The English law of homicide is in a mess. As the Law Commission said in 2006, it is “a rickety structure set upon shaky foundations.” It ought to have a rational structure. It does not. The pressing need for reform has been recognised for a long time. As Lord Mustill said in 1998:

“[M]urder is widely thought to be the gravest of crimes. One could expect a developed system to embody a law of murder clear enough to yield an unequivocal result on a given set of facts, a result which conforms with apparent justice and has a sound intellectual base. This is not so in England, where the law of homicide is permeated by anomaly, fiction, misnomer and obsolete reasoning.”

The manifold defects in the law have been pitilessly analysed by Terence Morris and Louis Blom-Cooper, most recently and most comprehensively in their eloquent and compelling book, ‘Fine Lines and Distinctions: Murder, Manslaughter and the Unlawful Taking of Human Life.’ I do not have the time, and this is not the occasion, to follow them into the morass. Let me identify just three problems with the law of murder, taken almost at random. First, there is no need to prove an intention to kill. It is enough, if death results, that there was an intention to cause grievous – really serious – bodily harm. So, as Lord Steyn has pointed out, murder has been turned into “a constructive crime”, resulting in “defendants being classified as murderers who are not in truth murderers.” Second, the law draws no distinction between, for example, serial killing or terrorist mass murder and mercy killing. Third, and exacerbating the problem, the law imposes the same mandatory sentence – imprisonment for life – on all murderers. It is no doubt these and other inflexibilities in the law that explain the need for the special defences of diminished responsibility and provocation (loss of self control as it is now called) which are themselves problematic in too many respects.
Some of these difficulties are exemplified most acutely in those areas where the law of murder intersects with medical practice. Since it is on medicine and the law that I am invited to speak it is on this that I shall accordingly focus.

As you may know, I am the Chairman of the Law Commission, but I speak to you today in a purely personal capacity. I should at once confess, however, to having appeared when I was at the Bar as counsel in some of the cases I will be referring to.

You will, I fear, be disappointed if you have come expecting me to talk about Dr Shipman, convicted at Preston Crown Court of poisoning 15 of his patients. Nor do I propose to speak of his infamous precursors, immortalised in the sombre pages of Notable British Trials. Their trials are of enduring forensic fascination but otherwise of interest only to students of toxicology, psychiatry and, perhaps, theology. To the mere lawyer they are of little interest: murderers who happened to be doctors; wicked men who put the knowledge and, in the case of Dr Shipman, the opportunities which medical practice had placed in their way to commit murder using more than usually subtle and wicked technologies of death.

No. What I have come to talk about is the Tale of Five (other) Doctors: Dr Bodkin Adams, Dr Cox, Dr Howe, Dr Holmes and Dr Moor. Drs Bodkin Adams, Cox and Moor are famous because they had the misfortune to find themselves standing in the dock: Dr Bodkin Adams at the Old Bailey, acquitted of the murder of his patient; Dr Cox at Winchester Crown Court convicted of the attempted murder of his patient; Dr Moor at Newcastle-upon-Tyne Crown Court acquitted of the murder of his patient. The names of their patients, Edith Morrell, Lillian Boyes and George Liddell, may be less familiar. Drs Howe and Holmes had the good fortune to find their conduct being scrutinised not in criminal proceedings in the Crown Court but in civil proceedings in the Family Division of the High Court. Perhaps for this reason it may be that their names are not so familiar; the cases in which they were involved are better known under the names of their patients, Tony Bland and Annie Lindsell.

Before proceeding further it may be helpful if I remind you briefly of the facts of the five cases.
First, Dr Bodkin Adams: He was a general practitioner in Eastbourne widely credited with having preyed on his elderly female patients, persuading them to make wills in his favour and then (so it was said) poisoning them with excessive doses of narcotics. After a sensational trial before Devlin J he was acquitted in April 1957.

Second, Dr Cox: He was a consultant rheumatologist. His patient, Lillian Boyes, was dying with only a very short time to live. She was, as Ognall J put it in his direction to the jury, suffering “many and dreadful afflictions”, she was “terminally ill and in considerable pain, if not agony”. She had expressed the wish to die; she told her son that she had had enough. Dr Cox deliberately gave her a lethal dose of a drug, potassium chloride, which has no analgesic properties and for which, according to unchallenged expert evidence, there was in the circumstances no clinical use. Mrs Boyes died almost immediately. Recognising that the Crown could not prove beyond reasonable doubt that the drug was the cause of his patient’s death – it was possible she had died from natural causes – the prosecution did not charge Dr Cox with murder. He was charged with, and in September 1992 convicted of, attempted murder.

Third, Tony Bland: He was asphyxiated at the Hillsborough stadium disaster in 1989. He was subsequently diagnosed as being in PVS. The essence of PVS is that the patient is alive, is not dying (and, if properly treated may live for many years), but is totally insensate. He can therefore feel neither pain nor distress, has no cognitive functions, requires artificial nutrition and hydration to remain alive, and has no hope of either recovery or improvement. Tony Bland was being cared for by Dr Howe and fed through a nasogastric tube. Dr Howe wished to discontinue his patient’s artificial feeding. In November 1992, just two months after Dr Cox had been convicted, the President of the Family Division granted a declaration that it would be lawful for Dr Howe to remove the tube. An appeal by the Official Solicitor, acting as Tony Bland’s guardian ad litem, was dismissed by the Court of Appeal in December 1992 and a further appeal to the House of Lords was likewise dismissed in February 1993. Shortly thereafter Dr Howe removed the tube and Tony Bland died. A subsequent attempt by a private citizen to prosecute Dr Howe for murder failed. The magistrates refused to issue a summons and their refusal was upheld by the Divisional Court in April 1994 on the ground that the ruling of the House of Lords would be an answer to any prosecution.
Next, Annie Lindsell: She was in the terminal stages of motor neurone disease. This is a progressive wasting illness which, whilst leaving the patient’s mind, eyes and ears unaffected, destroys the nerve cells controlling muscle movement, thereby causing progressive paralysis and, in the final stages of the disease, giving the patient the sensation that he is choking to death. Annie Lindsell was very anxious that prior to that final stage, her GP, Dr Holmes, should be able to administer appropriate drugs to control not merely her physical pain but also the mental anguish she would otherwise have to endure in contemplating her fate. Dr Holmes was unwilling to administer such drugs without the prior sanction of the court, as they might have the effect of accelerating his patient’s death. Annie Lindsell’s application to the President of the Family Division in October 1997 for a declaration that what Dr Holmes wished to do was lawful was abandoned after it had become clear that Dr Holmes was willing to proceed without the prior sanction of the court. It would seem that he changed his mind for two reasons: first, because all the medical witnesses had acknowledged that the proposed course of treatment was an acceptable (even if not the only acceptable) way of treating Annie Lindsell’s condition; secondly, because it was common ground between all the counsel involved in the case that on this footing what Dr Holmes was proposing to do was, in principle, lawful.

Finally, Dr Moor: He was a general practitioner in Newcastle-upon-Tyne. After being quoted in the media as having made a number of statements on the subject of euthanasia he was tried for murder, having, as the Crown alleged, given an elderly patient, George Liddell, an excessive injection of diamorphine. After a trial before Hooper J he was acquitted in May 1999.

There can be no doubt as to the legal correctness of the outcome in all these cases, but the result, at least at first blush, is puzzling. There is no doubt, given the finding of the jury in the one case and the undisputed evidence in the other, that both Dr Cox and Dr Howe intended to bring about the death of their patients. But whereas what Dr Cox did, dealing with a patient in terrible pain, was a very serious criminal offence, what Dr Howe did, dealing with a patient who was not suffering at all, was perfectly lawful. How can this be?
‘Thou shalt not kill’: thus the Old Testament; according to English law thou shalt not commit murder, manslaughter or suicide. Some definitions:

- **First, murder**: I am guilty of murder if (1) I do an act (2) which causes death (3) with ‘malice aforethought’, that is to say either intending to kill or intending to cause grievous – really serious – bodily harm.
- **Next, manslaughter**: The offence is manslaughter if, although I had no malice aforethought, I was acting recklessly or with gross negligence. (Note the vituperative epithet which qualifies the concept of negligence; we shall have to return to it in due course.)
- **Finally, suicide**: Suicide is no longer a crime but section 2(1) of the Suicide Act 1961 makes it an offence to aid, abet, counsel or procure the suicide of another person.

The criminal lawyer may complain – correctly – that these are not comprehensive definitions, but they are, I believe, accurate so far as they go and they will, I think, suffice for present purposes.

Returning to murder I must add a little by way of clarification of each of the three ingredients of the offence.

First, **intention**: The law concerns itself with intention, not with motive. What is intention? Once upon a time it was said that a man is to be taken to intend the natural and probable consequences of his actions. Nowadays the criminal law is more lenient. In accordance with the ruling in *Woollin*, a man will now be taken to intend only those consequences of his actions which it is his purpose to bring about or which he knows to be virtually certain (a high degree of probability is not enough). What of **motive**? However good the motive, intentional killing is murder. So ‘mercy killing’ by active means is murder. In 1915, Simpson, a soldier returning on leave from the front, found his 2 year old son dying in great distress and pain. He sat watching the child, brooding, and then cut the child’s throat with a razor. He was convicted of murder and sentenced to death, although subsequently reprieved after his appeal had been dismissed. Rowlatt J directed the jury that:
“It is my sad duty to tell you that if he injured the child even with the best and
kindest motive, you must find murder.”

So if I administer a lethal dose of sleeping pills to my dying and pain-racked relative
in order to put her out of her misery, I am guilty of murder. Likewise, if I hand her the
pills so as to enable her to put herself out of her misery I am guilty of aiding and
abetting a suicide. In neither case does it make any difference in law, as distinct from
morals, that I am acting with her fully informed knowledge and consent – even,
indeed, at her insistence. Consent is no defence to a charge of murder, even if the
murder is a ‘mercy killing’, nor, as cases such as Pretty and Purdy show, to a charge
of aiding and abetting a suicide. And as was emphasised by the Law Lords in Tony
Bland’s case, exactly the same principles apply in the case of a doctor as in the case of
anyone else. That ‘mercy killing’ by a doctor is murder was taken for granted in the
directions given to the jury by Devlin J in Bodkin Adams, by Ognall J in Cox and by
Hooper J in Moor. That they correctly stated the law has never been doubted.

Second, causing death: Since everyone must die sooner or later, every killing is
merely an acceleration of death. Again, the same principle applies in the case of a
doctor. Indeed, as Ognall J pointed out in Cox, it is murder even if the acceleration of
death is measured only in minutes.

Third, an act: Generally speaking the English law of homicide concerns itself only
with acts, and not with omissions. As Stephen J (Sir James Fitzjames Stephen) put it
in his Digest of Criminal Law:

“It is not a crime to cause death or bodily injury, even intentionally, by any
omission … A sees B drowning and is able to save him by holding out his
hand. A abstains from doing so in order that B may be drowned, and B is
drowned. A has committed no offence.”

Thus the law imposes no duty to go to the assistance of someone in peril, however
immediate and mortal the peril to the person in danger and however trivial or even
non-existent the possible risk to the rescuer. Again, the same principle applies in the
case of a doctor. There is, in general, no legal (as opposed to moral, ethical,
professional or civic) obligation to provide medical assistance to another. A doctor who witnesses a road accident is under no legal obligation to go to the assistance of the dying or injured. Moreover, the rescuer who, being under no duty to intervene, embarks upon an attempted rescue, is under no duty to continue the rescue; he can at any time abandon his attempts without being exposed to any liability for withdrawing, except insofar as his acts have made matters worse. So apparently in the case of the doctor who stops at the road accident.

Stephen’s example of the drowning man brings out an important point, namely that the deliberate omission to help someone in distress is not made criminal merely because one’s motive is evil. Just as an intentional act of killing is murder, however good the motive, so an intentional omission to act is not murder however wicked the motive. Let me give an example: X is lying in hospital recovering from a road accident, his life dependent on the proper functioning of some piece of medical apparatus. X is due to inherit £1 million from his uncle, but only if he attains the age of 21 in six days time; if he does not, the inheritance will go to his distant cousin Y. Y, intent on obtaining the inheritance for himself, disconnects the apparatus, intending X to die. As Y intended, X dies. Y is guilty of murder. But let us change the facts a little. Y, intent on obtaining the inheritance for himself, goes to the hospital, intending to disconnect the apparatus, but discovers on his arrival that the apparatus has become accidentally disconnected. X is still alive but Y, intending X to die, deliberately stands by, making no attempt either to reconnect the apparatus or to summon assistance. As Y intended, X dies. In the second case Y is not guilty of murder (or, indeed, of any offence) though morally it is difficult to see any real difference between the two cases.

So much for the general principles of the law of homicide.

Now at this point your thoughts may perhaps turn to the operating theatre and to the potential criminal liability of the surgeon. You might well say to me,

‘Well, I follow all that, but surely this cannot be right. Take the surgeon operating on a patient. Surely you are not suggesting that he can simply ‘down tools’ half way through the operation, allow his patient to die and then seek to
escape a conviction for manslaughter by saying that since, if he had not operated at all, the patient would have died in any event, he has not made the patient’s condition worse. Surely that cannot be the law.’

Or you might say,

‘Take the surgeon who is doing his absolute best but who without any negligence, and in circumstances which do not reflect at all upon his professional skill and competence, loses his patient in the operating theatre. Surely you are not suggesting that the surgeon is guilty of murder because his patient dies as a result of an intentional act – a surgical incision – which because it involves a major cutting of the skin amounts in law to grievous bodily harm. Surely that cannot be the law.’

In each case, of course, you would be absolutely right. The law is not that stupid. But why is this so? At this point I have to introduce a number of exceptions to the general principles which I gave you.

The first exception is to the principle that an omission to act does not in general give rise to criminal liability. A person who assumes the responsibility of caring for a helpless individual – for example, a young child or a bedridden invalid – thereby assumes a legal duty to provide for that individual’s needs, in particular, the duty to care for his health and welfare by providing food and appropriate medical attention. The carer can either perform his duty himself or by calling for the assistance of others, but if he wrongfully abandons the person he is caring for he may be held criminally responsible. Thus a breach of the duty of care which causes or accelerates death is murder if the intent was to cause death or really serious bodily harm: so in 1918 in the repulsive case of Gibbins and Proctor. It is manslaughter if there was reckless disregard of danger to the health and welfare of the person being cared for or gross negligence: so in 1977 in the almost grotesque case of Stone and Dobinson. Precisely the same principle applies in the case of a doctor, as has been recognised by the House of Lords in recent years. But this does not mean, of course, that a doctor who has assumed the responsibility of caring for his patient is obliged in all circumstances to engage in what are sometimes described as ‘heroic’ or ‘extraordinary’ measures to
prolong his patient’s life at all costs. That principle is well illustrated by a number of cases; two of the earliest were Baby C in 1989 and Baby J in 1990.

That this is law there can be no doubt. That the law is entirely satisfactory is less certain. As Lord Mustill has commented:

“Precisely in what circumstances such a duty [that is, to care for someone] should be held to exist is at present quite unclear … [T]he current state of the law is unsatisfactory both morally and intellectually, as shown by the troubling case of R v Stone.”

The next exception I must mention is to the principle that, even if there was no intention to kill, it is murder if death results from an act intended to cause grievous – really serious – bodily harm. What has variously been described as “bona-fide”, “proper” or “reasonable” medical or surgical treatment is not unlawful. Therefore death resulting from such treatment does not amount to murder or, in the absence of gross negligence, to manslaughter. What exactly constitutes “proper” or “reasonable” surgical treatment is not altogether clear. It may be difficult to believe, but as recently as 1954 Denning LJ felt able to state in emphatic terms that a sterilisation for contraceptive purposes was unlawful – indeed, criminal – even if done with the consent of both married partners. For present purposes this part of the debate if intellectually challenging is not very important. More important are two other points.

In the first place, the defence of “proper” or “reasonable” medical or surgical treatment is not confined to those who are medically qualified. This is merely an application of the wider principle, explicitly recognised by Devlin J in Bodkin Adams, that there is no special ‘doctor’s defence’.

The second point, which is vital, is that the defence of “proper” or “reasonable” medical or surgical treatment cannot avail the doctor – or the layman – whose intention was to kill. The plea of lawful surgery will protect the doctor who, intending to do what in law constitutes grievous bodily harm, unintentionally kills his patient; but as we have seen, the law treats as unlawful by definition any medical or surgical
procedure intended to cause death. To this fundamental principle I shall have to return in due course.

So the law would appear to be clear. The doctor who does an act which causes his patient to die is guilty of murder if his intention was to kill his patient. It matters not, as I have said, that the doctor’s motives may, like Dr Cox’s, have been of the purest, nor does it matter that in doing what he did the doctor was acting with his patient’s fully informed knowledge and consent, indeed at his insistence.

Consider, however, the cases of Elizabeth Bouvia in Los Angeles in 1986, Nancy B in Quebec in 1992 and Ms B in this country in 2002. Analytically the facts in the three cases are indistinguishable. I can illustrate the point by reference to Nancy B. She was a 25-year old in a hospital in Quebec suffering from Guillain-Barre syndrome, rational but trapped and mute in an unresponsive body. She could breathe only with the assistance of a mechanical respirator. Her intellectual capacity and mental competence were unimpaired. She sought and was granted by the Superior Court of Quebec an injunction requiring the hospital to remove the tube, even though it was clear that this would lead to her death after a very short time.

Now it was always clear that if a similar case were to arise in England the outcome would be exactly the same. So much was made clear by Lord Goff in Tony Bland’s case when approving the decision in Nancy B. And the subsequent decision in the case of Ms B establishes the point. But this is very puzzling.

Let me recapitulate. What the court was doing in the cases of Elizabeth Bouvia, Nancy B and Ms B was saying that it was perfectly lawful for a doctor, if he had the consent of his patient, to disconnect his patient’s life support machine, even though it was clear that this would inevitably hasten his patient’s death, and even though it was his patient’s intention that she should die. According to Lord Goff:

“in cases of this kind, there is no question of the patient having committed suicide, nor therefore of the doctor having aided or abetted him in doing so.”
What is perhaps the more pressing question is not why the doctor who disconnects the machine is, as Lord Goff would have it, not guilty of aiding and abetting a suicide, but rather why he is not simply guilty of murder. For on the face of it he is plainly doing an act (that is, disconnecting the machine) which in fact causes (that is, hastens or accelerates) his patient’s death, and in circumstances where his intention, just as in Tony Bland’s case, is, as Lord Browne-Wilkinson pointed out, to bring about his patient’s death. Why is that not murder?

The formal answer to this conundrum is that in English law the competent adult patient is treated as having an absolute right to refuse consent to any medical treatment or invasive procedure “for reasons which are rational or irrational or for no reason” and “even in circumstances where she is … certain to die in the absence of treatment”. “To this extent”, as Lord Goff observed in Tony Bland’s case, “the principle of the sanctity of human life must yield to the principle of self-determination”.

Now this is all very odd. It is absolutely clear that ‘mercy killing’ is murder whether or not the patient consents. Consent is never a defence to a charge of murder. But to put the point plainly, the orders granted to Elizabeth Bouvia, Nancy B and Ms B were granted only because they were consenting to being killed. Since in each case the hospitals had assumed the responsibility of caring for them, absent their consent to what was proposed the disconnection of the machines would in each case have been murder. So what made the doctors innocent of murder was, in reality, the consent of their patients. But how can this be? What the courts have done is to stand the doctrine of consent on its head. What is in reality a (legally invalid) consent to being killed is treated as being a (legally valid) refusal of consent to being treated, and thus, so it is said, the criminal law ceases to be implicated at all. But why? One is surely still left at the end of the day with the reality that what has legalised an intentional killing is the giving of the patient’s consent.

As Charles Foster has recently pointed in a very important book, ‘Human Dignity in Bioethics and Law’, there are deep problems lurking within the seeming certainties of English law. Many jurisdictions in the United States of America take a more nuanced view, but in this country autonomy is seen as absolute. The competent patient has an
absolute right to refuse treatment. Now this is rather curious, for the absolute right
which autonomy gives to refuse consent is not matched by an equally absolute right to
give consent. There are some things that the law forbids us to consent to. I cannot
consent to be killed. And as Brown shows, I cannot consent to be subjected to certain
extreme forms of sado-masochistic sexual behaviour. If I cannot consent to be killed,
why should I be entitled to bring about my death by refusing consent to life-saving
medical treatment? After all, my purpose, my motive, my intention, may be the same
in each case: I want to bring my life to an end. Why should the one means be licit, the
other illicit?

Foster’s solution to the conundrum is to suggest that autonomy is not absolute, that on
occasion it may have to give way to other principles, in particular, he proposes, to
dignity, which he calls “the bioethical Theory of Everything”. That raises a very large
question indeed which I cannot explore today.

At this point it may be useful to return the case of Tony Bland. As in the cases of
Elizabeth Bouvia, Nancy B and Ms B, Tony Bland’s doctor, Dr Howe, had assumed
the responsibility of caring for his patient. As in the cases of Elizabeth Bouvia, Nancy
B and Ms B what was proposed was the disconnection of the machine on which the
continuance of Tony Bland’s life depended, in circumstances where the intention was,
as I have said, to bring about his death. The only differences between Tony Bland’s
case and the three other cases were, first, that Tony Bland in his PVS was not in a
position to give any consent to what was proposed and, secondly, that he was totally
insentient and could therefore suffer neither pain nor distress, whether physical or
mental.

On the face of it, it might be thought that what Dr Howe was proposing to do was
murder on two quite separate grounds: first, because he was proposing to perform an
act (that is, disconnecting the machine), in circumstances where it was certain that this
would cause (that is, hasten or accelerate) his patient’s death and where his intention
was to do precisely that; second, because, having assumed the responsibility of caring
for his patient, he was proposing to withdraw treatment, without his patient’s consent,
in circumstances where his intention was to bring about death. As Lord Mustill
commented, comparing Tony Bland’s case with Gibbins and Proctor (where the
father and his mistress were convicted of the murder of the little girl whom they starved to death):

“Of course the cases are miles apart from an ethical standpoint, but where is the difference on the essential facts?”

It is not clear that his Lordship was able to find any very satisfactory answer to that very pertinent question. Similar doubts assailed Ward LJ subsequently in the case of the conjoined twins.

The House of Lords held that Dr Howe would not be guilty of murder, or, indeed, of any criminal offence. How did their Lordships arrive at this conclusion? In the first place they said that what was in fact a positive act (that is, Dr Howe’s disconnection of the nasogastric tube) was not to be “categorised” or “classified” as a positive act, but rather as an omission! Lord Goff sought to justify this surprising analysis as follows:

“I agree that the doctor’s conduct in discontinuing life support can properly be categorised as an omission. It is true that it may be difficult to describe what the doctor actually does as an omission, for example where he takes some positive step to bring life support to an end. But discontinuation of life support is, for present purposes, no different from not initiating life support in the first place.”

He continued:

“I also agree that the doctor’s conduct is to be differentiated from that of, for example, an interloper who maliciously switches off a life support machine because, although the interloper may perform exactly the same act as the doctor who discontinues life support, his doing so constitutes interference with the life-prolonging treatment then being administered by the doctor. Accordingly, whereas the doctor, in discontinuing life support, is simply allowing his patient to die of his pre-existing condition, the interloper is actively
intervening to stop the doctor from prolonging the patient’s life, and such conduct cannot possibly be categorised as an omission.”

One may perhaps be permitted to say that, although the doctor’s conduct can properly be differentiated from that of the interloper, and although one can readily agree that the interloper’s conduct cannot possibly be categorised as an omission, it is very hard to see how “exactly the same act” (to use Lord Goff’s own words) can in the one case be said to be a positive act and in the other case an omission.

Lord Browne-Wilkinson’s approach was even more stark:

“The positive act of removing the nasogastric tube presents more difficulty. It is undoubtedly a positive act, similar to switching off a ventilator in the case of a patient whose life is being sustained by artificial ventilation. But in my judgment in neither case should the act be classified as positive, since to do so would be to introduce intolerably fine distinctions.”

One may readily accept that the distinction between acts and omissions is a fruitful source not merely of the intolerably fine distinctions to which his Lordship was referring but also on occasions of downright absurdity. Moreover, as Lord Browne-Wilkinson pointed out, if the acts/omissions distinction is treated as being critical the outcome in any particular case will depend upon whether the machine runs automatically (in which case a positive act will be required to stop it) or requires to be reset periodically (in which case the same result can be achieved by inaction).

All this is true enough, but the fact is that the acts/omissions distinction is central to the criminal law of homicide; indeed, according to Lord Mustill (who also managed to persuade himself that Dr Howe’s act was in fact an omission), the very outcome in Tony Bland’s case depended crucially on the distinction drawn by the criminal law between acts and omissions.

The truth is that Tony Bland’s case was not decided on any meaningful distinction between acts and omissions, as that distinction is usually understood in the criminal
The real distinction on which the case turned was surely that identified in the Court of Appeal by Butler-Sloss and Hoffmann LJ. As Hoffmann LJ said:

“I do not think that the distinction turns upon whether what is done is an act or omission. This leads to barren arguments over whether the withdrawal of equipment from the body is a positive act or an omission to keep it in place. The distinction is between an act or omission which allows an existing cause to operate and the introduction of an external agency of death … This is not a case about euthanasia because it does not involve any external agency of death.”

This may be intellectually more satisfying than the approach adopted in the House of Lords, but in its overt rejection of the acts/omissions distinction it marks a significant departure from the existing law.

The plain fact is that the courts were able to exonerate Dr Howe from criminal liability only by distorting the framework of existing legal analysis. The Court of Appeal sought to do this by simply repudiating the long-established distinction between acts and omissions, the House of Lords by the scarcely more subtle or convincing ploy of calling (or, as their Lordships put it, “categorising” or “classifying”) something that was plainly an act as an omission. On neither approach is the result convincing.

But the distinction, however one analyses it, is critical. The doctor who deliberately brings about the death of a patient in PVS by discontinuing his artificial feeding commits no offence; the doctor who deliberately brings about the death of the same patient by administering a fatal drug is guilty of murder. The distinction is illustrated by the differing fates suffered by Dr Howe and Dr Cox. Both intended that their incurably ill patients should die. Dr Howe’s chosen method was to withdraw the artificial feeding which alone kept Tony Bland alive. Dr Howe committed no offence. Dr Cox’s chosen method was to administer a lethal dose of potassium chloride. Since this involved the introduction of an eternal agency of death he was convicted of attempted murder (attempted murder rather than murder because the prosecution could not prove it was the injection that actually caused his patient’s death).
The second line of argument, at least in Lord Goff’s view, was, as we have seen, that the cause of Tony Bland’s death was not Dr Howe’s conduct in disconnecting the nasogastric tube but rather his patient’s pre-existing-condition. As Lord Goff put it, in the passage I have already quoted,

“the doctor, in discontinuing life support, is simply allowing his patient to die of his pre-existing condition.”

This, with respect to Lord Goff, surely cannot be right. As Lord Mustill pointed out, if the argument was correct that the cause of Tony Bland’s death would be the Hillsborough disaster, and not anything done by Dr Howe, the argument would equally operate to exonerate Dr Howe from criminal liability if he chose to kill his patient in the same way as Dr Cox, that is, by active euthanasia.

Having thus disposed of the first of the arguments that what Dr Howe was proposing to do would be murder, namely because it would involve him in doing an unlawful act, the House of Lords had then to turn to the alternative argument. This, you will remember, was based on Dr Howe’s duty to provide medical assistance, and accordingly was not dependent on demonstrating that Dr Howe’s conduct involved a positive act rather than a mere omission. This argument was disposed of by the Houses of Lords on the grounds that (1) the doctor’s duty of care never requires him to provide medical treatment that is futile, (2) the provision of food by nasogastric tube is medical treatment and (3) feeding Tony Bland was, in all the circumstances, an exercise in futility, since his life was a nullity and he had in reality no interest in remaining alive.

One can readily accept the first of those three propositions, whilst questioning both the second and the third. As it was put in argument, mechanical hydration and nutrition are no more medical treatment than is the mechanical supply of air to a deep-sea diver. Moreover, even if feeding can in some circumstances properly be categorised as medical treatment it does not thereby cease to be feeding. Feeding can never be futile, because food and water, like air, are all basic necessities of existence. To categorise Tony Bland’s life as a nullity was wrongly to seek to justify the withdrawal of life-sustaining treatment by reference to the quality of the patient’s life,
something which the law does not permit. Tony Bland’s case was quite different from that of Baby J. Since he was insentient, felt no pain, and could not be said to be suffering, there was nothing to be put in the balance, as there was in Baby J’s case, to overturn the presumption in favour of treatment and life. I leave it to you to evaluate the merits of the argument.

Before leaving Tony Bland a question arises that may have puzzled you. As you will remember, I suggested that what made the withdrawal of treatment lawful in the cases of Elizabeth Bouvia, Nancy B and Ms B was the fact that, as competent patients, they were able to consent and had in fact consented to what was proposed. But Tony Bland, of course, was in no such condition. How then could the withdrawal of treatment in his case be lawful? The answer is that although in the case of a competent patient the critical factor is the presence or absence of the patient’s consent, in the case of an incompetent patient treatment questions fall to be decided by reference to the patient’s best interests. That was the test laid down by the House of Lords in Re F as applicable where the question was whether it was lawful to administer treatment to an incompetent adult (in that case a non-therapeutic sterilisation for contraceptive purposes). In Tony Bland’s case the House of Lords held that the same test was applicable where the question was whether it was lawful to withdraw or withhold treatment.

I do not pause to consider in what sense (if any) it can be said that what was done to Tony Bland was in his best interests. The point I should like to focus on is rather more limited. In Re F the House of Lords also laid down as a matter of law that whether or not medical treatment is in an incompetent patient’s best interests is to be judged by reference to the ‘Bolam’ test, that is, by reference to whether what is proposed accords with a (even if it is not the only) responsible and competent body of relevant medical opinion. The House of Lords applied the same test in the case of Tony Bland, on the footing that the Bolam principle must equally be applicable to decisions to initiate or to discontinue life support as it is to other forms of treatment.

This is a curious course for the law to have taken. In the first place, the decision whether a patient in PVS like Tony Bland should or should not be kept alive is not really a medical question at all; it is ultimately a question of morals, ethics, or public
policy on which doctors are in no better (though I entirely accept in no worse) position to express a view than judges, theologians, ethicists, or indeed, for that matter, anyone else. It is, to say the least of it, curious that in such circumstances the courts should have treated doctors as being the appropriate arbiters. As Lord Mustill said:

“These are problems properly decided by the citizens, through their elected representatives, not by the courts.”

The second comment to be made is this. The Bolam test is the test applied by the courts to determine whether a doctor has been guilty of professional negligence. To adopt the Bolam test as the criterion for deciding whether or not a doctor is acting lawfully in withdrawing treatment from his incompetent patient would seem to carry with it as a necessary corollary the proposition that the doctor who fails to meet the Bolam test, in other words, who is negligent, is not acting lawfully at all. But if this is so, the doctor who negligently withdraws treatment from an incompetent patient in circumstances otherwise indistinguishable from those in Tony Bland’s case would seem to be guilty of murder. The use of the Bolam test therefore seems to carry with it the possibility that a doctor can in some circumstances be guilty of murder even if he is only negligent, even though, as you will remember, he cannot normally be guilty of the lesser offence of manslaughter in the absence of gross negligence. Something seems to have gone very wrong here. Indeed, the use of the Bolam test in this context was subsequently repudiated by the Court of Appeal in Re S in 2000.

Two final questions arising from Tony Bland’s case: As Lord Browne-Wilkinson pointed out, if the retention of the nasogastric tube could no longer be justified as being in Tony Bland’s interests, not merely was the disconnection of the tube lawful, the retention of the tube would be both unlawful and, indeed, criminal. Does this mean that anyone, irrespective of motive, can with impunity disconnect the feeding tube of a PVS patient? You will remember the two cousins X and Y. Let us change the facts a little. Suppose that X is diagnosed as suffering from PVS. An application is pending before the court for a declaration that it will be lawful to disconnect X’s feeding tube. Because the application will not be heard until after X attains the age of 21 and inherits the £1 million, Y, intent on obtaining the inheritance for himself,
disconnects the feeding tube, intending X to die, as in the event he does. Is Y guilty of murder? I do not know. Finally, does it follow from the decision in Tony Bland’s case that the next time a defendant finds himself in the dock at the Old Bailey charged with manslaughter for allowing his helpless and senile relative to starve to death he is to be allowed to argue that in his bona fide and reasonable opinion his elderly relative was better off dead than alive? The House of Lords was asked this question but declined to provide an answer.

I turn to Annie Lindsell. Why was it lawful for Dr Holmes to do what he was proposing to do though not for Dr Cox to do what he did? After all, there could be no doubt that, on any view, Dr Holmes’ conduct, like Dr Cox’s, involved a positive and intentional act of injecting a drug which, as he well knew, might accelerate his patient’s death. Thus Dr Holmes, like Dr Cox, would plainly be introducing into his patient’s body an external agency of death. The contrast between Dr Holmes and Dr Howe is clear and stark. Why should Dr Holmes not be guilty of murder? The answer is to be found in the doctrine of ‘double effect’.

As the theologians will tell you, the doctrine of double effect originates in Catholic theology. It goes back a long way, but I can pick it up in February 1957 when Pope Pius XII addressed the question:

“Is the suppression of pain and consciousness by the use of narcotics … permitted by religion and morality to the doctor and the patient (even at the approach of death and if one foresees that the use of narcotics will shorten life)?”

He declared:

“If no other means exist, and if, in the given circumstances, this does not prevent the carrying out of other religious and moral duties: Yes.”

English law (and, in particular, the English law of murder) undoubtedly recognises and gives effect to the doctrine of double effect. It is, as I have said, murder intentionally to bring about your patient’s death by means of a lethal injection.
However, the use of drugs in order to relieve pain and suffering is not unlawful, even if, as the doctor recognises may be the case, they incidentally hasten the moment of death. The administration of a lethal drug which brings about or accelerate the patient’s death is murder if the drug was administered with the primary purpose of ending life; but it is perfectly lawful – indeed, laudable – if the primary purpose was to ease pain and suffering. There is equally no doubt that the doctrine of double effect is not confined to the relief of physical pain: it extends in principle to the relief of suffering or distress, whether physical or mental.

In the present context the classic statement of the doctrine of double effect is to be found in Devlin J’s summing up to the jury in Bodkin Adams in April 1957. It is reasonable to suppose that Devlin J’s direction was influenced in part by Pope Pius XII’s declaration, reported in the Times only 6 weeks earlier. Indeed, Sir Patrick Devlin, writing extra-judicially in 1962, suggested as much in his ‘Samples of Lawmaking’.

Devlin J’s view of the law accords entirely with the more general principle which I have already described, namely that, in the case of a terminally ill patient who cannot be expected to recover from a condition which is incurable, the goal should be to ease suffering rather than to achieve a short prolongation of life. Thus it can be perfectly lawful to ‘ease the passing’, the phrase used by Dr Bodkin Adams when being interviewed by the police in November 1956.

Writing extra-judicially many years later in 1985, Lord Devlin said:

“Even if Dr Adams was forced to admit that he knew the doses were large enough to kill, the Crown would still have to tackle his plea that all that he was doing was ‘easing the passing’ in a case of inevitable death … [W]e have to consider not what the advocates of euthanasia would like the law to be, but what it is. If he really had an honest belief in easing suffering, Dr Adams was on the right side of the law; if his purpose was simply to finish life, he was not.”
Devlin J’s view of the law has never been doubted, and has often been followed or approved. It was followed by Farquharson J in 1981 in *Arthur* and, more recently, by Ognall J in *Cox* and by Hooper J in *Moor*. It was approved by Lord Goff in Tony Bland’s case and, more recently, by Lord Steyn in *Pretty*. Perhaps the clearest statement of the principle, and one which has the merit of putting it in the wider context, is to be found in the judgment of Lord Donaldson of Lymington MR in the case of Baby J:

“‘Thou shalt not kill’ is an absolute commandment in this context. But, to quote the well known phrase of Arthur Hugh Clough in “The Latest Decalogue,” in this context it is permissible to add “but need’st not strive officiously to keep alive.” The decision on life and death must and does remain in other hands. What doctors and the court have to decide is whether, in the best interests of the child patient, a particular decision as to medical treatment should be taken which *as a side effect* will render death more or less likely. This is not a matter of semantics. It is fundamental. At the other end of the age spectrum, the use of drugs to reduce pain will often be justified, notwithstanding that this will hasten the moment of death. What can never be justified is the use of drugs or surgical procedures with the primary purpose of doing so (emphasis in original).”

The distinction is illustrated by the differing fates suffered by Dr Bodkin Adams, Dr Cox and Dr Moor. Dr Bodkin Adams was acquitted of murder in 1957, as was Dr Moor in 1999, because in neither case could the Crown prove that their primary purpose in administering pain relieving drugs was to kill. Dr Cox, as we have seen, was convicted of attempted murder because a jury was satisfied that his intention, when administering a drug that had no analgesic properties, had been to kill. So one can see that, whereas Dr Cox, to use Lord Devlin’s phrase, was not on the right side of the law, because, as the jury found, his purpose was simply to finish life, Dr Holmes was on the right side of the law, because his honest purpose was merely to ease Annie Lindsell’s suffering.

To summarise: ‘Mercy killing’ by active means – by the introduction of some external agency of death – is murder. What is sometimes called ‘active euthanasia’ is thus
murder. Likewise, ‘physician assisted suicide’ involves the commission of a criminal offence by the doctor. On the other hand, what Dr Bodkin Adams famously described as ‘easing the passing’, is not murder; on the contrary, the doctor who ‘eases the passing’ is, as Devlin J recognised, merely doing his duty.

So far so good, but the question remains how, as a matter of analysis, it is possible to accommodate the doctrine of double effect to the general principles of the law of murder. There are two problems here. The first has to do with intention. What the doctrine of double effect seeks to categorise as the undesired and unintended side-effect of what is done will almost invariably be the natural and probable consequence and will very frequently be the virtually certain consequence of what was done. Accordingly, if one applies the general principles of the law of murder, that which the doctrine of double effect treats as an unintended side-effect (and thus as lawful) may in fact be an intended consequence (and thus unlawful). Devlin J himself sought to escape from this difficulty by classifying the problem as one of causation, and by treating the cause of the patient’s death as being not the medication supplied by the doctor but the underlying disease or illness. But this merely solves one problem by creating another for, as you will remember, Lord Mustill pointed out that on this view of causation active euthanasia would be lawful. The truth is, as Ward LJ observed in the case of the conjoined twins, that it is difficult to reconcile the doctrine of double effect with Woollin.

It is probably better to treat the doctrine of double effect as something sui generis, as an arbitrary (but necessary) exception to the general principles of the law of murder.

So much for the law. You may think that what I have described to you is a system (if that is the right word) which lacks both analytical and intellectual coherence and any secure moral foundation. You would not be alone in that view. What is striking about Tony Bland’s case is the recognition by the Law Lords of how arbitrary and divorced from morality in the medico-legal context the law of homicide has become. Thus Lord Goff commented that the distinction their Lordships drew “may lead to a charge of hypocrisy”, whilst Lord Browne-Wilkinson said that it “will appear to some to be almost irrational.” Lord Mustill’s views were trenchant: the decision, he said,
“depends crucially on a distinction drawn by the criminal law between acts and omissions, and carries with it inescapably a distinction between, on the one hand what is often called “mercy killing”, where active steps are taken in a medical context to terminate the life of a suffering patient, and a situation such as the present where the proposed conduct has the aim for equally humane reasons of terminating the life of Anthony Bland by withholding from him the basic necessities of life. The acute unease which I feel about adopting this way through the legal and ethical maze is I believe due in an important part to the sensation that however much the terminologies may differ the ethical status of the two courses of action is for all relevant purposes indistinguishable. By dismissing this appeal I fear that your Lordships’ House may only emphasise the distortions of a legal structure which is already both morally and intellectually misshapen. Still, the law is there and we must take it as it stands.”

Some of the Law Lords sought refuge in the partial alibi that the problem lay in the inability of what they called “old law” to keep pace with “new medicine”, with “recent developments in medical science” and “the new technology”. I am not so sure. As the cases of Simpson in 1915 and Bodkin Adams in 1957 show, some of these problems have been around for a long time.

Some one would see the cause of the difficulty as the refusal (or perhaps I should say the inability) of the common law to recognise a ‘doctor’s defence’ or a separate category of ‘mercy killing’. Lord Mustill was surely right when he identified the urgent need to start with a clean slate. Perhaps he was also right when he called for:

“the establishment by legislation … of a new set of ethically and intellectually consistent rules, distinct from the general criminal law.”

I am not so sure. Almost inevitably the attempt to force the peculiar problems of medicine into the framework of the ordinary law of murder gives rise to distortions. But does not this suggest that perhaps the difficulty arises not so much from the problems of medicine but rather from the utter inadequacy of our law of murder.
Surveying the defective state of the law of homicide the Law Commission concluded in 2006 that “this state of affairs should not continue.” It recommended that the general law of homicide be rationalised through legislation. Who could sensibly disagree? At the very least, and as a first step, the mandatory sentence should be abolished. But I have to say that the prospects for such legislation do not look good. To speak plainly, the implementation of law reform requires political will; and that is sadly lacking. The reality, I fear, is that there is little enthusiasm either in Whitehall or in Westminster for any kind of systematic law reform.

I would invite anyone who thinks I may be taking too gloomy a view to ponder what I had to say in the Law Commission’s most recent annual report about Government’s response to a number of our reports relating to murder. The state of our law of homicide is, I said, a discredit to our legal system. It is long overdue for reform. Yet although some of our recommendations have been implemented, too many have not been, and some have simply been rejected. The Government, I said, has missed an opportunity to put right the serious shortcomings in this area of the law.

So the lawyers will have to muddle along as best they can.

I leave you with this final thought: You will remember poor Simpson, the man who cut his child’s throat in 1915. His jury sternly did their duty, though adding what was described as “the strongest recommendation to mercy”, a plea which the Home Secretary heeded. In a similar case in 1927 a father who had devotedly nursed his incurably ill child drowned her, after sitting up with her all night, because he could not bear to see her suffering. He was more fortunate, being acquitted by a compassionate jury. In the course of his summing-up to the jury Branson J said this:

“It is a matter which gives food for thought when one comes to consider that, had this poor child been an animal instead of a human being, so far from there being anything blameworthy in the man’s action in putting an end to its suffering, he would actually have been liable to punishment if he had not done so.”