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Killing and letting die; flaws in the current UK medico-legal position on euthanasia

Introduction

In recent times, euthanasia and assisted suicide have been medico-legal topics maintaining a constant presence in the media and public spotlight. Modern medical advances mean that patients who previously would have died from catastrophic injury or severe illness can now be kept alive for many years; whilst these advances can have many benefits they also create many issues, sustaining life for patients who may be legally alive but are not really living. At the time of writing, Lord Falconer's Assisted Dying Bill[1] has had its first reading in the House of Lords, and the second reading is to be scheduled; this is unprecedented progress for such a Bill in the United Kingdom (UK). The Bill seeks to enable terminally ill adults with capacity, who must have *"a voluntary, clear, settled and informed wish to end his or her own life"*[2], to be provided, at their request, with assistance to do so.

Under current United Kingdom law, euthanasia is a criminal offence; it is unlawful to follow a course of action intended to hasten death or end life. Any doctor acting to end a patient's life would be liable for murder, and face exclusion from the medical profession and a considerable jail sentence. However, a practice which meets the criteria for euthanasia, a course of action intended to bring about death and succeeding in doing so, has been legal for over two decades, since the landmark ruling on the case of Anthony Bland in 1993[3]. This essay examines the current legal position on euthanasia in light of the conclusions reached in Bland, with reference to more recent cases and consideration of the wider impact of the principles applied in these cases.

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Sanctioning the intentional ending of life; Bland 1993

Clinicians have been permitted by law to withdraw life-sustaining clinically assisted nutrition and hydration (CANH) from patients in a permanent vegetative state (PVS)[i] since 1993, when the first request for such permission was made to the Family Division of the High Court by the NHS Airedale Trust[4], responsible for the treatment of Anthony Bland, a young man in a PVS following hypoxic brain injury during the Hillsborough accident. Before Bland, judges had been sanctioning withdrawal of life-sustaining treatment from patients with other medical conditions, using poor quality of life as the determining factor, for many years. However, this had never been done with the intention of causing death, and in this sense the judgement in Bland, where the Law Lords openly acknowledged this as the intention[ii] behind withdrawing CANH[3] , was a landmark ruling. Since this case, which was appealed to both the Court of Appeal[5] and the House of Lords[3], many similar applications have been made to the High Court and later the Court of Protection from 2005 following the introduction of the Mental Capacity Act[6]. Applications have been successful in every instance.

The Law draws a very definite metaphorical line in the sand between acts and omissions; legally, an omission cannot cause death. Despite Bland's ensuing death, withdrawal of CANH was not considered murder because it was deemed an omission, and legally murder is the deliberate ending of life by means of an act. Despite the clear acknowledgement that the withdrawal of CANH was intended to bring about Bland's death, there was reluctance to identify the withdrawal of CANH as the cause of death. There were multiple mentions of 'allowing' Mr Bland to die, and of how withdrawing CANH would *"allow the original condition of the patient to resume and nature to take its course"*[7]. The proposed course of action would let Bland die, rather than kill him. In the law this is

[i] The permanent vegetative state is a neurological condition characterised by permanent unconscious, and wakefulness without awareness. Following brain injury, patients lose all higher brain function but retain some autonomic function such as the ability to breathe for themselves, meaning that they are reliant on feeding tubes but not artificial ventilation to survive.

[ii] Lord Lowry at page 876 *"the intention to bring about the patient's death is there"*; Lord Browne-Wilkinson at page 881 *"What is proposed in the present case is to adopt a course with the intention of bringing about Anthony Bland's death"*.

an important distinction, however ethically there is huge debate over whether this is a relevant distinction at all, or whether at that point the difference is purely methodological. The following discussion lays out how, regardless of whether withdrawal of CANH is considered an act, an omission, or an act of omission, it can certainly cause death.

The Royal College of Physicians' (RCP) current guidance states that patients in a PVS from whom CANH is withdrawn will die *"because they have a very severe brain injury and are unable to sustain their own food and fluid intake"*[8]; this is in line with the position of the Lords in Bland that withdrawing CANH 'allows' the patient to die/nature to take its course. A slight variation of this statement may be helpful in determining the usefulness of this position. If we were to slightly alter the RCP statement in the context of a patient paralysed from the neck down such that it read that the patient will die "because they have a very severe *physical* injury and are unable to sustain their own food and fluid intake" we may find ourselves questioning the rationale behind this position. It seems reasonable to argue that to allow a paralysed patient to die purely because they are physically unable to independently meet their own nutritional needs would be morally and legally impermissible; the cause of death would likely be attributed to neglectful behaviour on the part of carers, rather than the underlying physical injury. The RCP guidance taken at face value suggests that an inability to govern one's own nutritional state is a sufficient reason to allow a patient to die; the paralysed patient described above challenges this position. The RCP statement masks a value judgement on the undesirability of the PVS patient's life. It seems that a more accurate interpretation of this statement may be that the PVS patient will be allowed to die where the paralysed patient would not because the PVS patient's serious brain injury results in a condition deemed so undesirable that life is no longer benefitting them, and they are to be allowed to die by withdrawing CANH. This is particularly pertinent when we consider that patients in a PVS are generally medically stable, and are "neither dead nor dying"[9].

Following on from this, one tactic which was deployed in Bland to get around this issue of withdrawal of CANH causing death was the argument that, once a patient has been diagnosed as being in a PVS, all further treatment is futile. It was considered that the clinicians treating Bland were no longer under a legal obligation to continue to provide CANH to Mr Bland because this treatment was futile, as life in a PVS was considered not to be a benefit to Mr Bland. It was therefore concluded that the responsible doctor was *"not guilty of murder by omission"*[10]. A majority of the Law Lords felt that this withdrawal would be lawful despite the clear intention to end Mr Bland's life[11]. This relies on a very narrow definition of the term futile. Veatch and Spicer identify two distinct forms of futility: care that produces no effect (physiologically futile) and care that produces no benefit[12]. It is the latter of these which is used when the Lords describe all further treatment in PVS as being futile; the provision of nutrition through a feeding tube is physiologically effective in sustaining the patient and keeping them alive, but this outcome does not provide any benefit to the patient and therefore provision of CANH is deemed futile[13,14]. In this sense, it is not implausible to question whether withdrawing CANH on the ground of futility is what the Lords truly intended, or whether it was used as a guise to mask the monumental decision made on that day in 1993; to intentionally end a human life deemed not worth sustaining. If this is the case, the current law prohibiting euthanasia and assisted suicide for conscious patients with the capacity to make such a decision voluntarily seems morally incoherent with the practice of withdrawing CANH from PVS patients; the former obtains the patient's consent, whereas the latter does not. The patients in the former situation are also regularly suffering and in pain, physically and emotionally, providing factors against the sustainment of life, whereas PVS patients experience nothing. Many of the Lords in Bland made statements to this effect[iii].

Multiple authors have discussed the inconsistency of the current legal position, where it is lawful to withdraw of life-sustaining CANH from PVS patients with the intention of causing death but unlawful

[iii] Hoffmann L.JJ. at 829 *"He is alive but has no life at all"*; Lord Keith of Kinkel at page 858 *"It must be a matter of complete indifference whether he lives or dies."*

to administer, for example, a lethal injection to produce immediate death[11,15,16]. This morally incoherent state of the law was originally identified in the Bland judgement, but the legal distinction between acts and omissions meant that the Law Lords were unable to do anything more. Lord Mustill felt the Judges hands were tied by *"a legal structure which is already both morally and intellectually misshapen...Still, the law is there and we must take it as it stands"*[17].

Modern interpretations of the Bland judgement

As mentioned previously, many applications to withdraw CANH from PVS patients have been made to the Court of Protection since 1993; these have been successful in every case. Interestingly, these more modern cases seem to have shied away from the issue of intentionally bringing about death for these patients. In such cases, the ruling judges have been very clear to highlight that these judgements stop short of the supposed line between withdrawal of treatment and euthanasia.

In *NHS Trust A v M*[18], a case from 2001 concerning an application to withdraw CANH from a man who had been in a PVS for many years, Dame Butler-Sloss does at least acknowledge that *"the intention in withdrawing artificial nutrition and hydration in PVS cases is to hasten death"*. However, she then goes on to argue that *"in my judgment the phrase "deprivation of life" must import a deliberate act, as opposed to an omission"*[19]. It seems here that she is simultaneously acknowledging and denying the intention behind withdrawing CANH.

A similar case from 2014, *Gloucestershire Clinical Commissioning Group v AB*[20], saw no mention whatsoever of an intention to bring about death. The justification for withdrawing treatment came from the conclusion of the Court that *"AB's life is futile"*[20]; the term futile here is again used to mean of no benefit to the patient, as per Lord Goff in Bland. This evolution of a very specific definition of futility in defence of withdrawing CANH is only masking the true nature of the decisions being made; that some lives are not worth sustaining and that in those scenarios it is lawful bring about the end of said life.

Other cases of hospital trusts seeking permission to withdraw CANH from PVS patients have used the best interests test described in the Mental Capacity Act[21,22,23]; this was deemed an inappropriate test for these patients in Bland, and it is difficult to see how the pros and cons of withdrawing CANH can be weighed for a PVS patient when they can experience neither benefit nor burden.

As time has passed it seems that the Courts are increasingly willing to accept the 'misshapen' state of the law as the *status quo*, sanctioning withdrawal of CANH on the basis of medical futility or absurd use of the best interests test, without properly considering the true intentions behind these judgements. At the time of writing Lord Falconer's Assisted Dying Bill is awaiting its historical second reading in Parliament; for this Bill to fail would make our current law on the intentional taking of life to relieve suffering ethically inconsistent, and insulting to those desiring assisted suicide to free themselves of a life of pain and suffering; a right that PVS patients were awarded at the point of brain injury.

Conscious patients wanting to intentionally end their own lives

The 2012 case of *Nicklinson v Ministry of Justice*[24], which was escalated right up to the European Court of Human Rights, attracted a great deal of public attention. Mr Nicklinson had suffered a stroke which left him paralysed below the neck and unable to speak, although his mental capacity was unimpaired. His condition was such that he wished to terminate his own life but was unable to do so due to the profound disability resulting from his stroke. He therefore sought a declaration that it would not be unlawful for a doctor, on the basis of necessity, to terminate his life or assist in this process. The declaration was not granted, and Mr Nicklinson went on to end his life by refusing food, after a two year long legal battle escalated to the highest level.

In light of cases such as this, and the current progress through Parliament of Lord Falconer's Bill, we must as a society ask ourselves; how can we sanction the intentional ending of life for patients who experience no suffering without their consent, as in Bland, yet deem it unlawful to do the same thing

for patients experiencing daily suffering at their request, as in Nicklinson? The judgement in Bland created a case law that is morally misshapen, and the only way to address this would be by Parliamentary review; such a decision cannot rest on the Courts. The medico-legal community waits with baited breath to hear the fate of Lord Falconer's Bill.

2,200 words

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References

[1] Lord Falconer. Assisted Dying Bill. Private Members' Bill 2015.
[2] Lord Falconer. Assisted Dying Bill. Private Members' Bill 2015:1.2(a).
[3] Airedale NHS Trust v Bland. A.C. 789 (HL) 1993.
[4] Airedale NHS Trust v Bland. 142 N.L.J. 1648 (Fam) 1992.
[5] Airedale NHS Trust v Bland. 142 N.L.J. 1755 (CA) 1993.
[6] Mental Capacity Act. London, HMSO: 2005:1.4: Best Interests.
[7] Airedale NHS Trust v Bland. A.C. 789 (HL) 1993: 802.
[8] Royal College of Physicians. Prolonged disorders of consciousness: national clinical guidelines. London, RCP: 2013.
[9] Mitchell KR, Kerridge IH, Lovat TJ. Medical futility, treatment withdrawal and the persistent vegetative state. J Med Ethics 1993 Jun;19(2):71-76.
[10] Airedale NHS Trust v Bland. A C 789 (HL) 1993:884.
[11] Keown J. Medical murder by omission? The law and ethics of withholding and withdrawing treatment and tube feeding. Clin Med 2003 Sep-Oct;3(5):460-463.
[12] Veatch RM, Spicer CM. Medically futile care: the role of the physician in setting limits. Am.JL & Med. 1992;18:15.
[13] Mitchell KR, Kerridge IH, Lovat TJ. Medical futility, treatment withdrawal and the persistent vegetative state. J Med Ethics 1993 Jun;19(2):71-76.
[14] Airedale NHS Trust v Bland. A.C. 789 (HL) 1993:869
[15] Keown J. Beyond Bland: a critique of the BMA guidance on withholding and withdrawing medical treatment. Legal Studies 2000;20(1):66-84.
[16] Bell D. The legal framework for end of life care: a United Kingdom perspective. Intensive Care Med 2007;33(1):158-162.
[17] Airedale NHS Trust v Bland. A.C. 789 (HL) 1993:887.
[18] NHS Trust A v M. Fam. 348 2001
[19] NHS Trust A v M. Fam. 348 2001: 358
[20] Gloucestershire Clinical Commissioning Group v AB. WL 6792162 2014
[21] NHS Trust v D. EWHC 2439 (Fam) 2005.
[22] A Hospital v W. EWHC 425 (Fam) 2007.
[23] Re D. EWHC 885 (COP) 2012.
[24] Nicklinson v Ministry of Justice H.R.L.R. 16 (QB) 2012