The House of Lords on issues of life and death

Early in 1993 the House of Lords decided, in the light of recent cases which have been extensively reported in the media, including that of Dr Nigel Cox and the Tony Bland judgement, to establish a select committee to consider the ethical, legal and clinical implications of a person's right to withhold consent to life-prolonging treatment and the position of persons who are no longer able to give or withhold consent; and to consider whether, and in what circumstances, active euthanasia actions, by a doctor or some other person, that have as their intention, or as a likely consequence, the shortening of another person's life may be justified on the grounds that they accord with that person's wishes or with that person's best interests; and in all the foregoing considerations to pay regard to the likely effects of changes in law or medical practice on society as a whole.

I was invited to chair this committee which drew for its membership from Lords Spiritual and Temporal from all parts of the House. We considered a mass of written and oral evidence of the highest quality from individuals and many organisations. We also visited Holland to assess the present position there.

We recommended that the law should not be changed to permit active euthanasia. We did so because:

- while we have every sympathy with those in suffering close to the end of life who would wish to see an end to their misery (something which many of us have experienced in our own families), we did not believe that it would be proper to prefer the interests of the individual to those of society as a whole;
- we did not believe that it would be possible to set secure limits if euthanasia were to be legalised; and we were in no sense reassured by the evidence we obtained during our visit to Holland despite the obvious sincerity of the Dutch doctors and lawyers whom we met.

We strongly endorsed the right of the competent patient to refuse consent to any medical treatment. We recommended that full reasons should be given if a competent patient's wishes in this respect were to be overruled by a court of law.

We also welcomed, and indeed commended, the development and growth of palliative services in hospitals and in the community and we recommended that such services should be extended, with the corollary that further training in pain relief and additional training in medical ethics would be beneficial for doctors, nurses and medical students.

Even though we ruled out the legalisation of euthanasia, we wholly accepted that the so-called double effect is an established part of medical practice, recognised also in law. This means that should it be necessary to relieve pain and suffering in a patient who is terminally ill, it is proper to give doses of analgesic drugs and/or sedatives adequate to produce relief even if that action has the secondary consequence of shortening life. In such cases it is the doctor's *intent* which is crucial.

With respect to treatment-limiting decisions such as those which arose in the case of Tony Bland (a victim of the Hillsborough football stadium disaster who remained in a persistent vegetative state in hospital for several years until the High Court, the Appeal Court and the Appellate Committee of the House of Lords all agreed that it was proper for food and hydration, given by a feeding tube, to be withdrawn) we recommend that in such cases decisions should be made jointly by all involved in the care of the patient (doctors, nurses, other members of the health care team and the patient's family or friends). We were not able to reach a conclusion as to whether it was proper to withdraw food and nourishment, however administered; we felt that this question need not, and indeed should not, be asked as in such cases withdrawal of antibiotics might allow death to supervene. Such a decision would be made on the basis that treatment would be inappropriate if it added nothing to the individual's wellbeing as a person. Such treatment-limiting decisions should never be determined by considerations of resource availability. It would be helpful if the Medical Royal Colleges and related professional organisations produced an agreed definition of the persistent vegetative state and a code of practice relating to its management. When all those involved in the patient's care agree that treatment, as defined above, should be withdrawn or withheld, this should be done without reference to courts of law. If, however, there were to be a dispute among the carers, we have recommended the establishment of a locally based judicial forum with medical and lay input to make decisions in such cases.

Just as we recommended no change in the law with respect to voluntary euthanasia, we also did not wish to see any change in the law relating to assisted suicide, nor did we wish to recommend that a new offence of so-called mercy killing should be introduced into the

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UK's legal system. However, we were concerned to note from the evidence we received that in a number of prosecutions of family members who had taken acts to terminate the life of a loved one, the original charge had inevitably been one of murder. However, in most, if not all, such cases the prosecution recognised that the act had had a merciful motive and felt able in a sense to manipulate the law either by substituting a charge of attempted murder or by accepting a plea of diminished responsibility. This seemed to us unacceptable in principle and we therefore recommended that the mandatory life sentence for murder should be dropped, as previously proposed by another select committee in the Lords, so that the judge, when considering a sentence, would be allowed the latitude to be merciful in cases where a positive act to terminate life had clearly been carried out with a compassionate motive.

While we did not commend the widespread development of a system of proxy decision-making for incompetent patients, we expressed support for the concept of advance directives through which competent individuals would be able to specify in advance the types of intervention or treatment which they would not wish to accept in terminal illness in the event that they became incompetent. The validity of advance directives is now becoming widely accepted by the caring professions and by the law and we were satisfied that the present situation is sufficient to protect doctors who might be concerned on the one hand about complying with such directives, or who might, on the other hand, have a conscientious objection to doing so. For these and a number of other reasons set out in our report, not least the possibility that medical management might have changed significantly since such a directive was signed and witnessed, we concluded that there was no need for formal legislation on such directives, alternatively called living wills.

As I write, we are awaiting a formal debate in the House of Lords and the government's response to our report but trust nevertheless that members of the medical and other caring professions will find our unanimous report interesting and helpful.

Acknowledgements

I wish to pay a sincere tribute to the hard work and expertise of the members of the committee and to their remarkably dispassionate judgement, coming as they did from a variety of professional and lay backgrounds and representing very disparate religious interests. Our committee clerk, Mrs Mary Ollard, was in every way superb.

Related articles previously printed in the *Journal*

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