58 Ibid. pp. 260–1.
59 Sermon 14(b), Walshe, p. 127 (DW 16b).
60 *The Book of 'Benedictus ': The Book of Divine Consolation* in McGinn, *Meister Eckhart: Essential Sermons. . .*, p. 220.
61 Ibid.
62 *The Book of 'Benedictus': On Detachment* in McGinn *Meister Eckhart: Essential Sermons. . . .* p. 286.
63 Ibid.
64 Sermon 71, McGinn, *Meister Eckhart: Teacher and Preacher*, p. 323 (DW71).
65 Sermon 14, McGinn, *Meister Eckhart: Teacher and Preacher*, p. 272 (DW 14).
66 Sermon 22 in McGinn, *Meister Eckhart: Essential Sermons. . .*, p. 195 (DW 22).
67 ibid.

On Not Starving the Unconscious

Anthony Fisher OP

The Hillsborough football disaster in 1989 left Tony Bland in what doctors call a 'persistent vegetative state' ('PVS'). His heart still pumped, he breathed, and most of his other vital organs worked, all unassisted. His eyes opened and shut; he yawned and moved reflexively; he reacted to loud noises with a start. But as far as doctors could tell he could not perceive, think or feel, and would never regain consciousness in this life. The English High Court, the Court of Appeal and (last month) the House of Lords all ruled that all food, water and antibiotics might be withdrawn from Tony Bland and sedatives administered so that he would die peacefully and soon.[1]

The sanctity of life?

The judges were keenly aware of the moral, legal and social dilemmas which the case occasioned. In general they took the view that the law should closely reflect what is 'morally right' in such areas, or at least 'what society accepts as morally right'. They thought there were three principles to be balanced and applied in this case: the sanctity of life; the autonomy of the patient; and the duty of care. The principle of the sanctity of human life was said to be deeply embedded in our law and ethics, in Britain and throughout the world, included in international human rights documents, and strongly felt by people of all religions and none.

In the classical tradition human beings are held to be the bearers of

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the image and likeness of God, the pinnacle of creation, 'little less than gods', entitled to great and equal respect. Their lives are of such intrinsic dignity that no choice intentionally to bring about an innocent person's death can be right. This is true whether the death is caused by commission or omission, whether for 'noble' euthanasist reasons or less noble ones, such as because of the strain granny is on our patience or the cost she is to the community or the value of her estate. Thus the sanctity of life principle has often been worded 'you shall not kill' or 'everyone has (an equal and inalienable) right to life'. In medical situations that means that killing is one of the ways in which doctors may not deal with their patients.

While paying lip-service to the principle, the courts have chosen to rewrite it. Already respect for human life has been eroded in various ways in English law, e.g. legalized abortion and court decisions suggesting that some severely handicapped infants might properly be denied treatment if their continued life would be sufficiently 'awful'. The Bland case erodes the principle even further. It presumes or implies that not all human beings are equally entitled to great and equal respect: you have to qualify by having certain essential abilities. The sanctity of life principle can legitimately be compromised to serve other important values. Some people are simply 'better off dead'.

The underlying premise of this kind of reasoning, that our mere existence as human beings has no value as such or that it can be discounted by some countervailing disvalue, is clearly inconsistent with the traditional doctrine of the equal dignity of every human being, whatever his or her condition. It ultimately assesses some people as being of negative value.

Patient autonomy

The second principle invoked by the courts, often conflicting with and trumping the first, was autonomy. Traditionally talk of 'autonomy' is an acknowledgment that all human beings are free and equal, and have an inalienable duty to make responsible, rather than forced, arbitrary or whimsical decisions. Thus in law and ethics doctors only have as much authority as they are given by their patients. Doctors must respect the directions of their patients, or give those patients who cannot consent therapy which is in their best interests. Patients, for their part, must exercise this freedom responsibly, in pursuit of their own good health and respect for the good of persons in community.

A robust liberal doctrine of rights, with little attention to duties to self and others, underlay the judges' understanding of this principle. A whole range of rights was asserted by some, such as 'the right of a

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human being to make his own decisions', 'the right to decide whether to accept or reject treatment whether one's grounds are rational or irrational', 'the right to avoid unnecessary humiliation and degrading invasion', 'the right to be well-regarded by others', 'the right to be respected' and 'the right to be well-remembered by one's family'. All these were to be guaranteed so that people could pursue their own life (and death) plans, whatever they might be. The principle of the sanctity of life must sometimes be 'painfully compromised' and 'accommodated' to allow the pursuit of the individual's chosen ends.

This is not the place to offer a critique of contemporary liberalism. Suffice it to say that the ability to 'do whatever one pleases' is far from self-evidently ideal. Our moral tradition has held that we have to respect the rights of others; we have to consider the implications of our choices for their lives; and we have to take into account the intrinsic morality of our choices and their reflexive effects—what they do to us, what they make us and say about us. But abstracted from this context, autonomy can become a formula for rationalising selfishness and the neglect or even extermination of sick and handicapped persons, young and old. Thus it is argued: conscious adult patients can refuse treatments not burdensome in themselves, in order to allow self-determined liberation from 'a life not worth living'; therefore it would be inconsistent or discriminatory not to give the same 'right' to the permanently unconscious.

Care for the sick and hungry

The third principle referred to in Bland's case was what Lord Justice Hoffmann called 'the common humanitarian duty of care'. On the negative side this means we may not harm people or treat them negligently or with disrespect. On the positive side, it refers to the 'Good Samaritan' duty to show kindness to others. As the judge said, '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'. This is especially the case regarding persons in our care: young or old, sick, handicapped or dependent. '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 for himself'.

This is very much in keeping with the classical moral tradition, embodied in everything from the Bible to the International Covenant on Economic, Social and Cultural Rights. Individuals and the state have duties to ensure that each person has access to the basic necessities of life, and that a certain preference be given in mercy to those in greatest need (the option for the poor, dependent and powerless). Certain basic

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measures such as food, water, shelter, clothing, sanitary and nursing care must be maintained out of respect for the human dignity of every patient; anything less is unjust discrimination. To deny food and water to medically stable but severely mentally handicapped patients is discriminatory because they can enjoy the same substantial benefits of food and water as anyone with no neurological impairments. Where some of the judges in Bland's case differed from the traditional conception of the 'humanitarian duty of care' is in what is to be regarded as futile and unnecessary. Thus they concluded that to deny people food would not be wrong where they cannot suffer and are permanently unconscious.

In addition to these common humanitarian duties of all persons towards each other, there are the special duties of care peculiar to doctors (commonly known in medical ethics as the duties of medical beneficence and non-maleficence). The western medical tradition has held that doctors should not harm or take any undue risks with their patients, but should, rather, seek to promote their good health. Because of the special vulnerability of patients, it is important that doctors have a clear sense of what is owing to their patients by way of action and restraint. Thus the law holds that their general duty is to act professionally and to give their patients such medical attention as they are reasonably able to give in their patients' objective best interests. While recognising the complexity of notions like 'therapy', 'benefit', 'harm' and 'best interests', this principle (like the sanctity of life principle) has traditionally excluded medical homicide or exterminative medicine. Killing is not therapy, not nursing care, not medical treatment.

But is tube-feeding 'medical treatment'?

Because of the different standards applied to the provision of 'basic humanitarian care' and 'medical care', a major issue in the Bland case was whether tube-feeding is a 'medical treatment'. Catholic Church authorities have repeatedly said it is not,[2] although theologians are divided.[3] There really are two separate issues here. The first is the feeding-tube itself; the second is the provision of food through the feeding-tube. A feeding-tube is like a tracheal tube which allows some patients to breathe, or a catheter which allows them to pass water. The tube itself, or at least its insertion, might be regarded as medical treatment, in that it requires medical skill and context. (Its maintenance is nursing care.) The tube is, of course, entirely passive once inserted, somewhat like contact lenses. It allows a natural bodily function to take place, rather than actively taking it over.

But is the provision of food through such a feeding-tube medical treatment? If it is, so is allowing or providing air through a tracheal tube

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and draining urine through a catheter. Clean air, food, water, clothing and sanitation are needs of any person, well or ill. The giving of them merely provides for these basic, universal needs. When given to a dependent person, they are about as basic a kind of care as we can give, the bottom line of any active expression of equal concern and respect. Just as we do not define hunger and thirst as pathologies or clinical conditions, so we do not normally define the giving of food and water as treatments, even if it requires some medical assistance. Their teleologies are different. Giving food and water is not aimed at preventing or curing illness, retarding deterioration, or relieving pain and suffering (to use the courts' own definition of the objects of medicine). Thus unlike 'medical treatment' as it is ordinarily understood, no consent is required when providing clothing, shelter, hygienic and sanitary care, nutrition and fluids in a medical context.

Dr Stephen Miles, of the Center for Clinical Ethics in the University of Chicago testified to the New Jersey Bioethics Commission on 19 August 1987:

> The equation of nourishment with treatment was *constructed* in order to allow for the discontinuation of nourishment by analogy to now widely-accepted arguments for the use of other life-sustaining medical treatments, like respirators. The equation works this way. First, it makes the act of feeding as morally inert as a respirator. Second, it focuses the evaluation of nourishment on the disabled person and their disease . . .[Third], families who reject the feeding-treatment equation and claim that feeding is a fundamental interpersonal caring transaction . . . are seen as denying illness, afraid of death, engaging in primitive thinking, or (according to one prominent bioethicist, who should have known better), as violating the autonomy of their loved one.

Commenting on the Bland case, British PVS specialist Dr Keith Andrews wrote:

> If tube feeding is treatment: what is being treated? Surely not the patient's brain damage. The food is not being given to correct any abnormal biochemical or pathological process, but to provide nutrition to normal tissues. To my mind the tube is simply a tool for daily living, similar to the specially adapted spoons that enable arthritic patients to feed themselves. (*British Medical Journal* 12 December 1992).

The courts in the Bland case accepted the view that tube-feeding *is* a medical treatment, mainly on the basis that the medical profession

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thought it was. That decision has important implications for a whole range of people who require various degrees of technical assistance in order to receive nutrition. But as we will see below, even if tube-feeding is regarded as 'medical treatment' or part of a whole regime of medical and nursing care, it cannot properly be regarded as 'extraordinary' or optional care, since it is neither futile nor is its provision generally overly burdensome.

So why withdraw medical treatment?

Even if we accept that tube-feeding is medical treatment, it is far from clear that all medical treatment should be withdrawn from the permanently comatose. The courts in Bland's case stated or implied three reasons for doing so: (1) it is good professional practice; (2) it is in Tony Bland's best interests; (3) it is in everyone else's best interests.

Several points of interest arise here. The first is reliance on professional practice as the guide to law and ethics. Counsel for the Attorney-General argued before all three courts that 'the law should strive to be in accordance with contemporary medical ethics and good medical practice'. There was some initial resistance to this approach, with some of the judges arguing that the law in such areas should closely reflect what is 'morally right' and that medical ethics should be formed by the law rather than vice-versa. None the less, as the case progressed it became clear that the judges had abandoned the search for objective ethical standards: current practice would be decisive. The basis of the decision of the senior law lord (Lord Keith) was as follows:

> A medical practitioner is under no duty to continue to treat a patient where *a large body of informed and responsible medical opinion* is to the effect that no benefit at all would be conferred by continuance. 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.

Where are practitioners to discover this 'body of relevant professional opinion'? Several judges pointed to a *Discussion Paper on Treatment of Patients in Persistent Vegetative State* (London, 1992), published just before the Bland case was heard. Though it was a discussion paper only, never intended to be relied upon as conclusive; though it came not from the Council or members of the British Medical Association but from a small medical ethics sub-committee of that association; though it represents only one of a range of opinions on this question even within the medical profession; and though it was the

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product of doctors, rather than ethicists, patient interest groups, theologians, social workers, lawyers or policy-makers: it was none the less treated by the courts as the authoritative statement of ethics on this question.

At several points the judges sought to exclude comparisons with Nazi Germany's gradual introduction of euthanasia. Yet the history of the collusion between medical profession, courts and government in 1930s Germany, which led to the 'good medical practice' of the 'mercy killing' of many mentally handicapped people and eventually of a much wider group regarded as having 'lives not worth living', should serve as a cautionary tale to anyone who relies on medical associations and courts alone as the guardians of public morality.

Tony Bland's best interests?

In the Bland case the courts allowed that when assessing a patient's 'best interests' account can be taken, not merely of the therapeutic benefits and burdens of a particular proposed treatment (as has been the traditional standard), but of 'wider, less tangible' 'quality of life' considerations. These included (in some, though not all, of the judgments): whether Tony Bland would ever regain consciousness; the pain and indignity he suffered, not just because of the treatment in question, but due to the whole course of care or simply by continuing to live; how he would want to be remembered; the prolonged ordeal of his relatives and care-givers; and the cost to the community of his care.

Two of the law lords—the two who were most openly uneasy about the decision—recognized how subjective this judgment really is. Lord Browne-Wilkinson noted that:

> 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. . . [including] the Roman Catholic church and orthodox Jews . . . If the judges seek to develop new law to regulate the new circumstances, the law so laid down will of necessity reflect the judges' views on the underlying ethical questions, questions on which there is a legitimate division of opinion. . . [Likewise] different doctors may take different views both on strictly medical issues and broader ethical issues which the question raises...The doctor's answer may well be influenced by his own attitude to the sanctity of human life... 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...is in the patient's best interests. But, in the same circumstances, another doctor who sees

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> 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.

And Lord Mustill said:

> 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.

Traditional medical ethics has never required that doctors strive relentlessly to maintain the last vestiges of physical life. Some treatments will be withheld or withdrawn for good therapeutic reasons. Their continued use may be of no therapeutic value (futile). Or they may impose a burden (such as pain, indignity, risk, cost etc.) which those concerned feel is greater than the benefit gained. But here doctors do not indulge in arbitrary 'quality of life' decision-making; they do not give or remove treatments with intent to kill. Instead they make a therapeutic judgment about the helpfulness or not of the proposed medical treatment in dealing with the patient's illness. Thus some treatments will be medically indicated and morally required ('ordinary'); others will be optional ('extraordinary'); and still others will be contra-indicated (and immoral).[4]

By allowing treatment decisions on the basis of arbitrary quality of life assessments, the judges in the Bland case have made a radical departure from this traditional ethic, an ethic which the common law has till now more or less taken for granted. Lord Goff, in support of this approach, asserted that the traditional ethic,which allowed the administration of pain-killing drugs to the terminally ill even if they risked abbreviating the patient's life, was such a quality of life judgment. Here, however, his lordship failed to appreciate the basis of this traditional position: intention. When doctors administer such a pain-relieving drug and death results earlier than it might otherwise have done, hurrying up death may or may not be why they chose such a course of action. Shortening life is often no part of the reason for such chosen conduct; death may or may not be foreseen, but it is not intended: it belongs neither to the doctors' precise purpose, nor is it the means they use to achieve their purpose. On the other hand, doctors might administer the drug because they believe the patient would be 'better off dead', or others would be better off were the patient dead, etc.: in this case hurrying up the patient's death is certainly part or the whole of the reason

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for the chosen conduct.

Some of the judges drew an analogy between removing the ventilator of a dead or dying patient, and removing Tony Bland's artificial feeding. But there are crucial differences here. First, Tony Bland is not dead or dying, and thus his continued 'treatment' far from futile. Second, while removal of a ventilator often permits death to occur because of the failed respiratory function, withdrawing food and water is not an occasion but a cause of pathology and death: Tony Bland will die of starvation, not PVS. Thirdly, a respirator actively takes over a bodily function (breathing), whereas a feeding-tube merely enables the natural bodily function (nutrition) to take place. And fourthly, ventilation is often quite a burdensome procedure and thus often permissibly removed under the traditional criteria; Tony Bland's feeding is clearly not burdensome. Again, the difference comes down to one of intention. Ventilators might be removed with the intention of causing death (i.e. with suicidal or homicidal intent); but they might also be removed because they are no longer therapeutically useful or are causing more burden than benefit, in which case death is possibly foreseen but not intended.

Lord Mustill recognized the hollowness of the notion that discontinuing Tony Bland's treatment is in 'his best interests'. He suggested that the interests of the family, the medical staff, and the paying community were decisive here, and that all the talk of Tony Bland's personal dignity and so on was 'stretching the concept of personal rights beyond breaking point'. He concluded that 'the distressing truth which must not be shirked is that the proposed conduct is not in the best interests of Tony Bland.'

Lord Mustill was the only judge openly to recognize that the quality of life considerations which doctors and judges have been invited to take into account are not ones which they have any special qualifications to assess. The value of an unconscious life, the degree and significance of suffering and indignity, how a particular patient or patients in general would want to be remembered, the effects on relatives and bystanders, the costs to the community: all these are value judgments which are no part of medical or juridical science or skill. They are crucially different to diagnosis, prognosis, and therapeutic assessment of treatment options, and to assessing evidence and declaring on the law.

Who or what is Tony Bland?

Underneath the attitude of the courts to Tony Bland's treatment (or not) are little-examined notions about him as a moral and legal person. Is he really alive? His state of health as described at the beginning of this article suggests he clearly is. None the less, counsel for the Attorney-

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General referred to Tony Bland as having 'mere existence', 'life in the abstract', 'corporeal existence'; he said Tony Bland was one of 'the living dead', 'however miserable and merely metabolic may be what remains of his life'. Following these suggestions, Sir Stephen Brown said that the 'treatment' only sustained the 'shell of his body', and that 'to his parents and family he is dead. His spirit has left him and all that remains is the shell of his body... a biological unit.' Sir Thomas Bingham suggested that PVS patients are 'bereft of the prospect of returning to an even limited exercise of human life' and have no further interest in living. Like Sir Stephen he put inverted commas around 'life' and 'death' when describing Tony Bland. Other judges distinguished between 'a life in the abstract' and 'Mr Bland's actual existence', the latter being 'a living death', 'life in the purely physical sense' , 'alive without having a life in any sense at all'. Lord Justice Hoffmann concluded: 'the very concept of having a life has no meaning in relation to Tony Bland. He is alive but has no life at all... there is no question of his life being worth living or not worth living because the stark reality is that Tony Bland is not living a life at all.'

These claims are extraordinary. Body and mind are treated as different entities, and 'merely being alive' and 'living a real human life' as different properties, with the 'real' Tony Bland dead and only his 'shell' still alive in Airedale Hospital. Such a simplistic dualism, troublesome enough philosophically and theologically, runs clear contrary to the common law view that while ever 'the body' is alive the person is alive. However difficult it is at times to determine the exact moment of death, the law classifies persons as either alive or dead: it knows no such thing as a living corpse, the living dead, or a person who is alive but has no life at all. Until now the law has taken for granted that like all living beings, human beings cease to be alive when they die, i.e. when they irreversibly lose the capacity for that integrated, self-directed functioning characteristic of organisms.

The new definition has chilling implications. The push to declare people dead earlier, with less of their brains and other organs actually dead, is a powerful one today, motivated in part by the strain of long-term care on families and carers, in part by the demand for organs for 'harvesting' and transplant, and in part by the short supply of medical resources ('we need to clear the beds to make room for others').

Even if Tony Bland is alive, is he really a human being? The answer to this would seem to be obvious, or the question of homicide and euthanasia would not arise. Yet counsel for the Attorney-General distinguished between Tony Bland's 'mere existence' and 'life as a conscious individual', noted that he lacked the capacity 'for what can be

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considered an inherent feature of human life, namely a minimal capacity to experience, to relate with other human beings', and asserted that 'life is surely valued as a vehicle for consciousness'. Again the judges followed this lead. Some seemed to be fixated on the matter of Tony Bland's permanent unconsciousness or lack of cognitive capacity or absence of 'a working mind', pleading this point almost antiphonally throughout their judgments. Lord Keith said that in this case 'the consciousness which is the essential feature of individual personality has departed for ever' and that consequently Tony Bland's life had no meaning; and Lord Mustill declared that 'the continued treatment of Tony Bland can no longer serve to maintain that combination of manifold characteristics which we call a personality.'

The repeated implication of the reasoning in the Bland case was that consciousness is required to qualify as the kind of moral person which is respected as inalienable (unkillable) in law and morality. Until now, at least, all living human beings (except perhaps the unborn) have been regarded with equal concern and respect in English law, however intellectually handicapped they might be, and whether they are conscious or not. The human being has been regarded as a unified entity: the life manifest in thinking is the very same life that is exhibited in breathing, heartbeat and digestion. To cease to be conscious is to lose an ability, not to lose one's personhood or one's life. But because Tony Bland is permanently unconscious he has been treated by the courts as somehow less than human.

Again this has drastic moral and social implications. A whole range of patients (with PVS, comas and strokes, Guillain-Barre and locked-in syndrome, Alzheimer's disease, Lou Gehrig's disease, AIDS dementia etc.) lack consciousness to various degrees with various degrees of permanence; a larger group of the mentally handicapped and psychiatrically ill suffer conditions which are intellectually and socially impoverishing. If present consciousness, or some reasonable hope of recovering consciousness, is to be regarded as a necessary requirement for moral and legal citizenship and protection from homicide, a large and potentially widening group of people will be affected. And if humanity *per se* is no longer sufficient, then not only consciousness but other qualities such as a certain I.Q. or a certain quality of social relationships, may in the future be regarded as necessary by doctors and courts.

Euthanasia for Tony Bland?

Until now for doctors to withdraw food or care which is neither futile nor overly burdensome, with the sole objective of ending the patient's life, has been classified as murder by omission. Yet in the present case the

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lawyers and judges openly recognized that 'it may well be that the 'primary purpose' of the act or omission of withdrawing treatment is to bring about Tony Bland's death' (Counsel for the Attorney-General; likewise counsel for the Official Solicitor). Lord Mustill thought that 'it is perfectly obvious that the conduct will be, as it is intended to be, the cause of death', and Lord Lowry agreed that 'the intention to bring about the patient's death is there.' Lord Browne-Wilkinson said that this is 'a course of action designed to produce certain death. . . the whole purpose of stopping artificial feeding is to bring about the death of Tony Bland.' None the less the courts condoned the withdrawal of all measures designed to keep Tony Bland alive and the furnishing of measures to enable his peaceful and dignified death.

Does this order amount to permitting euthanasia? As law and ethics have long recognized, a person's death can be intentionally caused, whether actively or passively, by commission or omission. When killing is done in the course of medical care for the patient's supposed good we call it 'euthanasia'; when it is done by commission it is called 'active euthanasia'; when it is done by omission it is called 'passive euthanasia'.[5] Several of the judges recognized that, whatever the law said or had now been made to say, from the moral point of view it makes no difference whether euthanasia is brought about actively or passively.

Usually, of course, the distinction between action and omission, intervening and 'letting nature take its course', is morally important, even decisive, and much of law and social practice follows this. There are only so many things we reasonably can choose and do, and we are not guilty of failing to choose or do all the other possibilities. We are not morally responsible for the deaths of every person we might conceivably have helped, if we are devoting our time and energies to other morally reasonable purposes, fulfilling our responsibilities. But it is also the case that we can intend to kill someone but organise or exploit the situation so that the killing requires no positive act on our own part: only our failure to do something we should be doing. Earlier in this article we noted that there can be 'Good Samaritan duties' in justice and charity, and even stronger duties as a result of a relationship of dependence, whether natural or assumed. A failure to provide needs in this situation can amount to homicide. Obvious examples of this would be where a parent sees her baby drowning in the bath and fails to intervene; or where children fail to feed a starving elderly parent; or where ancient Greeks or modern doctors abandon handicapped infants. Of course in these situations the agents can say 'I didn't do anything': but that is precisely the problem: they should have, and someone died as a result.

Thus the question turns not on whether there is an act or omission

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(the route by which the law lords tried to solve it), but on intention. The importance of intentions lies in getting to the heart of who we are and what we are about, our real purposes in acting (including our chosen means). The Bland case is an example of intentional killing, a special *medical* kind of intentional killing: 'passive euthanasia'; and a special *social* kind of intentional killing: 'medical homicide by judicial fiat'. Lord Mustill admitted that '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' and Lord Lowry noted that 'it is not hard to see how the case might appear to a non-lawyer... [as] an example of euthanasia in action.'

Next on the agenda . . .

Does the decision invite gradual extension towards more active euthanasia? The judges in Bland's case sought to exclude such practices, confirming the conviction last year of Dr Nigel Cox for taking active steps to end his patient's life. Yet they recognized the moral equivalence of passive and active euthanasia, and some hinted that having allowed the former, more active euthanasia will be a logical next step, at least for Parliament.

The conduct of the Bland case raises many more questions. Why, for instance, were counsel for the Attorney-General and the judges so eager to rule that 'advance directives' or 'living wills' are legal, when this issue had no bearing on the present case? Counsel for the Attorney-General appeared with the self-styled brief to be an 'independent and impartial' friend of the court: why was he the strongest proponent of withdrawing Tony Bland's tube-feeding and legalizing this kind of passive euthanasia? Lord Mustill rightly thought it 'a great pity that the Attorney-General did not appear in these proceedings...to represent the interests of the state in the maintenance of its citizen's lives and in the due enforcement of the criminal law.' Did cost-cutting play a part in the attitude of the Government? Press estimates put the total cost of caring for PVS patients at somewhere between £40 to £150 million a year; were some or all of them 'allowed to die with dignity', there would be significant savings. The parties to the case were unwilling to raise the money matter; but counsel for the Attorney-General did so, and the judges followed the lead. But how can a society as affluent as Britain, even in recession, justify abandoning the severely handicapped on financial grounds? Has Tony Bland, as one press commentator suggested, been delivered 'into the jaws of the NHS's cost cutting piranhas'?

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Should Britain take the euthanasia path?

The judgments in Bland's case failed to present a coherent case *for* euthanasia. There is not the space here to present the case *against*. But for all the polemics about 'dignified death' and 'mercy killing' used by the euthanasia movement and now by the courts, we can forget that dignity is not recognised by telling the old, infirm or comatose how undignified their condition is, or how they would be better off dead - as when judges call Tony Bland 'grotesquely alive', 'an object of pity', 'the living dead', or when the judge in a similar case called some handicapped children 'cabbages'. Nor is mercy well expressed by turning our backs on the dependent, leaving them to die of thirst and hunger.

We should have great sympathy for the family and healthcare workers surrounding Tony Bland. When people take a long time to die, those who must accompany them often suffer the most. Perhaps we could have done more to support them in their suffering. In hard cases like these, sympathy and compassion also tempt us to compromise our basic norms and to fudge our laws. The temptation, one we all know in our moral lives, is to think that we can allow just one, or a few, exceptions; we can still hold the line 'as a general rule'. But rational reflection and human experience suggest that the implications of such exceptions go far wider than the relief of hard cases. Lawyers have long known that hard cases make bad law: moralists also know that convenient exceptions make bad morality.

Apart from the intrinsic evil of killing people, medical homicide changes us individually and as a society. Even discounting the person killed, medical homicide is not victimless because the person who does it is also significantly harmed in the process. The doctor's character will inevitably be very significantly shaped by killing a patient, however noble the motivation. It will change the doctor's attitudes, habits, dispositions, taboos. A doctor disposed to think that some patients lack inherent worth or may be killed has seriously undermined a disposition indispensable to the practice of medicine: a willingness to give what is due to patients just in virtue of their possession of basic human dignity. And the absence of that willingness is likely to be fateful for other patients. Ethically, psychologically and sociologically, medical homicide invites further extension of the killing principle, and discourages alternative approaches to suffering, such as research into cures and the provision of good palliative care and pain management.

A few other problems with euthanasia might be flagged here. There is the problem of the pressures, subtle and overt, conscious and unconscious, which would be put on patients to seek euthanasia, especially when they are very vulnerable, their freedom very limited,

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their self-esteem low. Pressures would also inevitably be brought to bear on families and medical staff to co-operate: licence for medical homicide would quickly become a duty to take part in it. There is the problem of the effects on the doctor-patient relationship, and family relationships, poisoning the atmosphere with suspicion and guilt. Medical ethics and wider societal respect for human life would be further eroded. And there is the spectre of the economic argument, in a rapidly-aging society in which healthcare costs are escalating, to keep extending the occasions for medical homicide.

The ultimate question for medical ethics today is how we face ineradicable suffering. In the end we have to admit in all humility we can only do so much to combat pain, disease and death. The mystery of evil, of innocent suffering, must be faced head-on, against the pervasive temptation to demand an immediate technological, consumer or government 'fix' for every discomfort, and to marginalize those who cannot be quick-fixed so that the rest can withdraw undisturbed. In the face of unfixable suffering our consumer culture stands in gaping incomprehension, or rails like a petulant child demanding immediate satisfaction. The fact is that there are evils we cannot 'solve' in any simple, morally acceptable way, and that call forth much that is most noble in the human spirit: patient endurance, fortitude, even heroism on the part of patients, doctors, families and communities. Sometimes this will be more demanding upon the caring bystanders than the patients themselves.

The Bland case also confronts us with the question of why it is that we care for people with PVS, permanent coma, profound intellectual handicap, Alzheimer's disease, and so on. For some of them we may hope that they might regain consciousness and some greater measure of health and independence. But we know many will not. By supporting them we affirm our respect for their humanity, express our love for them, maintain our human solidarity or communion with them, and conform with our basic duty of respect for every human life however diminished. This is a kind of respecting and loving which no one should pretend is easy. But it is surely more creative than 'benign neglect' and medical homicide.

1 *Airedale NHS Trust v. Anthony Bland (by his guardian ad litem, The Official Solicitor of the Supreme Court)*: High Court of Justice (Family Division), [1993] 2 WLR 322 *per* Sir Stephen Brown P; 19 November 1992; Court of Appeal (Civil Division), [1993] 2 WLR 332 *per* Sir Thomas Bingham, MR, Butler-Sloss and Hoffmann LJJ; House of Lords, [1993] 2 WLR 359 *per* Lords Keith, Goff, Lowry, Browne-Wilkinson and Mustill. References to the Attorney-General are to the 'Outline Submissions of the *Amicus Curiae*'.

2 Last year Bishop Christopher Budd of Plymouth said that feeding Tony Bland is the

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kind of basic care owed to every human being, not a form of "extraordinary care" which might properly be withheld (*The Tablet*, 28 November 1992). Many American bishops have repeatedly made similar statements. See also: Pontifical Academy of Sciences, *The Artificial Prolongation of Life and the Exact Definition of the Moment of Death.*, 30 October 1985; Committee for Pro-Life Activities of the US National Conference of Catholic Bishops, *Guidelines for Legislation on Life-Sustaining Treatment*, 10 November 1984, and *Statement on Uniform Rights of the Terminally Ill Act*, June 1986; New Jersey Catholic Conference, *Amicus curiae brief In the Matter of Nancy Ellen Jobes*, October 1986.

3 Those regarding tube-feeding as a medical treatment which can properly be withdrawn from the permanently comatose include: John Paris, S.J. & Richard McCormick, S.J., "The Catholic tradition on the use of nutrition and fluids," *America*, 2 May 1987, 358; Richard McCormick, S.J., "Caring or starving? The case of Claire Conroy," *America*, 6 April 1986; Edward Bayer, "Is food always obligatory?" *Ethics & Medicine*, 10 (1985); Kevin O'Rourke, O.P., "The AMA Statement on tube feeding: an ethical analysis," *America*, 22 November 1986, 321–323,331; Daniel Callahan, "On feeding the dying," *Hastings Center Report*, 131(5) (Oct 1983). Robert Barry, O.P., *Medical Ethics: Essays on Abortion and Euthanasia* (New York: Peter Lang, 1989) provides a summary and critique of these authors.

Those regarding tube-feeding as a medical treatment or quasi-medical treatment, but one which should normally be maintained for the comatose include: John Connery, S.J., "In the Matter of Clare Conroy," *Linacre Quarterly*, 52 (Nov 1985), 321–334 and "The ethics of withholding/withdrawing nutrition and hydration," *Linacre Quarterly*, 54 (Feb 1987); William E. May, "Feeding and hydrating the permanently unconscious and other vulnerable persons," *Issues in Law & Medicine*, 3 (1987), 203-217 and "Statement in support of the New Jersey Catholic Conference," in Barry (1989), 263-272; Germain Grisez, "Should nutrition and hydration be provided to permanently unconscious and other mentally disabled persons?" *Linacre Quarterly*, 57 (May 1990), 30–43.

Those opposed to regarding tube-feeding as a medical treatment, who argue instead that it is part of the normal or minimum care due to all patients, include: Robert Barry, O.P., "Facing hard cases: the ethics of assisted deeding," *Issues in Law & Medicine*, 2 (1986), 100-106, and "The ethics of providing life-sustaining nutrition and fluids to incompetent patients," *Journal of Family & Culture*, 1(2); Joseph Piccione, "The tradition of care," *Euthanasia Review*, 1(2): 129–31; William Smith, "Judaeo-Christian teaching on euthanasia: definitions, distinctions and decisions," *Linacre Quarterly*, 54 (Feb 1987).

4 John Finnis & Anthony Fisher O.P., "Theology and the four principles [of bioethics]: a Roman Catholic view," in Raanon Gillon (ed), *Principles of Health Care Ethics* (London: John Wiley & Sons, 1993); Luke Gormally, "Against voluntary euthanasia," in Gillon (1993); Linacre Centre for the Study of the Ethics of Health Care, *Euthanasia and Clinical Practice: Trends, Principles and Alternatives* (London, 1982).

5 See Sacred Congregation for the Doctrine of the Faith, *Jura et Bona* (Declaration on Euthanasia, 5 May 1980).

6 See John Finnis, *Natural Law and Natural Rights* (OUP, 1980), 176-77, 195.

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