Human Rights in the Age of Technology: Can Law Rein in the Medical Juggernaut?

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1. Introduction

This article examines two English cases concerning the relationship between the courts and the medical profession in decisions regarding life and death. In *Airedale NHS Trust v Bland*[1] the Law Lords held that withholding nutrition and hydration from a patient in a persistent vegetative state (PVS) was lawful even though death would result. This decision raised difficult questions concerning the priority to be given to the principle of preserving life, the applicability of the law of homicide to doctors and the appropriate balance between the courts and the medical profession in making life-ending decisions. These themes were common to the later *Re A (Children)(Conjoined Twins: Surgical Separation)*[2] in which the Court of Appeal held that separation surgery that would kill Mary to save Jodie was not unlawful. The majority in *Re A (Children)*, unlike the Law Lords in *Bland,* squarely confronted the fact that the separation surgery would have amounted to homicide in the absence of a lawful excuse. To this extent, *Re A (Children)* may represent a softening of the legal prohibition against intentional killing. The decision has ignited a debate over whether the 'sanctity of life' principle, which seeks to protect individuals from being intentionally killed, has been superseded as a foundational principle of the criminal law.[3] Choudhry asserts that modern 'criminal law has

* Lecturer, Faculty of Law, University of Sydney. The subtitle of this article combines two key concepts, which may require some elaboration. The first is the concept of the 'medical juggernaut'. This is a play on the phrase the 'juggernaut of medicalisation', which has been used by Sheila McLean to describe the building momentum of medical authority and technology as controlling forces in modern life (Sheila McLean, *Old Law, New Medicine: Medical Ethics and Human Rights* (1999) at 14). The second is the concept of law 'reining in' these forces. For this concept, I am indebted to Karen O'Connell for her thoughts on the impulse to 'rein in' information technologies; and to John Keown who used the term to describe the effect of *Bolitho v City and Hackney Health Authority* [1997] 3 WLR 582 on English medical law. See 'Reining in the *Bolam* Test' [1998] 57 *CLJ* 248. I would like to thank John Keown and an anonymous reviewer for their constructive comments on an earlier draft of this paper. I would also like to gratefully acknowledge the support of Gonville & Caius College, Cambridge University. Parts of this paper were written during the tenure of a W M Tapp Studentship.

1 [1993] 1 All ER 821 (hereinafter *Bland).*

2 [2000] 4 All ER 961 (hereinafter *Re A (Children)*).

3 Gemma McGrath & Noëlla Kreleger, 'The Killing of Mary: Have We Crossed the Rubicon?' (2001) 8 *JLM* 322; Kamran Choudhry, 'Unpicking the Foundations of the Criminal Law' (2001) 151 *NLJ* 158.

witnessed a revolution'[4] in its 'dramatic departure'[5] from the sanctity of life principle. This revolution has, it is argued, installed the quality of life principle as 'the new foundation.'[6]

The debate about whether the principle of protecting individuals from intentional killing remains a foundational principle of the English criminal law is an important discussion, but it is not the purpose of this article to examine that debate. Nor will this article provide any detailed examination of the many important differences between English and Australian law regarding decision-making for incompetent patients.[7] This article will examine a slightly different, though related, set of questions. These questions concern the broader relationship between medical technology and human rights and, in particular, how law protects the rights of individuals in circumstances where the very notion of 'individual' can no longer be taken for granted. To put this another way, if the meaning of 'life' and of 'individual' are each capable of radical revision in the context of medical technologies that have the capacity to attenuate existence, how does this affect the content and scope of legal rights? Does law provide an effective framework for supervising medical practices that concern fundamental human rights? Is law in danger of losing its authority and critical capacity to evaluate life-ending decisions?

One aspect of this inquiry is to consider the manner in which Bland and the twins were described by courts and, in particular, how judicial perceptions about their respective conditions were framed. The court accepted that Bland was a legal person because his brain stem was functioning. But Bland was simultaneously constructed as an insensate body devoid of personality and meaningful existence. This construction was key in a process which enabled the court to reason that the medical treatment was futile and therefore not in Bland's best interests. Similarly, in *Re A (Children)*, the court accepted medical evidence that Jodie and Mary were distinct, though conjoined, individuals who were born alive. This construction facilitated the weighing of Jodie's interests against Mary's as a basis for deciding that the surgery that would kill Mary was lawful. Both decisions appear to grapple with the same paradox: although Bland and Mary were alive and human, their

4 Choudhry, id at 158.

5 Ibid.

6 Id at 159.

7 Australian courts, unlike English courts, have retained their *parens patriae* powers with respect to incompetent adults and may, therefore, consent or refuse medical procedures in their best interests. See *Secretary, Department of Health & Community Services v JWB and SMB* (1991–92) 175 CLR 218. In addition, many Australian jurisdictions have enacted Guardianship legislation which, among other things, make provision for the appointment of a guardian to consent to medical treatment on an incompetent patient's behalf. See, for example, *Guardianship Act 1987 (NSW) ss32–48*. These measures mean that there is a reduced role for medical opinion in determining a patient's best interests in Australia compared with England. However, the manner in which this formal balance is struck between the decision-making powers of courts and the medical profession, though a persuasive indicator of the extent to which law is being medicalised, is not the only indicator. This article argues that the power of law and medicine intersect more fundamentally in the manner in which legal problems are framed. This intersection may also be an issue for Australian law.

'humanity' appeared questionable in light of their minimal or non-existent cognitive awareness. This paradox produced some interesting tensions in the judicial meanings ascribed to life and individuality and these will be discussed in Part 2.

Having considered the manner in which the courts framed the questions concerning the ending of Bland's and Mary's lives, a second aspect of this inquiry is to consider the manner in which other legal rights were analysed. *Bland* and *Re A (Children)* were not only concerned with the right to life: they were also concerned with the right to bodily integrity. Bland and the twins, though in different ways, lacked the sort of bounded bodies that might be regarded as normative. This appeared to prompt judicial concerns for their dignity, which may in turn have influenced the analysis of best interests in each case. In *Bland's* case, the right to bodily integrity was infringed by the invasion of his body by tubes and catheters for no good purpose or, at the very least, amounted to invasive treatment that was not in his best interests. In the case of the conjoined twins, the bodily integrity that nature had denied them could, in the court's opinion, be restored by surgical intervention. It is suggested that these discussions of the right to bodily integrity can illuminate our understandings of the relationship between bodily integrity, dignity and life. These matters will be considered in Part 3.

The manner in which the courts constructed the bodies of Bland and Jodie and Mary, and the implications of those constructions for the principles of life and bodily integrity, form part of a larger theoretical inquiry with which this article is concerned. This is an inquiry into the interactions between legal and medical forms of power, which is taken up in Part 4. These exchanges might be understood to be operating in the cases at two levels. The first level concerns the actual mechanics of decision-making: who decides whether treatment is necessary or in a patient's best interests? The second level at which the exchange can be considered concerns the framing of the problems and issues under consideration. These are questions of a different order: Is Bland dead or alive? Are Mary and Jodie one person or two? If the answers to these questions are largely determined by medicine, this might imply a larger role for medical knowledge in the development of the legal rights to life and bodily integrity than is currently acknowledged. Furthermore, law and medicine may be so thoroughly intertwined that claims about the power of rights-discourses to constrain abuses of medical power may need to be re-thought.

2. *The Medical Juggernaut*

There is a growing disquiet among some legal commentators about the interaction between law and medicine. Sheila McLean argues that western societies have become subjugated by our 'vision of medicine as a science.'[8] She accepts that 'much of what we expect, aspire to, need or choose is seen as dependent on our state of health'[9] and, indeed, that in many cases physicians can restore the much

8 Sheila McLean, *Old Law, New Medicine: Medical Ethics and Human Rights* (1999) at 13.

9 Id at 9.

desired health of their patients. McLean is, however, worried by the implications of this dependence:

> The guardians of that health have enormous power and their status as scientists reinforces their position in the new meritocracy. Authority is often uncritically invested in the physician at the expense of personal responsibility and power. The physician's role therefore expands, as new phenomena are absorbed into their domain of competence.[10]

Both the nature and degree of the power wielded by modern medicine concern McLean. She makes two related claims about what might be described as 'medical power'. The first concerns the authoritative status accorded to medicine as a rational and scientific form of knowledge about the body. McLean argues that western societies have elevated the medical profession to a position of dominance with respect to what constitutes 'health' largely because medicine claims for itself the power of being scientific. McLean challenges the contention that science is always 'rational, value-free and accurate'[11] by reminding us that it is science 'that has pursued policies of eugenics (in tandem with political will), assisted reproduction, the search for genetic explanations of social characteristics and the quest for control of life and death.'[12] Her second claim is that, in view of this position of dominance, the medical profession has also claimed powers of definition, that is, the power of determining the scope and meaning of 'health', the province of which continues to expand:

> [T]he question of what is properly a medical matter is obfuscated by the patina of certainty presented by orthodox medicine. So [for example] decisions about quality of life are substantially handed over by the law to the physician. Yet the decisions rest on a complex mix of values, intuitions and opinion, as well as on scientific criteria, not typically associated with medical practitioners, whose views are revered substantially, because they are seen to be scientific and therefore 'right'.[13]

The 'uncritical' investment of power and authority in the physician has, McLean suggests, contributed to the absorption of social and personal problems into medicine's 'unique sphere of influence.'[14] This is a form of 'medicalisation'[15] that she argues 'has the potential to threaten or infringe human rights.'[16] Her frustration with the privileging of the 'scientific' opinion is posed in the form of a challenge to law. Her argument is that the human rights implications of medical practice necessarily brings it within law's domain:

> The underlying matters of concern are issues of human rights. No discipline and no individual has, or should have, the power to strip others of their liberty to reach

10 Ibid.
11 Ibid.
12 Id at 13.
13 Id at 9.
14 Id at 16.
15 Ibid.
16 Ibid.

> out for their aspirations or to stake their legitimate claims. The danger is that human rights take second place to the paternalism or monopolisation of one group substantially because they can claim scientific reasoning as their bedrock. The location of power, then, is critical as is the need to address the human rights issues which underlie the distribution of that power. In liberal democracies, the notion of power can or should be exercised unfettered by constraints and accountability is anathema.[17]

Having grounded her claim that law should be concerned with the exercise of medical power, McLean uses the vocabulary of 'rights' to insist that law hold medicine accountable for the exercise of that power. Moreover, she casts the issue of medical power not just as a problem for patients but as a problem for democracy generally. By casting 'the juggernaut of medicalisation'[18] as a threat to human rights, McLean appeals to law as the sentinel that can 'be relied upon for the kind of disinterested decision-making which would serve to balance interests appropriately, and vindicate rights unequivocally.'[19] By her own reckoning, however, this is not always a straightforward task. She points to the fact 'that subtle shifts in social perception and relationships can lead to situations in which the traditional guardians of accountability, for example the law, are muted or neutered.'[20] Indeed, although McLean seems confident that the law is capable of reining in the medical juggernaut, she also concedes that 'law has reneged on its promise [to defend patient's rights] when evaluating matters which are claimed as falling within the province of medicine.'[21]

A. Matters Within the Province of Medicine

The manner in which English law has responded to the challenges presented by medical technologies, especially in the context of patients who do not have capacity to consent to medical treatment, provides an opportunity to analyse this relationship between legal and medical power. In *Re F (Adult: Sterilisation)*,[22] the House of Lords settled the uncertainty which then surrounded the *parens patriae* jurisdiction in respect of incompetent adults by deciding that there was no power to consent to medical treatment on an incompetent adult's behalf. The case involved an application for a declaration that it would be lawful to perform a tubal ligation on an adult woman who, by reason of intellectual handicap, could not consent to the procedure. It was held that although a court had no power to consent on the woman's behalf, the common law doctrine of necessity did provide an answer to the apparent quandary.[23] Accordingly, doctors could lawfully perform the sterilisation procedure if a responsible body of medical opinion supported the

17 Id at 14–15.

18 Id at 14.

19 Id at 17.

20 Id at 16.

21 Id at 20.

22 [1990] 2 AC 1 (hereinafter *Re F*).

23 Lord Brandon noted that the 'common law would be seriously defective if it failed to provide a solution to the problem', 'otherwise [incapacitated patients] would be deprived of medical care which they need and to which they are entitled.' Id at 55.

view that the sterilisation was in the patient's best interests.[24] Generally, medical treatment would be in a patient's best interests if it would save a patient's life or prevent a deterioration in their health.[25]

This application of the doctrine of necessity gave rise to the practice of petitioning the High Court for declarations that non-consensual treatment would be lawful. A particularly contentious category of these cases concerned the withdrawal of nutrition and hydration from patients in PVS.[26] The first such case was *Airedale NHS Trust v Bland*.[27] Anthony Bland had been in a persistent vegetative state for three years when, with the support of his family, a doctor and the Trust responsible for his care applied to the High Court for a declaration that it would be lawful to remove his naso-gastric tube, even though this would lead to his death by dehydration. The declaration was granted and the decision was appealed. The Law Lords held that the law of homicide did not cover the proposed course of conduct, the declarations were granted and Anthony Bland died.

In reaching this decision, the Law Lords rejected the proposition that Bland would be better off dead. This may seem a little strange; after all, it was accepted that the doctor's failure to feed Bland would cause his death and, moreover, that it was not in Bland's best interests to receive food and water. This raises an interesting question: how did the Law Lords reach their conclusion without conceding the above proposition? The question is, at least in part, concerned with how the problems associated with Bland's continued existence and medical care were framed. In his discussion of ethical problem-solving, Carl Elliott makes an observation that seems apposite. He observes:

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24 Id at 55–58 (Lord Brandon).

25 Id at 55 (Lord Brandon). Recent indications suggest an expansion of the narrow test of 'medical necessity', at least in the case of non-consensual sterilisation. See below n225–238 and accompanying text.

26 The current practice in England is not to apply to a court for a declaration until there is a diagnosis that the vegetative state is permanent. See *Practice Note (Official Solicitor: Declaratory Proceedings: Medical and Welfare Decisions for Patients Who Lack Capacity)* [2001] 2 FLR 158. Thus, a distinction has now been recognised between the persistent vegetative state and the permanent vegetative state: '[t]he adjective 'persistent' refers only to a condition of past and continuing disability with an uncertain future, whereas 'permanent' implies irreversibility. Persistent vegetative state is a diagnosis; permanent vegetative state is a prognosis.' See Multi-Society Task Force on PVS, 'Medical Aspects of the Persistent Vegetative State-Part I' (1994) 330 *New Engl J Med* 1499 at 1501. The Task Force describes the persistent vegetative state as 'a clinical condition of complete unawareness of the self and the environment, accompanied by sleep-wake cycles, with either complete or partial preservation of hypothalamic and brain stem autonomic functions.' Id at 1499. In 1996, the Royal College of Physicians adopted a distinction between continuing and permanent vegetative states, and concluded that the diagnosis of permanent vegetative state should not be made until the patient has been in a continuing vegetative state for 12 months (following head injury) or six months (in other cases of brain damage). See Working Group of the Royal College of Physicians, 'The Permanent Vegetative State' (1996) 30 *J R Coll Physicians* 119.

27 Above n1. Since *Bland*, feeding has been withdrawn from approximately 20 people diagnosed as being in the permanent vegetative state in the United Kingdom. See Derick Wade, 'Ethical Issues in Diagnosis and Management of Patients in the Permanent Vegetative State' (2001) 322 *BMJ* 352 at 352.

> One of the most alarming aspects of describing an ethical problem, and of hearing it described by others, is discovering just how many ways it can be done. How a moral problem is described will turn on an array of variables: the role and degree of involvement in the case of the person who is describing it, the person's particular profession or discipline, her religious and cultural inheritance–indeed, with all of the intangibles that have contributed to her character. What is more, the description any person offers will also vary-notoriously-according to whether an ethical decision has been made or is still to come, whether that decision is now judged to be a sound one or a poor one, whether the consequences were intended or unforseen.[28]

Elliott makes the further point that description involves important (but sometimes unacknowledged) processes of filtering and emphasis so that 'in describing a given case, one has done much of the ethical work already.'[29] In *Bland*, the relevant issue was described as whether the feeding regime was in Bland's best interests.[30] From this starting point issued the following chain of reasoning. Artificial nutrition and hydration was a form of medical treatment which was essential to Bland's survival. However, this treatment was medically futile in the sense that there was absolutely no hope for Bland's recovery and, therefore, it was not in Bland's best interests to continue to receive it. The doctors were under no legal duty to provide treatment that was not in their patient's best interests. Having reached this point, the Law Lords considered the lawfulness of removing the naso-gastric tube. It was held that the removal of the tube would be an omission rather than an act.[31] Accordingly, the removal could only be culpable if the doctor was under a duty to continue tube feeding, which they were not.[32] In the result, the removal of Bland's tube would not be unlawful even though the consequence would be his death. Lords Lowry and Browne-Wilkinson went further to find, in an apparently strong affirmation of the right to bodily integrity, that because Bland had not consented to it, the continuation of the treatment would be unlawful.[33]

It seems clear that at a number of junctures in this chain of reasoning, the description of the case might have been different: artificial feeding and hydration might have been described as necessaries of life rather than medical treatment, the

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28 Carl Elliot, 'Where Do Ethics Come From and What to Do About It' (1992) 22 (4) *Hastings Center Report* 28 at 28.

29 Ibid.

30 The careful crafting of the 'correct question' was significant for this reason. The correct question was 'whether it is in the best interests of Anthony Bland to continue the invasive medical care involved in artificial feeding?' rather than 'is it in Anthony Bland's best interests that he should die?' Above n1 at 883 (Lord Browne-Wilkinson).

31 Id at 867 (Lord Goff), 881 (Lord Browne-Wilkinson) and 885, 890 (Lord Mustill). The Law Lords specifically addressed the question of administering a lethal injection and concluded that this would constitute a positive act amounting to murder. Lord Keith stated that the principle of the sanctity of life 'forbids the taking of active measures to cut short the life of a terminally ill patient.' Id at 861. Lord Goff said 'it is not lawful for a doctor to administer a drug to his patient to bring about his death, even though that course is prompted by a humanitarian desire to end his suffering.' Id at 867.

32 Id at 861 (Lord Keith), 868 (Lord Goff), 880 (Lord Browne-Wilkinson) and 890 (Lord Mustill).

33 See below n119–121 and accompanying text.

fact that the naso-gastric feeding ensured Bland's survival might have been described as beneficial rather than futile; the removal of the tube might have been described as an act rather than an omission; and (for at least two judges) the non-consensual feeding might have been described as necessary for preserving Bland's life and preventing a deterioration in his health rather than an unlawful assault. It is not, for present purposes, important to defend or criticise these claims. It is, however, important to notice these filtering processes and to consider the beliefs which underwrite them.

B. The Meaning of Life

Bland was not the first occasion that a court had considered a life ending treatment decision. Prior to this, courts had been confronted with treatment withdrawal decisions in two types of situations, both involving children. In *Re J (a minor)(warship: medical treatment)*[34] the evidence was that, though not dying, J was profoundly disabled and experienced extreme pain and suffering. The question for the court was whether it was in J's best interests to be artificially ventilated, should such ventilation become necessary in the future. The medical team took the view that J's quality of life was so poor, and the ventilation procedure sufficiently invasive and distressing, that it would not be in J's best interests to receive artificial ventilation. Lord Donaldson MR approached the question of best interests as a balancing exercise. The procedures that would prolong life 'had to be balanced against what could possibly be achieved by the adoption of such active treatment.'[35] Thus, 'account had to be taken of the extremely poor quality of life at present enjoyed by the child, the fact that he has already been ventilated for exceptionally long periods, the unfavourable prognosis with or without ventilation and a recognition that if the question of re-ventilation ever arose, his situation would have deteriorated still further.'[36] Lord Donaldson MR cautioned against 'looking at the problem from the point of view of the decider' preferring 'the assumed point of view of the patient.'[37] Taylor LJ adopted elements of a substituted judgement test, involving two stages of inquiry. The first was to evaluate the 'quality of life' J would experience if the treatment was provided, and the second was to decide whether that life would be intolerable from J's perspective. Taylor LJ held that in reaching a judgment on the quality of life, a judge could consider the degree of existing disability, any additional suffering that the treatment would entail and the individual's perception of what they had lost as a result of the life-threatening event.[38]

The second situation in which the question had arisen was where the treatment was thought to be of no benefit to the patient because they were in a permanent state of unconsciousness or minimal consciousness. *Re C (a minor) (wardship:*

34 [1991] 1 FLR 366.

35 Id at 376. Balcombe and Taylor LJJ agreed that treatment to prolong J's life would not be in his best intesests. Id at 381 and 384 respectively.

36 Ibid.

37 Id at 375.

38 Id at 384.

medical treatment)[39] was a case concerning the medical treatment of a four month old infant with congenital hydrocephalus.[40] The High Court was petitioned for a declaration that it would be lawful to withhold life prolonging medical treatment from the infant. The evidence was that C had severe brain damage, that she had not developed any skills during her first four months of life and that she was unlikely to develop any. The consultant did not believe that she could be enjoying her life, and queried whether she experienced very much at all, save that she did cry irritably when not sedated. The court made the following important observation:

> I adjudge that any quality to life has already been denied to this child because it cannot flow from a brain incapable of even limited intellectual function. In as much as one judges, as I do, intellectual function to be a hallmark of humanity, her functioning on that level is negligible if it exists at all.[41]

The court decided that it was not in C's best interests to administer naso-gastric feeding or antibiotics in order to prolong her permanent state of minimal awareness. Broadly similar questions were raised in *Re C (a baby).*[42] In this case, the court described C's condition as 'almost a living death. She is not in a coma as medically defined; she has a very low awareness of anything, if at all.'[43]

In these attempts to discern the best interests of these patients, a troubling paradox emerges. The patient is undoubtedly alive and human, and yet the humanity of the patient is questioned by reason of his or her low state of awareness. This paradox is also at work in *Bland.* It was accepted that Bland was alive as a matter of law because his brain stem was functioning. But although law incorporated the medical definition of life for the purposes of determining legal personhood,[44] it was clear that the ambiguity of the persistent vegetative state was unsettling:

> I start with the simple fact that, in law, Anthony is still alive. It is true that his condition is such that it could be described as a living death; but he is nevertheless still alive. This is because, as a result of developments in modern medical

39 [1989] 3 WLR 240.

40 This case was distinguished from the earlier *Re B (A minor)* [1981] 1 WLR 1421 on the basis that C had a terminal illness and would die whereas B, who was afflicted with Down's Syndrome, could expect many years of life if the operation to remove the intestinal blockage was performed.

41 Above n39 at 246.

42 [1996] 2 FLR 43. This baby was born prematurely and within a few weeks of her birth, contracted meningitis which resulted in cerebral blindness. The doctors thought that artificial ventilation was no longer in her best interests and sought a declaration that it would be lawful to discontinue ventilation.

43 Id at 44. Although it might be questioned whether this second category of cases is, in truth, any less concerned with the 'quality of life' judgments than the first, in *Re A* Ward LJ contended that there is an important distinction between them. The second category was distinguished on the basis that it is the treatment (rather than the patient's life) that is deemed not worthwhile. Above n2 at 1001.

44 Above n1 at 859 (Lord Keith) and 878 (Lord Browne-Wilkinson).

> technology, doctors no longer associate death exclusively with breathing and heart beat, and it has come to be accepted that death occurs when the brain, and in particular the brain stem, has been destroyed.[45]

At first instance, Sir Stephen Brown described the withdrawal of naso-gastric feeding as 'bring[ing] an end to the physical functioning of the body of Anthony Bland' with the effect that 'he would in terms 'die'.'[46] This bracketing of the term 'die' implies that Bland was, at least in some sense, already dead. Elsewhere the judge was explicit about this, referring to Bland as having already 'suffered cognitive death'[47] and commenting that 'to his parents and friends he is 'dead.' His spirit has left him and all that remains is the shell of his body.'[48] The Court of Appeal shared this emphasis. Butler-Sloss LJ was critical of the arguments in favour of preserving Bland's life for assuming 'life in the abstract' and for making no accommodation for the 'reality of Mr Bland's actual existence'.[49] Hoffman LJ said 'the very concept of having a life has no meaning in relation to Anthony Bland. He is alive but he has no life at all.'[50]

There is a tension between Bland's condition and judicial understandings of what it means to be an authentic or real person (as opposed to a legal person). Bland was disruptive for law precisely because his 'body' was alive but 'he' was not living. This detachment of the body from the self is evident in the observation that 'although Anthony Bland's body breathes and reacts in a reflex manner to painful stimuli it is quite clear that there is no awareness on his part of anything that is taking place around him.'[51] This conception is also behind references by Lord Keith and Lord Goff to 'living death.'[52] The divisibility of Bland into a 'body' and a 'self' was therefore important because it enabled the Court to find that the food and water that kept him alive was futile. This treatment was futile because he (that is, Bland's self) had no hope of recovering any consciousness. Bland's self could then be seen to be deriving no benefit, as opposed to his body which, on the contrary, would die without it. Lord Mustill emphasised the significance of the death of Bland 'as a person' when he decided that 'the continued treatment of Anthony Bland can no longer serve to maintain the combination of manifold characteristics which we call a personality.'[53]

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45 Id at 865 (Lord Goff).

46 Id at 825.

47 Id at 827.

48 Id at 832.

49 Id at 846.

50 Id at 853.

51 Id at 824–25.

52 Lord Keith said 'it is true that his condition is such that it can be described as a living death.' Id at 865. The point is made slightly differently by Lord Browne-Wilkinson who thought that Bland embodied life only in the minimalist and 'purely physical sense'. Id at 878.

C. *The Meaning of Individuality*

A similar process of rhetorical cleavage into 'body' and 'self' was evident in *Re A (Children)*[54] where the UK Court of Appeal granted a declaration that it would be lawful for doctors to surgically separate conjoined twins, known as Jodie and Mary. The conjoined twins were born joined at the lower abdomen, with their lower spines fused. Mary's heart and lungs were severely underdeveloped, but the twins shared an aorta which enabled Mary to receive enough oxygenated blood to survive. The concern was that Jodie's heart would inevitably succumb to the strain of pumping blood throughout both bodies – somewhere in the order of 3 to 6 months – or possibly years according to second opinion. At some point Jodie would suffer a cardiac arrest and die and in that event, Mary would die also. The evidence was that Jodie's prognosis would be good if separated from Mary, but that Mary would die as a result of the operation.[55] Like Bland, the twins posed a challenge to any clear demarcation between life and death. But, in addition to this, they disrupted the usually clear demarcation between self and other, which is fundamental to individuality. These ambiguities were expressed in different ways. Ward LJ asked 'is this a fused body of two separate persons, each having a life in being?'[56] Brooke LJ asked 'is Mary a reasonable creature?'[57] and Robert Walker LJ, 'are these conjoined twins two persons or one in the eyes of the law? If they are two persons, was Mary born alive?'[58]

Each judge concluded that Mary and Jodie were distinct individuals in the eyes of the law, notwithstanding the fusion of their bodies. There was also unanimous agreement that they were both 'born alive', notwithstanding Mary's condition. Robert Walker LJ gave two reasons for deciding that Jodie and Mary were individuals. First, they each had a brain and second, they each had 'nearly complete bodies, despite the grave defects in Mary's brain and her heart and lungs.'[59] This focus on the brain as central to legal personhood is consistent with the criterion of brain stem functioning at the other end of life observed in *Bland.*

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53 Id at 896. He went on to say 'some who have written on this subject maintain that this is too narrow a perspective, so I must make it clear that I do not assert that the human condition necessarily consists of nothing except a personality, or deny that it may also comprise a spiritual essence distinct from both body and personality. But of this we can know nothing, and in particular we cannot know whether it perishes with death or transcends it. Absent such knowledge we must measure up what we do know.' Ibid.

54 Above n2.

55 First, doctors would need to explore the twins' anatomy to confirm which organs, or portions of organs, belonged to whom. Second, in the event of shared organs, doctors would need to determine which parts of each organ would be given to whom. Third, the shared bladder would be separated, followed by the separation of the skin, spinal chord, and bones at the fused lower abdomen and the muscle union at pelvic floor. The final step would involve clamping the aorta and vena cava, which connected the twins' circulatory systems. At that point Mary would cease to receive oxygenated blood and die. Id at 978–979.

56 Id at 994.

57 Id at 1025.

58 Id at 1053.

59 Ibid.

The limits and scope of the 'born alive' rule have historically involved deference to medical understandings of 'life'. The originating moment of personhood can be traced to Coke who claimed that in law the individual 'is accounted a reasonable creature in rerum natura when it is born alive'.[60] But the question of when an individual is 'live born' is not purely a matter of fact. Law has traditionally understood a person to be born when their body has been completely removed from the body of their mother. In *R v Poulton,* this was expressed as the moment when 'the whole body is brought into the world'.[61] Glanville Williams puts it more robustly and with a fuller sense of the necessary spatial arrangements between bodies. He said 'the child must have been wholly extruded from the body of the mother. No part of the child must remain within the parts of the mother if it is to be regarded born.[62] A child wholly extruded from the body of its mother but nonetheless attached via the umbilical cord is still regarded as born.

In addition to being 'born', the legal person must be 'alive'. The precise dimensions of this requirement have been more challenging for law. As medicine's knowledge of human biology continues to expand, and its practices of maintaining life increase in power and sophistication, law's understandings of 'live' have been contested. The older authorities adopted different standards. *R v Enoch* adopted the standard of 'an independent circulation'[63] which was thought to occur after the child's first breath.[64] In contrast, *R v Brain* held that a child may be alive even if it had not yet started to breathe.[65] *R v Handley*[66] adopted the standard of unassisted breathing, that is breathing through the child's own lungs 'without deriving any of its living or power through any connection with the mother.'[67]

60 Edward Coke, *The Third Part of the Institutes of the Laws of England* (1628) at 50. It was on this basis that Coke reasoned that the intentional killing of a foetus was not murder: 'If a woman be quick with childe, and by a potion or otherwise killeth it in her wombe; or if a man beat her, whereby the child dieth in her body, and she is delivered of a dead childe; this is a great misprison, and no murder.' Ibid. However, 'if the childe be born alive, and dieth of the potion, battery or other cause, this is murder.' Ibid. In modern law this is known as the 'born-alive' rule. See *Attorney-General's Reference (No 3 of 1994)* [1997] 3 WLR 421 at 427.

61 (1832) 5 C & P 329 at 330, quoted in *Rance v Mid-Downs Health Authority* [1991] 1 QB 587 at 619.

62 Glanville Williams, *Textbook of Criminal Law* (2nd ed, 1983) at 289–290.

63 (1833) 5 C & P 539, quoted in *Rance v Mid-Downs Health Authority* above n61 at 619.

64 The independent circulation standard was rejected by Williams as anachronistic on the ground that it was based on the 'biological misconception' that independent circulation does not exist before birth. 'Some authorities lay it down that a child must have had a circulation independent of the mother, but this proposition is based on a biological misconception, since the 'independent circulation exists before birth. For several months the foetus has had a circulation independent of the mother in the sense that the embryonic heart maintains a foetal blood stream, which does not directly communicate with the maternal blood. The two blood-streams are separated by a thin membrane, through which oxygen and nutrients pass to the foetus, and waste products back to the mother. When the child is born, if it does not breathe, its existence is dependent on the umbilical cord, through which the blood-stream is passing in both directions, and so long as the umbilical cord is pulsating in this way the child is dependent on its mother for life.' Above n62 at 290.

65 (1834) 6 C & P 349.

66 (1874) 13 Cox CC 79.

67 Ibid.

The precise meaning of 'alive' has also been controversial in the modern law.[68] In *C v S*,[69] a case involving judicial interpretation of the *Infant Life (Preservation) Act* 1929, the court held that to be born alive a child must be able to breathe.[70] It was not made clear whether mechanically assisted breathing counted as breathing for the purposes of being alive, although Lord Donaldson MR commented that 'it is not a case of the foetus requiring a stimulus or assistance. It cannot and will never be able to breathe.'[71] This suggests that initial reliance on a respirator will not affect a child's status as 'alive'. If this is correct, then it would seem that 'alive' is a quality that law determines with reference to the child's state of dependency on the body of its mother.[72]

Although *Re A (Children)* confronted a novel legal question – whether conjoined twins were distinct legal persons – there was a predictable homage to the medical viewpoint. Ward LJ appeared to find that Mary was a live person in her own right largely on the basis of medical evidence:

> The medical notes from the hospital show that Mary was struggling to breathe, although sadly in vain, when she and Jodie were brought from the operating theatre into the recovery ward. Mr B (who would lead the operating team) was clear in his oral evidence to this court that Mary was not still-born, but that she could not be resuscitated and was not viable. Since her umbilical cord was cut she has been dependent for life on her sister. The fact that she is alive as a distinct personality but is not viable as a separate human being is the awful paradox at the centre of this case.[73]

It was by no means clear that law had always considered conjoined twins to be two distinct legal persons. Brooke LJ commented that seventeenth century thinking may have been to exclude conjoined twins from the definition of murder on grounds that they were not 'reasonable creatures' but, rather, 'monstrous birth[s].'[74] However, he also pointed out that:

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68 Above n62 at 290; John Keown, 'The Scope of the Offence of Child Destruction' (1988) 104 *LQR* 141; Glanville Williams, 'The Foetus and the 'Right to Life''(1994) 53 *CLJ* 71 at 72. See also discussion in J K Mason & R A McCall-Smith, *Law and Medical Ethics* (5th ed, 1999) at 130–131.

69 [1988] QB 135.

70 It is possible that the meaning of 'born alive' for the purposes of this Act is different from the meaning of born alive for the purposes of homicide. See Keown above n68.

71 Above n69 at 151.

72 In the subsequent *Rance v Mid-Downs Health Authority*, Brooke J probed the questions a little further. The court adopted the criterion of 'breathing through its own lungs alone, without deriving any of its living or power by or through any connection with its mother' but it stopped short of embracing 'viable' as a pre-requisite to being 'alive'. There is first a question about what viable means. Counsel contended that viable meant 'capable of being born alive and surviving into old age in the normal way without intensive care or surgical intervention' but this was rejected. A neonate that is afflicted with a congenital disease such as anencephaly or spina bifida, for example, is still born alive even though she or he may die soon after birth. The suggestion that a child must survive for a reasonable period before it can be live was also rejected. Above n61 at 621–623.

73 Above n2 at 1053.

74 Id at 1025.

> Advances in medical treatment of deformed neonates suggest that the criminal law's protection should be as wide as possible and a conclusion that a creature in being was not reasonable would be confined only to the most extreme cases of which this is not an example. Whatever might have been thought of as monstrous by Bracton, Coke, Blackstone, Locke and Hobbes, different considerations would clearly apply today.[75]

It is interesting to consider the role of technology in the framing of the legal dilemma. The court was eager to demarcate between ancient conceptions of 'monsters' as 'superstitious' and the modern conception of distinction as 'enlightened.' Robert Walker LJ echoed Brooke's LJ remarks, stating that 'it hardly needs to be said that there is no longer any place in legal textbooks for expressions (such as 'monster') which are redolent of superstitious horror. Such disparagingly emotive language should never be used to describe a human being, however disabled and dysmorphic.'[76] Although it is not possible to claim that the difference in attitude is wholly attributable to modern medical technology, it is likely to have been an influential factor. Unlike the authorities of centuries past, this court did not have to rely merely on what it could (or could not) see, but what it was reliably told about the presence or absence of critical organs (eg, brain) and of the internal distribution of organs. Perhaps an even more significant factor was the court's awareness of the technological feasibility of disentangling the bodies of the twins in an attempt to reshape them as individuals.

3. *Rights to Life and Bodily Integrity*

Both *Bland* and *Re A (Children)* threw up questions about the relationship between bodies and individuality, as well as the importance of separateness (or at least the possibly of becoming separate) and dignity to these central concerns. In *Bland*, the question raised was the extent to which permanent technological penetration of the body eroded judicial perceptions of his dignity. In *Re A (Children)* the challenge was even more profound. How does law characterise the legal personality of conjoined twins?

The legal right to bodily integrity places a premium on the separateness of individuals by operating to protect citizens from unconsented bodily contact. In his *Commentaries on the Laws of England,*[77] Blackstone nominated the 'right to personal security' as one of three absolute rights ascribed to citizens. He described this right as 'consist[ing] in a person's legal and uninterrupted enjoyment of his

75 Id at 1026.

76 Id at 1054.

77 William Blackstone, *Commentaries on the Laws of England* (A Facsimile of the First Edition of 1765–1769) (1979).

life, his limbs, his body, his health and his reputation.'[78] Blackstone's exposition of the offence of battery remains authoritative:[79]

> The least touching of another's person wilfully, or in anger, is a battery; for the law cannot draw the line between different degrees of violence, and therefore totally prohibits the first and lowest stage of it: every man's person being sacred, and no other having a right to meddle with it, in any the slightest manner.[80]

There are two points that stand out in Blackstone's formulation. The first is that touching another's body wilfully or in anger is a form of violence. The second is that the physical person is sacred, or to use a secular term, inviolable. Fleming's discussion of the rationale for battery suggests that these intuitions about the body survive in modern law. Fleming contends that the rationale for battery is not only to protect the individual from bodily harm (the violence aspect) but also to protect from 'any interference with his person which is offensive to a reasonable sense of honour and dignity.'[81] He observes that 'the insult in being touched without consent has been traditionally regarded as sufficient, even though the contact is trivial and not attended with actual physical harm.'[82] Thus, there is no requirement that the non-consensual contact result in physical damage.[83] The further implication of this principle is that 'everybody is protected not only against physical injury but against any form of physical molestation.'[84] Implicit in this formulation is the idea that the legal rules that prohibit battery seek to protect a fundamental interest that all human beings possess. Cane offers some support for this conclusion, noting that tort law protects each individual's 'interest in personal health and safety',[85] an interest 'which each human being has by virtue of being human.'[86] In *Collins v Wilcock*, the court articulated the nature and breadth of this interest:

> The fundamental principle, plain and incontestable, is that every person's body is inviolate. It has long been established that any touching of another person, however slight, may amount to battery ... The breadth of the principle reflects the fundamental nature of the interest being protected.[87]

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78 Id Book I at 125. Homicide punished the unlawful taking of life and mayhem (maim) punished the unlawful interference with limbs necessary for fighting. The misdemeanours of assault and battery punished unlawful interferences with other parts of the body and the civil action of *trespass vi et armis* could be used to recover damages for dismemberment caused by mayhem and for interferences with the body caused by threats, assault or battery. Ibid.

79 Margaret Brazier & John Murphy, *The Law of Torts* (10th ed, 1999) at 30.

80 Above n77 Book III at 120. Indeed, this passage was quoted by Goff LJ in *Collins v Wilcock* [1984] 1 WLR 1172 at 1177.

81 John Fleming, *The Law of Torts* (8th ed, 1992) at 24. Fleming cites as examples spitting in another's face: *R v Cotesworth* (1874) 6 Mod. 172 and cutting another's hair: *Forde v Skinner* (1830) 4 C. & P. 239.

82 Ibid.

83 *Collins v Wilcock* above n80.

84 Ibid.

85 Peter Cane, *The Anatomy of Tort Law* (1997) at 11.

86 Ibid.

87 *Collins v Wilcock* above n80.

The construction of the offence and tort of battery posits the physical body as inviolable to the unauthorised contact of others. This is true of contacts in a medical context, as in other contexts:

> Any treatment given by a doctor to a patient which is invasive (i.e. involves any interference with the physical integrity of the patient) is unlawful unless done with the consent of the patient: It constitutes the crime of battery and the tort of trespass to the person.[88]

Hyde remarks that bodily integrity 'is the strongest concept of body autonomy'[89] known to law. In his theorising of the relationship between embodiment and legal personhood, he claims that 'law's discourse of the body constructs the body as a thing, separate from the person, but the bearer of that person as constructed as a legal subject in civil society.'[90] He notes that the relationship of the mind to the body of the legal subject is hierarchical. Thus, 'the legal subject has a sort of free will, a mental autonomy. It commands the body and the body obeys.'[91] Hyde goes further to observe that it is because of this elevation of consciousness that 'law rarely constructs a body with independent agency, which acts without mental or moral direction or may even control the mind of the person within it.'[92] This analysis is supported by the significance attached to the distinction between the mind and the body, both in *Bland* and *Re A (Children)*.

Just as the legal subject is an individual, so is the subject's body. Hyde claims that law's conception of the body is 'an individuated entity with distinct boundaries, an outside and an inside.'[93] Within the traditional framework of liberalism, 'defining those boundaries is an individuated judgment that calls for no consideration of other legal subjects.'[94] Naffine probes the relationship between the inviolable body and the integrity and dignity of the self a little further. Analysing Kant's conception of self-respect as elaborated in the *Metaphysics of Morals* she suggests that:

> Kant believed that the self-respecting body is one which must not lust in inappropriate ways, which must respect a distance from other bodies, and which must tend to itself, but not in such a way that it becomes too much like a female body. For Kant, liberal dignity demanded a bounded masculine body.[95]

Naffine argues that law's principal concern 'is (the policing of the boundaries of) the bounded heterosexual male body. Bodies which are not like this, or are not allowed to be like this, are somehow deviant and undeserving bodies. They are 'unnatural', even 'loathsome' because they have apparently lost their clear

88 Above n1 at 882.

89 Alan Hyde, *Bodies of Law* (1997) at 88.

90 Id at 258.

91 Id at 259.

92 Ibid.

93 Id at 258.

94 Id at 258–259.

95 Ngaire Naffine 'The Body Bag' in Ngaire Naffine & Rosemary Owens (eds), *Sexing the Subject of Law* (1998) 79 at 82.

definition.'[96] This produces what Naffine describes as the 'logic of a bounded self.'[97] Within this logic, bodies that appear to lack definition appear to be 'unbounded'. Furthermore, because bodily boundary is an essential pre-requisite to dignity, the 'unbounded' subject is reduced in status. Hyde finds support for this argument in the judicial construction of some bodies as less than inviolable:

> The legal subject must, however, tolerate or consent to some fairly massive social uses of the body, which law facilitates by constructing the body so as to permit such social use ... While all these represent permissible social uses or invasions of the body, law facilitates these by constructing various discursive bodies sometimes defined as interests in liberty or property, sometimes as things or property, sometimes through euphemistic language that makes the body disappear.[98]

Naffine also recognises, echoing Hyde's analysis, that the bounded self or the 'body bag' is a metaphor that courts use politically.[99]

A. The Grotesque Prolongation of Life

There is some support for this correlation between bounded bodies and judicial understandings of dignity in both *Bland* and *Re A (Children)*. In *Bland*, the Court of Appeal took the view that Bland's integrity and dignity was diminished by the bodily invasions associated with his treatment. The court reasoned along the following lines: the fact that Anthony Bland was completely unaware of his condition did not mean that he had no interests. As a person, rather than an object, he retained a right to be respected. He retained a right to be treated in a dignified manner. He had the right to be well regarded by others and to be well remembered by his family. He had the right to be properly cared for. The continuation of futile and invasive medical treatment, however, amounted to a humiliating and degrading invasion of his body for no good purpose.

The concern for Bland's dignity was aroused by the perception that his body had been invaded with 'tubes, catheters, probes and injections.'[100] There is a sense that, in this instance, the body penetrated and invaded by machinery was regarded as an undesirable deviation from the norm of the inviolable body.[101] As Hoffman LJ put it, 'Anthony Bland is a person to whom respect is owed and we think it that

96 Ibid at 84.

97 Ibid.

98 Above n89 at 259–260.

99 Above n95 at 88–91.

100 Above n1 at 853 (Hoffman LJ).

101 It could also be argued that this purported concern for Bland's dignity had more to do with being kept 'grotesquely alive' (id at 854) than with any sense that a body invaded by tubes and catheters is, by itself, undignified. It does seem rather unlikely that a court would consider the *temporary* insertion of life-sustaining medical apparatuses to be undignified (at least not sufficiently so to warrant their removal). This line of analysis would seem to dovetail with Kristeva's concept of 'abjection' to the extent that the discussion about the indignity of the treatment is a deflection of the central (though implicit) concern of the court which is the indignity of being alive in a PVS state. See below n110–114 and accompanying text.

it would show greater respect to allow him to die and be mourned by his family than to keep him grotesquely alive.'[102] Butler-Sloss LJ thought that the dignity considerations constituted burdens, which could then be balanced against the benefits of treatment. Hoffman LJ also accepted that the dignity interests were important to be weighed in the balance:

> [T]he sanctity of life is only one of a cluster of ethical principles which we apply to decisions about how we should live. Another is respect for the individual human being and in particular for his right to choose how he should live his life. We call this individual autonomy or the right of self-determination. Another is respect for the dignity of the individual human being: our belief that quite irrespective of what the person concerned might think about it, it is wrong for someone to be humiliated or treated without respect for his value as a person.[103]

Butler-Sloss LJ quoted a very evocative passage from *Re Conroy*[104] which contended that 'pervasive bodily intrusions... will arouse feelings akin to humiliation and mortification for the helpless patient. When cherished values of human dignity and personal privacy, which belong to every person, living or dying, are sufficiently transgressed by what is being done to the individual, we should be ready to say: enough.'[105] Thus, transgressing the body in this way and for this apparent lack of purpose amounted to a transgression of Bland's dignity.[106] This emphasis is clear in the following passage from *Auckland Area Health Board v A-G*[107] quoted by Butler-Sloss LJ:

> Human dignity and personal privacy belong to every person, whether living or dying. Yet, the sheer invasiveness of the treatment and the manipulation of the human body which it entails, the pitiful helplessness of the patient's state, and the degradation and dissolution of all bodily functions invoke these values . . .[108]

These correlations between dignity and bodily integrity might be challenged on the ground that without any consciousness at all, Bland cannot be humiliated in the manner contended.[109] Rather, what judges are really talking about here are the

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102 Above n1 at 854.

103 Id at 851.

104 89 NJ 321 (1985).

105 Id at 398–399, quoted in *Bland* above n1 at 847 (Butler-Sloss LJ).

106 There is a legitimate question as to whether the 'feelings akin to humiliation and mortification' are responses experienced 'for' the patient as the *Re Conroy* passage suggests, or whether a patient in that state is actually provoking feelings of fear and horror in the onlooker. In any event, law does not draw this distinction explicitly (although Hoffman LJ's reference to 'grotesquely alive' comes close) and there is little discussion of the possibility that onlookers might feel so confronted by the presence of Bland that the humiliation and degradation that they experienced was for themselves. Such a discussion would have provided material against which to test the applicability of Kristeva's theory of abjection to this case. See below n110–114 and accompanying text.

107 [1993] 1 NZLR 235.

108 Id at 245, quoted in *Bland* above n1 at 847 (Butler-Sloss LJ).

109 For an elaboration of this argument see Carl Elliot & Britt Elliott, 'From the Patient's Point of View: Medical Ethics and the Moral Imagination' (1991) 17 *J Med Ethics* 173.

feelings of disgust they experience when faced with the ambiguity of the PVS patient. Julia Kristeva argues that death, bodily disintegration and bodily waste are all aspects of human experience that disrupt identity and order and provoke a reaction that she calls 'abjection'.[110] The abject is that which must be expelled or radically excluded so that we can maintain our sense of identity. It is both necessary to life (so that we can never completely escape it) and it draws us closer to the 'place where meaning collapses'.[111] She says:

> The corpse (or cadever: cadere, to fall) that which has irremediably come a cropper, is cesspool and death;... A wound with pus, or the sickly, acrid smell of sweat, of decay, does not *signify* death. In the presence of signified death — a flat encephalogram for instance — I would understand, react or accept. No, ... refuse and corpses *show me* what I permanently thrust aside in order to live. These body fluids, this defilement, this shit are what life withstands, hardly and with difficulty, on the part of death.[112]

For Kristeva, the corpse provokes the most intense horror because it is a 'border that encroaches on everything'.[113] The corpse is a body that has fallen beyond that limit which makes it possible to be and, in this sense, goes to the very heart of our notions of 'identity, system and order'.[114]

The Law Lords did not explicitly engage with these questions concerning dignity and bodily penetration. Nonetheless, there is evidence that their Lordships were disconcerted by the 'invasion' of Bland's body. Lord Keith referred to 'the invasive manipulation of the patient's body to which he has not consented'[115] and Lords Goff, Browne-Wilkinson and Mustill adverted to the 'invasiveness of the treatment,'[116] the 'invasive medical care'[117] and 'invasive treatment and care'[118] respectively. In the judgment of Lord Browne-Wilkinson and Lord Lowry, bodily integrity assumes a more central role. As mentioned earlier, they not only decided that the withdrawal of naso-gastric feeding was lawful but that its continuance in the circumstances was unlawful.[119] In this regard, Lord Browne-Wilkinson said that '[u]nless the doctor has reached the affirmative conclusion that it is in the patient's best interests to continue the invasive care, such care must cease.'[120] Lord Lowry was even more explicit:

> The doctors consider that in the patient's best interests they ought not to feed him and the law, as applied by your Lordships, has gone further by saying that they are not entitled to feed him without his consent, which cannot be obtained.[121]

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110 Julia Kristeva, *Powers of Horror: An Essay on Abjection* (1982) at 4.
111 Ibid.
112 Ibid at 3 (original emphasis).
113 Ibid.
114 Id at 4.
115 Above n1 at 861.
116 Id at 870.
117 Id at 883.
118 Id at 895.
119 Id at 882 (Lord Browne-Wilkinson) and 876 (Lord Lowry).
120 Id at 883.
121 Id at 876.

One could interpret this response as an attempt to set limits on doctors and the technological prolongation of futile life to prevent the abuse of patients. Sir Stephen Brown P captured this sentiment when he described the PVS patient as 'a passive prisoner of technology':[122]

> I doubt if it has ever been an object of medical care merely to prolong the life of an insensate patient with no hope of recovery where nothing can be done to promote any of these objects [to prevent and cure illness and to alleviate pain and suffering]. But until relatively recently the question could scarcely have arisen since the medical technology to prolong life in this way did not exist. That is also a new feature of this case.[123]

The metaphor of the PVS patient as the 'passive prisoner of technology' appeared to place doctors in the position of presiding over a technological dystopia which law needs to bridle. But this account of law restraining medicine may be too simplistic. It does not take account of the fact that the concern about limits originated in the medical profession itself nor that the 'limit' law ultimately adopted was the limit proposed by Bland's doctors. Thus, although medical technology created the dilemma of the 'futile prolongation of life', it was also medical opinion that named this as a dilemma and which framed a solution to it. As McLean observes '[m]edicine first defines its own competence, then finds clinical answers to the questions it itself has posed. Finally it decides who shall benefit from its capacities or be subject to its experiments.'[124] This is a point to which we will return in Part 4.

B. A Life Unnaturally Supported

The prisoner metaphor was deployed in the twins' case in a different way. In this case, Jodie was the prisoner of Mary and, accordingly, it was nature rather than technology that denied them bodily integrity. In contrast to *Bland*, this not only placed doctors in the position of saviours: it cast medical technology in the role of restoring order to nature's chaos.

Jodie and Mary were characterised as legal persons on the basis of medical evidence as to their physiological makeup (which supported the conclusion that they were two individuals) and medical evidence as to 'life' for the purposes of the 'born alive' rule. Most importantly, the divisibility of the conjoined twins into 'separate' individuals enabled the court to determine their best interests separately. The court concluded that it was in Jodie's best interests that the operation be performed. In reaching this decision, considerable weight was placed on the fact that she appeared to be neurologically normal and doctors were confident that, in the event of separation, her vital organs could sustain her. Serial major reconstructive surgery of her ano-genital region, however, would be required if she survived surgery. It was possible that she would be doubly incontinent, and/or unable to walk.

122 Id at 833.
123 Id at 837.
124 Above n8 at 12.

There was disagreement as to Mary's best interests. In the High Court, Johnson J decided that the separation would also be in Mary's best interests. This decision rested on three principal grounds. First, Mary's current state 'was pitiable.'[125] She was tube fed and blind, she had little or no heart or lung function and her brain function was probably deteriorating. There was little prospect that her functioning was likely to improve. Second, there was no way of ascertaining whether she was experiencing pain. Third, and somewhat at odds with the previous finding, it was likely that as Jodie developed and became mobile, Mary would experience the pain associated with being 'dragged around' by her sister. In weighing up the circumstances and assessing the evidence, Johnson J found that the few months of M's life 'would not simply be worth nothing to her, they would be hurtful.'[126] In the result, the court found that 'to prolong M's life for those few months was very seriously to her disadvantage'[127] and, accordingly, the separation was in her best interests.

Ward LJ, with whom Brooke LJ agreed, criticised Johnson J's findings on Mary's best interests for failing to distinguish between the futility of life and of treatment. As a result, Johnson J reached the impermissible conclusion that Mary's life was worthless.[128] Ward LJ was very careful to maintain the distinction between the futility of life and of treatment for reasons that are clearly linked to the principle of equality:

> Given the International Conventions protecting 'the right to life', to which I will return later, I conclude that it is impermissible to deny that every life has an equal inherent value. Life is worthwhile in itself whatever the diminution in one's capacity to enjoy it and however gravely impaired some of one's vital functions of speech, deliberation and choice may be.[129]

In addition to finding that Mary's life was worth nothing to her, Johnson J found that to 'prolong' her life would be seriously to her disadvantage. This is premised on characterising the circulation of blood between Jodie and Mary as a form of treatment. Ward LJ was again critical:

> What is under consideration is the active invasion of her body. That will not prolong her life. It will terminate it. With respect to the judge he asked the wrong question. The question is not: is it in Mary's best interests that the hospital should discontinue to provide her with treatment which will prolong her life. This case is not about providing that kind of treatment. What is being proposed should be done and what the court is being asked to sanction demands that the question be

125 Above n2 at 988.

126 Ibid.

127 Ibid.

128 However, Robert Walker LJ (dissenting) reached the same conclusion as the High Court. He commented that 'it is hard to see any benefit to her from continued life. In *Bland*, Lord Goff drew a distinction between cases in which the patient has (or may come to have) some awareness of his or her quality of life, and cases of total unconsciousness. Whichever category Mary should be put in I do not differ from the judge's conclusion that to prolong Mary's life for a few months would confer no benefit on her but would be to her disadvantage.' Id at 1057.

129 Id at 1001.

> framed in this way: is it in Mary's best interests that an operation be performed to separate her from Jodie when the certain consequence of that operation is that she will die? There is only one answer to that question. It is: no, that is not in her best interests.[130]

The majority concluded that it was in Jodie's best interests that the operation be performed but in Mary's best interests that the operation not be performed. The problem was to reconcile the directly conflicting duties that the court owed to each twin. In the result, the majority found that it this was an impossible conflict to resolve. The only solution available was to balance the welfare of each child against the other to find the least detrimental alternative.

Here the majority must be understood as conceding the limitations of the rights-based approach and, furthermore, adopting a utilitarian 'balancing' exercise in its stead.[131] This balancing exercise proceeded on the following basis.[132] First, the scale is evenly weighted with each twin's right to life.[133] Because the right is universal, the scales remain in balance. Second, Ward LJ considered the actual condition of the children as they are and as they would be after separation, being careful to focus on the worthwhileness of treatment and not life.[134] In relation to Mary, he concluded that 'the operation will shorten Mary's life but she remains doomed for death'[135] because 'her capacity to live has been fatally compromised.'[136] In relation to Jodie, Ward LJ found that 'the operation is overwhelmingly likely to have the consequence that Jodie's life will be extended for the period of three to six months or a little more to one where she may enjoy a normal expectancy of life.'[137] This left the scales weighted in Jodie's favour.[138] Finally, Ward LJ considered it important to add to the scales 'the manner in which they are individually able to exercise their right to life.'[139] In conclusion Ward LJ held that:

> I am in no doubt that the scales come down heavily in Jodie's favour. The best interests of the twins is to give the chance of life to the child whose actual bodily condition is capable of accepting the chance to her advantage even if that has to be at the cost of the sacrifice of the life which is so unnaturally supported.[140]

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130 Id at 1003–4.

131 On this point, see Mirko Bargaric, 'The Jodie and Mary (Siamese Twins) Case: The Problem with Rights' (2001) 8 *JLM* 311.

132 Above n2 at 1010–1011 (Ward LJ).

133 Id at 1010.

134 Ibid.

135 Ibid.

136 Ibid.

137 Id at 996.

138 Id at 1010.

139 Ibid.

140 Id at 1010.

C. *Sucking Lifeblood*

Independently of the decision as to best interests, the courts in *Bland* and *Re A (Children)* required satisfaction that the proposed courses of action would not amount to homicide. This was achieved in *Bland* by characterising the discontinuance of feeding as an omission which was not criminally culpable unless doctors were under a duty to feed. In *Re A (Children)*, the majority found that surgery would amount to homicide absent some lawful justification or excuse.

The majority specifically acknowledged that their decision had a sacrificial dimension. Ward LJ referred in the passage cited above to the 'cost of the sacrifice.' Brooke LJ referred to the surgery as a 'sacrificial separation operation.'[141] The notion of sacrifice in this context carried two connotations. The first was that although Mary was understood to be the subject (or object) of sacrifice, the dimensions of that sacrifice were plainly minimised by reference to the claim that Mary was a distinct individual who was 'designated for death':

> Mary may have a right to life, but she has little right to be alive. She is alive because and only because, to put it bluntly, but nonetheless accurately, she sucks the lifeblood of Jodie and she sucks the lifeblood out of Jodie. She will survive only so long as Jodie survives. Jodie will not survive long because constitutionally she will not be able to cope. Mary's parasitic living will be the cause of Jodie's ceasing to live. If Jodie could speak, she would surely protest, 'Stop it, Mary, you're killing me'. Mary would have no answer to that. Into my scales of fairness and justice between the children goes the fact that nobody but the doctors can help Jodie. Mary is beyond help.[142]

Thus, although the idea of sacrificing a life is anathema to rights-based conceptions of the individual, the 'sacrifice' was rendered tolerable by the fact that Mary was 'self-designated for death'[143] and Jodie would survive and achieve independence. But it is worth considering the extent to which Mary is only 'self-designated' for death within a system of thought which conceived the conjoined twins as notionally separate and distinct individuals. As Sheldon and Wilkinson point out '[q]uestions about sacrificing one twin to save the other are significant only if we assume that we are dealing with two human beings who, in spite of their physical conjoinment, are legally and morally distinct. Indeed, one reason why the issues raised by cases of conjoined twins appear so intractable is that law and ethics have developed along a model of physically separate, individual human beings with competing needs and interests which often provides the basic unit in considering legal and ethical wrongs.'[144] As we have seen, the court, and it seems the doctors and the parents too, assumed that 'Mary' and 'Jodie' were distinct beings. But to claim that Mary was 'self-designated for death' implies that the decision to view her in this way was located outside the court and even the medical

141 Id at 1051.

142 Id at 1010 (Ward LJ).

143 Id at 1010.

144 Sally Sheldon & Stephen Wilkinson, 'Conjoined Twins: The Legality and Ethics of Sacrifice' (1997) 5 *Med L Rev* 149 at 151.

profession, which was patently not the case. A further implication of this construction based on distinction was that the dilemma was not that the conjoined twins would tragically die within months or years because of the circumstances of their birth, it was that Mary was actually killing Jodie.

The second connotation of sacrifice, therefore, was that Mary was, in effect, a parasite. Ward LJ observed that:

> The reality here – harsh as it is to state it, and unnatural as it is that it should be happening – is that Mary is killing Jodie. That is the effect of the incontrovertible medical evidence and it is common ground in the case. Mary uses Jodie's heart and lungs to receive and use Jodie's oxygenated blood. This will cause Jodie's heart to fail and cause death just as surely as a slow drip of poison. How can it be just that Jodie should be required to tolerate that state of affairs?[145]

It does not take much of a leap to conceive of the dilemma of the conjoined twins in terms of self-defence (or defence of another). Indeed Ward LJ evoked the vocabulary of self-defence dramatically by giving Jodie a pleading voice: 'Stop it, Mary, you're killing me.'[146] He reasoned that doctors were under a legal duty to do what is best for their patient. But in this situation they were faced with a conflict – their duty to Jodie was to operate and their duty to Mary was to refrain. Law must offer them an 'escape through choosing the lesser of two evils.'[147] A further reason for advancing the doctor's right of choice in this case is that the doctors were in the position of being able to 'defend' Jodie from Mary.

Brooke LJ decided that the principle of necessity would excuse the surgery. As a defence to a criminal offence, necessity generally involves the claim that the 'conduct promotes some value higher than the value of literal compliance with the law.'[148] As a possible defence to homicide, necessity has always provoked analysis and comment.[149] Conundrums appear in the literature in a number of forms.[150] Can the mountaineer who is attached by rope to the companion who has lost her grip, cut the rope to save herself even if it is certain that her companion will die? Can the speluncean explorers kill of one of their number for food if they

145 Above n2 at 1016–7.

146 Id at 1010.

147 Id at 1016. Similar reasoning was adopted by the Queensland Supreme Court in *Queensland v Alyssa Nolan & Anor* [2001] QSC 174 which was a case concerning the separation of the conjoined twins, Alyssa and Bethany. The court decided that the separation would be lawful because s286 of the Criminal Code 1901 (Qld) imposed a duty on the doctors to 'supply such medical and surgical care and skill as is reasonable in the circumstances to prevent ... harm'. Id at para 22. It was held that this duty extended to saving Alyssa's life, even though the means taken to achieve this would end Bethany's life: 'the operation which is compelled by law is a justification for the act which has that result. The killing is therefore not unlawful'. Ibid.

148 Glanville Williams, *Criminal Law: The General Part* (2nd ed, 1961) at 722.

149 More recently, the question arose before the Supreme Court of Canada in *R v Latimer* [2001] 1 SCR 3. The facts concerned a father who took the life of his severely disabled 12 year old daughter. It was argued on appeal that the trial judge erred in removing the defence of necessity from the jury, resulting in an unfair trial. The appeal was dismissed on the basis that, on the evidence adduced, there was no air of reality to the defence.

150 Id at 737–741.

have drawn lots to determine who will be sacrificed to save the remainder?[151] Can the shipwrecked sailor throw another off a plank, if it is only sufficient to hold one?[152] The many examples of scenarios that raise necessity as a defence to intentional killing usually possess some or all of the following features. First, the number of lives saved by the conduct is greater than the number of lives lost. Second, the victim's existence threatens the life of the defendant (but not by aggression). Third, the victim will die in any event. And, finally, the victim is either self-designated for death (as in the mountaineer's case) or chosen by some non-arbitrary method (as in the case of the speluncean explorers).

Necessity had never before been recognised as a defence to murder in English law. In *R v Dudley and Stephens*,[153] the defendants were indicted for murder for killing and feeding upon the flesh of a cabin boy with whom they were lost at sea. They claimed that it was necessary to kill the cabin boy in order to survive. The evidence was that none of the crew would have survived if they had not killed the boy. Coleridge LCJ gave two reasons for his rejection of the defence. The first concerned the issue of choosing the victim. Who was to be the judge of this sort of necessity? By what measure was the comparative value of lives to be measured? The second reason was that to permit such a defence would mark an absolute divorce of law from morality. Brooke LJ's answers to both objections were:

> In my judgment, neither of these objections are dispositive of the present case. Mary is, sadly, self-designated for a very early death. Nobody can extend her life beyond a very short span. Because her heart, brain and lungs are for all practical purposes useless, nobody would have even tried to extend her life artificially if she had not, fortuitously, been deriving oxygenated blood from her sister's bloodstream.[154]

Brooke LJ decided that the defence could be made out in this case.[155] As Robert Walker LJ did not regard the surgery as a case of 'intentional killing', he did not need to decide whether there would be a defence of necessity. He did, however, indicate that he 'would extend the doctrine, if it needs to be extended, to cover the case':[156]

> It is a case of doctors owing conflicting legal (and not merely social or moral) duties. It is a case where the test of proportionality is met, since it is a matter of life and death, and on the evidence Mary is bound to die soon in any event. It is not the case of evaluating the relative worth of two lives, but of undertaking

151 Lon Fuller, 'The Case of the Speluncean Explorers' (1949) 62 *Harv L R* 616.

152 This problem has been discussed down the ages see Williams, above n148 at 724–728. See also George Christie, 'The Defense of Necessity Considered From the Legal and Moral Points of View' (1999) 48 *Duke L J* 975; and Alan Brudner, 'A Theory of Necessity' (1987) 7 *Oxford J Legal Stud* 339.

153 (1884) 14 QBD 273.

154 Above n2 at 1051 (Brooke LJ).

155 He observed that there are three requirements for the application of the doctrine of necessity. First, the act must be needed to avoid inevitable and irreparable evil; second, no more should be done than is reasonably necessary for the purpose to be achieved; and third, the evil inflicted must not be disproportionate to the evil avoided. Id at 1052.

156 Id at 1067.

> surgery without which neither life will have the bodily integrity (or wholeness) which is its due.[157]

The criminal law analysis offered by the majority confronted the same difficulty that emerged in their welfare analysis, namely whether and how the rights to life ascribed to each twin were to be respected. The problem was that once the twins had been notionally dissected, their equal rights to life were incommensurable. Faced with this crisis of 'rights' the majority judges again resorted to a utilitarian principle in an effort to affirm the value of 'life' by saving Jodie from premature death.

The rights analysis was revived, to some extent, by a return to the notion of dignity. In addition to saving Jodie, both Jodie and Mary would achieve the bodily integrity and autonomy denied them by nature. The court remarked on the relationship between dignity and bodily integrity.[158] Robert Walker LJ observed that:

> Every human being's right to life carries with it, as an intrinsic part of it, rights of bodily integrity and autonomy – the right to have one's body whole and intact and (on reaching an age of understanding) to take decisions about one's body.[159]

He reasoned that there was a strong presumption in favour of the operation in part because it would restore the bodily integrity of each twin. Thus, although the separation would surely violate Mary's right to life, it was also characterised as an attempt to restore to her 'natural rights' which had been denied her:

> For the twins to remain alive and conjoined in the way they are would be to deprive them of the bodily integrity which is the right of each of them.[160]

The court did not expressly consider that it is not only Mary that was being sacrificed. The existence of the conjoined twins was also being sacrificed.

4. *Has Law Been Medicalised?*

Having analysed the processes of definition which shaped the questions asked, and the conclusions reached in *Bland* and *Re A (Children)* it is worth returning to McLean's argument. It will be recalled that although McLean appeared confident that the law was capable of reining in what she calls the 'juggernaut of medicalisation', she also complained that 'law has reneged on its promise [to defend patient's rights] when evaluating matters which are claimed as falling within the province of medicine.'[161] It seems reasonable to suggest that the extent to which law can effectively 'rein in' medicine might depend on the nature of the relationship between juridical and medical forms of power.

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157 Ibid.

158 Id at 1052 (Brooke LJ), 1069–70 (Robert-Walker LJ).

159 Id at 1070.

160 Id at 1069.

161 Above n8 at 20.

A. The Extension of Medicine

Foucault attempted to theorise what he called the 'extension of medicine'.[162] In aspects of his work, this extension is treated as a function of the emergence of disciplinary power in modern society. Foucault uses the term 'disciplinary power' to describe power in its modern form. It consists in the myriad mechanisms of power to which the disciplines (eg, medicine, criminology, psychiatry, and epidemiology) have given rise. He juxtaposes it with juridical power based on sovereign right. Thus, disciplinary power:

> ... is in every aspect the antithesis of that mechanism of power which the theory of sovereignty described or sought to transcribe. The latter is linked to a form of power that is exercised over the Earth and its products, much more than human bodies and their operations.[163]

Foucault argues that a conception of power based on the juridical model is inadequate to capture the way that power operates under modern conditions. Power, under modern conditions, is no longer 'dealing simply with legal subjects over whom the ultimate dominion was death, but with living beings, and the mastery it would be able to exercise over them would have to be at the level of life itself.'[164] This 'task of administering life',[165] he argues, revolves around two basic forms of power: disciplinary power and bio-power.[166] These forms of power developed sequentially during the eighteenth century and are distinct from the juridical and repressive form of power formerly exercised by the sovereign. The former is 'centred on the body as a machine; its disciplining, the optimization of its capabilities, the extortion of its forces, the parallel increase of its usefulness and its docility, and its interrogation into systems of efficient and economic controls'[167] and is 'ensured by the procedures of power that characterised the disciplines.'[168] Its counterpart, bio-power, focuses on the 'species body',[169] the 'body imbued with the mechanics of life and serving as the basis of the biological processes: propagation, births and mortality, the level of health, life expectancy and longevity, with all the conditions that can cause these to vary.'[170]

The important question is where does this analysis leave law or juridical power, both as a force and, as McLean wishes to uses it, as an antidote to the encroachment of the disciplinary power exercised by medicine? At the conclusion of *Discipline and Punish* Foucault foreshadows the gradual colonisation of penal institutions by disciplinary power:

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162 Michel Foucault, 'Two Lectures' in Colin Gordon (ed) *Power/Knowledge: Selected Interviews & Other Writings by Michel Foucault 1972–1977* (1981) 78 at 107.

163 Id at 104.

164 Michel Foucault, *The History of Sexuality: Volume One* (1990) at 142–143.

165 Id at 139.

166 Ibid.

167 Ibid.

168 Ibid.

169 Ibid.

170 Ibid.

> The second process is the growth of the disciplinary networks, the multiplication of their exchanges with the penal apparatus, the ever more important powers that are given them, the ever more transference to them of juridical functions; now, as medicine, psychology, education, public assistance, 'social work' assume a greater share of the powers of supervision and assessment the penal apparatus will be able in turn to become medicalized, pychologized, educationalized...[171]

Although Foucault is not always clear on the relation between old and new forms of power, he makes a number of observations about this relationship.[172] The first is that disciplinary power 'ought to have led to the disappearance of the grand juridical edifice created by...[the sovereign] theory.'[173] In reality, however, 'the theory of sovereignty has continued to exist not only as an ideology of right, but also to provide the organising principle of the legal codes which Europe acquired in the nineteenth century.'[174] Foucault suggests that one reason for this persistence is that:

> [t]he theory of sovereignty, and the organisation of a legal code centred on it, have allowed a system of right to be superimposed upon the mechanisms of discipline in such a way as to conceal its actual procedures, the element of domination inherent in its techniques, and to guarantee to everyone, by virtue of the sovereignty of the State, the exercise of his proper sovereign rights.[175]

The result is that 'power is exercised simultaneously'[176] through the discourses of right and the discourses and techniques of normalisation to which the disciplines gave rise. However, he sees disciplinary power 'invad[ing] the area of right so that the procedures of normalisation come to be ever more constantly engaged in the colonisation of those of law.'[177] He specifically uses 'the extension of medicine'[178] to illustrate this point:

> It is precisely in the extension of medicine that we see, in some sense, not so much the linking as the perpetual exchange or encounter of mechanisms of discipline with the principle of right. The developments of medicine, the general medicalisation of behaviours, conducts, discourses, desires, etc. take place at the intersection between the two heterogenous levels of discipline and sovereignty.[179]

Although Foucault implicitly recognises that perhaps the only strategy presently available to counter 'usurpations by the disciplinary mechanisms'[180] is a 'return to a theory of right organised around sovereignty',[181] which appears to be the

171 Michel Foucault, *Discipline and Punish: The Birth of the Prison* (1979) at 306.
172 Above n162 at 78.
173 Id at 105.
174 Ibid.
175 Ibid.
176 Id at 107.
177 Ibid.
178 Ibid.
179 Ibid.
180 Ibid.
181 Id at 108.

strategy adopted by McLean, he appears less confident that this strategy can be effective.[182] On this point he observes that '[i]t is not through recourse to sovereignty against discipline that the effects of disciplinary power can be limited, because sovereignty and disciplinary mechanisms are two absolutely integral constituents of the general mechanism of power in our society.'[183]

B. The Extension of Law

Although Foucault's analysis of the 'extension of medicine' offers support to McLean's critique, Smart observes 'a move in the opposite direction... [in] the growing legalization of everyday life from the moment of conception (ie, increasing foetal rights) through to the legal definition of death (ie, brain or 'body' death).'[184] Smart seems unconvinced by claims that law, and rights discourses, are diminishing in importance. Smart argues for a conception of law that incorporates disciplinary power operating through discourses of normalization, whilst recognising the enduring significance of traditional forms of juridical power. This is a dynamic and complex conception of law as both co-opting and being co-opted by disciplinary power:

> Through the appropriation of medical categorizations and welfare-oriented practices, law itself becomes part of a method of regulation and surveillance. Law, therefore, has recourse to both methods, namely control through the allocation of rights and penalties, and regulation through the incorporation of medicine, psychiatry, social work and other professional discourses of the modern episteme.[185]

Hunt and Wickham interpret Foucault as distinguishing law and discipline as 'dual but opposing processes.'[186] They argue that whilst Foucault frequently 'counterposes law and discipline in order to highlight the distinctiveness of the modern disciplines'[187] he is best understood as 'drawing attention to the interaction and interdependence of disciplinary practices and their legal framework.'[188] They offer two interpretations of the relationship between law and discipline in Foucault's thought. The first is the 'broadly historical thesis'[189] that the 'advent of representational democracy existed side by side with the rise of an expanding disciplinary continuum'[190] with the result that law legitimated disciplinary power and merely masked the domination of normalising discourses.

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182 He suggests that turning to rights discourse as a strategy to prevent the encroachment of surveillance is unlikely to be successful because these mechanisms of power are symbolically linked. Ibid. See also Smart's discussion of this point in Carol Smart, *Feminism and the Power of Law* (1989) at 9.

183 Above n162 at 108.

184 Ibid.

185 Id at 96.

186 Alan Hunt & Gary Wickham, *Foucault and Law: Towards a Sociology of Law as Governance* (1994) at 46.

187 Id at 47.

188 Ibid.

189 Ibid.

190 Id at 48.

The second 'and more interesting'[191] interpretation is that law exists in competition with disciplinary power, without resolution. Expanding on this argument they write:

> Law in this guise expresses the paradox of modernity. Confronted by the rise of new disciplines, that are themselves exterior to law, the response of law is to seek to control or 'recode them in the form of law'.[192]

Smart's use of the term 'refraction' to describe the impact of disciplinary power seems to reflect similar reasoning. This concept of refraction carries two connotations. In the first sense, it refers to the expansion of bodily spaces and processes over which law can assert jurisdiction. Thus, 'law's power has become *refracted* as technology has accumulated knowledge about women's bodies and reproductive capacities.'[193] It is in this 'refraction' of law that we see the extension of law's authority, for example, in the regulation of the unborn foetus, IVF and its products, surrogacy and contraception. On this point, Smart contends that 'as medicine creates new terrains, so law can extend its authority, not just in terms of discovering new objects for scrutiny, but in terms of new methods of application.'[194] But at the same time, refraction connotes the lack of coherence to this phenomenon. Smart is emphatic about this when she says '[w]hilst acknowledging that law can extend regulation into more and more intimate areas of the body, we should also acknowledge that the law does not stand in one position. The law does not have a completely unified policy...'[195] Thus, the relationship between law and medicine (as a form of disciplinary power) is not straightforward. There are situations where law may incorporate medical knowledge to determine an outcome (as in *Bland*) and situations where legal rights may be invoked to regulate areas of life previously unknown to law. The decision in *Re A (Children)* could be interpreted as an example of the latter in the sense that the court hinted that advanced technology was in part responsible for its jurisdiction over the twins.

C. A Complex Matrix of Power Relations

A more direct example of the perpetual exchange between medical and legal power concerns the determination of best interests. In *Re F,* Lord Goff recognised that the declaratory procedure laid down by the House of Lords in relation to non-consensual sterilisation might have a deterrent impact on the medical profession, but he urged that the procedures would be 'conducted sensitively and humanely'[196] and, accordingly, should not 'be feared by responsible practitioners.'[197] Significantly, he did not accept the proposition that the role of the

191 Ibid.
192 Ibid.
193 Smart, above n182 at 97.
194 Id at 96 (original emphasis).
195 Id at 97.
196 Above n22 at 80.

court would be to 'rubber-stamp' sterilisation proposals. To this suggestion he said:

> I do not think it is possible or desirable for a court to so exercise its jurisdiction. In all proceedings where expert opinions are expressed, those opinions are listened to with great respect: but in the end, the validity of the opinion has to be weighed and judged by the court ... For a court to automatically accept an expert opinion, simply because it was concurred in by another appropriate expert, would be a denial of the function of the court.[198]

Lord Goff's attitude appeared to have softened in *Bland*. There he favoured a model of 'mutual understanding'[199] between judges and doctors. He thought that such a model offered the 'best way to ensure the evolution of a sensitive and sensible legal framework for the treatment and care of patients... in the interest of the patients themselves.'[200] Within this model, judges state the legal principles that render certain actions lawful and others unlawful, and doctors make individual decisions about the continuation of treatment within that framework:

> The truth is that, in the course of their work, doctors frequently have to make decisions which may affect the continued survival of their patients, and are in reality far more experienced in matters of this kind than are the judges. It is nevertheless the function of the judges to state the legal principles upon which the lawfulness of the actions of the doctors depend: but in the end the decisions to be made in individual cases must rest with the doctors themselves.[201]

This account attempts to strike a balance between the expertise and knowledge of the medical profession and the traditional role of law in distinguishing lawful from unlawful conduct in the protection of individuals. But in viewing the model in this way, a great deal of authority has already been ceded to the medical profession. With the exception of Lord Mustill,[202] the content and tone of the Law Lords' speeches in *Bland* suggest a relatively uncritical posture of reverence in relation to medical knowledge.

(i) A Reverence for Medical Opinion

The Law Lords found that the British Medical Association guidelines indicated that a responsible body of medical opinion thought that the continuation of feeding and hydration was not in Bland's best interests. Lord Keith observed that even if the BMA opinion was not unarguably correct, it was a proper basis for making the decision to discontinue treatment and care.[203] The inquiry into Bland's best

197 Ibid.

198 Ibid.

199 Above n1 at 872.

200 Ibid.

201 Ibid.

202 Id at 895–896.

203 Lord Goff accepted that there was no weighing operation to be performed in the evaluation of Bland's best interests because his condition was such that 'life-prolonging treatment is properly regarded as being, in medical terms, useless.' Id at 870 and 882 (Lord Browne-Wilkinson).

interests was thus given the complexion of a medical investigation and therefore, in a substantive sense, beyond the province of the court. Lord Browne-Wilkinson said:

> [T]he legal question in this case (unlike the question which would arise if there was a *parens patriae* jurisdiction under which the court has to make a decision) is not whether the court thinks it is in the best interests of Anthony Bland to continue to receive intrusive medical care but whether the responsible doctor has reached a reasonable and bona fide belief that it is not... the court's only concern will be to be satisfied that the doctor's decision to discontinue is in accordance with a respectable body of medical opinion and that it is reasonable.[204]

It is not clear that the Law Lords specifically intended to qualify the 'responsible body of medical opinion' test with a separate test for reasonableness, although this has since been clarified.[205] Lord Browne-Wilkinson also acknowledged that the application of a professional standard for determining the question of best interests meant that there was a possibility that the law could support different decisions in respect of the same patient. Thus, if a doctor believed that sustaining life in a persistent vegetative state was of benefit to his patient, and this was supported by a responsible body of medical opinion, that doctor might continue the treatment. Although Lord Browne-Wilkinson might have been troubled by the incongruity that like individuals might end up receiving, or not receiving, life-sustaining treatment depending on the views of their treating doctor, Lord Goff was not. He regarded the possibility 'more theoretical than real'[206] and unlikely to arise in practice 'if only because the solution could be found in a change of medical

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204 Id at 883. This is to be contrasted with the position in Australia, where the court does have a *parens patriae* jurisdiction in relation to incompetent adults. In *Northridge v Central Sydney Area Health Service* [2001] NSWSC 1241 (hereinafter *Northridge*), a case involving the withdrawal of feeding from a patient who was diagnosed as being in a 'chronic vegetative state', the court stated that 'what constitutes appropriate medical treatment in a given case is a medical matter in the first instance. However, where there is doubt or a serious dispute in this regard the court has the power to act to protect the life and welfare of the unconscious person.' Id at para 24. In *Northridge*, the hospital had withdrawn feeding from the patient six days after his admission following a herion overdose. The family of the patient sought orders from the court that treatment should be reinstated. The court was critical of the diagnosis of 'chronic vegetative state' on the basis that it did not reflect any recognised clinical category. There was, accordingly, an absence of recognised criteria for the making of the diagnosis. To that extent, the decision taken by the doctors was not in accordance with accepted medical opinion. Id at para 107.

205 Recourse to the professional standard first articulated in *Bolam v Friern Hospital Management Committee* [1957] 1 WLR 582 appears to have been tempered by *Bolitho v City and Hackney Health Authority* [1997] 3 WLR 1151 where it was held that a court could find that a practice, though supported by a body of medical opinion, might be unreasonable. This appears to bring English law closer to the position adopted in Australia and Canada where there has been a tendency to move away from a professional standard as the sole criterion for determining the doctor's standard of care. See *Rogers v Whitaker* (1992) 175 CLR 479 (Australia) and *Reibl v Hughes* (1980) 114 DLR (3d) 1 (Canada). For a comparative assessment of the approach of English courts, see P. D. G. Skegg, 'English Medical Law and 'Informed Consent': An Antipodean Assessment and Alternative' (1999) 7 *Med L Rev* 133.

206 Above n1 at 875.

practitioner.'[207] Lord Goff assumed that most doctors who are likely to encounter patients in PVS would reach the conclusion to discontinue treatment in accordance with the BMA guidelines and that, in the event that some doctors did not, the family could arrange for a change of doctor.[208] Elsewhere in his judgment, Lord Goff accepted that although doctors should consult with relatives about the treatment, the views of the family were not determinative. Otherwise, he reasoned 'the relatives would be able to dictate to the doctors what is in the best interests of the patient, which cannot be right.'[209]

A study conducted after *Bland* raised concerns about the indeterminacy of the PVS diagnosis.[210] This study re-tested the diagnoses of patients who had been referred to a specialised rehabilitative unit. Of these, 25 per cent remained vegetative, 33 per cent slowly emerged from the vegetative state after rehabilitation and 43 per cent were misdiagnosed as being in the vegetative state. With one exception, consultants from specialties that ordinarily diagnose vegetative state had misdiagnosed all of these patients. They had been treated as having been completely unaware when in fact they were not, some for many years.[211] After occupational therapy these patients were able to communicate and it was found that thirty seven percent of them had near normal cognitive ability. The authors of the study emphasised two important points. The first was that the clinical assessment of PVS is not a straightforward task, even for clinicians with considerable experience. The results of the study lend further support to earlier findings that PVS cannot be diagnosed by a bed-side assessment or by neurodiagnostic tests. The diagnosis requires regular assessment including the observations of carers and family. The second important finding was that the patient's awareness was nearly always first identified by the occupational therapist, then by the clinical psychologist and later by the other members of the medical team. The authors emphasised the importance of this finding given that 'it

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207 Ibid.

208 This does not address the reverse scenario where the family wishes treatment to be continued in the face of a refusal to do so by the medical team. This issue arose in *Re C (a Minor)(Medical Treatment)* [1997] 1 FLR 384 where the parents and doctors clashed over the withdrawal of ventilation to a 16 month old child. The doctors considered that a terminally ill 16 month old fell within the 'no-chance' category of the Royal College of Paediatrics' Guidelines on the Withholding and Withdrawing of Life-Saving Treatment in Children. Stephen Brown P held that the court would not make an order which would directly or indirectly require a doctor to treat a child in a manner contrary to his clinical judgment. On a slightly different, but important note, English courts will not quash a health authority's decision not to allocate resources to a patient unless the decision is irrational. See *R v Cambridge Health Authority, ex parte B* [1995] 1 WLR 898; *R v North Derbeyshire Health Authority, ex parte Fisher* [1997] 8 Med LR 327; *West Lancashire Health Authority v A, D and G* [1999] Lloyd's Rep Med 399 and *R v Portsmouth Hospitals NHS Trust Ex parte Glass* [1999] 2 FLR 905.

209 Above n1 at 872.

210 Keith Andrews, Leslie Murphy, Ros Munday & Clare Littlewood, 'Misdiagnosis of the Vegetative State: Retrospective Study in a Rehabilitation Unit' (1996) 313 *BMJ* 13.

211 Forty one per cent of the misdiagnosed patients had been thought to be vegetative for more than one year (18 per cent of these for between four and seven years). Ibid.

is usually on the basis of bed-side observations by a physician or surgeon that decisions are made to refer a patient for specialist treatment programmes, or decisions are made to apply to the courts to withhold or withdraw medical treatment or artificial nutrition and hydration.'[212]

The point is not that Bland had been misdiagnosed but rather that, as McLean argues, medical knowledge presented as fact may not warrant such an authoritative descriptor.[213] Furthermore, the hierarchies within the medical profession may not always provide a reliable or exhaustive guide to all there is to know about a patient or a condition.[214] It might be objected that this study brought to light certain inaccuracies in the diagnosis of PVS by careful assessment and by the application of techniques that were not available when Bland was decided. Although this may be so, it is not the case that the misdiagnosed PVS patients in the study were brought to awareness by novel techniques. It was that their existing awareness, which had been dismissed, was brought to the attention of doctors.

(ii) Treating Professional Standards with Respect

In addition to placing a heavy reliance on medical opinion as to best interests, it is also clear that the court was mindful of the concerns held by the medical profession about their potential criminal responsibility. Lord Goff urged courts to understand the problems faced by the medical profession and to regard 'their professional standards with respect.'[215] He also thought that it would be a 'deplorable state of affairs'[216] if courts could not give authoritative guidance to doctors on how they should act. If courts were not willing or able to give such guidance, then a doctor in the present situation would be placed in the untenable position of being 'compelled either to act contrary to the principles of medical ethics established by his professional body or to risk a prosecution for murder.'[217] Lord Browne-Wilkinson and Lord Mustill also expressed a concern that doctors should not be placed in the position of having to run the risk of a criminal prosecution.[218] Lord

212 Ibid. The BMA responded to the study by revising the guidelines on withdrawing feeding from PVS patients. The revised guidelines stress that PVS can be difficult to diagnose and thus recommend that treatment withdrawal decisions be deferred for 12 months following the initial diagnosis. The BMA also recommends aggressive medical treatment during the period of initial assessment, and rehabilitation efforts as soon as the patient has stabilised. The BMA recommends further that the diagnosing clinician seek the views of two other doctors, one of whom should be a neurologist, for confirmation of the diagnosis of irreversibility. If there is any doubt about the irreversibility of the patient's condition, decisions about withdrawing treatment should be deferred. See BMA, *Treatment Decisions For Patients in Persistent Vegetative State* (1996).

213 This point was frankly acknowledged in *Northridge* where the court discussed the limitations of the chronic vegetative state diagnosis. Above n204 at para 109.

214 This issue was raised in *Northridge* where the court noted that the observations of the patient's family were brushed aside by the medical team. Id at para 114.

215 Above n1 at 872.

216 Id at 865.

217 Ibid.

Browne-Wilkinson spoke of the 'great advantage'[219] doctors had bestowed on society in assuming responsibility for difficult decisions about death. This conception of the doctor performing a valued social function underscored the importance of maintaining a sphere of protection for medical decisions that cause death. In this sense, the delineation of a boundary between the withholding of food and hydration and the administration of lethal drugs operated both to sanitise the lawful conduct by designating it 'not murder' and to provide reassurance that as long as a doctor did not administer lethal injections, he or she was not a murderer. The effect was to bring the proposed conduct, and the professionals who presided over it, within the bounds of acceptability.

Notwithstanding the respect accorded to medical opinion, the Law Lords held that courts should retain a supervisory function. Accordingly, the declaratory jurisdiction should be invoked prior to removing food and water from PVS patients. This measure would protect patients from the consequences of a wrong decision and it would also protect doctors from allegations of misconduct or criminal prosecution. Lord Lowry thought applications to the court both necessary and desirable. Without this requirement he reflected, 'the doctor who proposes the cessation of life-supporting treatment ... will be judge in his own cause unless and until his chosen course of action is challenged.'[220] At the other end of the spectrum, Lord Goff found many compelling reasons against requiring applications to the court,[221] and thought that this condition might be relaxed in due course.[222] Indeed, some seven years later, members of the medical profession started to question the need to obtain a declaration.[223]

If the declaratory procedure was relaxed, doctors' attitudes about removal of hydration and feeding and their diagnostic abilities would become an important factor in the frequency of the practice. A study published in 1996 found that British consultants in specialties that are likely to come into contact with PVS are supportive of the practice of withholding treatment from PVS patients.[224] Significantly, about two-thirds of the doctors who thought that treatment limiting decisions could be appropriate, also thought that these decisions could be taken within the first year of the patient being in PVS. This is earlier than the BMA

218 The passage is worth quoting in full: 'In the past, doctors exercised their own discretion, in accordance with medical ethics, in cases such as these. To the great advantage of society, they took the responsibility of deciding whether the perpetuation of life was pointless. But there are now present amongst the medical and nursing staff of hospitals those who genuinely believe in the sanctity of human life, no matter what the quality of that life, and report doctors who take such decisions to the authorities with a view to prosecution for a criminal offence. I am not criticising such people ... But their actions make it extremely risky for a doctor to take a decision of this kind ...' Id at 880.

219 Ibid.

220 Id at 876.

221 In particular, that the guidance provided to the profession by the ethics committee of the British Medical Association was impressive and careful, and the costs of bringing an application were considerable. Id at 874.

222 Ibid.

223 See Editorial 'Withdrawing or Withholding Life Prolonging Treatment' (1999) 318 *BMJ* 1709–1710.

guidelines, which recommended a period of 12 months for diagnosis and decisions about discontinuing treatment. It is also noteworthy that most doctors in the survey stated a preference for deciding to discontinue treatment in conjunction with the patient's family and without going to court.

(iii) Re-asserting Judicial Authority

Two further legal developments since *Bland* suggest an ongoing tension surrounding the appropriate balancing of judicial and medical opinion as to best interests. The first concerns the scope of the best interests test. Butler-Sloss P has, on two occasions, indicated that the best interests test has a broader content than 'medical interests'. In *Re MB (Medical Treatment)*, the Court of Appeal held that 'best interests are not limited to best medical interests'[225] and in *R-B (A Patient) v Official Solicitor*,[226] Butler-Sloss P added 'best interests encompasses medical, emotional and all other welfare issues.'[227]

Importantly, the Law Commission has recommended, and the UK Government has accepted,[228] that there should be statutory guidance on how the best interests of an incapacitated person should be determined. The Commission has drafted a non-exhaustive list of factors to be taken into account. These factors would provide a basis for considering matters beyond the purely medical. They include: the ascertainable past and present wishes of the person concerned, the need to permit and encourage the person to participate as fully as possible in decisions, the views of appropriate others about what would be in the person's best interests; and whether the purpose for which any action or decision is required could be achieved by any less restrictive action.[229] To these, the Government added a further two factors. These are: whether there is any reasonable expectation of the person recovering capacity to make the decision; and the need to be satisfied that the wishes of the incapacitated person are not the result of undue influence.[230]

The second development concerns the relationship between the duty to act in a patient's best interests and the doctor's duty of care. The Law Commission observed that *Re F* appeared to have conflated the standard for negligence and best

224 Andrew Grubb, Pat Walsh, Neil Lambe, Trevor Murrells & Sarah S, 'Survey of British Clinicians' Views on Management of Patients in PVS' (1996) 348 *J-Lancet* 35. This survey included 1027 consultants drawn from the membership of the British Association of Orthopaedic Surgeons, the Association of British Neurologists, the Society of British Neurosurgeons and the British Society of Rehabilitative Medicine. Ninety per cent of responding doctors thought that it was sometimes appropriate not to treat acute infections and other life-threatening conditions in PVS patients. Sixty five per cent thought that the withdrawal of feeding and hydration was sometimes appropriate.

225 [1997] 2 FLR 426 at 439.

226 [2000] Lloyd's Rep Med 87 (hereinafter *R-B (A Patient)*).

227 Id at 91. The open question is whether this expansion might lead to the recognition of third party interests. Although this possibility was rejected in *Re Y (Mental Incapacity: Bone Marrow Transplant)* [1996] 2 FLR 787. The President and Thorpe LJ each left this question open. Id at 92 and 93.

228 Lord Chancellor's Department, *Making Decisions* (1999) at para 1.10–1.11.

229 Law Commission, *Mental Incapacity*, (1995) at para 3.28–3.37.

230 Above n228 at para 1.10–1.11.

interests.[231] Furthermore, the uncertainty surrounding the requirement of best interests was not clarified when the opportunity arose in *Bland*.[232] The Commission took the view that:

> ... acting in a person's best interests amounts to something more than not treating that person in a negligent manner. Decisions taken on behalf of a person lacking capacity require a careful, focused consideration of that person as an individual. Judgments as to whether a professional has acted negligently, on the other hand, require a careful, focused consideration of how that particular professional acted as compared with the way in which other reasonably competent professionals would have acted.[233]

In *R-B (A Patient)* Butler-Sloss P disagreed that the Law Lords had conflated the tests. The President preferred the alternative interpretation that the Law Lords intended two distinct duties: to meet the professional standard of care *and* act in the best interests of the patient.[234] She also made it clear that 'in the case of an application for approval of a sterilisation operation, it is the judge, not the doctor, who makes the decision that it is in the best interests of the patient that the operation be performed.'[235] In *Re S (Adult Patient:Sterilisation)*[236] the Court of Appeal found that the trial judge erred in his application of the *Bolam* test to a situation where there was evidence of two responsible bodies of medical opinion, each supporting different remedial treatment for excessive menstruation. Wall J left the choice to the patient's mother (in consultation with the doctors). Butler-Sloss P, with whom Thorpe and Mance LJJ agreed, found that in such a case the court must decide which of the two treatments was in the patient's best interests.[237] It was held that once a court is satisfied that the range of options are within the range of acceptable opinion, the *Bolam* test becomes irrelevant and the court must decide what treatment, if any, will serve the best interests of the patient having regard to the welfare principle.[238]

These developments, read against a history of judicial deference to medical opinion, lend some support to Foucault's thesis of a 'perpetual exchange' between medical and juridical power. The normalising power of medicine is apparent in court's recourse to the medical profession for expert evidence on legal issues such as best interests; and, for a time, English courts' interpretation of the *Bolam* test seemed to effectively cede control over these issues to the medical profession. Recently, however, courts have re-asserted judicial authority over the issue of whether a body of medical opinion is reasonable and, in the non-consensual hysterectomy context, which of two bodies of responsible medical opinion should be preferred in the best interests of the patient. In addition to this, the UK

231 Above n229 at para 3.26.
232 Id at para 3.26.
233 Id at para 3.27.
234 Above n226 at 92.
235 Ibid.
236 [2000] 3 WLR 1288.
237 Id at 1299 (Butler-Sloss P) and 1302 (Thorpe LJ).
238 Ibid.

government will, in the future, legislate to provide courts and health care providers with more authoritative guidance on capacity and best interests. Although these developments are consistent with law 'reasserting its traditional dominion', it should be kept firmly in mind that the meanings given to best interests will continue to be powerfully shaped by medical power. In any event, it might be argued that the distribution of power in its juridico-discursive and disciplinary forms is unstable; and that the constant interactions between these forms of power produce a dynamic environment which renders problematic any assertion of the essential dominance of either.

5. *Conclusion*

There is no straightforward answer to the question whether law can 'rein in' medical technology through the medium of rights discourse. As the foregoing analysis of *Bland* and *Re A (Children)* has shown, the power of law and medicine appear to be intertwined. Medical understandings of concepts such as 'life' and 'individuality' were central to the manner in which the relevant legal issues were framed in each case and, accordingly, on the rights analysis that followed. In *Bland*, the medical concept of 'futility' was central to the court's criminal law analysis of the act of withholding food and water. In *Re A (Children)*, scientific evidence about the distinctiveness of each twin was similarly central to the subsequent legal analysis concerning the lawfulness of separation. In addition, the court in *Bland* struggled with questions about who would decide (courts or doctors) that treatment was not in an incompetent patient's best interests. From this perspective, Foucault's theorising of a 'perpetual exchange' between juridical and medical power offers a richer explanatory account of the approach taken by English law to end of life decisions than does a model based on law 'reining in' medicine. Moreover, there are larger implications to this 'perpetual exchange': the meanings judicially ascribed to the rights to life and bodily integrity, and the priority to be given to these rights in the event of a conflict, are all capable of revision as medical perceptions change and as technological innovation evolves.