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PRESIDENTIAL ADDRESS: IS THE SANCTITY OF LIFE ETHIC TERMINALLY ILL?

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ABSTRACT

Our growing technical capacity to keep human beings alive has brought the sanctity of life ethic to the point of collapse. The shift to a concept of brain death was already an implicit abandonment of the traditional ethic, though this has only recently become apparent. The 1993 decision of the British House of Lords in the case of Anthony Bland is an even more decisive shift towards an ethic that does not ask or seek to preserve human life as such, but only a life that is worth living. Once this shift has been completed and assimilated, we will no longer need the concept of brain death. Instead we can face directly the real ethical issue: when may doctors intentionally end the life of a patient?

I INTRODUCTION

It is surely no secret to anyone at this Congress that I have for a long time been a critic of the traditional sanctity of life ethic. So if I say that I believe that, after ruling our thoughts and our decisions about life and death for nearly two thousand years, the traditional sanctity of life ethic is at the point of collapse, some of you may think this is mere wishful thinking on my part. Consider, however, the following three signs of this impending collapse, which have taken place — coincidentally but perhaps appropriately enough — during the past two years in which I have had the honour of holding the office of President of the International Association of Bioethics.

- On February 4, 1993, in deciding the fate of a young man named Anthony Bland, Britain's highest court threw out many centuries of traditional law and medical ethics regarding the value of human life and the lawfulness of intentionally ending it.
- On November 30, 1993, the Netherlands parliament finally put into law the guidelines under which Dutch doctors have

for some years been openly giving lethal injections to patients who suffer unbearably without hope of improvement, and who ask to be helped to die.

- On May 2, 1994, twelve Michigan jurors acquitted Dr Jack Kevorkian of a charge of assisting Thomas Hyde to commit suicide. Their refusal to convict Kevorkian was a major victory for the cause of physician-assisted suicide, for it is hard to imagine a clearer case of assisting suicide than this one. Kevorkian freely admitted supplying the carbon monoxide gas, tubing and a mask to Hyde, who had then used them to end a life made unbearable by the rapidly progressing nerve disorder ALS.

These three events are the surface tremors resulting from major shifts deep in the bedrock of Western ethics. We are going through a period of transition in our attitude to the sanctity of human life. Such transitions cause confusion and division. Many factors are involved in this shift, but today I shall focus on ways in which our growing technical capacity to keep human beings alive has brought out some implications of the sanctity of life ethic that — once we are forced to face them squarely — we cannot accept. This will lead me to suggest a way forward.

II REVOLUTION BY STEALTH: THE REDEFINITION OF DEATH

The acceptance of brain death — that is, the permanent loss of all brain function — as a criterion of death has been widely regarded as one of the great achievements of bioethics. It is one of the few issues on which there has been virtual consensus; and it has made an important difference in the way we treat people whose brains have ceased to function. This change in the definition of death has meant that warm, breathing, pulsating human beings are not given further medical support. If their relatives consent (or in some countries, as long as they have not registered a refusal of consent), their hearts and other organs can be cut out of their bodies and given to strangers. The change in our conception of death that excluded these human beings from the moral community was among the first in a series of dramatic changes in our view of life and death. Yet, in sharp contrast to other changes in this area, it met with virtually no opposition. How did this happen?

Everyone knows that the story of our modern definition of death begins with "The Ad Hoc Committee of the Harvard Medical School to Examine the Definition of Brain Death". What is not so

well known is the link between the work of this committee and Dr Christiaan Barnard's famous first transplantation of a human heart, in December 1967. Even before Barnard's sensational operation, Henry Beecher, chairman of a Harvard University committee that oversaw the ethics of experimentation on human beings, had written to Robert Ebert, Dean of the Harvard Medical School, suggesting that the Committee should consider some new questions. He had, he told the Dean, been speaking with Dr Joseph Murray, a surgeon at Massachusetts General Hospital and a pioneer in kidney transplantation. "Both Dr Murray and I", Beecher wrote, "think the time has come for a further consideration of the definition of death. Every major hospital has patients stacked up waiting for suitable donors."[1] Ebert did not respond immediately; but within a month of the news of the South African heart transplant, he set up, under Beecher's chairmanship, the group that was soon to become known as the Harvard Brain Death Committee.

The committee was made up mostly of members of the medical profession — ten of them, supplemented by a lawyer, an historian, and a theologian. It did its work rapidly, and published its report in the *Journal of the American Medical Association* in August 1968. The report was soon recognised as an authoritative document, and its criteria for the determination of death were adopted rapidly and widely, not only in the United States but, with some modification of the technical details, in most countries of the world. The report began with a remarkably clear statement of what the committee was doing and why it needed to be done:

> Our primary purpose is to define irreversible coma as a new criterion for death. There are two reasons why there is a need for a definition: (1) Improvements in resuscitative and supportive measures have led to increased efforts to save those who are desperately injured. Sometimes these efforts have only a partial success so that the result is an individual whose heart continues to beat but whose brain is irreversibly damaged. The burden is great on patients who suffer permanent loss of intellect, on their families, on the hospitals, and on those in need of hospital beds already occupied by these comatose patients. (2) Obsolete criteria for the definition of death can lead to controversy in obtaining organs for transplantation.

[1] Henry Beecher to Robert Ebert, 30 October 1967. The letter is in the Henry Beecher Manuscripts at the Francis A. Countway Library of Medicine, Harvard University, and is quoted by David Rothman, *Strangers at the Bedside*, New York: Basic Books, 1991, pp. 160–1.

To a reader familiar with bioethics in the 1990's, there are two striking aspects of this opening paragraph. The first is that the Harvard committee does not even attempt to argue that there is a need for a new definition of death because hospitals have a lot of patients in their wards who are really dead, but are being kept attached to respirators because the law does not recognise them as dead. Instead, with unusual frankness, the committee said that a new definition was needed because irreversibly comatose patients were a great burden, not only on themselves (why to be in an irreversible coma is a burden to the patient, the Committee did not say), but also to their families, hospitals, and patients waiting for beds. And then there was the problem of "controversy" about obtaining organs for transplantation.

In fact, frank as the statement seems, in presenting its concern about this controversy, the Committee was still not being entirely candid. An earlier draft had been more open in stating that one reason for changing the definition of death was the "great need for tissues and organs of, among others, the patient whose cerebrum has been hopelessly destroyed, in order to restore those who are salvageable". When this draft was sent to Ebert, he advised Beecher to tone it down it because of its "unfortunate" connotation "that you wish to redefine death in order to make viable organs more readily available to persons requiring transplants".[2] The Harvard Brain Death Committee took Ebert's advice: it was doubtless more politic not to put things so bluntly. But Beecher himself made no secret of his own views. He was later to say, in an address to the American Association for the Advancement of Science:

> There is indeed a life-saving potential in the new definition, for, when accepted, it will lead to greater availability than formerly of essential organs in viable condition, for transplantation, and thus countless lives now inevitably lost will be saved. . .[3]

The second striking aspect of the Harvard committee's report is that it keeps referring to "irreversible coma" as the condition that it wishes to define as death. The committee also speaks of "permanent loss of intellect" and even says "we suggest that responsible medical opinion is ready to adopt new criteria for pronouncing death to have occurred in an individual sustaining irreversible coma as a result of permanent brain damage". Now "irreversible coma as a result of

[2] The first draft and Ebert's comment on it are both quoted by Rothman, *Strangers at the Bedside*, pp. 162–4. The documents are in the Beecher Manuscript collection.

[3] Henry Beecher, "The New Definition of Death, Some Opposing Viewpoints", *International Journal of Clinical Pharmacology*, 5 (1971), pp. 120–121 (italics in original).

permanent brain damage" is by no means identical with the death of the whole brain. Permanent damage to the parts of the brain responsible for consciousness can also mean that a patient is in a "persistent vegetative state", a condition in which the brain stem and the central nervous system continue to function, but consciousness has been irreversibly lost. Even today, no legal system regards those in a persistent vegetative state as dead.

Admittedly, the Harvard committee report does go on to say, immediately following the paragraph quoted above: "*we are concerned here only with those comatose individuals who have no discernible central nervous system activity.*" But the reasons given by the committee for redefining death — the great burden on the patients, their families, the hospitals and the community, as well as the waste of organs needed for transplation — apply in every respect to *all* those who are irreversibly comatose, not only to those whose entire brain is dead. So it is worth asking: why did the committee limit its concern to those with no brain activity at all? One reason could be that there was at the time no reliable way of telling whether a coma was irreversible, unless the brain damage was so severe that there was no brain activity at all. Another could be that people whose whole brain is dead will stop breathing after they are taken off a respirator, and so will soon be dead by anyone's standard. People in a persistent vegetative state, on the other hand, may continue to breathe without mechanical assistance. To call for the undertakers to bury a "dead" patient who is still breathing would be a bit too much for anyone to swallow.

We all know that the redefinition of death proposed by the Harvard Brain Death Committee triumphed. By 1981, when the United States President's Commission for the Study of Ethical Problems in Medicine examined the issue, it could write of "the emergence of a medical consensus" around criteria very like those proposed by the Harvard committee.[4] Already, people whose brains had irreversibly ceased to function were considered legally dead in at least fifteen countries, and in more than half of the states of the United States. In some countries, including Britain, parliament had not even been involved in the change: the medical profession had simply adopted a new set of criteria on the basis of which doctors certified a patient dead.[5] This was truly a revolution without opposition.

[4] President's Commission for the Study of Ethical Problems in Medicine, *Defining Death: A Report on the Medical, Legal and Ethical Issues in the Determination of Death*, U.S. Government Printing Office, Washington,DC, 1981, pp. 24, 25.

[5] *Defining Death*, pp. 67, 72.

The redefinition of death in terms of brain death went through so smoothly because it did not harm the brain-dead patients and it benefitted everyone else: the families of brain-dead patients, the hospitals, the transplant surgeons, people needing transplants, people who worried that they might one day need a transplant, people who feared that they might one day be kept on a respirator after their brain had died, taxpayers, and the government. The general public understood that if the brain has been destroyed, there can be no recovery of consciousness, and so there is no point in maintaining the body. Defining such people as dead was a convenient way around the problems of making their organs available for transplantation, and withdrawing treatment from them.

But does this way round the problems really work? On one level, it does. By the early 1990s as Sweden and Denmark, the last European nations to cling to the traditional standard, adopted brain death definitions of death, this verdict appeared to be confirmed. Among developed nations, only Japan was still holding out. But do people really think of the brain dead as *dead*? The Harvard Brain Death Committee itself couldn't quite swallow the implications of what it was recommending. As we have seen, it described patients whose brains have ceased to function as in an "irreversible coma" and said that being kept on a respirator was a burden to them. Dead people are not in a coma, they are dead, and nothing can be a burden to them any more.

Perhaps the lapses in the thinking of the Harvard committee can be pardoned because the concept of brain death was then so new. But twenty-five years later, little has changed. Only last year the *Miami Herald* ran a story headlined "Brain-Dead Woman Kept Alive in Hopes She'll Bear Child"; while after the same woman did bear her child, the *San Francisco Chronicle* reported: "Brain-Dead Woman Gives Birth, then Dies". Nor can we blame this entirely on the lamentable ignorance of the popular press. A study of doctors and nurses who work with brain dead patients at hospitals in Cleveland, Ohio, showed that one in three of them thought that people whose brains had died could be classified as dead because they were "irreversibly dying" or because they had an "unacceptable quality of life".[6]

Why do both journalists and members of the health care professions talk in a way that denies that brain death is really death?

[6] Stuart Youngner et al, " 'Brain Death' and Organ Retrieval: A Cross-sectional Survey of Knowledge and Concepts Among Health Professionals", *Journal of the American Medical Association*,261 (1090) 2209.

One possible explanation is that even though people know that the brain dead are dead, it is just too difficult for them to abandon obsolete ways of thinking about death. Another possible explanation is that people have enough common sense to see that the brain dead are not really dead. I favour this second explanation. The brain death criterion of death is nothing other than a convenient fiction. It was proposed and accepted because it makes it possible for us to salvage organs that would otherwise be wasted, and to withdraw medical treatment when it is doing no good. On this basis, it might seem that, despite some fundamental weaknesses, the survival prospects of the concept of brain death are good. But there are two reasons why our present understanding of brain death is not stable. Advances in medical knowledge and technology are the driving factors.

To understand the first problem with the present concept of brain death, we have to recall that brain death is generally defined as the irreversible cessation of all functions of the brain.[7] In accordance with this definition, a standard set of tests are used by doctors to establish that all functions of the brain have irreversibly ceased. These tests are broadly in line with those recommended in 1968 by the Harvard Brain Death Committee, but they have been further refined and updated over the years in various countries. In the past ten years, however, as doctors have sought ways of managing brain dead patients, so that their organs (or in some cases, their pregnancies) could be sustained for a longer time, it has become apparent that even when the usual tests show that brain death has occurred, *some brain functions continue*. We think of the brain primarily as concerned with processing information through the senses and the nervous system, but the brain has other functions as well. One of these is to supply various hormones that help to regulate several bodily functions. We now know that some of these hormones continue to be supplied by the brains of most patients who, by the standard tests, are brain dead. Moreover, when brain dead patients are cut open in order to remove organs, their blood pressure may rise and their heartbeat quicken. These reactions mean that the brain is still carrying out some of its functions, regulating the

[7] See, for example, the United States Uniform Determination of Death Act. Note that the Harvard committee had referred to the absence of central nervous system "activity" rather than function. The use of the term "function" rather than "activity", makes the definition of brain death more permissive, because, as the United States President's Commission recognised (*Defining Death*, p. 74), electrical and metabolic activity may continue in cells or groups of cells after the organ has ceased to function. The Commission did not think that the continuation of this activity should prevent a declaration of death.

responses of the body in various ways. As a result, the legal definition of brain death, and current medical practice in certifying brain dead people as dead, have come apart.[8]

It would be possible to bring medical practice into line with the current definition of death in terms of the irreversible cessation of *all* brain function. Doctors would then have to test for all brain functions, including hormonal functions, before declaring someone dead. This would mean that some people who are now declared brain dead would be considered alive, and therefore would have to continue to be supported on a respirator, at significant cost, both financially and in terms of the extended distress of the family. Since the tests are expensive to carry out and time consuming in themselves, continued support would be necessary during the period in which they are carried out, even if in the end the results showed that the person had no brain function at all. In addition, during this period, the person's organs would deteriorate, and may therefore not be usable for transplantation. What gains would there be to balance against these serious disadvantages? From the perspective of an adherent of the sanctity of life ethic, of course, the gain is that we are no longer killing people by cutting out their hearts while they are still alive. If one really believed that the quality of a human life makes no difference to the wrongness of ending that life, this would end the discussion. There would be no ethical alternative. But it would still be true that not a single person who was kept longer on a respirator because of the need to test for hormonal brain functioning would ever return to consciousness.

So if it is life with consciousness, rather than life itself, that we value, then bringing medical practice into line with the definition of death does not seem a good idea. It would be better to bring the definition of brain death into line with current medical practice. But once we move away from the idea of brain death as the irreversible cessation of *all* brain functioning, what are we to put in its place? Which functions of the brain will we take as marking the difference between life and death, and why?

The most plausible answer is that the brain functions that really matter are those related to consciousness. On this view, what we really care about — and ought to care about — is *the person* rather

[8] Robert Truog, "Rethinking brain death", in K. Sanders and B. Moore, eds., *Anencephalics, Infants and Brain Death Treatment Options and the Issue of Organ Donation*, Law Reform Commission of Victoria, Melbourne, 1991, pp. 62–74; Amir Halevy and Baruch Brody, "Brain Death: Reconciling Definitions, Criteria and Tests", *Annals of Internal Medicine*, 119:6 (1993) 519–525; Robert Veatch, "The Impending Collapse of the Whole-Brain Definition of Death", *Hastings Center Report*, 23:4 (1993) 18–24.

than the body. Accordingly, it is the permanent cessation of function of the cerebral cortex, not of the whole brain, that should be taken as the criterion of death. Several reasons could be offered to justify this step. First, although the Harvard Brain Death Committee specified that its recommendations applied only to those who have "no discernible central nervous system activity", the arguments it put forward for its redefinition of death applied in every respect to patients who are permanently without any awareness, whether or not they have some brainstem function. This seems to have been no accident, for it reflected the view of the committee's chairman, Henry Beecher, who in his address to the American Association for the Advancement of Science, from which I have already quoted, said that what is essential to human nature is:

> . . . the individual's personality, his conscious life, his uniqueness, his capacity for remembering, judging, reasoning, acting, enjoying, worrying, and so on . . .[9]

As I have already said, when the Harvard Committee issued its report, the irreversible destruction of the parts of the brain associated with consciousness could not reliably be diagnosed if the brainstem was alive. Since then, however, the technology for obtaining images of soft tissues within the body has made enormous progress. Hence a major stumbling block to the acceptance of a higher brain definition of death has already been greatly diminished in its scope, and will soon disappear altogether.

Now that medical certainty on the irreversibility of loss of higher brain functions can be established in at least some cases, the inherent logic of pushing the definition of death one step further has already led, in the United States, to one Supreme Court judge suggesting that the law could consider a person who has irreversibly lost consciousness to be no longer alive. Here is Mr Justice Stevens, giving his judgment in the case of Nancy Cruzan, a woman who had been unconscious for eight years and whose guardians sought court permission to withdraw tube feeding of food and fluids so that she could die:

> But for patients like Nancy Cruzan, who have no consciousness and no chance of recovery, there is a serious question as to

[9] Henry Beecher, "The New Definition of Death, Some Opposing Views", unpublished paper presented at the meeting of the American Association for the Advancement of Science, December 1970, p. 4, quoted from Robert Veatch, *Death, Dying and the Biological Revolution*, New Haven: Yale University Press, 1976, p. 39.

> whether the mere persistence of their bodies is "life", as that word is commonly understood ... The State'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.[10]

Admittedly, this was a dissenting judgment; the majority decided the case on narrow constitutional grounds that are not relevant to our concerns here, and what Stevens said has not become part of the law of the United States. Nevertheless, dissenting judgments are often a way of floating an idea that is "in the air" and may become part of the majority view in a later decision. As medical opinion increasingly comes to accept that we can reliably establish when consciousness has been irreversibly lost, the pressure will become more intense for medical practice to move to a definition of death based on the death of the higher brain.

Yet there is a very fundamental flaw in the idea of moving to a higher brain definition of death. If, as we have seen, people already have difficulty in accepting that a warm body with a beating heart on a respirator is really dead, how much more difficult would it be to bury a "corpse" that is still breathing while the lid of the coffin is nailed down? That is simply an absurdity. Something has gone wrong. But what?

In my view, the trouble began with the move to brain death. The Harvard Brain Death Committee was faced with two serious problems. Patients in an utterly hopeless condition were attached to respirators, and no-one dared to turn them off; and organs that could be used to save lives were rendered useless by the delays caused by waiting for the circulation of the blood in potential donors to stop. The committee tried to solve both these problems by the bold expedient of classifying as dead those whose brains had ceased to have an discernible activity. The consequences of the redefinition of death were so evidently desirable that it met with scarcely any opposition, and was accepted almost universally. Nevertheless, it was unsound from the start. Solving problems by redefinition rarely works, and this case was no exception. We need to begin again, with a different approach to the original problems, one which will break out of the intellectual straight-jacket of the traditional belief that all human life is of equal value. Until last year, it seemed difficult to imagine how a different approach could ever be accepted. But last

[10] *Cruzan v. Director, Missouri Department of Health* (1990) 110 S. Ct. pp. 2886–7.

year Britain's highest court took a major step toward just such a new approach.

III REVOLUTION BY THE LAW LORDS: THE CASE OF ANTHONY BLAND

The revolution in British law regarding the sanctity of human life grew out of the tragedy at Hillsborough Football Stadium in Sheffield, in April 1989. Liverpool was playing Nottingham Forest in an FA Cup semi-final. As the match started, thousands of supporters were still trying to get into the ground. A fatal crush occurred against some fencing that had been erected to stop fans getting onto the playing field. Before order could be restored and the pressure relieved, 95 people had died in the worst disaster in British sporting history. Tony Bland, a 17-year-old Liverpool fan, was not killed, but his lungs were crushed by the pressure of the crowd around him, and his brain was deprived of oxygen. Taken to hospital, it was found that only his brain stem had survived. His cortex had been destroyed. Here is how Lord Justice Hoffmann was later to describe his condition:

> Since April 15 1989 Anthony Bland has been in 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.[11]

[11] *Airedale N.H.S. Trust v. Bland (C.A)* (19 Feburary 1993) 2 Weekly Law Reports, p. 350. Page numbers given without further identifying details in subsequent footnotes are to this report of the case.

Whatever the advances of modern medicine might permit, neither Tony Bland's family, nor his doctors could see any benefit to him or to anyone else, in keeping him alive for decades. In Britain, as in many other countries, when everyone is in agreement in these situations it is quite common for the doctors simply to withdraw artificial feeding. The patient then dies within a week or two. In this case, however, the coroner in Sheffield was inquiring into the deaths caused by the Hillsborough disaster, and Dr Howe decided that he should notify the coroner of what he was intending to do. The coroner, while agreeing that Bland's continued existence could well be seen as entirely pointless, warned Dr Howe that he was running the risk of criminal charges — possibly even a charge of murder — if he intentionally ended Bland's life.

After the coroner's warning, the administrator of the hospital in which Bland was a patient applied to the Family Division of the High Court for declarations that the hospital might lawfully discontinue all life-sustaining treatment, including ventilation, and the provision of food and water by artificial means, and discontinue all medical treatment to 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".

At the Family Division hearing a public law officer called the Official Solicitor was appointed guardian for Bland for the purposes of the hearing. The Official Solicitor did not deny that Bland had no awareness at all, and could never recover, but he nevertheless opposed what Dr Howe was planning to do, arguing that, legally, it was murder. Sir Stephen Brown, President of the Family Division, did not accept this view, and he made the requested declarations to the effect that all treatment might lawfully be stopped. The Official Solicitor appealed, but Brown's decision was upheld by the Court of Appeal. The Official Solicitor then appealed again, thus bringing the case before the House of Lords.

We can best appreciate the significance of what the House of Lords did in the case of Tony Bland by looking at what the United States Supreme Court would not do in the similar case of Nancy Cruzan. Like Bland, Cruzan was in a persistent vegetative state, without hope of recovery. Her parents went to court to get permission to remove her feeding tube. The Missouri Supreme Court refused, saying that since Nancy Cruzan was not competent to refuse life-sustaining treatment herself, and the state has an interest in preserving life, the court could only give permission for the withdrawal of life-sustaining treatment if there were clear and convincing evidence that this was what Cruzan would have wanted. No such evidence had been presented to the court. On appeal, the

United States Supreme Court upheld this judgment, ruling that the state of Missouri had a right to require clear and convincing evidence that Cruzan would have wanted to be allowed to die, before permitting doctors to take that step. (By a curious coincidence, that evidence was produced in court shortly after the Supreme Court decision,and Cruzan was allowed to die.)

The essential point here is that in America the courts have so far taken it for granted that life-support must be continued, *unless* there is evidence indicating that the patient would not have wished to be kept alive in the circumstances in which she now is. In contrast, the British courts were quite untroubled by the absence of any information about what Bland's wishes might have been. As Sir Thomas Bingham, Master of the Rolls of the Court of Appeal said in delivering his judgment:

> 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.[12]

But the British courts did not therefore conclude that Bland must be treated until he died of old age. Instead, the British judges asked a different question: what is in the best interests of the patient?[13] In answer, they referred to the unanimous medical opinion that Bland was not aware of anything, and that there was no prospect of any improvement in his condition. Hence the treatment that was sustaining Bland's life brought him, as Sir Stephen Brown put in in the initial judgment in the case, "no therapeutical, medical, or other benefit".[14] In essence, the British courts held that when a patient is incapable of consenting to medical treatment, doctors are under no legal duty to continue treatment that does not benefit a patient. In addition, the judges agreed that the mere continuation of biological life is not, in the absence of any awareness or any hope of ever again becoming aware, a benefit to the patient.

On one level, the British approach is straightforward common sense. But it is common sense that breaks new legal ground. To see this, consider the following quotation from John Keown:

> Traditional medical ethics . . ., never asks whether the patient's *life* is worthwhile, for the notion of a worthless life is as alien to the Hippocratic tradition as it is to English criminal law, both of

[12] p. 333; the passage was quoted again by Lord Goff of Chieveley in his judgment in the House of Lords, p. 364.

[13] pp. 374, 386.

[14] p. 331.

> which subscribe to the principle of the sanctity of human life which holds that, because all lives are intrinsically valuable, it is always wrong intentionally to kill an innocent human being.[15]

As a statement of traditional medical ethics and traditional English criminal law, this is right. The significance of the *Bland* decision is that it openly embraces the previously alien idea of a worthless life. Sir Thomas Bingham, for example, said:

> 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 . . .[16]

When the case came before the House of Lords, their Lordships took the same view. Lord Keith of Kinkel discussed the difficulties of making a value judgment about the life of a "permanently insensate" being, and concluded cautiously that:

> 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.[17]

In a similar vein, Lord Mustill concluded that to withdraw life-support is not only legally, but also 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".[18]

There can therefore be no doubt that with the decision in the Bland case, British law has abandoned the idea that life itself is a benefit to the person living it, irrespective of its quality. But that is not all that their lordships did in deciding Tony Bland's fate. The second novel aspect of their decision is that it was as plain as anything can be that the proposal to discontinue tube feeding was *intended* to bring about Bland's death. A majority of the judges in the House of Lords referred to the administrator's intention in very direct terms. Lord Browne-Wilkinson said:

> What is proposed in the present case is to adopt a course with the intention of bringing about Anthony Bland's death . . . the whole

[15] John Keown, "Courting Euthanasia? Tony Bland and the Law Lords", *Ethics & Medicine* 9:3 (1993) p. 36.
[16] p. 339.
[17] p. 361.
[18] p. 400.

> purpose of stopping artificial feeding is to bring about the death of Anthony Bland.[19]

Lord Mustill was equally explicit:

> the proposed conduct has the aim for . . . humane reasons of terminating the life of Anthony Bland by withholding from him the basic necessities of life.[20]

This marks a sharp contrast to what for many years was considered the definitive view of what a doctor may permissibly intend. Traditionally the law had held that while a doctor may knowingly do something that has the effect of shortening life, this must always be a mere side-effect of an action with a different purpose, for example, relieving pain. As Justice (later Lord) Devlin said in the celebrated trial of Dr John Bodkin Adams:

> . . . it remains the fact, and it remains the law, 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 human life.[21]

In rewriting the law of murder regarding the question of intention, the British law lords have shown a clarity and forthrightness that should serve as a model to many others who try to muddle through difficult questions by having a little bit of both sides. There is no talk here of ordinary and extraordinary means of treatment, nor of what is directly intended and what is merely foreseen. Instead the judges declared that Bland's doctors were entitled to take a course of action that had Bland's death as its "whole purpose"; and they made this declaration on the basis of a judgment that prolonging Bland's life did not benefit him.

Granted, this very clarity forces on us a further question: does the decision allow doctors to kill their patients? On the basis of what we have seen so far, this conclusion seems inescapable. Their Lordships, however, did not think they were legalising euthanasia. They drew a distinction between ending life by actively doing something, and ending life by not providing treatment needed to sustain life. That distinction has long been discussed by philosophers and bioethicists, who debate whether it can make good sense to

[19] p. 383.

[20] p. 388.

[21] *R. v. Adams* (1959), quoted by Derek Morgan, "Letting babies die legally", *Institute of Medical Ethics Bulletin*, May 1989, p. 13. See also Patrick Devlin, *Easing the Passing: The Trial of Dr John Bodkin Adams*, London: Faber and Faber, 1986, pp. 171, 209.

accept passive euthanasia while rejecting active euthanasia. In the *Bland* case, it is significant that while the Law Lords insist that in distinguishing between acts and omissions they are merely applying the law as it stands, they explicitly recognise that at this point law and ethics have come apart, and something needs to be done about it. Lord Browne-Wilkinson, for example, expressed the hope that Parliament would review the law. He then ended his judgment by admitting that he could not provide a moral basis for the legal decision he had reached! Lord Mustill was just as frank and even more uncomfortable about the state of the law, saying that the judgment, in which he had shared, "may only emphasise the distortions of a legal structure which is already both morally and intellectually misshapen".[22]

The law lords' problem was that they had inherited a legal framework that allowed them some room to manoevre, but not a great deal. Within that framework, they did what they could to reach a sensible decision in the case of Anthony Bland, and to point the law in a new direction that other judges could follow. In doing so, they recognised the moral incoherence of the position they were taking, but found themselves unable to do anything about it, beyond drawing the problem to the attention of parliament. They could hardly have done more to show clearly the need for a new approach to life-and-death decisions.

IV CONCLUSION

What is the link between the problems we face in regard to the concept of brain death, and the decision reached by their Lordships in the case of Tony Bland? The link becomes clearer once we distinguish between three separate questions, often muddled in discussions of brain death and related issues:

1. When does a human being die?
2. When is it permissible for doctors intentionally to end the life of a patient?
3. When is it permissible to remove organs such as the heart from a human being for the purpose of transplantation to another human being?

Before 1968, in accordance with the traditional concept of death, the answer to the first question would have been: when the circulation of the blood stops permanently, with the consequent cessation of

[22] pp. 388–9.

breathing, of a pulse, and so on.[23] The answer to the second question would then have been very simple: never. And the answer to the third question would have been equally plain: when the human being is dead.

The acceptance of the concept of brain death enabled us to hold constant the straightforward answers to questions two and three, while making what was presented as no more than a scientific updating of a concept of death rendered obsolete by technological advances in medicine. Thus no ethical question appeared to be at issue, but suddenly hearts could be removed from, and machines turned off on, a whole new group of human beings.

The *Bland* decision says nothing about questions 1 and 3, but dramatically changes the answer that British law gives to question 2. The simple "never" now becomes "when the patient's continued life is of no benefit to her": and if we ask when a patient's life is of no benefit to her, the answer is: "when the patient is irreversibly unconscious". If we accept this as a sound answer to question 2, however, we may well wish to give the same answer to question 3. Why not, after all? And if we now have answered both question 2 and question 3 by reference not to the death of the patient, but to the impossibility of the patient regaining consciousness, then question 1 suddenly becomes much less relevant to the concerns that the Harvard Brain Death Committee was trying to address. We could therefore abandon the redefinition of death that it pioneered, with all the problems that have now arisen for the brain death criterion. Nor would we feel any pressure to move a step further, to defining death in terms of the death of the higher brain, or cerebral cortex. Instead, we could, without causing any problems in the procurement of organs or the withdrawal of life-support, go back to the traditional conception of death in terms of the irreversible cessation of the circulation of the blood.[24]

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[23] For a statement of the traditional definition, see, for example, *Blacks Law Dictionary*, fourth edition, West Publishing Company, 1968.

[24] This address incorporates material subsequently published in my book *Rethinking Life and Death* (Text, Melbourne, 1994. St. Martin's Press, 1995).