He said there is no possibility whatsoever that he will recover. He too expressed the opinion that it would be medically justifiable to withdraw the artificial feeding process for there was no useful purpose in continuing it and it was not in the patient's best interests to prolong



survival in these circumstances. Professor Peter Behan FRCP of the Department of Neurology at the Institute of Neurological Sciences at the Southern General Hospital of Glasgow was instructed by the Official Solicitor to examine Anthony Bland. The court has the advantage of a report prepared by Professor Behan which has been accepted in evidence. He was unable to attend court to give oral evidence. In his report he said:

> '1) What is the diagnosis? This can be confidently answered that on the basis of history, physical and neurological examination supplemented by laboratory data, this is a classical example of the persistent vegetative state …
>
> 2) I am confident that from my knowledge of other patients, neurophysiology, previous cases from the literature and from animal experimentation that the patient has no awareness nor can he suffer pain or experience pleasure …
>
> 3) The prospect of improvement can also confidently be answered since based on what we know of the degree of damage to his brain, the comparison of his case with those recorded in the literature (particularly considering the nature of his damage and the duration of his illness) and the type of symptoms and signs he exhibits, there is no hint or hope or any prospect of improvement.
>
> 4) In my opinion artificial feeding and hydration constitutes medical treatment. If a patient was to be admitted under my care and was for one reason or another unable to feed himself, the setting up of a nasogastric tube for feeding and hydration would constitute beyond any measure of doubt medical treatment as opposed to normal feeding.'

He further stated that he was very impressed by the recommendation of the British Medical Association, that is to say in respect of the consultation and treatment of patients in the persistent vegetative state, which seemed to him to be a recommendation that where the diagnosis had been well established, the differential diagnoses had been ruled out and all the necessary laboratory tests done, then 'the prognosis could confidently be given as zero if after one year there was no sign of improvement'.

Dr Keith Andrews FRCP is the Director of Medical Research Services at the Royal Hospital and Home, Putney. At his hospital there is a 20-bed brain injury rehabilitation unit. Dr Andrews has had experience of about 50 patients in a persistent vegetative state.

He examined Anthony Bland. He told the court: 'I regard [him] as being in persistent vegetative state and indeed … the most severe case … I have seen … I do not consider that Tony Bland will make any recovery whatsoever.' He went on to say that if the regime continues as at present 'he is likely to survive a few years … not more than about five, mainly because he … is very prone to develop infections …' He expressed the view that feeding by tube was not in his view medical treatment. In amplification he said: 'The use of the equipment might be thought to be medical treatment but not the supply of food which is a basic human requirement.' He said he would not favour the withdrawal of treatment because he would find the means of death worrying. It would be distressing to watch, although Anthony Bland himself would not experience any sensation. He agreed that sedative drugs could be given to lessen the unpleasant features which he felt would inevitably follow from the withdrawal of the artificial feeding.

The plaintiffs' submissions have been put clearly and succinctly by Mr Francis QC both in a written skeleton argument and also in oral submissions. He submits that it is the unanimous opinion of all the expert medical witnesses that Anthony Bland is in a severe persistent vegetative state. There is no hope of any improvement. His parents with knowledge of their son say that he would not wish his present condition to be continued. Although Anthony Bland himself



cannot express any view it should be inferred in the light of the medical evidence as well as of the evidence of his own father and mother that the prolongation of the present treatment is not in his best interests. Good medical practice, accepted by a large and responsible body of medical opinion, suggests that the course proposed by Dr Howe, and supported by Professor Jennett and by Dr Cartlidge, should be followed. Mr Francis referred to a passage in the speech of Lord Bridge in the leading case of F v West Berkshire Health Authority (Mental Health Act Commission intervening) [1989] 2 All ER 545 at 548–549, [1990] 2 AC 1 at 52 where he said:

> 'Moreover it seems to me of first importance that the common law should be readily intelligible to and applicable by all those who undertake the care of persons lacking the capacity to consent to treatment. It would be intolerable for members of the medical, nursing and other professions devoted to the care of the sick that, in caring for those lacking the capacity to consent to treatment, they should be put in the dilemma that, if they administer the treatment which they believe to be in the patient's best interests, acting with due skill and care, they run the risk of being held guilty of trespass to the person, but, if they withhold that treatment, they may be in breach of a duty of care owed to the patient. If those who undertake responsibility for the care of incompetent or unconscious patients administer curative or prophylactic treatment which they believe to be appropriate to the patient's existing condition of disease, injury or bodily malfunction or susceptibility to such a condition in the future, the lawfulness of that treatment should be judged by one standard, not two. If follows that if the professionals in question have acted with due skill and care, judged by the well-known test laid down in Bolam v Friern Hospital Management Committee [1957] 2 All ER 118, [1957] 1 WLR 582, they should be immune from liability in trespass, just as they are immune from

liability in negligence.'

It is acknowledged that the present case is not a similar situation to that of the mental patient in F v West Berkshire Health Authority. There is no curative or therapeutic treatment which can be applied to Anthony Bland. However, Mr Francis submits, the same basic principles should be followed because what is proposed by Dr Howe is effectively medical treatment and it is in the patient's best interests. He submits that it would be intolerable if Dr Howe were to be put at risk of a prosecution for murder if he were to follow what he submits is generally regarded now as good medical practice.

In his detailed and erudite submission Mr Munby QC on behalf of the Official Solicitor challenged the view that the artificial feeding regime could be considered as 'medical treatment'. He sought support for that submission from the evidence of Dr Keith Andrews. However, his principal submission was that what is proposed by Dr Howe is the doing of an act intended to lead to the death of Anthony Bland. In the result, he argued, the withdrawal of the feeding regime would amount to unlawful killing and would in fact be the crime of murder. He referred to the summing up of Devlin J in R v Adams (Bodkin) [1957] Crim LR 365. He picked out a phrase used by the learned judge, 'cutting the thread of life'. Mr Munby argued that even if the artificial feeding process were to be considered to be medical treatment it would nevertheless be unlawful in the instant case to withdraw that treatment. He referred to what Lord Donaldson MR described as the 'critical equation' in Re J (a minor) (wardship; medical treatment) [1990] 3 All ER 930 at 938, [1991] Fam 33 at 46. That case concerned the consideration of potential further treatment to a severely brain damaged child. The problem raised in the case was what should be done if the child should suffer another



collapse, which might occur at any time. Should resuscitative treatment be given in such a case? Mr Munby, relying upon a passage in the judgment of Lord Donaldson MR, submitted that because of the very strong presumption which exists in favour of preserving life a withholding or withdrawing of treatment could only be justified in the critical case where the pain and suffering likely to be suffered by the patient exceeded the benefit to the patient of preserving life. Lord Donaldson MR said ([1990] 3 All ER 930 at 938, [1991] Fam 33 at 46):

> 'This brings me face to face with the problem of formulating the critical equation. In truth it cannot be done with mathematical or any precision. There is without doubt a very strong presumption in favour of a course of action which will prolong life, but, even excepting the “cabbage” case to which special considerations may well apply, it is not irrebuttable. As this court recognised in Re B [Re B (a minor) (wardship: medical treatment) (1981) [1990] 3 All ER 927, [1981] 1 WLR 1421], account has to be taken of the pain and suffering and quality of life which the child will experience if life is prolonged. Account has also to be taken of the pain and suffering involved in the proposed treatment itself … But in the end there will be cases in which the answer must be that it is not in the interests of the child to subject it to treatment which will cause increased suffering and produce no commensurate benefit, giving the fullest

possible weight to the child's, and mankind's, desire to survive.'

In this case however, said Mr Munby, there is no question of suffering because Anthony Bland is totally without feeling or awareness. He went on to speak of 'the slippery slope' which would be embarked upon if the court were to make a declaration in the terms sought by the plaintiffs: a dangerous precedent would be established. He developed in depth his submission that there is an absolute prohibition upon a doctor against taking active steps designed to bring about death. He likened the situation to that of two climbers roped together where one climber deliberately cut the rope which bound his companion to himself, or to switching off an iron lung.

Mr Anthony Lester QC, instructed by the Attorney General to appear as amicus curiae, made submissions which in effect supported the plaintiffs' case. He acknowledged that the subject matter of this case is obviously emotive and difficult. He said that the court would not be assisted by an absolutist or dogmatically legalistic approach. It was not a so-called euthanasia case; it was in terms a case about whether in the view of the doctors and the court a particular treatment decision should be taken which would remove the artificial support for life and allow nature to take its course so that death supervenes. He submitted that the law should strive to be in accordance with contemporary medical ethics and good medical practice. He acknowledged that Anthony Bland's case is difficult because, at first sight, it seems to require the court to reject the vital principle of the sanctity of life in favour of value judgments as to the quality of the further artificial prolongation of the life of Anthony Bland. He submitted however that there is no inherent conflict between having regard to the quality of life and respecting the sanctity of life; on the contrary, they are complementary; the principle of sanctity of life embraces the need for full respect to be accorded to the dignity and memory of the individual human being. The meaning and, criteria of quality of life should focus on benefit to the patient. He contended that Anthony Bland had an interest in the way in which his family would remember him after his death and in the manner of his dying and submitted that where one could be medically sure on all the evidence that the patient in a persistent



vegetative state is suffering permanently from loss of consciousness, there is no legal duty to maintain what remains of his or her 'life' whether by feeding or by giving medication. It is not in the patient's best interests to do so. In those circumstances he submitted there would be no breach of duty or criminal liability in ceasing to feed or otherwise to treat the patient. Such a conclusion, he argued, is in accordance with existing English case law. If the court declared the treatment proposed by Dr Howe to be 'lawful' then he said the criminal law would not become involved because a basic element of criminal liability, that is to say an unlawful act (the actus reus) is not made out.

It is correct that there has been no previous case of this nature in this jurisdiction. Mr Lester referred to a case before the Supreme Court of the United States, Cruzan v Director, Missouri Dept of Health (1990) 110 S Ct 2841. The headnote of the report reads:

'Guardians of patient in persistent vegetative state brought declaratory

> judgment action seeking judicial sanction of their wish to terminate artificial hydration and nutrition for patient. The Circuit Court, Jasper County, Probate Division, Charles E. Teel Jr., J., directed state employees to cause request of guardians to be carried out. Appeal was taken. The Missouri Supreme Court reversed. Certiorari was granted. The Supreme Court, Chief Justice Rehnquist, held that: (1) the United States Constitution did not forbid Missouri from requiring that clear and convincing evidence of an incompetent's wishes to the withdrawal of life-sustaining treatment; (2) state Supreme Court did not commit constitutional error in concluding that evidence adduced at trial did not amount to clear and convincing evidence of patient's desire to cease hydration and nutrition; and (3) due process did not require state to accept substituted judgment of close family members absent substantial proof that their views reflected those of patient.'

The decision therefore turned on a constitutional point as to the jurisdiction of the State of Missouri. However, in dissenting judgments Brennan J and three other justices referred to what may be regarded as the substantive merits of the case with regard to the treatment of patients in a persistent vegetative state. Mr Lester referred to passages in the judgments of Brennan and Stevens JJ. He drew attention to a passage (at 2883):

> 'Medical advances have altered the physiological conditions of death in ways that may be alarming: highly invasive treatment may perpetuate human existence through a merger of body and machine that some might reasonably regard as an insult to life rather than as its continuation. But those same advances, and the reorganization of medical care accompanying the new science and technology, have also transformed the political and social conditions of death: people are less likely to die at home, and more likely to die in relatively public places, such as hospitals or nursing homes. Ultimate questions that might once have been dealt with in intimacy by a family and its physician have now become the concern of institutions.'

Stevens J observed (at 2886–2887):

> 'But for patients like Nancy Cruzan, who have no consciousness and no chance of recovery, there is a serious question as to whether the mere persistence of their bodies is “life” as that word is commonly understood … The State's [Missouri's] unflagging determination to perpetuate Nancy Cruzan's physical existence is comprehensible only as an effort to define life's



> meaning, not as an attempt to preserve its sanctity … In any event, absent some theological abstraction, the idea of life is not conceived separately from the idea of a living person.' (Stevens J's emphasis.)

Brennan J used a phrase (at 2864) to which Mr Lester also pointed when he described

the subject in that case as 'a passive prisoner of medical technology'.

Mr Lester also drew attention to the Canadian Law Reform Commission Working Paper of July 1983. I do not need to comment in detail upon it but in it the Law Reform Commission of Canada recommended that the cessation of life-sustaining treatment in such cases should not attract criminal liability. There are a number of other decisions of state courts in the United States in which applications for a declaration, or for leave to withdraw life-sustaining treatment have been granted. However they are not strictly comparable to cases in this jurisdiction because many of them import a consideration of parens patriae in the particular states.

In the present case there is no question but that Anthony Bland is in a condition known as the persistent vegetative state. He has no feeling, no awareness, nor can he experience anything relating to his surroundings. To his parents and family he is 'dead'. His spirit has left him and all that remains is the shell of his body. This is kept functioning as a biological unit by the artificial process of feeding through a mechanically operated nasogastric tube. Intensive attention by skilled nurses assists the continuation of the existence of the body. It is a desperately tragic situation both for what remains of Anthony Bland and for the devoted members of his family. The doctor having the responsibility for the care of Anthony Bland has come to a very clear medical conclusion. He is supported in his assessment and opinion by doctors of unrivalled experience and professional standing. They say in terms that it is in accordance with good medical practice and in accordance with the true benefit to Anthony Bland himself that the artificial feeding regime should be withdrawn. The Official Solicitor has made clear to the court the possible implications of a precedent being established by a decision in favour of the plaintiffs in this case, although such a decision would accord with decisions taken in other common law jurisdictions.

The court must consider this case in the light of its particular facts and upon the principles of law obtaining in this jurisdiction. In my judgment the provision of artificial feeding by means of a nasogastric tube is 'medical treatment'. The court has before it overwhelming medical evidence which supports this view. I accept it. The clinical judgment of Dr Howe is to the effect that it would be in the best interests of Anthony Bland for that artificial feeding regime to be withdrawn at this stage. He has cogently given his reasons for reaching that conclusion. After three and a half years he has not lightly made that decision. It is a clinical decision arrived at in the honest and responsible exercise of his duty of caring for his patient. The fact that Anthony Bland's existence will terminate does not in my judgment alter the reality that the true cause of death will be the massive injuries which he sustained in what has been described as the Hillsborough disaster. I am satisfied that there is no reasonable possibility of Anthony Bland ever emerging from his existing persistent vegetative state to a cognitive sapient state. I am satisfied that there is no therapeutic, medical or other benefit to Anthony Bland in continuing to maintain his ventilation, nutrition and hydration by artificial means. I am further satisfied that to discontinue the same would accord with good medical practice as recognised and approved within the medical profession and finally that the order that I propose to make is in the circumstances in the best interests of Anthony Bland. His parents and sister concur in the making of the order which I propose to make and I therefore declare that despite

the inability of Anthony Bland to consent thereto the plaintiffs and the responsible attending physicians: (1) may lawfully discontinue all life-sustaining treatment and medical support measures designed to keep Anthony Bland alive in his existing persistent vegetative state including the termination of ventilation, nutrition and hydration by artificial means; and (2) that they may lawfully discontinue and thereafter need not furnish medical treatment to Anthony Bland except for the sole purpose of enabling Anthony Bland to end his life and to die peacefully with the greatest dignity and the least distress.

I do not consider it appropriate to make any declaration with regard to any possible consequences so far as the criminal law is concerned. In my judgment the declaration that the course proposed is lawful is sufficient to give to the doctors and to the hospital the necessary assurance as to the lawfulness of what is proposed. There will of course be liberty to apply in the event of there being any material change in the existing circumstances before the withdrawal of the artificial feeding. May his soul rest in peace.

It is understandable that those who are concerned with patients in the persistent vegetative state should seek assistance as to the appropriate practice in the future. Because of the gravity of the decision and the likely possible variation in the facts of individual cases I consider that the approval of the court should be sought in cases of a similar nature. In accordance with the procedures indicated by Lord Brandon of Oakbrook in F v West Berkshire Health Authority [1989] 2 All ER 545 at 558, [1990] 2 AC 1 at 65 the appropriate procedure should be by a summons for a declaration made to the Family Division of the High Court. The Official Solicitor should in my judgment be invited to act as the guardian ad litem of the patient, which would guarantee the fullest possible investigation of all the facts and circumstances of the individual case. Although essentially the decision is one for the clinical judgment of responsible medical practitioners, in my judgment it is desirable as a safeguard and for the reassurance of the public that the court should be involved in the way that I have indicated. I would expect that in all similar applications there would be not merely one medical opinion but at least two responsible medical opinions. Further, the position of the members of the family is very important. It may be that there will be cases where there is a division of opinion among members of a family. In such cases it would be essential in my judgment for responsible medical carers to seek the authority of the court.

Declarations accordingly. No order as to costs.
Bebe Chua Barrister.
Appeal

The defendant, acting by the Official Solicitor as his guardian ad litem, appealed from so much of the order as declared that, despite the inability of the defendant to consent thereto, the plaintiffs and the responsible physicians (1) might lawfully discontinue all life-sustaining treatment and medical support 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 (2) might 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 to die peacefully with the greatest dignity and the least distress.

James Munby QC (instructed by the Official Solicitor) for the Official Solicitor as guardian ad litem.
Robert Francis QC and M R Taylor (instructed by Penningtons, agents for W J M Lovel, Harrogate) for the plaintiffs.
[1993] 1 All ER 821 at 834
Anthony Lester QC and Pushpinder Saini (instructed by the Treasury Solicitor) for the Attorney General as amicus curiae.

At the conclusion of the argument the appeal was dismissed and leave to appeal to the House of Lords was granted for reasons to be given later.

9 December 1992. The following judgments were delivered.

SIR THOMAS BINGHAM MR.

Mr Anthony David Bland, then aged 171/2, 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 (PVS).

PVS is a recognised medical condition quite distinct from other conditions sometimes known as 'irreversible coma', 'the Guillain-Barré 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 PVS 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.

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

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 liquefied 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 has, 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 rise. The catheter must be monitored: it may cause infection (and has repeatedly done so); it has had to be resited, 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 PVS 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 tubes 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 NHS 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, Sir Stephen Brown P 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 on behalf of Mr Bland appeals against that decision: in doing so he fulfils his traditional role as the voice of those who, for reasons of incapacity, cannot speak for themselves, ensuring that their interests do not go by default because of their involuntary silence.

The present appeal raises moral, legal and ethical questions of a profound and fundamental nature, questions literally of life and death. The case has naturally provoked much public discussion and great anxiety. Strong and sincerely held opinions have been expressed both in favour of the decision under appeal and against it. The issues are such as inevitably to provoke divisions of opinion. But they are fairly and squarely before the

court, which has had the benefit of eloquent and erudite argument. It cannot shirk its duty to decide. It is, however, important to be clear from the outset what the case is, and is not, about. It is not about euthanasia, if by that is meant the taking of positive action to cause death. It is not about putting down the old and infirm, the mentally defective or the physically imperfect. It has nothing to do with the eugenic practices associated with fascist Germany. The issue is 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.

There are certain important principles relevant to this issue which both parties accept. (1) A profound respect for the sanctity of human life is embedded in our law and our moral philosophy, as it is in that of most civilised societies in the East and the West. That is why murder (next only to treason) has always been treated here as the most grave and heinous of crimes. (2) It is a civil wrong, and may be a crime, to impose medical treatment on a conscious adult of sound mind without his or her consent: see F v West Berkshire Health Authority (Mental Health Act Commission intervening) [1989] 2 All ER 545, [1990] 2 AC 1. (3) A medical practitioner must comply with clear instructions given by an adult of sound mind



as to the treatment to be given or not given in certain circumstances, whether those instructions are rational or irrational: see Sidaway v Bethlem Royal Hospital Governors [1985] 1 All ER 643 at 665–666, [1985] AC 871 at 904–905 and Re T (adult: refusal of medical treatment) [1992] 4 All ER 649, [1992] 3 WLR 782. This principle applies even if, by the time the specified circumstances obtain, the patient is unconscious or no longer of sound mind. (4) Where an adult patient is mentally incapable of giving his consent, no one (including the court) can give consent on his behalf. Treatment in such a case may lawfully be provided by a doctor where the treatment is in the best interests of the patient: see F v West Berkshire Health Authority. (5) Where the patient is a child and a ward of court, it will itself decide (paying appropriate regard to professional medical opinion) whether medical treatment is in the best interests of the patient: see Re B (a minor) (wardship: medical treatment) (1981) [1990] 3 All ER 927, [1981] 1 WLR 1421, Re B (a minor) (wardship: sterilisation) [1987] 2 All ER 206, [1988] AC 199, Re C (a minor) (wardship: medical treatment) [1989] 2 All ER 782, [1990] Fam 26 and Re J (a minor) (wardship: medical treatment) [1990] 3 All ER 930, [1991] Fam 33.

It follows from these propositions that, if, presciently, Mr Bland had given instructions that he should not be artificially fed or treated with antibiotics if he should become a PVS patient, his doctors would not act unlawfully in complying with those instructions but would act unlawfully if they did not comply even though the patient's death would inevitably follow. If Mr Bland were a child and a ward of the court, it would decide what was in his best interests, having regard to the views of his parents but not treating them as conclusive: see Re B (a minor) (wardship: medical treatment). If the ratio of Re J (a minor) (wardship: medical treatment) is sound, an issue expressly reserved by Mr Munby QC (for the Official Solicitor) for argument in the House of Lords, the court may judge it to be in a child's best interest that life-saving measures be withheld if of opinion that the life thereby prolonged would be one of intolerable pain and deprivation: see Re B (a minor) (wardship: medical treatment) and Re J (a minor) (wardship: medical treatment). This case is novel because Mr Bland is not a child and a ward of the court, he

is immune to suffering and, as already stated, he gave no instructions concerning his treatment if he were to become a PVS patient.

There can be no doubt that the administration of antibiotics is medical treatment: they cannot be lawfully obtained in this country without prescription and the choice of antibiotic to treat a given condition calls for professional skill and knowledge. The overwhelming consensus of medical opinion in this country and the United States is that artificial feeding by nasogastric tube is also medical treatment. This is a readily understandable view. The insertion of the tube is a procedure calling for skill and knowledge, and the tube is invasive of the patient's body to an extent which feeding by spoon or cup is not. An intubated patient certainly looks as if he is undergoing treatment, and the mechanical pumping of food through the tube is a highly unnatural process. It does not, however, seem to me crucial whether this is regarded as medical treatment or not, since whether or not this is medical treatment it forms part of the patient's medical care and I cannot think the answer to this problem depends on fine definitional distinctions.

It is relevant to consider the objects of medical care. I think traditionally they have been (1) to prevent the occurrence of illness, injury or deformity (which for convenience I shall together call 'illness') before they occur, (2) to cure illness when it does occur, (3) where illness cannot be cured, to prevent or retard deterioration of the patient's condition and (4) to relieve pain and suffering in body and mind. I doubt if it has ever been an object of medical care merely to prolong the life of an insensate patient with no hope of recovery where nothing



can be done to promote any of these objects. But until relatively recently the question could scarcely have arisen since the medical technology to prolong life in this way did not exist. That is also a new feature of this case.

There are, however, a number of other jurisdictions in which the question has arisen and been squarely confronted.

In the United States the issue has been much litigated. Despite variations of practice and strong expressions of dissent, the courts have in the great majority of cases sanctioned the discontinuance of artificial feeding of PVS patients. They have reached this result in deference to the express wishes of the patient where there were such and, where there were not, on the basis either that the court could judge what the patient's wishes would have been if expressed or that such discontinuance was in all the circumstances in the patient's best interests. The courts have consistently rejected the suggestion that such discontinuance amounts to suicide or criminal homicide. Since US courts exercise a parens patriae jurisdiction even in relation to adults, these cases must be viewed with reserve, but the trend of authority is clear.

In the South African case Clarke v Hurst (30 July 1992, unreported) there was evidence of a PVS patient's wish that his life should not be artificially prolonged, but the court acted on wider grounds in sanctioning the discontinuance of nasogastric and other non-natural feeding methods and the withholding of medical treatment.

In New Zealand the question arose in relation to a victim of the Guillain-Barré syndrome who had expressed no wishes concerning his treatment: see Auckland Area Health Board v A-G [1993] 1 NZLR 235. Thomas J delivered a comprehensive oral judgment in the course of which he said (at 250):

> 'In my view, doctors have a lawful excuse to discontinue ventilation when there is no medical justification for continuing that form of medical assistance. To require the administration of a life-support system when such a system has no further medical function or purpose and serves only to defer the death of the patient is to confound the purpose of medicine. In such circumstances, the continuation of the artificial ventilation may be lawful, but that does not make it unlawful to discontinue it if the discontinuance accords with good medical practice.'

Having considered Re J (a minor) (wardship: medical treatment) [1992] 4 All ER 614, [1993] Fam 15 he said (at 252):

> 'The point, for present purposes is, as I apprehend it, that a doctor acting in good faith and in accordance with good medical practice is not under a duty to render life support necessary to prolong life if that is, in his or her judgment, contrary to the best interests of the patient.'

Finally he concluded (at 253):

> 'Medical science and technology has advanced for a fundamental purpose; the purpose of benefiting the life and health of those who turn to medicine to be healed. It surely was never intended that it be used to prolong biological life in patients bereft of the prospect of returning to an even limited exercise of human life. Nothing in the inherent purpose of these scientific advances can require doctors to treat the dying as if they were curable. Natural death has not lost its meaning or significance. It may be deferred but it need not be postponed indefinitely. Nor, surely, was modern medical science ever developed to be used inhumanely. To do so is not consistent with its



> fundamental purpose. Take the case of a man riddled with cancer, in constant agony, and facing imminent death. Is he to be placed upon a respirator? On the contrary, it has been generally accepted that doctors may seek to alleviate a patient's terminal pain and suffering even though the treatment may at the same time possibly accelerate the patient's death. As I perceive it, what is involved is not just medical treatment, but medical treatment in accordance with the doctor's best judgment as to what is in the best interests of his or her patient. They remain responsible for the kind and extent of the treatment administered and, ultimately, for its duration. In exercising their best judgment in this regard it is crucial for the patient and in the overall interests of society that they should not be inhibited by considerations pertinent to their own self-interest in avoiding criminal sanctions. Their judgment must be a genuinely

> independent judgment as to what will best serve the well-being of their dying patients. Conscientious doctors will undoubtedly continue to strive with dedication to preserve and promote the life and health of their patients. That is their primary mission. But with a patient such as Mr L, where "life" is being prolonged for no therapeutic or medical purpose or, in other words, death is merely being deferred, the doctor is not under a duty to avert that death at all costs. If, in his judgment, the proper medical practice would be to discontinue the life-support system, and that would be in the best interests of his patient, he may do so subject to adhering to a procedure which provides a safeguard against the possibility of individual error.'

In Nancy B v Hôtel-Dieu de Québec (1992) 86 DLR (4th) 385 the Quebec Superior Court granted the plaintiff, a victim of the Guillain-Barré syndrome whose intellectual faculties were unimpaired but whose survival was dependent on artificial respiration, an order that further treatment be discontinued. That was, however, in response to her express and informed wish. A question closer to the present was addressed by the Law Reform Commission of Canada in its Working Paper 28 on Euthanasia, Aiding Suicide and Cessation of Treatment (1982), which stated (at p 65):

> 'At this stage, it may be useful to summarize the tentative conclusions which the Commission has reached to date. These conclusions are as follows: (1) the law should recognise the competent patient's wishes and respect them as regards the cessation or non-initiation of treatment; (2) the law should clearly state that a physician acts legally when he decides to terminate or not to initiate treatment which is useless or which no longer offers reasonable hope, unless the patient has expressed his wishes to the contrary; (3) the law should recognize that the prolonging of life is not an absolute value in itself and that therefore a physician does not act illegally when he fails to take measures to achieve this end, if these measures are useless or contrary to the patient's wishes or interests; (4) the law should recognize that a physician who continues to treat a patient against his wishes is subject to the provisions of the Criminal Code; (5) the law should recognize that the incapacity of a person to express his wishes is not sufficient a reason to oblige a physician to administer useless treatment for the purpose of prolonging his life; (6) the law should recognize that in the case of an unconscious or incompetent patient, a physician incurs no criminal responsibility by terminating treatment which has become useless.'

After extensive consultation the commission recommended in Report 20 (on the same subject) (at p 27) that—



> 'a physician should not incur any criminal liability if he decides to discontinue or not initiate treatment for an incompetent person, when that treatment is no longer therapeutically useful and is not in the person's best interest.'

In this country, a discussion paper published by the ethics committee of the British Medical Association (the BMA) in September 1992 recorded (at p 22) that there had been no prosecutions in Scotland in cases where doctors had withdrawn nutrition from PVS patients with the agreement of the patients' families. An earlier BMA report had expressed the view that—

> 'feeding/gastrostomy tubes for nutrition and hydration are medical treatments and are warranted only when they make possible a decent life in which the patient can reasonably be thought to have a continued interest … There is no justification for continuing medical intervention in such a state [PVS] and the working party feels that the individual concerned is most appropriately treated as an incompetent patient with a terminal condition.'

In 1991 the Institute of Medical Ethics published a majority view (at p 16) that—

> 'it can be morally justified to withdraw artificial nutrition and hydration from patients in persistent vegetative state.'

In seeking declarations from the court Mr Francis QC for the plaintiff trust relied on the reasoning underlying this weight of authority, as did Mr Lester QC who supported the plaintiff's application. The central steps in the argument were, I think, these. (1) The question whether artificial feeding and antibiotic treatment of Mr Bland should be discontinued is one to be resolved by the doctors in charge of his case, in consultation with independent medical experts conscientiously exercising a careful and informed judgment of what the best interests of their patient require. In forming that judgment it is appropriate for them to take full account of the family's wishes, as they have done. (2) While the respect accorded to human life always raises a presumption in favour of prolonging it, that presumption is not irrebuttable. (3) Mere prolongation of the life of a PVS patient such as Mr Bland, with no hope of any recovery, is not necessarily in his best interests, if indeed such prolongation is in his interest at all. (4) In making an objective judgment of Mr Bland's best interests, account can be taken not only of any pain and suffering which prolonged feeding and medication might cause but also of wider, less tangible considerations. (5) The assessment of Mr Bland's best interests, although a matter for his doctors in the first instance, is ultimately subject to the sanction of the court where (as here) its jurisdiction is invoked. There is no ground for overriding their judgment.

Step (1) of this argument is in my view consistent with the English authority already referred to. I do not think there is any English authority inconsistent with it.

If the reasoning of Re J [1992] 4 All ER 614, [1993] Fam 15 is sound, step (2) of the argument is also sound. I think that the reasoning in Re J is sound. It is also consistent with the reasoning in Re B (a minor) (wardship: medical treatment) (1981) [1990] 3 All ER 927, [1981] 1 WLR 1421 and Re C [1989] 2 All ER 782, [1990] Fam 26. In any event the ratio of Re J is binding on this court.

I would for my part accept step (3). Looking at the matter as objectively as I can, and doing my best to look at the matter through Mr Bland's eyes and not my own, I cannot conceive what benefit his continued existence could be thought to give him. It might be

different were it possible to hope that, if he lived long enough, means might be found to restore some part of his faculties, but no



grounds have been suggested for cherishing such a hope and the physiological findings appear to preclude it.

It is of course true that pain and suffering, which may (if the foregoing reasoning is sound) weigh in the balance against the presumption in favour of life, are here to be ignored because of Mr Bland's insensible condition. But I accept the argument in step (4) that account may be taken of wider and less tangible considerations. An objective assessment of Mr Bland's best interests, viewed through his eyes, would in my opinion give weight to the constant invasions and humiliations to which his inert body is subject; to the desire he would naturally have to be remembered as a cheerful, carefree, gregarious teenager and not an object of pity; to the prolonged ordeal imposed on all members of his family, but particularly on his parents; even, perhaps, if altruism still lives, to a belief that finite resources are better devoted to enhancing life than simply averting death.

I accept step (5). In cases where assessment of the patient's best interests is not undertaken by the court itself (as in wardship), the doctors' assessment is none the less subject to the court's review, where its jurisdiction is invoked. Such review may be of real value in excluding the possibilities of medical error, misapprehension of the correct approach, divisions of opinion, conflicts of interest, improper motives and so on. On the doctors' premises, Sir Stephen Brown P found no reason to impugn the doctors' judgment and none was suggested. Unless their premises can be effectively challenged, there is in my view no ground for withholding the court's sanction.

I have not so far directly addressed the submissions made to the court by Mr Munby for the Official Solicitor. He did, however, challenge, radically and robustly, the premises upon which the doctors' judgment was based. To those submissions I now turn.

Mr Munby's first submission was:

> 'To withdraw Anthony Bland's feeding tube is to do an act which will inevitably cause, and is intended to cause, his death. It is, therefore, necessarily unlawful and criminal. This is so whether or not artificial feeding is medical treatment.'

The submission was a short one. Reliance was placed on Devlin J's famous direction in R v Adams (8 April 1957, unreported) that 'no doctor, nor any man, no more in the case of the dying than of the healthy, has the right deliberately to cut the thread of life'. Attention was also drawn to Ognall J's recent direction to the jury in R v Cox (18 September 1992, unreported) that there is an 'absolute prohibition on a doctor purposefully taking life as opposed to saving it'. Accordingly it is said that the doctors' proposed course of action (at least in relation to feeding) would amount at least to manslaughter, at most to murder.

I have some difficulty in regarding this as a practical issue, since both R v Adams and R

v Cox concerned drugs said to have been deliberately administered to cause or hasten death and I cannot on the present facts imagine any prosecutor prosecuting, any judge leaving the issue to a jury or any jury convicting. But that does not meet the theoretical argument.

The submission may perhaps be tested by three hypothetical examples.

(1) In compliance with the express instructions of a PVS patient given before onset of the condition, when the patient was adult and of sound mind, a doctor discontinues artificial feeding after three years and the patient dies. Has the doctor aided and abetted suicide? I think the answer plainly is that he has not. Why not? There are several possible answers. One is that it cannot be unlawful to act in accordance with the instructions of an adult patient of sound mind. Another is



that the patient lacked the intent necessary for suicide. A third is that it was not the discontinuance of artificial feeding but the patient's condition and its underlying cause which caused his death. A fourth is that the doctor lacked the intent necessary for aiding and abetting suicide. It may be all four answers are correct. But if it was not the discontinuance which caused the death or if the doctor lacked the intent to kill he would have defences to murder and perhaps manslaughter also even if the patient had given no instructions.

(2) A PVS patient's nasogastric tube becomes defective after years of use and has to be removed. The doctor has to decide whether to continue artificial feeding through a replacement nasogastric tube or a newly implanted gastrostomy tube. He decides that, in all the circumstances, three years after the onset of the condition and with no hope of improvement, it is not in the patient's best interests to do so. He does not do so and the patient dies. Is the doctor guilty of murder or manslaughter? In my view plainly not. If that is so, and the doctors here were to be guilty, it could only be because of a distinction between initiating a new regime of artificial feeding and discontinuing an existing regime. Where the doctor's duty to the patient (to care for him with ordinary professional skill in the patient's best interests) is the same in the two cases, I cannot think that criminal liability depends on such a distinction. The doctor must be guilty in both cases or neither.

(3) A PVS patient shows signs of life-threatening failure of, in succession, heart, lungs, liver, kidneys, spleen, bladder, pancreas. In each case the failure can be safely rectified by serious surgery, carried out without pain or distress to the unconscious patient. Is the doctor obliged to undertake these life-saving procedures? Although pointing out, correctly, that his first submission related only to artificial feeding, Mr Munby answered that the doctor was so obliged. Such a suggestion is in my view so repugnant to one's sense of how one individual should behave towards another that I would reject it as possibly representing the law. But if I am right to reject it, the doctors could only be guilty here if some distinction were to be drawn between the surgical procedures described and artificial feeding. But I do not think that criminal liability can depend on the relative invasiveness of different invasive procedures.

A doctor who discontinues artificial feeding of a PVS patient, after a lapse of time which

entitles him to be sure that there is no hope of recovery, in pursuance of a conscientious and proper judgment that such discontinuance is in the patient's best interests, is in my view guilty of no crime. For present purposes I do not think it greatly matters whether one simply says that that is not an unlawful act, or that the doctor lacks criminal intent, or that he breaches no duty or that his act did not cause death. But even if this first submission were (contrary to my view) sound, it would leave the doctors free to discontinue antibiotics, with the result that Mr Bland would die sooner rather than later, perhaps less peacefully than on withdrawal of artificial feeding. The factual merits of the submission are not compelling.

Mr Munby's second submission was:

> 'To withdraw Anthony Bland's feeding tube is a breach of the doctors' duty to care for and feed him: discontinuance of mechanical hydration and nutrition involves the withdrawal of food, whether or not it also involves the withdrawal of medical treatment. Since it will inevitably cause, and is intended to cause, his death, it is necessarily unlawful and criminal.'

I think it is evident from what I have already said that I do not accept any ingredient of this submission for reasons I have given. Its falsity is in my view highlighted by an attempted analogy with R v Stone [1977] 2 All ER 341, [1977]

[1993] 1 All ER 821 at 842

QB 354, where the defendant convicted of manslaughter had failed to supply food or procure medical attention for an elderly and infirm but conscious woman who was perfectly capable of feeding herself if food was supplied.

Mr Munby's third submission was:

> 'In any event, and even assuming that artificial feeding is properly to be regarded as medical treatment (and it ought not to be), there is no justification for withdrawing that treatment. To withdraw Anthony Bland's feeding tube is a breach of the doctors' duty to treat and nurse him. Since it will inevitably cause, and is intended to cause, his death, it is necessarily unlawful and criminal.'

Again, I think it is evident from what I have already said that I do not accept any ingredient of this submission for reasons I have given.

I turn lastly to the issue of procedure, on the assumption that the plaintiff trust is entitled to the declarations made. There was only limited dispute about this. At the end of his judgment Sir Stephen Brown P held that in cases of this kind application should be made to the court to obtain its sanction for the course proposed. 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 Sir Stephen Brown P

described should be followed.

I would dismiss the appeal. I have read in draft the judgments of Butler-Sloss and Hoffmann LJJ and agree also with their reasons for reaching this conclusion.

BUTLER-SLOSS LJ.

This is a tragic case and the necessary dispassionate consideration of all the necessary components of the issues before us should not blind us to the anguish of the family for whom everyone feels the greatest sympathy.

Each court seised of these issues has an awesome task to face. In doing so we have to rid ourselves of emotional overtones and emotive language which do not assist in elucidating the profound questions which require to be answered.

The facts are not in dispute. The present condition of Tony Bland has been described by Sir Thomas Bingham MR. He is at the extreme end of the spectrum of those suffering from the condition of persistent vegetative state (PVS). He has been in that state for three and a half years and there is, while he lives, no release from it. He is in a 'state of chronic wakefulness without awareness' (American Medical Association Council Report, January 1990), and has irreversible loss of cognition. A recent surgical operation was carried out on him without anaesthetic, and his future care and whether he does or does not receive nutrition and hydration, or the manner in which he will die will be a matter of indifference to him in his present state.

His ability to survive with artificial support is a product of the medical advances in recent years. Medical science and technology have provided for many a cure or alleviation of injury or disease but have also created conditions which allow Anthony Bland to exist in a twilight world. Twenty years ago he would not have survived.

Self-determination

The starting point for consideration, in my view, is the right of a human being to make his own decisions and to decide whether to accept or reject treatment,



the right of self-determination. Such a decision may be rational or irrational (see Sidaway v Bethlem Royal Hospital Governors [1985] 1 All ER 643 at 665–666, [1985] AC 871 at 904–905). Counsel all agree that the right to reject treatment extends to deciding not to accept treatment in the future by way of advance directive or 'living will'. A well-known example of advance directive is provided by those subscribing to the tenets of the Jehovah's Witnesses, who make it clear that they will not accept blood transfusions (see for example Malette v Shulman (1990) 72 OR (2d) 417). The provision of treatment by a doctor without the consent of the patient other than in an emergency is likely to be a trespass (see F v West Berkshire Health Authority (Mental Health Act Commission intervening) [1989] 2 All ER 545 at 562, [1990] 2 AC 1 at 71 per Lord Goff of Chieveley and Schloendorff v Society of New York Hospital (1914) 211 NY 125

at 129 per Cardozo J).

In this case Anthony Bland has not given a clear indication of his views. His family are unable to consent on his behalf (see Re T (adult: refusal of medical treatment) [1992] 4 All ER 649 at 653, [1992] 3 WLR 782 at 787 per Lord Donaldson MR). His father expressed in evidence his view that his son would not have wished to live in his present state. As Lord Donaldson MR said the views of relatives may reveal that the patient had made an anticipatory choice which does not arise here. The views of the family must always be treated with respect and will be an important consideration in the overall assessment. In some cases the evidence of relatives will require to be treated with great caution since there may be hidden motives. There is no suggestion that such concerns arise in this family.

Lack of consent

Mr Bland is both by medical and legal standards incompetent in that he lacks the capacity to give valid consent to medical treatment. No one can consent on his behalf. The parens patriae jurisdiction of the High Court no longer exists and in F v West Berkshire Health Authority the House of Lords held that at common law there was no jurisdiction in the court to approve or disapprove the giving of medical treatment to such a patient. The lawfulness of the action depended upon whether the treatment was in the best interests of the patient. The House of Lords then devised a procedure in cases of proposed sterilisation of those unable to consent that a declaration might be made by the High Court as to whether such an operation was in the best interests of the patient.

Two possible approaches have been suggested to us, the United States preferred route of substituted judgment or the objectively ascertained best interests of the patient. The majority of state superior courts (of the United States) have, in the absence of expressed wishes, founded their decisions on similar issues on the exercise of a substituted judgment based upon ascertaining the patient's known views, beliefs, philosophy and lifestyle. In the absence of sufficient information many of the American courts have made decisions based upon the patient's 'best interests'.

Although it appears in origin derived from the English common law, the American approach based on substituted judgment appears to have little in common with the trend discernible in recent English decisions, all of which consider the objective best interests of the patient (see for example F v West Berkshire Health Authority and Re T). I can see no reason to extend the test of substituted judgment beyond the Court of Protection. In assessing the best interests of Anthony Bland, however, his views, personality, how others including his family saw him before his accident will form part of that assessment, although that evidence has a subjective element.

[1993] 1 All ER 821 at 844
Medical treatment

Before considering the duty of care of the doctor towards his patient, it is necessary to deal with the argument of Mr Munby QC that the method of providing nutrition to Anthony Bland is not 'medical treatment'. All but one of the doctors who gave evidence to Sir Stephen Brown P treated it as such, and even Dr Andrews, who disagreed, accepted that, if asked to do so by a patient who was capable of making a decision, he

would remove the nasogastric tube. The evidence of the doctors was supported by a wealth of medical expertise that it is medical treatment, the report of the British Medical Association, the American Medical Association, the medical ethics committees of England and of the United States. It is also the conclusion of the Supreme Courts of many of the states of the United States and, even more persuasive, of the Supreme Court of the United States in Cruzan v Director, Missouri Dept of Health (1990) 497 US 261. Interestingly, the Mental Health Act 1983 includes nursing in its definition of 'medical treatment'.

Although Mr Munby for the Official Solicitor argued that it is not 'medical treatment' there was overwhelming evidence upon which Sir Stephen Brown P was entitled to conclude that it is.

If we describe what is being done by the doctors and nurses for Anthony Bland and others in his condition as medical care rather than treatment, it may to the layman make more sense and avoid the uncomfortable attempt to draw a line between different forms of feeding such as spoon-feeding a helpless patient or inserting a tube through the nose or direct into the stomach.

The definition of medical treatment does not, in my view, of itself resolve the problem. The underlying issue is whether, under the extreme circumstances of this case, there is a duty upon his doctor to continue to provide to Anthony Bland nutrition and hydration by an artificial method. Mr Munby argued that there are basic needs which are the right of a patient, the need for air and the need for nutrition. That is in my view too narrow an expression of basic needs, which cannot be seen in isolation from general care including for instance warmth and hygiene.

Duty of care

A doctor owes a duty of care towards his patient and in the case of a patient unable to give instructions or consent to treatment, a duty to treat him in the patient's best interests (see F v West Berkshire Health Authority). The general duty of a doctor is to act in accordance with a responsible and competent body of relevant professional opinion based upon the principles laid down in Bolam v Friern Hospital Management Committee [1957] 2 All ER 118, [1957] 1 WLR 582 (the Bolam test). In carrying out his duty towards his patient a doctor is faced all the time with a series of decisions each of which requires choices—a choice whether to operate, whether to initiate other invasive treatment such as chemotherapy, whether to give antibiotics. As his care of the patient progresses he may have to decide whether to discontinue a process conscious that such a choice marks not only the cessation of effective treatment but also brings closer the end of his patient's life. Medical ethics draw no distinction between the withholding of treatment and the withdrawing of treatment. It is accepted by Mr Munby that in making those decisions and choosing one course rather than another the doctor is rightly guided by the value of the treatment given and the lack of value of other treatment proposed and from time to time the futility of giving any further treatment which will not benefit the patient. The assessment of the futility of the treatment is in his view justification for ceasing the treatment. He argued none the less that, since feeding is not treatment, the futility of

continuing useless treatment does not arise, and in any event it is never futile to feed. None the less decisions have to be made about future treatment which involve choices such as whether to provide antibiotics. Sir Stephen Brown P found that it was the unanimous opinion of all the distinguished doctors who have examined Mr Bland that there is no hope whatsoever of recovery or improvement of any kind. The only purpose of the present care is to keep him artificially alive within his present condition. The medical team caring for Mr Bland have formed the medical opinion that it is in his best interests to discontinue all forms of treatment including the provision of nutrition and hydration.

The question then arises as to the extent or limit of the duty of care of the doctor towards a PVS patient. The formulation of the duty of care within the Bolam test may not by itself be an adequate basis for this grave decision which requires more than the decision as to the uselessness of future treatment. The principle of the best interests of an incompetent patient in the present circumstances encompasses wider considerations, including some degree of monitoring of the medical decision.

There is a conflict between the principle of self-determination and whatever may be the equivalent right of those who cannot choose and another basic principle of our society, the preservation of life. Lord Donaldson MR spoke in Re J (a minor) (wardship: medical treatment) [1990] 3 All ER 930 at 938, [1991] Fam 33 at 46 of the vast importance of the sanctity of the human life. I respectfully agree with him. Its importance cannot be overemphasised. He said:

> 'The decision on life and death must and does remain in other hands. What doctors and the court have to decide is whether, in the best interests of the child patient, a particular decision as to medical treatment should be taken which as a side effect will render death more or less likely. This is not a matter of semantics. It is fundamental. At the other end of the age spectrum, the use of drugs to reduce pain will often be fully justified, notwithstanding that this will hasten the moment of death. What can never be justified is the use of drugs or surgical procedures with the primary purpose of doing so.' (Lord Donaldson MR's emphasis.)

Lord Donaldson MR then set out the balancing exercise to be performed:

> 'This brings me face to face with the problem of formulating the critical equation. In truth it cannot be done with mathematical or any precision. There is without doubt a very strong presumption in favour of a course of action which will prolong life, but, even excepting the “cabbage” case to which special considerations may well apply, it is not irrebuttable.'

Mr Munby argued in Re J the fundamentalist or absolutist approach, that the pain and suffering experienced and to be experienced by that child should not displace the sanctity of life, including the preservation of the life of that child, whatever it was to be. This court rejected that approach and placed on the other side of the critical equation the tragic situation of the child concerned and the quality of her life. Lord Donaldson MR did not feel bound to follow the views expressed (obiter) in Re B (a minor) (wardship: medical treatment) (1981) [1990] 3 All ER 927, [1981] 1 WLR 1421 as to the degree of

awfulness or intolerability of treatment which might be proposed as providing a quasi-statutory yardstick. He left the door open. Apart from preferring to use a word other than 'cabbage', I respectfully agree with him. In Re B this court was considering a simple operation to clear an intestinal obstruction of a Down's syndrome baby. The circumstances of Re J or of this appeal were not considered by the members of the court. Dunn



LJ pointed out that there was no reliable prognosis as to the life expectancy of the child and no evidence at all about the quality of life the child might expect (see [1990] 3 All ER 927 at 929–930, [1981] 1 WLR 1421 at 1424).

Although this court in Re J was exercising the parens patriae jurisdiction, the approach is equally apposite to an incompetent adult, since the consideration of best interests has to import a balancing exercise which Mr Munby recognised. His answer was that severe pain and suffering as experienced by the child in Re J is the only factor which can be put on the other side of the equation to the sanctity of life. He reserved his position to argue elsewhere that Re J was wrongly decided and there was nothing to place in the balance against the sanctity of life. In his argument to this court the interests of the PVS patient are limited to that sole consideration.

To place pain and suffering in a unique category, the existence of which may justify foregoing the preservation of the sanctity of life, does not appear to me to be justifiable. Two reasons come immediately to mind. First, on a practical level, according to Mr Munby the exception of extreme pain can be justified on the basis that it can be objectively verified. The degree of resistance to pain varies enormously from person to person and is intensively subjective however its existence as such may be objectively verified. It is not an absolute state and it will always be a matter of degree as to whether the state of pain of an incompetent patient is sufficiently severe to meet the necessary criterion. If it is to be the only criterion, excluding all other considerations, the lack of clarity in formulating when it comes into play, creates for me a logical problem in accepting it alone on the other side of the equation.

There is however a second and more fundamental objection. The case for the universal sanctity of life assumes a life in the abstract and allows nothing for the reality of Mr Bland's actual existence. There are clearly dangers in departing from the fundamental approach to the preservation of life, but in the American decisions it is not conclusive. Two exceptions are already recognised in English common law, the right of self-determination and the Re J situation of extreme pain and suffering. The quality of life has already been recognised as a factor and placed in the equation to allow a life not to be prolonged at all costs. Taylor LJ said in Re J [1990] 3 All ER 930 at 945, [1991] Fam 33 at 55: 'Once the absolute test is rejected, the proper criteria must be a matter of degree.' To limit the quality of life to extreme pain is to take a demeaning view of a human being. There must be something more for the humanity of the person of a PVS patient. He remains a person and not an object of concern. In Re Conroy (1985) 98 NJ 321 at 396 Handler J supports this approach:

> 'Clearly, a decision to focus exclusively on pain as the single criterion ignores and devalues other important ideals regarding life and death.

> Consequently, a pain standard cannot serve as an indirect proxy for additional and significant concerns that bear on the decision to forego life-prolonging treatments.'

The concentration exclusively upon pain is to me an unacceptable approach to a patient in Anthony Bland's extreme situation. There are other factors to be placed in the critical equation.

Those other factors have not so far been explored in English decisions but they have been considered extensively in the United States and in a recent case in New Zealand. In Cruzan v Director, Missouri Dept of Health (1990) 110 S Ct 2841 at 2885–2886 (a PVS case) Stevens J (in a dissenting opinion) said:



> 'But Nancy Cruzan's interest in life, no less than that of any other person, includes an interest in how she will be thought of after her death by those whose opinions mattered to her. There can be no doubt that her life made her dear to her family, and to others. How she dies will affect how that life is remembered.'

In Guardianship of Jane Doe (1992) 411 Mass 512 the Supreme Judicial Court of Massachusetts (in a PVS case where the patient had always been incompetent) held that incompetent individuals have the same rights as competent individuals to refuse and terminate medical treatment. Abrams J, giving the majority opinion, accepted the rights of the patient to bodily integrity and privacy and upheld the judge's decision to terminate nasoduodenal feeding and hydration. Re Jobes (1987) 108 NJ 394 (a PVS patient) following Re Quinlan (1976) 70 NJ 10 upheld the principle of self-determination for the incompetent. The views of the family were accepted in each of those cases. Handler J in a concurring opinion considered the best interests test and, after describing the extreme physical condition of Mrs Jobes (very similar to Mr Bland), quoted a passage in his opinion in Re Conroy (1985) 98 NJ 321 at 398–399:

> '"The medical and nursing treatment of individuals in extremis and suffering from these conditions entails the constant and extensive handling and manipulation of the body. At some point, such a course of treatment upon the insensate patient is bound to touch the sensibilities of even the most detached observer. Eventually, pervasive bodily intrusions, even for the best motives, will arouse feelings akin to humiliation and mortification for the helpless patient. When cherished values of human dignity and personal privacy, which belong to every person living or dying, are sufficiently transgressed by what is being done to the individual, we should be ready to say: enough." Based upon such factors it should be possible to structure critical treatment decisions that are reliable, understandable and acceptable.' (See 108 NJ 394 at 443–444.)

Auckland Area Health Board v A-G [1993] 1 NZLR 235 was an extreme example of a Guillain-Barré syndrome, causing a condition somewhat similar to a PVS patient, where the doctors sought a declaration that to withdraw artificial ventilation would not constitute culpable homicide. Thomas J granted the declaration and in doing so

considered decisions from a number of common law jurisdictions including the American and our own. He referred (at 245) to—

> 'values of human dignity and personal privacy… Human dignity and personal privacy belong to every person, whether living or dying. Yet, the sheer invasiveness of the treatment and the manipulation of the human body which it entails, the pitiful and humiliating helplessness of the patient's state, and the degradation and dissolution of all bodily functions invoke these values …'

The judge based his decision upon the best interests test. Mr Munby accepted that there was no difference in principle between the ventilator and the nasogastric tube.

Although the American decisions are often based upon the principle of achieving the right of an incompetent patient to make decisions as if competent through the device of the substituted judgment, in many cases the distinction from best interests is blurred, as Handler J pointed out in Re Jobes (1987) 108 NJ 394 at 436, and in some cases it is clearly an objective assessment of best interests



and the decisions are persuasive support for considerations far wider than the factor of pain to be taken into account in balancing the critical equation.

We all of course recognise that a patient unable to choose cannot himself exercise his right of self-determination and he cannot make the irrational decision he might notionally have made if in possession of his faculties. But not to be able to be irrational does not seem to me to be a good reason to be deprived of a rational decision which could be taken on his behalf in his best interests. Otherwise, if, as I believe they are, other factors as well as pain are relevant considerations, he is put at an unfair disadvantage.

A mentally incompetent patient has interests to be considered and protected, the basic one being the right to be properly cared for by others. He retains the right to have proceedings taken on his behalf, for instance to claim damages for negligence, or to have his estate or other property managed for him, or to respond to actions or proceedings taken against him, such as divorce proceedings. He retains in my view the right to be well regarded by others, and to be well remembered by his family. That right is separate from that of his family to remember him and to have the opportunity to grieve for him when he is dead. He has the right to be respected. Consequently he has a right to avoid unnecessary humiliation and degrading invasion of his body for no good purpose. I was dismayed to hear the argument of the Official Solicitor that, if Mr Bland suffered a cardiac arrest or a renal failure, it would be the duty of the doctors to perform a heart bypass operation or a kidney transplant. I cannot believe that a patient in the situation of Mr Bland should be subjected to therapeutically useless treatment contrary to good medical practice and medical ethics which would not be inflicted upon those able to choose. It is an affront to his right to be respected.

The considerations as to the quality of life of Mr Bland now and in the future in his extreme situation are in my opinion rightly to be placed on the other side of the critical

equation from the general principle of the sanctity and inviolability of life. In this appeal those factors which include the reality of Mr Bland's existence outweigh the abstract requirement to preserve life. The doctors charged with his care have balanced that equation from the medical standpoint and, after consultation with the family, who are in agreement, have concluded that his best interests lie in not artificially prolonging his life. Sir Stephen Brown P reconsidered all the relevant matters and came to the conclusion that to discontinue the artificial feeding would be in accordance with good medical practice and was in the best interests of Mr Bland. In my respectful view he was right and I entirely agree with his conclusion. The duty of the doctors towards a PVS patient at the extreme end of the spectrum does not extend to prolonging his life at all costs. Where they can be medically certain on all the evidence that he has been suffering from loss of consciousness without hope of recovery for a substantial period of time, in my judgment they are not in breach of their duty of care if they discontinue the artificial nutrition and hydration.

The criminal law

The thrust of Mr Munby's argument has been that it is unlawful to discontinue artificial feeding and consequently the doctors would be at risk of criminal proceedings. If a doctor owes a duty to continue to treat or to provide artificial nutrition, his failure to do so is a breach of his duty to the patient and may not only be actionable, but also a criminal act. In my view, as I have already set out in this judgment, I do not consider that there remains a duty of care upon the doctors to continue the artificial feeding and I agree with Mr Lester QC that there is no actus reus and no unlawful act or omission. The issue of mens rea does not arise.



There has been no criminal prosecution on these facts in England. My view is supported, however, by the decision of the Superior Court of the State of California, in the County of Los Angeles, in Barber v Superior Court of Los Angeles County (1983) 147 Cal App 3d 1006. The court held that the doctors' omission to continue treatment though intentional and with knowledge that the patient would die was not unlawful failure to perform a legal duty.

The position of Dr Cox is different (see R v Cox (18 September 1992, unreported), Ognall J). He injected a lethal dose, which was designed to cause death and was an external and intrusive act committed by an outsider and was not in accordance with his duty of care as a doctor. The effect of the cessation of artificial feeding is to place the patient in the position he would have been in before the nasogastric tube was inserted. Without the tube he would have died from his medical condition and with it he has been artificially kept alive despite that condition until now. Whether this is an act or omission carries the matter no further. The distinction between Mr Bland's doctors and Dr Cox is between an act or omission which allows causes already present in the body to operate and the introduction of an external agency of death.

The idea of ceasing the artificial feeding is a distressing one for all of us to contemplate. It would no doubt also be distressing for those who are caring for Mr Bland. We know however from the medical evidence that it would not be a distressing or painful experience for him in his state of non-cognition. The manner of his death can be eased

for him and those seeing it by appropriate medical and nursing care until the end of his life.

I have anxiously considered whether this is a decision which ought to be taken by the doctors alone. As the House of Lords said in F v West Berkshire Health Authority [1989] 2 All ER 545, [1990] 2 AC 1 it is not generally for the courts to intervene in the decision-making process as to whether a course of action is in the best interests of a patient. That process is for the doctors. The BMA have laid down careful guidelines for these cases. None the less in F v West Berkshire Health Authority the House of Lords recognised an exceptional situation which required guidance from the High Court. I have been persuaded by the amicus that in a decision-making process of such gravity as whether to continue treating a PVS patient, the intervention of the High Court is a proper safeguard. I respectfully agree with the formulation of the procedures proposed by Sir Stephen Brown P and that, for the time being at least, each application to discontinue treatment should be made to the High Court. The rapid advances of medical technology create problems which may require the intervention of the courts from time to time. Such intervention may also reassure public concern.

I would dismiss the appeal.

HOFFMANN LJ.

Anthony Bland was a cheerful teenager from Keighley in Yorkshire. He enjoyed pop music, football and drinking with his friends. In the spectators' pen at Hillsborough football stadium on 15 April 1989 his lungs were crushed by the pressure of the crowd around him. He ceased breathing until resuscitated by first aid. While he could not breathe his brain was deprived of oxygen.

The human brain consists of the cerebral hemispheres and the lower centre of the brain, which is called the brain stem. The cerebral hemispheres, or more precisely their outer layers, which are called the cerebral cortex, contain the function of consciousness. Without them, we cannot see, hear, feel pain or pleasure, or make any voluntary movements. The brain stem controls the body's semi-autonomous movements, like breathing, reflex actions and the beating of the heart.



The cerebral cortex requires a constant supply of oxygen, glucose and blood. An interruption of oxygen for a few minutes can cause extensive damage to the cells of the cortex, which never regenerate. But the brain stem is relatively resistant to being deprived of oxygen. It may therefore continue to function, and enable the heart to beat, the lungs to breathe and the stomach to digest, after the cortex has been irretrievably destroyed. This condition has been called 'persistent vegetative state'.

Since 15 April 1989 Anthony Bland has been in a persistent vegetative state. He lies in Airedale General Hospital in Keighley, fed liquid food by a pump through a tube passing through his nose and down the back of his throat into the stomach. His bladder is emptied through a catheter inserted through his penis, which from time to time has caused infections requiring dressing and antibiotic treatment. His stiffened joints have

caused his limbs to be rigidly contracted so that his arms are tightly flexed across his chest and his legs unnaturally contorted. Reflex movements in the throat cause him to vomit and dribble. Of all this, and the presence of members of his family who take turns to visit him, Anthony Bland has no consciousness at all. The parts of his brain which provided him with consciousness have turned to fluid. The darkness and oblivion which descended at Hillsborough will never depart. His body is alive, but he has no life in the sense that even the most pitifully handicapped but conscious human being has a life. But the advances of modern medicine permit him to be kept in this state for years, even perhaps for decades.

The question in this appeal is whether the court should in these circumstances declare that those in charge of caring for Anthony Bland may lawfully stop providing the artificial means of keeping him alive. This is a terrible decision because the consequence is that he will die. It is a question which until relatively recently would never have arisen. A person who had irreversibly lost consciousness would quickly have died: from lack of nutrition or from one of the many complications which have afflicted Anthony Bland's body over the past three years and which medical technology has been able to hold at bay. Modern medicine therefore faces us with fundamental and painful decisions about life and death which cannot be answered on the basis of normal everyday assumptions.

For reasons which I will eventually state quite briefly, I agree with Sir Thomas Bingham MR and Butler-Sloss LJ that in English law it would be lawful for the Airedale Hospital to stop keeping Anthony Bland alive. But this case has caused a great deal of public concern. People are worried, perhaps not so much about this particular case, but about where it may lead. Is the court to assume the role of God and decide who should live and who should die? Is Anthony Bland to die because the quality of his life is so miserable? Does this mean that the court would approve the euthanasia of seriously handicapped people? And what about the manner of his death? Can it ever be right to cause the death of a human being by deliberately depriving him of food? This is not an area in which any difference can be allowed to exist between what is legal and what is morally right. The decision of the court should be able to carry conviction with the ordinary person as being based not merely on legal precedent but also upon acceptable ethical values. For this reason I shall start by trying to explain why I think it would be not only lawful but right to let Anthony Bland die. In the course of doing so I shall also try to explain why the principles upon which this judgment rests do not make it a precedent for morally unacceptable decisions in the future.

To argue from moral rather than purely legal principles is a somewhat unusual enterprise for a judge to undertake. It is not the function of judges to lay down systems of morals and nothing which I say is intended to do so. But it seemed to



me that in such an unusual case as this, it would clarify my own thought and perhaps help others, if I tried to examine the underlying moral principles which have lead me to the conclusion at which I have arrived. In doing so, I must acknowledge the assistance I have received from reading the manuscript of Professor Ronald Dworkin's forthcoming book, Life's Dominion, and from conversations with him and Professor Bernard

Williams.

I start with the concept of the sanctity of life. Why do we think it would be a tragedy to allow Anthony Bland to die? It could be said that the entire tragedy took place at Hillsborough and that the curtain was brought down when Anthony Bland passed into a persistent vegetative state. Until then his life was precious to him and his family. But since then he has had no consciousness of his life and it could be said to be a matter of indifference to him whether he lives or dies. But the fact is that Anthony Bland is still alive. The mere fact that he is still a living organism means that there remains an epilogue of the tragedy which is being played out. This is because we have a strong feeling that there is an intrinsic value in human life, irrespective of whether it is valuable to the person concerned or indeed to anyone else. Those who adhere to religious faiths which believe in the sanctity of all God's creation and in particular that human life was created in the image of God himself will have no difficulty with the concept of the intrinsic value of human life. But even those without any religious belief think in the same way. In a case like this we should not try to analyse the rationality of such feelings. What matters is that, in one form or another, they form part of almost everyone's intuitive values. No law which ignores them can possibly hope to be acceptable.

Our belief in the sanctity of life explains why we think it is almost always wrong to cause the death of another human being, even one who is terminally ill or so disabled that we think that if we were in his position we would rather be dead. Still less do we tolerate laws such as existed in Nazi Germany, by which handicapped people or inferior races could be put to death because someone else thought that their lives were useless.

But the sanctity of life is only one of a cluster of ethical principles which we apply to decisions about how we should live. Another is respect for the individual human being and in particular for his right to choose how he should live his own life. We call this individual autonomy or the right of self-determination. And another principle, closely connected, is respect for the dignity of the individual human being: our belief that quite irrespective of what the person concerned may think about it, it is wrong for someone to be humiliated or treated without respect for his value as a person. The fact that the dignity of an individual is an intrinsic value is shown by the fact that we feel embarrassed and think it wrong when someone behaves in a way which we think demeaning to himself, which does not show sufficient respect for himself as a person.

No one, I think, would quarrel with these deeply rooted ethical principles. But what is not always realised, and what is critical in this case, is that they are not always compatible with each other. Take, for example, the sanctity of life and the right of self-determination. We all believe in them and yet we cannot always have them both. The patient who refuses medical treatment which is necessary to save his life is exercising his right to self-determination. But allowing him, in effect, to choose to die, is something which many people will believe offends the principle of the sanctity of life. Suicide is no longer a crime, but its decriminalisation was a recognition that the principle of self-determination should in that case prevail over the sanctity of life.

I accept that the sanctity of life is a complex notion, often linked to religion, on

which differing views may be held. The Jehovah's Witness who refuses a blood transfusion even though he knows this may result in his death, would probably not consider that he was sacrificing the principle of the sanctity of life to his own right of self-determination. He would probably say that a life which involved receiving a transfusion was so defiled as no longer to be an object of sanctity at all. But someone else might think that his death was a tragic waste and did offend against the sanctity of life. I do not think it would be a satisfactory answer to such a person to say that if he could only see it from the point of view of the Jehovah's Witness, he would realise that the principle of the sanctity of life had not been sacrificed but triumphantly upheld. Similarly it is possible to qualify the meaning of the sanctity of life by including, as some cultures do, concepts of dignity and fulfilment as part of the essence of life. In this way one could argue that, properly understood, Anthony Bland's death would not offend against the sanctity of life. But I do not think that this would satisfy the many people who feel strongly that it does. I think it is better to accept this and confront it.

A conflict between the principles of the sanctity of life and the individual's right of self-determination may therefore require a painful compromise to be made. In the case of the person who refuses an operation without which he will certainly die, one or other principle must be sacrificed. We may adopt a paternalist view, deny that his autonomy can be allowed to prevail in so extreme a case, and uphold the sanctity of life. Sometimes this looks an attractive solution, but it can have disturbing implications. Do we insist upon patients accepting life-saving treatment which is contrary to their strongly held religious beliefs? Should one force-feed prisoners on hunger strike? English law is, as one would expect, paternalist towards minors. But it upholds the autonomy of adults. A person of full age may refuse treatment for any reason or no reason at all, even if it appears certain that the result will be his death.

I do not suggest that the position which English law has taken is the only morally correct solution. Some might think that in cases of life and death, the law should be more paternalist even to adults. The point to be emphasised is that there is no morally correct solution which can be deduced from a single ethical principle like the sanctity of life or the right of self-determination. There must be an accommodation between principles, both of which seem rational and good, but which have come into conflict with each other.

It would therefore be in accordance with the English approach to resolving the conflict between the right to self-determination and the sanctity of life that, if Anthony Bland were to be momentarily restored to consciousness with full knowledge that he would shortly revert to his persistent vegetative state, and if he were to instruct those caring for him that he no longer wanted artificially to be kept alive, the doctors and nurses would be obliged to respect his wishes. If he were to give such an instruction, I think that many would feel that his wishes be obeyed, not only because they were his wishes, but because (unlike the case of a person who for religious reasons refuses treatment which could restore him to vigorous health) his wishes were entirely understandable. The horror of his situation is such that few would not think it perfectly reasonable for him to decide that, as he had already lost all sense and consciousness, he would prefer to die.

In this case, however, Anthony Bland has not made such a decision and never will. Some people make it clear in advance that, if they should fall into a state which seems to them

in anticipation to be intolerable, they do not want life-sustaining treatment to be continued. The right of self-determination entails that such wishes should be respected. Different jurisdictions have varying requirements about how clearly such wishes should be expressed. But Anthony Bland expressed



none at all. There is nothing to show that in the course of his short life he gave the matter any thought. All that his family can say is that from their knowledge of him and his general attitude to life, the things that interested him and gave him pleasure, he would not have wanted to survive in his present state.

Does this mean that people who have not expressed their wishes in advance and are now incapable of expression must lose all right to have treatment discontinued and that those caring for them are in every case under a corresponding duty to keep them alive as long as medical science will allow? Counsel for the Official Solicitor said that this was so. If they have not chosen, the court has no right to choose on their behalf. I think that the fallacy in this argument is that choice cannot be avoided. To continue treatment is as much a choice as to discontinue it. Why is it not an act of choice to decide to continue to invade the privacy of Anthony Bland's body with tubes, catheters, probes and injections? If on account of his unconsciousness he is obliged to submit to such treatment, one cannot say that it is because the court is refusing to choose on his behalf. One way or the other, a choice is being made. It is only if one thinks it natural and normal to want treatment that continuing to provide it seems not so much a choice as a given state of affairs. And of course in most cases this would be true. In a case in which it was being said that a person should not be given treatment which would avoid death and restore him to full health, one would want to know that this was his personal choice and that it had been expressed very clearly indeed.

But Anthony Bland's is not a normal case. The continuation of artificial sustenance and medical treatment will keep him alive but will not restore him to having a life in any sense at all. It is necessary to emphasise the awful certainty of his fate. We all know of cases in which doctors have been mistaken and where people have recovered to live meaningful lives after being given over for dead. But no one has ever recovered any vestige of consciousness after being in a persistent vegetative state for more than a year. Anthony Bland has been in this state for more than three years. He has been examined by a number of the most eminent doctors and they are unanimous that there is no hope whatever of any consciousness being regained. They say that this is the worst case of irreversible cortex damage that they have seen. Nor is this a case in which one has to make an assessment of the quality of life which Anthony Bland has. We all know and admire people who suffer pain and disability, of whom many would think that in their position they would rather be dead, and yet who endure their lives and derive meaning and satisfaction from living. But the very concept of having a life has no meaning in relation to Anthony Bland. He is alive but has no life at all.

Counsel for the Official Solicitor argued that however vestigial Anthony Bland's life might be, one could not assume that he would choose to die. Being unconscious, he felt no pain or humiliation and therefore had no interests which suffered from his being kept alive. Anthony Bland was in fact indifferent to whether he lived or died and there was

nothing to put in the balance against the intrinsic value of his life.

I think that the fallacy in this argument is that it assumes that we have no interests except in those things of which we have conscious experience. But this does not accord with most people's intuitive feelings about their lives and deaths. At least a part of the reason why we honour the wishes of the dead about the distribution of their property is that we think it would wrong them not to do so, despite the fact that we believe that they will never know that their will has been ignored. Most people would like an honourable and dignified death and we think it wrong to dishonour their deaths, even when they are unconscious that this is



happening. We pay respect to their dead bodies and to their memory because we think it an offence against the dead themselves if we do not. Once again I am not concerned to analyse the rationality of these feelings. It is enough that they are deeply rooted in our ways of thinking and that the law cannot possibly ignore them. Thus I think that counsel for the Official Solicitor offers a seriously incomplete picture of Anthony Bland's interests when he confines them to animal feelings of pain or pleasure. It is demeaning to the human spirit to say that, being unconscious, he can have no interest in his personal privacy and dignity, in how he lives or dies.

Anthony Bland therefore has a recognisable interest in the manner of his life and death which help the court to apply the principles of self-determination and the value of the individual. We can say from what we have learned of Anthony Bland from those closest to him that, forced as we are to choose, we think it is more likely that in his present state he would choose to die than to live. There is no suggestion that he was, for example, motivated by any religious principles which would have made him want his life in its present state prolonged. We can also say that in allowing him to die, we would be showing more respect to him as an individual than by keeping him alive.

Thus it seems to me that we are faced with conflicting ethical principles. On the one hand, Anthony Bland is alive and the principle of the sanctity of life says that we should not deliberately allow him to die. On the other hand, Anthony Bland is an individual human being and the principle of self-determination says he should be allowed to choose for himself and that, if he is unable to express his choice, we should try our honest best to do what we think he would have chosen. We cannot disclaim this choice because to go on is as much a choice as to stop. Normally we would unquestioningly assume that anyone would wish to live rather than die. But in the extraordinary case of Anthony Bland, we think it more likely that he would choose to put an end to the humiliation of his being and the distress of his family. Finally, Anthony Bland is a person to whom respect is owed and we think that it would show greater respect to allow him to die and be mourned by his family than to keep him grotesquely alive.

There is no formula for reconciling this conflict of principles and no easy answer. It does no good to seize hold of one of them, such as the sanctity of life, and say that because it is valid and right, as it undoubtedly is, it must always prevail over other principles which are also valid and right. Nor do I think it helps to say that these principles are all really different ways of looking at the same thing. Counsel for the Attorney General said that

there was—

> 'no conflict between having regard to the quality of life and respecting the sanctity of life; on the contrary they are complementary; the principle of the sanctity of life embraces the need for full respect to be accorded to the dignity and memory of the individual.'

To my mind, this is rhetoric intended to dull the pain of having to choose. For many people, the sanctity of life is not at all the same thing as the dignity of the individual. We cannot smooth away the differences by interpretation. Instead, we are faced with a situation which has been best expressed by Sir Isaiah Berlin in 'Two concepts of liberty' in Four Essays on Liberty (1969) pp 168, 170:

> 'The world that we encounter in ordinary experience is one in which we are faced with choices between ends equally ultimate, and claims equally absolute, the realisation of some of which must inevitably involve the sacrifice of others … The knowledge that it is not merely in practice but in principle impossible to reach clear-cut and certain answers, even in an ideal world of



> wholly good and rational men and wholly clear ideas—may madden those who seek for final solutions and single, all-embracing systems, guaranteed to be eternal. Nevertheless it is a conclusion that cannot be escaped by those who, with Kant, have learnt the truth that out of the crooked timber of humanity no straight thing was ever made.'

In my view the choice which the law makes must reassure people that the courts do have full respect for life, but that they do not pursue the principle to the point at which it has become almost empty of any real content and when it involves the sacrifice of other important values such as human dignity and freedom of choice. I think that such reassurance can be provided by a decision, properly explained, to allow Anthony Bland to die. It does not involve, as counsel for the Official Solicitor suggested, a decision that he may die because the court thinks that his 'life is not worth living'. There is no question of his life being worth living or not worth living because the stark reality is that Anthony Bland is not living a life at all. None of the things that one says about the way people live their lives—well or ill, with courage or fortitude, happily or sadly—have any meaning in relation to him. This in my view represents a difference in kind from the case of the conscious but severely handicapped person. It is absurd to conjure up the spectre of eugenics as a reason against the decision in this case.

Thus in principle I think it would be right to allow Anthony Bland to die. Is this answer affected by the proposed manner of his death? Some might say that as he is going to die, it does not matter how. Why wait for him to expire for lack of food or be carried off by an untreated infection? Would it not be more humane simply to give him a lethal injection? No one in this case is suggesting that Anthony Bland should be given a lethal injection. But there is concern about ceasing to supply food as against, for example, ceasing to treat an infection with antibiotics. Is there any real distinction? In order to come to terms with our intuitive feelings about whether there is a distinction, I must start

by considering why most of us would be appalled if he was given a lethal injection. It is, I think, connected with our view that the sanctity of life entails its inviolability by an outsider. Subject to exceptions like self-defence, human life is inviolate even if the person in question has consented to its violation. That is why although suicide is not a crime, assisting someone to commit suicide is. It follows that, even if we think Anthony Bland would have consented, we would not be entitled to end his life by a lethal injection.

On the other hand, we recognise that, one way or another, life must come to an end. We do not impose on outsiders an unqualified duty to do everything possible to prolong life as long as possible. I think that the principle of inviolability explains why, although we accept that in certain cases it is right to allow a person to die (and the debate so far has been over whether this is such a case) we hold without qualification that no one may introduce an external agency with the intention of causing death. I do not think that the distinction turns upon whether what is done is an act or omission. This leads to barren arguments over whether the withdrawal of equipment from the body is a positive act or an omission to keep it in place. The distinction is between an act or omission which allows an existing cause to operate and the introduction of an external agency of death.

What complicates this distinction, however, is another ethical principle which demands that we should show kindness and humanity to our fellow human beings. At the most basic level, this principle insists that we should, if we are able to do so, provide food and shelter to a human being in our care who is unable to provide them for himself. If someone allows a small child or invalid in his care to starve to death, we do not say that he allowed nature to take its course. We think



he has committed a particularly wicked crime. We treat him as if he had introduced an external agency of death. It is the same ethical principle which requires doctors and hospitals to provide the patients in their care with such medical attention and nursing as they are reasonably able to give.

In the normal case there is no moral difference between violations of these two principles—the prohibition on violating the person and the positive duty to act with humanity towards the helpless. Starving a child to death is no different from giving him poison. But there are two distinctions between the prohibition on external violation and the duty to provide humane care and assistance. One distinction is that the duty to provide care—for example to provide medical treatment—ceases when such treatment can serve no humane purpose. In cases when further treatment can prolong the life of the patient only for a short period and at the cost of great pain and suffering, the doctor is under no obligation to continue. Indeed, the duty to act with kindness and humanity points in the opposite direction. But the prohibition on violating the person is absolute. Whatever the patient's sufferings, no one is entitled to introduce an external agency of death. It was this prohibition which Dr Cox violated by injecting Mrs Boyes with potassium chloride (see R v Cox (18 September 1992, unreported), Ognall J). The debate over euthanasia centres on the agonising conflict which can arise when, as in that case, the duty to act with kindness and humanity comes into conflict with the absolute prohibition on the violation of the person. At the moment English law unequivocally resolves this conflict by giving priority to the latter principle. This is not the place to

debate whether this is the only morally or socially acceptable position. In the present case, no such issue arises. This is not a case about euthanasia because it does not involve any external agency of death. It is about whether, and how, the patient should be allowed to die.

It is, I think, the duty to act with kindness and humanity which leads people to say that, whatever may be the position about artificial medical treatment, it cannot be right to deny the patient food. The giving of food to a helpless person is so much the quintessential example of kindness and humanity that it is hard to imagine a case in which it would be morally right to withhold it. If it is right that Anthony Bland should be allowed to die, then refrain from giving antibiotics and let him be carried off by an infection. But do not allow him to starve.

American writers have referred to these qualms about denial of food as the 'sloganism' and 'emotional symbolism' of food. I do not think that one should make light of these deeply intuitive feelings, which derive, as I have said, from a principle of kindness which is a badge of our humanity. But like the principle of the sanctity of life, they cease to provide true guidance in the extreme case. It is of course hard to imagine a case in which it could be humane to deny food to a patient. But this case stretches the imagination. To deny someone food is wrong because it causes suffering and death. But Anthony Bland cannot suffer and his condition is such that it is right that he should be allowed to die. His interest in the manner of his death—and it is a very important one—is that it should not be distressing or humiliating. If therefore, withdrawal of nourishment would produce distressing symptoms of which Anthony Bland was unconscious but which were visible to the nursing staff and family, this would be a good reason for allowing him to die in some other way. But the medical evidence is that suitable sedation can prevent any untoward symptoms and that withdrawal of nourishment is the most gentle and controlled way in which to allow him to die.

Counsel for the Official Solicitor opened this appeal by saying that Sir Stephen Brown P 'had held that it was lawful for a doctor to starve his patient to death'. This is emotive language and by that I do not mean that this is not a proper case



for emotion. It certainly is. By emotive language I mean language which evokes emotional images which are false, which have no application to the present case. The use of the language is intended to evoke images of cruelty, suffering and unwelcome death. Such images have no part to play in arriving at an answer to the problem, already difficult enough, which this case presents to the court.

I said that there were two distinctions between the prohibition on violating the person and the duty to provide care and assistance. So far I have mentioned only one. The second is that while the prohibition on violation is absolute, the duty to provide care is restricted to what one can reasonably provide. No one is under a moral duty to do more than he can, or to assist one patient at the cost of neglecting another. The resources of the national health service are not limitless and choices have to be made. This qualification on the moral duty to provide care did not enter into the argument in this case at all. The Airedale NHS Trust invited us to decide the case on the assumption that its resources were unlimited and we have done so. But one is bound to observe that the cost of

keeping a patient like Anthony Bland alive is very considerable and that in another case the health authority might conclude that its resources were better devoted to other patients. We do not have to consider such a case, but in principle the allocation of resources between patients is a matter for the health authority and not for the courts.

I can deal with the authorities very shortly. The House of Lords decided in F v West Berkshire Health Authority (Mental Health Act Commission intervening) [1989] 2 All ER 545, [1990] 2 AC 1 that the duty of a doctor towards a patient who lacks mental capacity to express his own wishes (and has not expressed any at a time when he had such capacity) is to give or withhold treatment according to what appears to be the best interests of the patient. The best interests of the patient in my judgment embrace not only recovery or the avoidance of pain (neither of which apply to this case) but also a dignified death. On this issue I respectfully agree with the dissenting judgments of Handler J in Re Conroy (1985) 98 NJ 321 and Brennan and Stevens JJ in Cruzan v Director, Missouri Dept of Health (1990) 497 US 261. The patient's best interests would normally also include having respect paid to what seems most likely to have been his own views on the subject. To this extent I think that what the American courts have called 'substituted judgment' may be subsumed within the English concept of best interests. On the other hand, cases involving minors like Re J (a minor) (wardship: medical treatment) [1990] 3 All ER 930, [1991] Fam 33 show that full weight has to be given to the principle of the sanctity of life before deciding that a test of best interests justifies a decision to allow the patient to die. In my judgment, however, such a decision is justified here. I agree with what Sir Thomas Bingham MR and Butler-Sloss LJ have said about the procedure to be followed in future cases.

Finally, I must deal with some aspects of the judgment of Sir Stephen Brown P. As will be apparent, I am in agreement with the decision which he reached. But there are certain points in his judgment which may have given rise to concern. First, the judgment contains some discussion about whether the administration of liquid food through a tube can properly be called medical treatment. Some have felt that the issues in this case could not depend upon a semantic point like that. I agree. As I see it, there are only two ways in which it may be relevant to call the feeding medical treatment. They are to identify it as something upon which, first, the hospital can properly ask for the guidance of the court as to what it should do and, secondly, the medical profession can properly express a view. Once one is clear about why the question is being asked, it does not matter whether one calls it medical treatment, nursing, care or anything else. There is in my view no distinction between medical treatment and other kinds of



care for the purposes of deciding the central issue in this case. This brings me to the second point of concern. Sir Stephen Brown P laid some emphasis upon the fact that according to professional medical opinion and the British Medical Association's statement on ethics, ending artificial feeding would be in accordance with good medical practice. Some have felt concern at the suggestion that questions of whether patients should live or die should be decided according to what was thought to be good practice by the medical profession. Once again, I sympathise with this concern.

I do not think that Sir Stephen Brown P was saying that the views of the medical profession should determine the legal and moral questions which I have discussed in this

judgment. Nor do I think that the profession would be grateful to the court for leaving the full responsibility for such decisions in its hands. It seems to me that the medical profession can tell the court about the patient's condition and prognosis and about the probable consequences of giving or not giving certain kinds of treatment or care, including the provision of artificial feeding. But whether in those circumstances it would be lawful to provide or withhold the treatment or care is a matter for the law and must be decided with regard to the general moral considerations of which I have spoken. As to these matters, the medical profession will no doubt have views which are entitled to great respect, but I would expect medical ethics to be formed by the law rather than the reverse.

I should emphasise that this is not a case in which some past act on the part of a doctor is being called into question. If the issue was whether such an act had given rise to civil or criminal liability, the fact that the doctor has acted in accordance with responsible professional opinion would usually be determinative. But in this case the plaintiff hospital trust is seeking the opinion of the court as to whether future conduct will be lawful. It has invited the court to decide whether, on medical facts which are not in dispute, the termination of life-support would be justified as being in the best interests of the patient. This is a purely legal (or moral) decision which does not require any medical expertise and is therefore appropriately made by the court.

I would dismiss the appeal.

Appeal dismissed. Leave to appeal to the House of Lords granted. No order as to costs.
Francis Rustin Barrister.
Appeal

The defendant, acting by the Official Solicitor as his guardian ad litem, appealed with the leave of the Court of Appeal.

James Munby QC (instructed by the Official Solicitor) for the Official Solicitor as guardian ad litem.
Robert Francis QC and M R Taylor (instructed by Penningtons, agents for W J M Lovel, Harrogate) for the plaintiffs.
Anthony Lester QC and Pushpinder Saini (instructed by the Treasury Solicitor) as amicus curiae.

Their Lordships took time for consideration.

4 February 1993. The following opinions were delivered.

LORD KEITH OF KINKEL.
[1993] 1 All ER 821 at 859

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 (PVS). 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 NHS 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 Sir Stephen Brown P on 19 November 1992. That judgment was affirmed by the Court of Appeal (Sir Thomas Bingham MR, Butler-Sloss and Hoffmann LJJ) on 9 December 1992. The declarations are in these terms:

> '… that despite the inability of [the defendant] to consent thereto the Plaintiffs and the responsible attending physicians: (1) may lawfully discontinue all life-sustaining treatment and medical support 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 (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 QC 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: see F v West Berkshire Health Authority (Mental Health Act Commission intervening) [1989] 2 All ER 545, [1990] 2 AC 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 PVS, 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 PVS 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 PVS, 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 F v West Berkshire Health Authority [1989] 2 All ER 545, [1990] 2 AC 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 Re J (a minor) (wardship: medical treatment) [1990] 3 All ER 930, [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: see R v Stone [1977] 2 All ER 341, [1977] QB 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: see Bolam v Friern Hospital Management Committee [1957] 2 All ER 118, [1957] 1 WLR 582.

Given that existence in the persistent vegetative state is not a benefit to the patient, it remains to consider whether the principle of 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 PVS 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 PVS patients and others in similar conditions.

The decision whether or not the continued treatment and care of a PVS 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 indorsement or the reverse. The view taken by Sir Stephen Brown P 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 Sir Thomas Bingham MR said (at p 842, ante), 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 (see p 824, ante); they have been admirably summarised in the judgment of Sir Thomas Bingham MR in the Court of Appeal (see p 834, ante); 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 Sir Thomas Bingham MR (see pp 834–835, ante), which, for convenience of reference, I will now incorporate into this opinion.

> 'Mr Anthony David Bland, then aged 171/2, 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 (PVS). PVS is a recognised medical condition quite distinct from other conditions sometimes known as “irreversible coma”, “the Guillain-Barré

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 PVS 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. 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 PVS case he had ever seen. 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 liquefied 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 rise. The catheter must be monitored: it may cause infection (and has repeatedly done so); it has had to be resited, 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 PVS 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 NHS 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, Sir Stephen Brown P 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, which 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 QC, 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 Sir Stephen Brown P. 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 QC, appearing as amicus curiae, instructed by the Treasury Solicitor, and of the thoughtful argument of Mr Robert Francis QC 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 F v West Berkshire Health Authority (Mental Health Act Commission intervening) [1989] 2 All ER 545, [1990] 2 AC 1 provided the most appropriate means by which authoritative guidance could be provided for the respondents to the appeal, the Airedale NHS 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 F v West Berkshire Health Authority 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 A-G [1980] 1 All ER 866 at 875, 884, [1981] AC 718 at 741, 752 per Viscount Dilhorne, and see also 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 UK v Dept of Health and



Social Security [1981] 1 All ER 545, [1981] AC 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 Los Angeles County (1983) 147 Cal App 3d 1006 at 1011: '… 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 (1987) 534 A 2d 947 at 949), New Zealand Auckland Area Health Board v A-G [1993] 1 NZLR 235 at 241–244, 255 per Thomas J, to whom submissions had been addressed upon the point) and South Africa (Clarke v Hurst (30 July 1992, unreported) per Thirion J).

The central issue in the present case has been aptly stated by Sir Thomas Bingham MR 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 Sir Stephen Brown P,

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) esp at 351–352 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 art 2 of the European Convention on Human Rights (Convention for the Protection of Human Rights and Fundamental Freedoms (Rome, 4 November 1950; TS 71 (1953); Cmd 8969)) and in art 6 of the International Covenant on Civil and Political Rights (New York, 19 December 1966; TS 6 (1977); Cmnd 6702).

[1993] 1 All ER 821 at 866

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 (1914) 211 NY 125 at 129–130 per Cardozo J, S v S, W v Official Solicitor [1970] 3 All ER 107 at 111, [1972] AC 24 at 43 per Lord Reid and Sidaway v Bethlem Royal Hospital Governors [1985] 1 All ER 643 at 649, [1985] AC 871 at 882 per Lord Scarman). To this extent, the principle of the sanctity of human life must yield to the principle of self-determination (see p 851 ante, per Hoffmann LJ), 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 Hôtel-Dieu de Québec (1992) 86 DLR (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 eg Re T (adult: refusal of medical treatment) [1992] 4 All ER 649, [1992] 3 WLR 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 Belchertown State School Superintendent v Saikewicz (1977) 373 Mass 728 at 747 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 R v Cox (18 September 1992, unreported) per Ognall J in the Crown Court at Winchester. 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 Textbook of Criminal Law (2nd edn, 1983) 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 F v West Berkshire Health Authority [1989] 2 All ER 545, [1990] 2 AC 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 the High Court of New Zealand in Auckland Area Health Board v A-G [1993] 1 NZLR 235 at 253, 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.

[1993] 1 All ER 821 at 869

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 Auckland Area Health Board v A-G [1993] 1 NZLR 235 at 247. 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 Re J (a minor) (wardship: medical treatment) [1990] 3

All ER 930 at 945, [1991] Fam 33 at 55 the approach to be adopted in that case was stated by Taylor LJ as follows:

> 'I consider that 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 Sir Thomas Bingham MR 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 F v West Berkshire Health Authority [1989] 2 All ER 545, [1990] 2 AC 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] 2 All ER 118, [1957] 1 WLR 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 12 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

[1993] 1 All ER 821 at 872

with the relatives of PVS patients are consistent with the opinion expressed by your Lordships' House in F v West Berkshire Health Authority 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 British Medical Association 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. 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 eg Re Quinlan (1976) 70 NJ 10 and Belchertown State School Superintendent v Saikewicz (1977) 373 Mass 728. 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 F v West Berkshire Health Authority 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 Auckland Area Health Board v A-G [1993] 1 NZLR 235, unreported), a case concerned with the discontinuance of life support provided by ventilator to a patient suffering from the last stages of incurable Guillain-Barré 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 Re J (a minor) (wardship: medical treatment) [1990] 3 All ER 930, [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 in 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 in the Working Paper (at pp 65–66), 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. Sir Stephen Brown P considered that the opinion of the court should be sought in all cases similar to the present. In the Court of Appeal Sir Thomas Bingham MR expressed his agreement with Sir Stephen Brown P in the following words (see p 842, ante):

> '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 Sir Stephen Brown P 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, ie (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 Sir Thomas Bingham MR; 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 Barré 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, l 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.

1. 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.

2. As noted in F v West Berkshire Health Authority (Mental Health Act Commission intervening) [1989] 2 All ER 545, [1990] 2 AC 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 F v West Berkshire Health Authority 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.



3. 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.

4. 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 respondents' 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 respondents' 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 combating 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 necessarily 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 patient's 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, F v West Berkshire Health Authority (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 NHS 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 Hoffmann LJ 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, ie 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 persistent vegetative state (PVS) is very severe, what of others in this country also in PVS (whom we were told numbered between 1,000 and 1,500) and others suffering from medical conditions having similar impact,



eg the Guillain-Barré 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 benefited, eg 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 PVS 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, attaches importance to impalpable factors such as personal dignity and the way Anthony Bland would wish to be remembered but does 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, ie, 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 criticised 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 (see R v

[1993] 1 All ER 821 at 881

Gibbins (1918) 13 Cr App R 134) or manslaughter (see R v Stone [1977] 2 All ER 341, [1977] QB 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 (1) the withdrawal of artificial feeding is a positive act of commission or (2) 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 QC, 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 (1985) p 169ff), 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 reset every 12 hours: the failure to reset 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 edn, 1983) p 282 and Skegg p 169ff.

In my judgment, there is a further reason why the removal of the nasogastric 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 sign 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 1959 Act: see F v West Berkshire Health Authority (Mental Health Act Commission intervening) [1989] 2 All ER 545, [1990] 2 AC 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 to refuse consent to the continuation of the invasive procedures involved in artificial feeding.

Faced with this lacuna in the law, this House in F v West Berkshire Health Authority 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 F v West Berkshire Health Authority? Both Lord Brandon of Oakbrook and Lord Goff 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 (see [1989] 2 All ER 545 at 557, 565–566, 567, [1990] 2 AC 1 at 64, 75, 77). 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] 2 All ER 118, [1957] 1 WLR 582, viz is the decision in accordance with a practice accepted at the time by a responsible body of medical opinion? (see [1989] 2 All ER 545 at 559, 567, [1990] 2 AC 1 at 66–67, 78 per Lord Brandon and Lord Goff). 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 court's 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 is satisfied.

[1993] 1 All ER 821 at 884

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 analysed, 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 in 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 QC, 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': see 'Medical technology and the law' (1989) 103 Harv LR 1519 at 1665n. 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.

[1993] 1 All ER 821 at 886
I. THE ROLE OF THE COURT

The issues now before the House fall into three groups. (1) 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? (2) 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 judgment, 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 analysed 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 one ever been



proposed, for conducting such an inquiry 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 Ltd v A-G [1980] 1 All ER 866, [1981] AC 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 for the Official Solicitor and Mr Lester QC 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.

(1) The effect of the declarations is to change the legal status of the proposed conduct in this particular case. 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 indorsing, but the matter need not be further pursued, since it became plain during argument that none of the counsel were advocating this route.

(2) 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 20 out of the 39 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 Dept of Health (1990) 110 S Ct 2841 at 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 R v Laskey and ors 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

[1993] 1 All ER 821 at 890

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 F v West Berkshire Health Authority (Mental Health Act Commission intervening) [1989] 2 All ER 545, [1990] 2 AC 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 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 R v Adams (Bodkin) [1957] Crim LR 365, R v Arthur (1981) Times, 5 November, Farquharson J) and R v Cox (18 September 1992, unreported), was the subject of direct decision by an appellate court in Barber v Superior Court of Los Angeles County (1983) 147 Cal App 3d 1006 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' 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 R v Gibbins (1918) 13 Cr App R 134.

[1993] 1 All ER 821 at 891

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 bringing 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 R v Stone [1977] 2 All ER 341, [1977] QB 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 R v Gibbins. 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 Quinlan (1976) 70 NJ 10, 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, that 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, re Eichner (1981) 52 NY 2d 363.

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 Belchertown State School Superintendent v Saikewicz (1977) 373 Mass 728. 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: Skegg Law, Ethics and Medicine (1985) ch 6, where it represents the author's chosen solution, and also Glanville Williams Textbook of Criminal Law (2nd edn, 1983) pp 282–283 and Professor Ian Kennedy's paper Treat me Right, Essays in Medical Law and Ethics (1988) 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 R v Blaue [1975] 3 All ER 446, [1975] 1 WLR 1411, R v Malcherek [1981] 2 All ER 422, [1981] 1 WLR 690 and Finlayson v HM Advocate 1979 JC 33. 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 inquiry 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 Auckland Area Health Board v A-G [1993] 1 NZLR 235 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 F v West Berkshire Health Authority [1989] 2 All ER 545, [1990] 2 AC 1 by concentrating on the best interests, not of the community at large, but of Anthony Bland himself. Just as in F v West Berkshire Health Authority, 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 F v West Berkshire Health Authority 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-Barré 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 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 inquiry 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 which he was unable to make for himself. In accordance with F v West Berkshire Health Authority [1989] 2 All ER 545, [1990] 2 AC 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 correlative 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.

[1993] 1 All ER 821 at 895

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 edn, 1988) p 51, Beynon 'Doctors as murderers' [1982] Crim LR 17 and Gunn and Smith 'Arthur's case and the right to life of a Down's syndrome child' [1985] Crim LR 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 v Superior Court of Los Angeles County (1983) 147 Cal App 3d 1006 at 1017 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] 2 All ER 118, [1957] 1 WLR 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.

Appeal dismissed. No order as to costs.
Mary Rose Plummer Barrister.
[1993] 1 All ER 821 at 897