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For Peter

DEATH WITH DIGNITY:

LEGAL AND ETHICAL ASPECTS OF EUTHANASIA

BY

HAZEL BIGGS

1997.

Abstract

There is an active debate as to whether euthanasia is socially acceptable as a mechanism for achieving dignity in dying for many terminally ill and incurable people. The debate reveals a tension between the criminal law and social and medical ethics, and questions whether the criminal law of homicide is an appropriate mechanism to adjudicate the humanitarian issues raised by euthanasia. Euthanasia may provide death with dignity in some circumstances but not at the same time as the law requires the undignified criminalisation of the practitioner. Legal reform permitting some forms of euthanasia may offer a solution.

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Preface

This analysis of legal and ethical aspects of euthanasia will consider whether death with dignity can be achieved through euthanasia and assisted death. The first chapter will introduce the issues and concepts to be examined throughout by defining the parameters of the discussion and the terminology to be used. The definition of the term 'euthanasia' and the extent to which various societies have formally defined and permitted it is pivotal to Chapter One, as are legal and medical definitions of death and the interaction between euthanasia and the criminal law of homicide.

The concept of human dignity and the perceived ability of euthanasia to provide a dignified death is a central and recurring theme of the thesis which is introduced in the first chapter. It later provides a focus for the discussion of the relationship between killing and caring, the significance of autonomy and the legal status of living wills. The interaction between autonomy and the law of consent is the subject of Chapter Four which outlines the criminal and tortious consequences of failing to obtain consent to treatment, and also considers the mechanisms for facilitating treatment for those people who are unable to give consent. The final chapter considers the relationship between euthanasia and dignity and the whether legal reform to permit euthanasia would be likely to enhance dignity in dying.

The thesis is concerned with legal status of euthanasia in Britain but comparisons will be drawn with the position in other jurisdictions where appropriate. Issues surrounding the social and legal status of euthanasia are highly topical such that the law is subject to constant review as new cases frequently come to the fore. As a result this work aims to take account of developments up until August 1997 and does not guarantee to incorporate cases which emerge thereafter. The term 'patient' is used throughout for want of a more suitable way to describe people who are in receipt of medical care. 'She' is used in preference to 'he' as a device to avoid gender stereotypical assumptions.

Completing this thesis has been a salutary and at times desolate experience. Many people are deserving of my heartfelt thanks for their unflinching support and encouragement, especially during the final six weeks of frenetic writing and editing. Robin Mackenzie has always been there to offer a word of advice and a calm influence over a cup of tea; the staff of Kent Law School, not least Liz

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Chapter One

To Kill or Not to Kill; is that the Euthanasia Question?[1]

> Every day, rational people all over the world plead to be allowed to die. Sometimes they plead for others to kill them. Some of them are dying already ... Some of them want to die because they are unwilling to live in the only way left open to them.[2]

Introduction

Advances in medical science now allow both living and dying to be prolonged, a fact which has raised awareness of issues relating to death and dying in the community at large, popular fiction, and the medical professions. Dworkin's sentiments above reflect a commonly held belief that modern medicine can force people to endure life beyond what they perceive to be dignified bounds. Statistical evidence also supports the popular perception that some doctors do engage in excessive treatment to prolong the lives of the terminally ill.[3] As a result recent years have seen repeated calls for legal reform to permit euthanasia and assisted death.[4]

In modern Western culture death has traditionally been a private affair occurring behind closed doors and with minimal observation or discussion. Yet in Britain today approximately seventy per cent of all deaths occur under the bright lights of hospital where the natural processes of dying are often transformed into a medical event and subordinated to technology. Advanced medical knowledge and technology has increased the average life expectancy in the United Kingdom by twenty five years during this century.[5] As a result the numbers of people aged eighty and over rose nearly threefold between 1951 and 1988, from 0.7 million to

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[1] This chapter has formed the basis of an article entitled, "Euthanasia and Death with Dignity: Still poised on the Fulcrum of Homicide" (1996) *Crim. L. R.* 878-88.

[2] R. Dworkin, *Life's Dominion* (1993) Harper-Collins at 179.

[3] See for example, J. Brody, "Doctors Admit Ignoring Patients Wishes" *The New York Times* Jan 1993, which reports on a survey conducted by the *American Journal of Public Health* in January 1993.

[4] G. Williams, "Euthanasia" (1973) 41 *Medico-Legal Journal*, R. Veatch, *Death, Dying and the Biological Revolution* (1976) New Haven: Nash Publications, I. Kennedy, "Euthanasia", in A. Grubb (ed.), *Choices and Decisions in Health Care* (1993) Chichester: Wiley.

[5] *Social Trends*, Table 1.2, Age sex structure of the population (1990) London: HMSO, at 24.

2.0 million. It is estimated that this increase in longevity alone will cause a rise in the numbers of new cancer patients of 0.5% a year over the next twenty years[6] and the numbers of those suffering from chronic and incurable disease will grow proportionately. Alongside this, increasing awareness of patient's rights to self-determination, has stimulated public, academic, medical and legal debate about euthanasia, assisted dying, and treatment withdrawal.[7]

Central to this discourse is the dilemma encountered by doctors attempting to provide appropriate terminal care while respecting patient autonomy. Medical decisions in the terminal stages of life are frequently being questioned by patients and their relatives, while the options available to the personnel responsible for those decisions are strictly defined by the law. As a consequence the legal system is being called upon to define the boundary between patient's rights and doctor's responsibilities with regard to potentially life-limiting treatment decisions.[8] The following hypothetical case is illustrative of the issues exposed when modern medicine views death as defeat and strives to maintain life at all costs.

> The scene under consideration is one of impending despair. An anxious relative sits at the bedside of a hospital patient expecting the imminent arrival of the Grim Reaper and the ultimate departure of a loved one. But the deathly visitation is not forthcoming and the patient lingers on interminably. The prospect of recovery is negligible but the expectation of death recedes with the passage of time.
>
> Eventually, it is apparent that medical technology has exceeded its ability to preserve life and has embarked on an odyssey of prolonging the dying process. The options available for the continuing care and treatment of this patient are readily apparent. She can be maintained indefinitely in her present condition, or she can be allowed, or enabled to die. Sadly however, the availability of these options is limited and constrained by both social mores and the criminal law.
>
> The implications of this for the patient, her relatives and dependants, the medical carers, and for the allocation of scarce

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[6] *Review of National Cancer Registration System*, Series MBI, no. 17 (1990) London: OPCS.

[7] The level of interest in euthanasia and assisted death in order to avoid prolonged dying is illustrated by the fact that Derek Humphry's book, *Final Exit* (1991) Oregon: Hemlock Society, was listed as number one in the *New York Times* list of best selling self help books.

[8] Examples of these include *R v Cox* (1992) 12 B.M.L.R. 38, *Airedale NHS Trust v Bland* [1993] 1 All E.R. 821, and *Frenchay NHS Trust v S* [1994] 2 All E.R. 403.

> resources are profound and emblematic of the experiences of people everywhere. Her dilemma raises legal, social, ethical and medical questions to which there are no easy solutions. Should she be kept alive as long as technology allows? Is it ethical to keep her alive just because we can, or can we morally let her die? Can her family insist that she is kept alive or, conversely, that her life is not maintained? What are the legal rights of the patient and her family? What is the responsibility of the clinicians providing medical care? Is it legal for care to be discontinued? Can the patient herself influence the decisions taken regarding her future medical care?

These are questions which are confronted by real people every day around the world. The patients involved may encounter their personal dilemmas due to terminal or incurable disease, the effects of trauma, or simply the degeneration associated with old age. How they came to occupy their present position is often relatively unimportant compared with what happens to them next. It is commonplace today for people to be kept alive or brought back from the brink of death where in the past they would have died. But what kind of life are they living and how can their carers respond? The answer was considered by the Institute of Medical Ethics Working Party on the Ethics of Prolonging Life and Assisting Death which reported that,

> ... The lives of an increasing number of patients, predominantly but by no means all elderly, are now being prolonged by modern medicine in states of coma, severe incapacity, or pain they consider unrelievable and from which they seek release. Doctors in charge of such patients have to decide not only whether they are morally bound to continue with life-prolonging treatment, but also, if no such treatment is being given, whether and in what circumstances it is ethical to hasten their deaths by administration of narcotic drugs.[9]

Thus, as in the case of the hypothetical patient depicted above, life for these patients may amount to little more than survival; life has been saved but only because dying has been prolonged. A crucial question raised by this situation is exactly how are life and death defined, and is our understanding of these concepts rigid or must it be flexible in the face of such rapid medical and technological advancement? Peter Singer suggests that "the traditional ethic will be unable to accommodate the present demand for control over how we die".[10]

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[9] (1990) 336 *The Lancet*, at 610.

[10] P. Singer, *Rethinking Life and Death* (1995) Oxford: Oxford University Press, at 148.

What is certain is that the ability to preserve life despite trauma and terminal disease, has resulted in more people demanding the right to die with dignity rather than endure the perceived indignity of a dependent existence.[11] Euthanasia in its various forms is commonly regarded as a mechanism for promoting death with dignity. Whether dignity can be achieved through euthanasia may depend upon the individual circumstances of each case and on the type of euthanasia used.

Strictly defined euthanasia means "a good death" derived from the Greek *eu*, meaning well or good, and *thanatos*, meaning death. Present day understandings of the term imply the bringing about of a painless and gentle death, particularly in respect of those suffering from painful and incurable disease. Euthanasia may be described as voluntary and involuntary, where voluntary denotes that it is performed with the consent of the recipient as will be the primary focus of this analysis. Involuntary euthanasia suggests that the recipient has not agreed to the procedure and is an unwilling participant. A further classification of non-voluntary euthanasia denotes that the patient has been unable to express an opinion, usually because she lacks the capacity so to do.

Euthanasia can be active or passive, distinctions which relate closely to the legal understanding of act and omission whereby a positive action constitutes an act and a failure to act amounts to an omission. Death can be procured in a variety of different ways such as selective non-treatment, where life prolonging treatment is withdrawn or withheld; double effect, whereby pain relieving medication is given and death is incidentally hastened; assisted suicide, where one person offers another the assistance required to bring about her own suicide; and mercy killing which is described as the intentional killing of a person with benevolent motives. All have been described as euthanasia but there are significant practical and ethical distinctions between them which will be the focus of Chapter Two.

In Britain several unsuccessful attempts have been made to legalise euthanasia. For example, in 1936 The Euthanasia Bill provided for a system of prior notification whereby adult patients (then classified as persons over twenty-one) suffering from terminal or incurable disease would be permitted to sign a form

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[11] Opinion polls suggest that, because of fears of prolonged dying, public support for euthanasia has increased from about 50% in the 1960s to approximately 75% in 1992. See, T. M. Helme, "Euthanasia Around the World" (1992) 304 *British Medical Journal*, 717.

requesting euthanasia. Two witnesses were required at the signing and the form would then be scrutinised by a referee who was authorised to interview the patient and all other interested parties. After that the matter would be passed to a court which would be authorised to issue a certificate permitting euthanasia to be performed by a doctor in the presence of witnesses. The court was empowered to examine the evidence and decide whether or not the granting of a certificate was appropriate.

The Voluntary Euthanasia Bill 1969 would have allowed euthanasia for patients aged over twenty-one who requested it. Under this Bill a system was proposed whereby if two doctors were satisfied that the patient was suffering from an illness which was serious enough to be "incurable and expected to cause him severe distress or render him incapable of rational existence" they could be authorised to perform euthanasia. Several Bills in the 1970s[12] attempted to provide incurable patients with rights to receive pain relieving drugs in quantities which could induce unconsciousness. Such a right would in practice amount to little short of assisted suicide as the calculation of the dosage necessary to induce loss of consciousness would necessarily be imprecise. In 1991 the Euthanasia Bill, which would have allowed doctors to provide active euthanasia to incurable patients who requested it, was introduced. Despite a great deal of publicity and support from a parliamentary euthanasia group this measure met the same fate as the others and ultimately failed to gain the force of law.

There is presently no legal right to euthanasia in any western jurisdiction. The Netherlands is frequently quoted as providing an example of legally permissible euthanasia. However, euthanasia[13] remains proscribed in the Netherlands and has only been permitted subject to strict procedural guidelines and the efficacy of a defence of necessity.[14] In Switzerland and the German Republic the position is similar. Assisted suicide is practised but only in extremely limited and strictly controlled circumstances.

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[12] Known as the Incurable Patients Bills.

[13] Euthanasia is defined in the Netherlands as any behaviour carried out with the "victim's" consent, which causes that person's death.

[14] See J. Keown, "The Law and Practice of Euthanasia in the Netherlands" (1992) 108 *Law Quarterly Review*, 51-78, and J. Griffiths, "The Regulation of Euthanasia and Related Medical Procedures that Shorten Life in the Netherlands" (1994) 1 *Medical Law International*, 137-58, for a full account.

In Australia's Northern Territory legislation was enacted in 1996[15] to permit medically assisted suicide. Four patients successfully exercised the rights granted by the Act and were helped to die by their doctor before the legislation was challenged in the Supreme Court of Australia. The Rights of the Terminally Ill Act 1996 has now been overruled by the Federal Parliament.[16] In the American state of Oregon legislation was passed in 1994 permitting physician assisted suicide. This has subsequently been held to be unconstitutional by a federal court but that ruling is now the subject of an appeal which seeks to have the legislation reinstated.

Away from legislation, the common law position has been extensively reviewed in Britain and America. The issue of the right to die by assisted suicide was recently considered by the American Supreme Court in the cases of *State of Washington et al v Glucksberg et al* and *Vacco et al v Quill et al.*[17] The case concerned whether or not New York State's ban on assisted suicide amounted to a violation of the Fourteenth Amendment's Equal Protection Clause. At first instance it was held not to, but on appeal this decision was reversed. The decision was based on the fact that different treatment was being accorded to those seeking to end their lives by self administering prescription drugs than was available to those who declined therapeutic life support. The respondents argued that there was no relevant distinction between refusal of life support and assisted suicide and therefore equal treatment ought to be offered to each group.

The Supreme Court in America relied upon the well established distinction between on the one hand, allowing a person to die because they have declined further treatment and on the other, making them die by administering drugs.[18] The fact that the drugs are self administered is not relevant to this distinction and the crucial test is one of causation. When a person dies because treatment is not started or is withdrawn it is the underlying pathology which causes death. However, where death results from the administration of drugs, death is caused by the medication. Therefore the Equal Protection Clause was not violated by

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[15] The Rights of the Terminally Ill Act 1996.

[16] The operation of this legislation is discussed in detail in Chapter Two.

[17] The decision of the Supreme court was published on June 26th 1997 and is available on LEXIS.

[18] See for example, *Matter of Conroy*, 98 N.J. 321, 355, 486 A. 2d 1209, 1226 (1985) which held that, "when feeding tube is removed, death results ... from [the patient's] underlying medical condition", *Cruzan v Director, Mo. Dept. of Health*, 497 U.S. 261, at 278-80, *Airedale NHS Trust v Bland* [1993] 2 W.L.R. 316, at 368, *People v Kevorkian*, 447 (1997) U.S. LEXIS 4038 *3.

upholding this distinction because everyone is allowed to refuse treatment while nobody is permitted to assist suicide hence New York's prohibition of assisted suicide was not found to be unconstitutional.

In England the common law of homicide is central to the proscription of euthanasia. If the dying process is hastened by one person to limit the suffering of another the criminal law makes no concession for benevolent motives or the wishes of the alleged victim; it steadfastly refuses to "leave the issue in the hands of doctors; it treats euthanasia as murder."[19] John Keown describes the notion that any life may be worthless enough to be discontinued as "alien" to the English criminal law since the principle of the sanctity of human life means that, "because all lives are intrinsically valuable, it is always wrong intentionally to kill an innocent human being".[20]

Despite the validity of such widely held opinions, the words of one woman dying of a brain tumour epitomise the close association between voluntary euthanasia and dignified death in the minds of many,

> If I had my way I could say good-bye ... I could choose my time and be calm and collected about it. I have had a good life and I would dearly like a good death ... my last wish is to die with dignity[21]

In this context voluntary euthanasia offers the opportunity to select the time and manner of one's dying in order to secure a peaceful death, unencumbered by intrusive medical technology. Such a death is perceived as inherently dignified.[22]

It must be recognised that clinicians and carers do not approach voluntary euthanasia with malicious intent. They do so through a desire to exercise compassion and give effect to the autonomous wishes of patients seeking death with dignity. To police the practice of euthanasia with the blunt instrument of the criminal law of homicide which emphasises sanction, prevention, and

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[19] G. Williams, *Textbook of Criminal Law* (2nd edn) (1983) London: Stevens, at 580.

[20] J. Keown, "Courting Euthanasia? Tony Bland and the Law Lords" (1993) 9 (3) *Ethics and Medicine*, 15.

[21] C. Taylor-Watson in Margarette Driscoll "After a Good Life, Why can't we Choose a Good Death?" *The Sunday Times*, Jan 15th 1995.

[22] There is a range of terminology in common currency to describe the various forms of euthanasia, including, voluntary and non-voluntary euthanasia, active and passive euthanasia, and mercy killing. This study is primarily concerned with an analysis of consensual, or voluntary, euthanasia as a means of achieving the *dignified* death here described.

retribution, may not be appropriate in such an environment. The fundamental ethical and humanitarian questions raised by voluntary euthanasia are perhaps too complex to facilitate resolution through the criminal justice system. Therefore, having identified what is meant by the term euthanasia, it is important to determine how euthanasia and the law of homicide interact and how they relate to the concept of human dignity. Before this can be achieved it is particularly important to define when life ends and death begins both medically and legally since these definitions impact significantly upon our social, moral and legal understanding of euthanasia and any criminal culpability that attaches to it.

Defining Death

There was a time when it was obvious to even the casual observer that a person had died. There would be no respiration or pulse and the body would cease to function finally and irrevocably. This is no longer the case. Even lay people now have the knowledge and ability to resuscitate a person who has suffered a heart attack or respiratory failure and effectively bring them back from the dead. Medical professionals, aided by technology, have the expertise to revive a person who in earlier times would have been considered dead, and to keep a body alive even after the brain has died. As a result questions of exactly when life ends and how death is defined have become significant both clinically and legally. Some commentators have regarded the definitions of death available to them as equivocal,

> ... At whatever level we choose to call death, it is an arbitrary decision. Death of the heart? The hair still grows. Death of the brain? The heart may still beat.[23]

This being the case, exactly when is somebody medically and legally dead?

A Medical Definition of Death

Determining the answer to this question with certainty depends upon an understanding of what categorises the distinction between life and death. Currently accepted definitions of life and death are informed by religious,

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[23] H. Beecher, "The New Definition of Death, Some Opposing Viewpoints" (1971) 5 *International Journal of Clinical Pharmacology*, 120-1.

philosophical, cultural, and legal perceptions, and are historically specific, having evolved alongside the development of medical science. But if a person is warm to touch, rosy and alive to the eye and breathing with the aid of a machine, how can we tell if she is alive or dead?

When the first heart transplant surgery was performed in South Africa in 1967 this question took on a new significance. To transplant a heart successfully the operation must be performed before the organ stops functioning in order to ensure that it is not damaged. But if death is defined in terms of continuing respiration and circulation removal of the heart may appear to cause death which would of course constitute murder. Therefore an accurate and readily understandable definition of death is essential to the practice of modern medicine which accepts as commonplace techniques such as artificial ventilation, organ donation and transplantation. The everyday use of techniques such as these has meant that traditional understandings of life and death are less clearly defined. Similarly, the assessment of potential criminal culpability for euthanasia and assisted death is dependant upon cognisance of exactly when and how a person has died.

Death does not occur in an instant but is the result of the culmination of the processes of dying. Even after the cardio-vascular and the respiratory systems have ceased to function the death of the body tissues at cellular level is a gradual and variable process whereby some tissues and organs continue to *live* after others have died, a phenomenon that was clearly described in a report by the Conference of the Medical Royal Colleges,

> ... death is not an event: it is a process, the various organs and systems supporting the continuation of life failing and eventually ceasing altogether to function, successively and at different times.[24]

All body tissues die if they are permanently deprived of oxygen. However, most have the capacity to withstand a degree of oxygen starvation and to repair themselves once their oxygen supply is restored. This, together with the progressive nature of dying, necessitates the identification of those organs which are most vital to the maintenance of life and whose failure effectively defines death.

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[24] "Diagnosis of Death" (1979) 1 *British Medical Journal,* 332.

The cells of the brain and spinal cord are unique in that they do not possess the capacity to regenerate. Therefore, once brain damage has occurred it is irreversible. However, some areas of the brain, most notably the brain stem, are less susceptible to oxygen deficiency than others and can endure longer periods of hypoxia before permanent damage occurs. But, the brain stem is the region of the brain which controls the autonomic functions of the body including respiration so if it is damaged breathing will stop. The cessation of spontaneous respiration due to circulatory arrest or "intercranial catastrophe" caused by disease or trauma,[25] will ultimately result in death yet it may be many minutes before cardiac failure finally occurs. At this point modern medical technology can interrupt the natural processes and the patient may be resuscitated and placed on a mechanical respirator. Breathing and circulation will then continue even though the brain stem has ceased to function. Nevertheless a person whose brain stem has been damaged in this way can never regain the ability to function independently.

In 1976, in the light of the impact of medical advances and authoritative academic and medical comment from around the world,[26] the Report of the Medical Royal Colleges considered how death should be defined and recommended that, "...permanent functional death of the brain constitutes brain death".[27] The following recommendations for the diagnosis of brain stem death were also contained in the 1976 Report,

- the patient should exhibit fixed and dilated pupils (the eyes move with the head and there is no "dolls eye" response),
- there should be no response to touching the eye with a wisp of cotton wool or similar material,
- there should be no eye movement in response to cold water being passed into the ear,
- there should be no gag reflex,
- there should be no response to pain,
- there should be no respiratory response, i.e. the patient will fail to breath spontaneously when the respirator is withdrawn.

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[25] C. Pallis "Return to Elsinore" (1990) 16 *Journal Medical Ethics*, 10.

[26] Perhaps most influential was the Report of the Harvard Brain Death Committee, *Journal of the American Medical Association*, August 1968.

[27] "Diagnosis of Death" (1976) 2 *British Medical Journal*, at 1187.

This definition of death was affirmed by the Conference of the Medical Royal Colleges in 1979 with the statement that brain death could be diagnosed when brain "functions" had, "permanently and irreversibly ceased".[28] The tests outlined above are designed to determine that brain functions have permanently ceased, a state which is irreversible. The use of the word "functions" was carefully chosen to eliminate the possibility of failure to diagnose death in circumstances where continuing metabolic or electrical activity in isolated areas of the brain is demonstrable. Such activity does occasionally occur but if the criteria and tests used to diagnose brain stem death have been satisfied it has no bearing on the patient's prospects of recovery. The medical definition of death is now associated with this kind of irreversible damage to the brain and patients who have sustained such trauma have been variously described as "brain dead" or "brain stem dead". The body remains artificially alive but the brain has died.

The adoption of this definition of death has wide reaching implications for the law, as well as for the practice of medicine. Once it is recognised that a patient's body can be artificially maintained, beyond the point where brain death is established but that somatic death has not yet occurred, then it must be accepted that a doctor's role is no longer one of merely treating disease and saving life. Indeed the role of the doctor has inevitably been broadened to include the ability to, "take decisions which may affect the span of human life".[29]

However, to define death as occurring when the brain ceases to retain the capacity to maintain the bodily functions can sit uneasily with everyday perceptions of life and death. A dead person is thought of as inanimate, cold and pale, but a person who is "brain dead" and connected to a life support system does not appear to be dead in this sense. While respiration and circulation continue the body appears to be alive, even if the stimulus is inorganic, and this can create false impressions. Those who care for patients maintained in this way habitually refer to them as if they were still alive as do visiting relatives and friends.[30] It is alien to human understanding to relate to a warm "breathing" body as if it were dead; to do so seems destructive of human dignity.

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[28] "Diagnosis of Death" (1979) 1 *British Medical Journal*, 332 at para 7.
[29] H. Beynon, "Doctors as Murderers" (1982) *Crim. L.R.*. 17.
[30] Several examples of this phenomenon are offered by Peter Singer in *Rethinking Life and Death* (1995), Oxford University Press, at 32.

Conversely some commentators argue that to remain alive but devoid of the ability to function as an independent human being is an undignified state which ought to be defined as death. This is the situation that arises when a diagnosis of persistent vegetative state (PVS) is made. A person who has been correctly diagnosed as suffering from PVS or long term coma will never regain the ability to function as a social human being, spontaneous respiration and circulation continue but there is no capacity for cognitive awareness or interaction with the world.

PVS has been described as cognitive or cerebral death, a definition of death that centres on the distinctiveness of the entity which is the human being, and provides that once that distinctiveness is lost that person is dead,

> ... if the medical tests have in fact determined that there is no potential for spontaneous cerebral brain function, even if spontaneous respiration continues, then the human person is dead.[31]

Cognitive function is what gives value to human life and when it is permanently lost the unique reasoning character of the human personality is lost with it. Therefore, if "the personal, identifiable life of an individual human can be equated to the living function of that part of the brain called the cerebrum"[32] the individual must be considered dead once cognitive or cerebral function has ceased.

The notion of cognitive death being equivalent to complete death reflects the fact that a human being is more than just a functioning, breathing body and takes account of theories of mind/body dualism. In these theories the mind and the body can be separated so that the body constitutes the physical being, the flesh and bones and organs that make up the tangible person, and the mind "is what differentiates a man from other less interesting objects in the world- plants, rocks, and masses of gas, for example".[33] The mind is also the ultimate repository of the individual human personality so that,

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[31] E.W. Keyserlingk, "Sanctity of Life or Quality of Life" (1979) Law Reform Commission of Canada, Protection of Life Series Study Paper, 62.

[32] S.D. Olinger, "Medical Death" (1975) 27 *Baylor Law Review*, 22.

[33] K. Campbell, *Body and Mind* (2nd ed.) (1984) Indiana: Notre Dame Press, at 2.

> ... cerebral function is manifested in consciousness, awareness, memory, anticipation, recognition and emotions ... there is no human life in the absence of these.[34]

But the implications of these notions about what constitutes death extend beyond the realms of the practical and obvious to the philosophical and religious, as Janet Daley explains,

> To move from the religious idea that what sanctifies human beings is the possession of an immortal soul, to the rationalist one that the only thing that is sacred -the only thing that gives us a right to live- is a fully functioning mind, is a moral shift of considerable significance.[35]

It is a moral shift that the medical profession appears not to have adopted since "doctors invariably regard such [*PVS*] patients as alive".[36] Cognitive death is contrary to established medical criteria for defining death and therefore is not regarded as definitive of death. Yet, as will be discussed in Chapter Two, the treatment of patients in a persistent vegetative state who have suffered cognitive death can be problematic. Frequently the relatives do not wish their loved one to be maintained in such a condition indefinitely, and the demands on scarce medical resources dictate that there is reluctance to persist with costly but futile treatment. As a consequence law courts have been required to decide whether or not a person must be maintained or may lawfully be allowed to die, and the significance of brain stem death and cognitive death has been assessed in order to establish a legal definition of death.[37]

A Legal Definition of Death

There is no statutory definition of death in the United Kingdom, although the merits and demerits of introducing such a definition have been widely discussed.[38] By comparison, in America death has been defined by statute for many years. For example, Kansas Statutes 1971 includes the statement that,

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[34] Supra, n.32.

[35] J. Daley, "Where's Mercy in Such Killings?" *Daily Telegraph* 16th April 1996.

[36] P. D. G. Skegg, *Law, Ethics and Medicine* (1984) Oxford: Clarendon, at 215, parenthesis added.

[37] Cases include *Re Quinlan*, 70 NJ 10 353A 2d 647 (1976), *Cruzan v Dept. of Health of Missouri*, 110 S Ct 2841 (1990), *Airedale NHS Trust v Bland*, [1993] 1 All E.R. 821, and *Re A* [1992] 3 Med. L.R. 303.

[38] Examples of the arguments for and against implementing a statutory definition are included in, I. Kennedy, "Alive or Dead" (1969) 22 *Current Legal Problems*, 102, P.D.G. Skegg, "The

> A person will be considered medically and legally dead if, in the opinion of a physician, based on ordinary standards of medical practice, there is the absence of spontaneous brain function ...

There are many diverse situations where a clear legal definition of death can be a significant advantage. For example, it may be necessary to determine exactly when a person died in order to establish who will benefit from the deceased's estate, or to allocate criminal responsibility for causing the death, or to absolve professional carers of responsibility by negating any possible duty of care. Each of these situations has featured in cases which have sought to clarify the issue of when a person is legally dead.

Smith v Smith[39] was an early American case wherein a legal definition of death was sought. Mr and Mrs Smith had died following a road accident. Mr Smith was declared to be dead on arrival at hospital but Mrs Smith was unconscious and remained so until certified dead seventeen days later. The Smiths had no children and each had made a will to the effect that their property should pass to the other in the event of death. The dispute arose over who should inherit Mr Smiths estate? If Mrs Smith had not died in the accident then Mr Smith's property would pass to her and thence to her beneficiaries on her death. But if they had died simultaneously in the accident then the joint estate would pass to Mr Smith's family.

The Court held that while a person continued to breathe, even if aided by a machine, he or she remained legally alive, a judgement which reflects traditional approach to defining when death occurs. However, it was an approach which was becoming increasingly problematic as is demonstrated by the British case *R v Potter*.[40]

The victim, was admitted to hospital with severe head injuries following a fight with the defendant in the case. Fourteen hours later he stopped breathing and was placed on a respirator. After twenty-four hours a kidney was removed for

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Case for a Statutory Definition of Death", (1976) *Journal of Medical Ethics*, 190, and the report of the Criminal Law Revision Committee, *Fourteenth Report: Offences Against the Person*, Cmnd. 7844 (1980) London: HMSO at para 37.

[39] (1958) 317, SW 2d, 275 Supreme Court of Arkansas.

[40] *The Times* 26th July 1963, discussed in D.W. Myers, *The Human Body and the Law* (2nd ed.) (1990) Edinburgh University Press, at 190, and I. Kennedy, A. Grubb, *Medical Law: Text with Materials* (2nd ed.) (1994) London: Butterworths, at 1389.

transplantation and subsequently the respirator was switched off. He then failed to breath spontaneously and was declared dead. The traditional definition of death dictates that the victim / patient remained alive while respiration and circulation continued even if this was artificially maintained. Therefore the kidney had been removed while he was still alive, without consent, and for no purpose which was beneficial to him, thus the surgeons had committed a battery. Furthermore, the defendant then argued that the actions of the doctor had broken the chain of causation between the assault, for which he was responsible, and the death of the victim. The court appears to have agreed because the assailant was convicted only of common assault.

As we have seen the medical definition of death was being clarified in the light of technical advancement throughout the 1960s and 70s and the advent of two important criminal appeal cases made it imperative that the law keep pace with medical developments.[41] In *R v Steel* the victim was a young woman, Carol Wilkinson, who left her job in a bakery at about 9a.m. on 10th October 1977 to walk home. At some time between 9o'clock and 9.30 a.m. she was attacked, stripped of her clothing and beaten about the head with a 50lb stone which was later found nearby. She was discovered in a field next to the road soon after and taken to hospital where she was found to have suffered multiple skull fractures and concomitant brain damage. Ms Wilkinson was connected to a ventilator but this was disconnected two days later when no electrical brain activity could be detected. The post-mortem examination suggested that decomposition of the brain had already begun. the question was, when did she die?

The same issue arose in *R v Malcherek*, which involved a violent marital dispute. The victim was 32 year old Christina Malcherek who was estranged from her husband. On March 26th 1979 Malcherek visited his wife's flat, they argued and the wife was stabbed nine times. One wound penetrated the abdomen resulting in surgery to remove a section of intestine. Mrs Malcherek was expected to make a full recovery but on April 1st she collapsed and was transferred to a hospital which was better able to treat her condition. She deteriorated further and was thought to have suffered a massive pulmonary embolism, a recognised complication of major abdominal surgery. She was resuscitated and surgery was performed to remove a large blood clot from her heart. Once this was done her heart began to function normally.

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[41] *R v Malcherek and Steel* [1981] 2 All E. R. 422.

However there had been no circulation for approximately 30 minutes and anoxic brain damage was anticipated. Mrs Malcherek was placed on a ventilator and an electro-encephalogram was performed to determine the level of brain function. The prognosis was poor. On removal from the ventilator however Mrs Malcherek did breathe spontaneously for a while until a further deterioration occurred which was thought to be the result of a blood clot in the brain. Tests were carried out to confirm that there was irreparable damage to the brain, before the relatives were consulted and the life support system was switched off and she died.

At the trials of both Malcherek and Steel the juries were advised to consider only the established facts and the intentions of the defendants. Both were convicted but appealed on the basis that cause of death should have been left for the jury to consider. It was contended that death had actually been caused by the doctors switching off the machines and not by the actions of the defendants; a view which was consistent with traditional definitions of death.

It was held on appeal that in each case, the medical treatment had been competent and adequate. The wounds inflicted on the victims remained "a continuing and indeed substantial cause of death" such that the defendants must be convicted. Lord Lane said,

> ... Where the medical practitioner using generally acceptable methods, came to the conclusion that the patient was, for all practical purposes dead and that such vital functions as remained were being maintained solely by mechanical means and accordingly discontinued treatment, that did not break the chain of causation between the initial injury and death.[42]

The judgement recognised that the action of the doctors was not responsible for the death of the patients and that there could be multiple causes, but it did not explicitly define what constitutes death. Subsequent cases similarly failed to adequately address the issue, despite having the opportunity so to do. The case of *Mail Newspapers PLC v Express Newspapers PLC*[43] was one where it would have been appropriate and beneficial for the court to clearly define death.

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[42] *ibid* at 430 per Lord Lane.

[43] [1987] F.S.R. 90.

The case concerned the ownership of photographs taken at the wedding of Mr and Mrs Bell which had been published in seven daily newspapers. The issue arose because, at twenty-four weeks pregnant Mrs Bell had suffered the brain haemorrhage and was thought to be clinically dead. She was being maintained on a life support system in the hope that her baby could be born alive, hence the media interest.

Mr Bell had signed an agreement with Mail Newspapers PLC, giving them sole rights to future publication. There was some doubt as to whether Mr Bell owned the copyright to the photographs and therefore had the authority to agree to their publication. There was evidence to suggest that the copyright was in fact vested in Mrs Bell, since it was she who had commissioned them. However, she had acted in consultation with her future husband and it was he that had ultimately paid for them.

The court found that the copyright was jointly owned by the couple and that neither co-owner was entitled to grant an exclusive license. Only in the event of Mrs Bell's death would Mr Bell be empowered to grant the sole rights to Mail Newspapers PLC, prompting Millet J.'s assertion that, "there is at the very least a serious question to be tried whether Mrs Bell is alive or dead".[44] No tests had been undertaken to determine whether Mrs Bell was clinically dead and, in the absence of any medical evidence to confirm her legal status as alive or dead, the case was decided according to the probability that she was indeed dead,

> The overwhelming probability must be that, if Mrs Bell is not already dead, she will incontrovertibly be dead immediately or very shortly after the birth of the baby, when it is virtually certain that the life support system, having fulfilled its purpose, will be switched off, so that at that time, if not before the overwhelming likelihood is that the sole title to the copyright will have vested in Mr Bell.[45]

The determination of Mrs Bell's status as dead or alive was recognised as "a serious question" but nevertheless the court avoided providing a legal definition of death, being content to decide the case on the basis of the probability that she was dead. Accordingly British law remained devoid of a legal definition of

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[44] *ibid* at 94.

[45] [1987] F.S.R. 90 at 95.

death until the position was finally clarified by Johnson J. in *Re A (A Minor)*[46] in 1992.

Child *A* was admitted to hospital via the accident and emergency department following an injury suffered at home. At the time of admission no heart beat could be detected and initial attempts at resuscitation proved unsuccessful, although cardiac function was eventually restored. The next day he was transferred to a second hospital for assessment and intensive therapy, but still no signs of recovery could be induced. The consultant overseeing *A*'s treatment carried out tests to determine whether the child was in fact, brain stem dead, according to the criteria outlined by the Medical Royal Colleges.[47] The tests confirmed that he was indeed clinically dead. A second consultant (a paediatric neurologist) repeated the tests and reached the same conclusion, hence it was proposed that Child *A* be disconnected from the ventilator.

Child *A* and his siblings were the subject of an emergency protection order under the Childrens Act 1989. This order decreed that parental responsibility for the children was conferred upon the local authority under s.44 (4)(c), but that this was imposed without absolving the parental responsibility of the parents.[48] The parents were hostile to the clinicians and their findings because suspicions had been raised that the child had sustained non-accidental injuries. They refused to give permission for the life support to be withdrawn. Therefore the local authority sought a precise declaration as to the child's status and the legal position should artificial life support be withdrawn. After hearing the evidence Johnson J. declared,

> ... *A* is now dead for all legal, as well as medical, purposes, and ... [I] make a declaration that should the consultant, or other consultants ... consider it appropriate to disconnect *A* from the ventilator, in so doing they would not be acting contrary to the law ... I hold too that it would be wholly contrary to the interests of that child, as they may now be, for his body to be subjected to what would seem to me to be the continuing indignity to which it is subject[49]

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[46] [1992] 3 Med. L. R. 303.

[47] "The Diagnosis of Brain Death" (1976) 2 *British Medical Journal*, 1187, and "Diagnosis of Death" (1979) 1 *British Medical Journal*, 332.

[48] s2 (b) Childrens Act 1989.

[49] *supra*, n.46, at 305.

This statement effectively incorporates the definition of death adopted by the medical professions in 1976 into the common law by accepting that the legal and medical definitions of death are the same. Brain stem death can now be considered as medical and legal death, provided that the procedures and recommendations of the Report of the Royal Colleges have been strictly adhered to and the brain stem has totally and irreversibly ceased to function.

The highly publicised case of *Airedale NHS Trust v Bland*[50] scrutinised the issue of what constitutes death with particular reference to the debate concerning the distinction between brain stem death and cognitive death. Anthony Bland had been in a PVS for four years when his family and doctors applied to the Court for a declaration that to withdraw nutrition and hydration would be lawful. Advocates of the theory that individuals who have permanently lost cognitive function should be regarded as dead would argue that Anthony Bland had been dead since the accident which resulted in his irreversible coma; those caring for Anthony Bland regarded him as alive but accepted that treatment withdrawal would lead to his death. The Law Lords carefully considered the issue of when death occurs,

> as a result of developments in modern medical technology, doctors no longer associate death exclusively with breathing and heartbeat, and it has come to be accepted that death occurs when the brain, and in particular the brain stem, has been destroyed.[51]

and concluded that,

> ... in law, Anthony is still alive. It is true that his condition is such that it can be described as a living death; but he is nevertheless still alive ... The evidence is that Anthony's brain stem is still alive and functioning and it follows that, in the present state of medical science, he is still alive and should be so regarded as a matter of law.[52]

Cognitive death is not therefore a state presently recognised as death by medicine or the law. Were it to be so it would raise serious problems concerning the cause of death in trauma victims and the victims of crime, as well as for the care of

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[50] [1993] 2 W.L.R. 316.

[51] *ibid* per Lord Goff at 366.

[52] *supra*, n. 50, per Lord Goff at 368.

brain damaged infants and adults. These issues will be discussed in greater detail in Chapter Two.

Euthanasia as Homicide

These medical and legal definitions of death have been outlined in order to facilitate this discussion of the ethical and legal implications of euthanasia and assisted death. It is also necessary to consider the relationship between euthanasia and homicide which dictates criminal culpability where euthanasia and assisted death are at issue. Homicide includes murder and manslaughter[53] both of which are common law offences, without statutory definition. Murder is classically defined as,

> ... when a man of sound memory, and the age of discretion unlawfully killeth within the country of the realm any reasonable creature ... under the Kings peace, with malice aforethought ...[54]

Modern language therefore describes murder as the intentional, unlawful killing of one human being by another and it is clear that will tend to fall within this definition.

Yet the criminalisation of voluntary euthanasia is increasingly at odds with our libertarian society's definition of morally wrong behaviour and conduct which is harmful to others. Harm itself is a concept susceptible to a variety of moral interpretations and Ashworth correctly states that, "one cannot proceed far without adopting a definition of harm".[55] John Stuart Mill's liberal philosophy declares that individual autonomy should be respected and that the state should criminalise only conduct which is harmful to others.[56] Voluntary euthanasia is outside the scope of criminal behaviour in this model since the harm is not inflicted on others and is performed at the volition of the "victim". Against this, Feinberg has argued that the criminal law should be invoked to prevent or reduce *any* conduct which *may* prove harmful to others,[57] of which voluntary euthanasia

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[53] Infanticide is also defined as homicide but, under the Infanticide Act 1938, it applies only where a woman causes the death of her own child before that child reaches the age of twelve months.

[54] Coke, 3 Inst 47.

[55] A. Ashworth, *Principles of Criminal Law* (2nd edition) (1995) Oxford: Clarendon Press at 30.

[56] J. S. Mill, *On Liberty* (1859) London: Parker.

[57] J. Feinberg, *Harm to Others* (1984) Oxford University Press, J. Feinberg, *Harmless*

is clearly an example. Euthanasia therefore is technically criminal but may not in practice be contrary to the principles that underpin the criminal law. The following cases demonstrate that as a consequence, people (doctors, patients, and carers) who confront a choice between protracted, undignified, suffering, and quick release, are not well served by a criminal justice system which rests upon such uncertainty and inconsistency.

In 1957 Dr. John Bodkin Adams was tried for the murder of an eighty-four year old woman in his care, who had named him as a beneficiary in her will.[58] The patient was terminally ill and succumbed following the administration of large doses of narcotics prescribed by Dr. Adams. Devlin J. advised the jury that, regardless of the health of the victim and the motive of the accused, the law would treat as murder any action which intended to kill and did in fact kill. He also ruled that,

> If the first purpose of medicine, the restoration of health, can no longer be achieved there is still much for a doctor to do, and he is entitled to do all that is proper and necessary to relieve pain and suffering, even if the measures he takes may incidentally shorten human life.[59]

After a seventeen day trial the jury declined to convict. They deliberated for only forty-five minutes before finding Dr. Adams not guilty.

Acquittal was also the outcome of the trial of Dr. Leonard Arthur, a paediatrician who was charged with the murder of a neonate with Down's Syndrome.[60] The child had been rejected by his parents who instructed Dr. Arthur that they did not wish the baby to survive. Subsequently a note was entered in the medical records that the baby should receive "nursing care only". The infant was not fed but received strong pain killing drugs, allegedly to ease his distress. He died three days later. The doctor argued that the child died of natural causes due to Down's Syndrome, and when evidence was revealed that other significant congenital abnormalities were also present, the charge was reduced to attempted murder. Despite being advised that doctors, like everyone else, must practise

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Wrongdoing (1988) Oxford University Press.

[58] H. Palmer, "Dr. Adams on Trial for Murder", *R v Adams* [1957] Crim. L.R. 365.

[59] *ibid*, at 375.

[60] *R v Arthur*, The Times, 6th November 1981, 1, and (1993) 12 B. M. L. R. 1. This case remained officially unreported for many years but many accounts are available, see for example, Poole, "Arthur's Case: A Comment" [1986] *Crim. L. R.*. 383.

within the law, and that benevolent motives are irrelevant in determining intention, the jury failed to convict Dr. Arthur.

This pattern was repeated in the trial of Dr. Carr who was charged with attempted murder when his patient died after he injected him with a huge dose of phenobarbitone (a barbiturate).[61] However, evidence was presented that the patient had been suffering terribly with inoperable lung cancer and had repeatedly requested that his inevitable death be hastened. Dr. Carr was acquitted.

Finally came *R v Cox*.[62] Here the clinician carried out the wishes of his distressed and dying patient and deliberately injected her with strong potassium chloride, a drug which causes death but has no therapeutic value. She died soon afterwards and Dr Cox was charged with attempted murder. The jury were given no choice but to convict in this instance since the death had resulted from deliberate unlawful killing and was therefore categorised as homicide. Their extreme reluctance to find Nigel Cox guilty was apparent in the fact that many of them wept openly as the verdict was returned. The patient's family considered that Dr Cox had enabled their elderly relative to secure a merciful release from the terrible pain and distress she was enduring so that she could die with dignity. The case resulted in considerable public debate and concern for the doctor, the patient, her family, and others who may find themselves in a similar situation.

These cases stand as authority for the basic premise that deliberately to take the life of another is a crime. They are also testimony to the hesitance of juries to disregard the compelling motives of the individuals concerned, unless the evidence is incontrovertible. Against this background, *Airedale NHS Trust v Bland*,[63] was presented to the courts to obtain a declaration that withdrawal of "treatment"[64] leading to death was lawful, so that the medical attendants could avoid criminal prosecution. Those caring for Anthony Bland faced an ethical dilemma if they continued to treat him and a legal one if they did not. His condition offered no prospect of recovery or improvement, so to maintain a regime of burdensome and invasive treatment was medically futile. Yet to

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[61] *R v Carr*, The Sunday Times, 30th November 1986, 1.

[62] *R v Cox* (1992) 12 B.M.L.R. 38.

[63] [1993] 1 All E.R. 821.

[64] The emphasis on "treatment" is intended to demonstrate the unease with which many commentators have approached the fact that the provision of nutrition and hydration was described as such.

discontinue treatment would cause his death and give rise to criminal culpability. Withholding nutrition and hydration from Tony Bland would inevitably result in his death; this was clearly understood, even desired, by those responsible for his care, and signifies the appropriateness of murder charges.

Similar issues were graphically depicted by the harrowing experiences of Thomas Creedon and his family.[65] This child was born so severely brain damaged that he could never interact with the world around him or those in it. He could only sustain nourishment through intrusive tube feeding and was often inconsolable. The paediatrician responsible for Thomas' initial care dismissed his parents' pleas for their son's life to be brought to a peaceful and dignified conclusion, arguing that to do so would contravene the criminal law. Feeding, he stated, was a basic right and he had a duty to provide it. Perhaps fortunately for all the Creedons, Thomas died before it became necessary to determine through the courts whether allowing Thomas to die, at his parents' request, would constitute homicide.

The issues raised by these cases characterise the medico-legal dilemma generated by voluntary euthanasia. Good medical practice requires that patients do not experience unnecessary and unwelcome suffering but the criminal law is inconsistent in its response to practitioners who take life limiting decisions. Clinicians like Nigel Cox, who openly end their patients' lives out of compassion, are sanctioned,[66] while euthanasia through the subterfuge of selective non-treatment,[67] and double effect, whereby beneficial medication is given in the certain knowledge that death will occur as a side effect,[68] has been permitted.[69] Some authors have suggested that if Dr Cox had used pain relieving medication, instead of strong potassium chloride, he would have been shielded from conviction by the doctrine of double effect.[70] Such an approach would have placed Cox's conduct firmly within Devlin J.'s contention that, "the doctor is entitled to relieve pain and suffering even if the measures he takes may incidentally shorten life",[71] but would not have avoided the simple truth that it

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[65] K. Toolis, "A Death for Thomas", *The Guardian Weekend*, February 3rd 1996, 18-23.

[66] *supra*, n. 62.

[67] *Airedale NHS Trust v Bland* [1993] 1 All E.R. 821, *Frenchay NHS Trust v S* [1994] 2 All E.R. 403.

[68] *supra*, n. 58.

[69] These issues will be discussed in detail in Chapter Two.

[70] C. Wells, "Patients, Consent and Criminal Law" (1994) 1 *Journal Social Welfare and Family Law*, 65, at 73.

[71] *supra*, n. 58.

was his intention to kill the patient albeit for benevolent motives. Dr. Cox was criminally culpable because he had foresight of the consequences of his actions,[72] and those actions were a probable cause of the patient's death. The consent of the deceased was irrelevant in this context, providing no effective defence for the clinician.

The law of consent was similarly limited in Tony Bland's case, although his parents and the clinicians responsible for his care postulated that had Bland had the capacity to give consent he would not have done so.[73] The allocation of criminal responsibility in cases involving euthanasia and assisted death are, as in all criminal cases, dependent upon determining the *actus reus* and *mens rea* of the crime involved, namely homicide. The requisite *mens rea* is apparent in *Bland* in that the purpose of withdrawing treatment is to bring about death. The *actus reus* is less clear cut, depending on whether treatment withdrawal is properly described as an act or an omission, whether the cessation of treatment is a demonstrable cause of death and, if treatment withdrawal constitutes an omission, was there a duty of care?

These points are discussed in Chapter Two which analyses the legal and ethical issues raised by the withdrawal of nutrition and hydration alongside those of other forms of euthanasia such as assisted suicide, double effect and mercy killing in order to examine the distinctions between killing and caring. Generally the criminal law distinguishes conduct which society considers harmful as worthy of criminal sanction. Therefore in most instances of homicide death is the harm caused by the conduct of the accused who has killed the victim. With euthanasia, the indignity of a *living death* in a persistent vegetative state, or the protracted dying process associated with terminal disease, can appear more harmful than death itself and bringing the life of the victim of this harm to a dignified end can be considered caring. Great significance is attached to the perceived need for dignity in dying by those who advocate euthanasia but there are fundamental questions which need to be addressed before a valid case can be made for euthanasia as a mechanism for providing dignity in dying.

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[72] *R v Moloney* [1985] A.C. 905, *R v Nedrick* [1986] 3 All E.R. 1.

[73] The relevance of the law of consent and the assessment of an individual's capacity to give or withhold consent will be considered in Chapters Four and Five.

Euthanasia as Death with Dignity

Human dignity is a descriptive and value-laden quality, encompassing self-determination and the ability to make autonomous choices, which is gaining currency with modern political philosophers. Ronald Dworkin, for example, describes belief in individual human dignity as the most important feature of Western political culture giving people the moral right "to confront the most fundamental questions about the meaning and value of their own lives".[74] People who examine the meaning and value of their lives in the face of imminent death often express concerns that their dignity may be compromised if the dying process is prolonged and involves becoming incapacitated and dependent. The ability to retain a similar level of control over dying as one has exercised during life is seen by many as the way to achieve death with dignity. Madan argues that this is because,

> dignity does not come to the dying from immortality fantasies, or compensatory ideas, such as reincarnation and paradise, nor does it come from empowerment through modern medicine. It comes from the affirmation of values, not only up to the boundaries of death ... but in a manner that encompasses dying under living and does not oppose the two in a stern dualistic logic.[75]

Advocates of euthanasia as death with dignity believe that respect for individual autonomy should allow patients the opportunity to choose euthanasia as an alternative to becoming dependent upon medical carers and burdensome to family and society.[76] Patient autonomy, self-determination, and control are given legal expression through the law of consent which theoretically offers every person the right to "determine what shall be done with his own body"[77] and ensures that anyone who imposes medical treatment, involving physical contact or harm upon another, in the absence of valid consent, will be criminally culpable. Any patient with the mental capacity to give consent is also entitled to withhold consent,[78] "even if a refusal may risk personal injury to his health or even lead to premature death".[79] Established exceptions to this general rule

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[74] *supra*, n. 2, at 166.

[75] T.N. Madan, "Dying with Dignity" (1992) 35 (4) *Social Science and Medicine*, 425-32.

[76] M. Kelner, I. Bourgeault, "Patient Control Over Dying: Responses of Health Care Professionals" (1993) 36 *Social Science and Medicine*, 757-765; C. Seale, J. Addington-Hall, "Euthanasia: Why People Want to Die Earlier" (1994) 39 *Social Science and Medicine*, 647-54.

[77] *Schloendorf v Society of New York Hospital* (1914) 105 N.E. 92, 93, (N.Y.) per Cardozo J.

[78] *Re C (Adult Refusal of Treatment)* [1994] 1 W.L.R. 290.

[79] *Re T (An Adult) (Consent to Medical Treatment)* [1992] 2 F.L.R. 458, per Lord Donaldson

allow for treatment to be administered in the absence of consent if there is a duty to act,[80] or necessity.[81] Failure to obtain consent where these exceptions are not present can amount to criminal assault and battery. The law pertaining to consent and issues relating to it are therefore pivotal to an analysis of euthanasia and death with dignity and will be explored in detail in Chapter Four which will demonstrate that in practice an individual's right autonomously to determine what is done with his or her body is often limited.

The law of consent gives individuals the ability to choose whether or not to accept whatever treatment is offered; it does not confer any right to demand that particular forms of treatment be provided, even in the quest for death with dignity. Voluntary passive euthanasia, whereby death results from selective non-treatment because consent is withheld, is therefore legally possible while active euthanasia is prohibited. In this way people with the capacity to do so can orchestrate the timing of their own deaths, in an attempt to achieve dignity in dying. However, many of those who may become the potential subjects of concerns about euthanasia are lacking in the mental capacity to give or withhold consent to medical treatment. Consequently Chapters Four and Five will investigate the legal rights of those who are unable to decide for themselves and the responsibilities of those who care for them.

The exercise of autonomy through the formation and expression of a living will that can provide the mechanism whereby a person's wishes can be recognised and acted upon even after the capacity to consent is lost is discussed in detail in Chapter Five. Living wills appear to many to provide the opportunity to take and maintain control of ones life throughout its entirety. As a result they are frequently promoted as a means of achieving dignity in dying and are therefore of great concern to the central themes of this study. The usefulness of living wills, as a mechanism for advanced decision making by those who fear that they might become incapacitated and therefore unable to participate in medical decision making at some time in the future, will be carefully assessed to determine their relevance to euthanasia and death with dignity.

MR at 473C.

[80] *R v Stone* [1977] Q.B. 354, *R v Wilkinson, The Times*, 19th April 1978, 5, *R v Smith* [1979] Crim. L.R. 251.

[81] *Murray v McMurchy* [1949] 2 D.L.R. 442, *Re F* [1990] 2 A.C. 1.

In jurisdictions other than Britain cases have been brought based upon claims of a constitutional right to die with dignity.[82] These examples focus on the right to selective non treatment and assisted suicide as an alternative to a perceived life of indignity but do not adequately address the fundamental issue of whether this kind of death constitutes dignified dying. British law however does not explicitly recognise any right to die with dignity, although both *Airedale NHS Trust v Bland*[83] and *Frenchay NHS Trust v S*[84] referred to the importance of dignity and the *indignity* of being maintained in a living death.

Yet in all probability non-treatment will result in a death which has little to do with dignity. Death will result from slow starvation, for those like Bland who have been diagnosed as PVS; untreated infection, for handicapped infants like Thomas Creedon, or perhaps AIDS sufferers; or suffocation due to the discontinuation of artificial respiration for those inflicted with Guillain-Barre syndrome or similar pathology. Moreover, in the broader context of active voluntary euthanasia, death may be caused by drug overdose, asphyxiation, or lethal injection.[85] Such conduct promotes patient autonomy but may not be inherently dignified. Simultaneously it may be detrimental to the dignity of others because over-emphasising individual autonomy can cause other concepts of private and public good, which might permit greater recognition of the potential effects on people other than the patient, to be overlooked.[86] In particular it is important to consider whether the ability to choose and practise euthanasia can actually promote dignity in dying while it remains unlawful.

R v Cox,[87] where the doctor exercised absolute respect for his patient's autonomy by responding to her appeals that he curtail her suffering by killing her, illustrates this dilemma. The patient allegedly achieved her dignified death but the doctor who assisted her was subjected to the indignity of a criminal trial. He was convicted of attempted murder and as a consequence faced a professional disciplinary hearing which questioned his professional and moral integrity. Dr

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[82] *Rodriguez v A-G of British Columbia* [1993] 3 WWR 553, *B(Nancy) v Hotel-Dieu de Quebec* (1992) 86 DLR (4th) 385, (Quebec Supreme Court), *Cruzan v Missouri Department of Health* (1990) 110 US Supreme Court 2841, and *Re Quinlan* (1976) NJ 355 A. 2d. 647.

[83] *supra*, n. 63.

[84] *supra*, n.64.

[85] It is interesting to note that in the context of execution, lethal injection is considered more humane, and therefore perhaps more dignified, than hanging or gassing.

[86] S. Jinnet-Sack, "Autonomy in the Company of Others", in A. Grubb (ed), *Choices and Decisions in Health Care* (1993) Chichester: Wiley, 97.

[87] *supra*, n. 62.

Cox received a suspended jail sentence and may now practise medicine only under the close supervision of other physicians. *His* dignity was jeopardised because he acceded to his patient's request for a dignified death.

The methods adopted by other health care professionals, who have been acknowledged as instrumental in the premature deaths of others, also demonstrate that euthanasia does not necessarily impart dignity. For example the Dutch doctor, Boudewijn Chabot, was subjected to the indignity of several court and disciplinary procedures after he assisted in the suicide of a physically healthy but depressed patient. Chabot was steadfast in his defence of his actions, believing that his response had been humane, but the court refused to accept his plea that he had acted out of the recognised defence of necessity. It is interesting to ponder on the impact of the court cases and media attention on the dignity of his patient's family.

The practices of the American doctor Jack Kevorkian, alias "Dr. Death", also suggest that enabling people to fulfil their desire for death with dignity may simultaneously be destructive of the dignity of others. The former pathologist uses the media to promote the commercial use of his suicide machines to people seeking assisted death. One highly publicised criminal case in Michigan involved Janet Adkins, who was suffering from the initial stages of Alzheimer's disease and was anxious to avoid the debilitating progression of the condition. She and her husband met and dined with the doctor and two days later she used Kevorkian's specially converted Volkswagen van to kill herself in a public park. Mrs Adkin's motivation may be wholly understandable as may the doctor's respect for her wish to escape the undignified death she anticipated, but Dr. Death's methods do little to advance the cause of death with dignity. Of concern here is whether respect for human dignity extends beyond the dignity of the individual involved in a particular enterprise, namely suicide and assisted suicide, to the wider community, in this instance other users of the public park. The dignity of one may be achieved by compromising the dignity of others. Despite this however juries have repeatedly declined to convict Dr. Kevorkian of homicide or assisting suicide.[88] His techniques may be undignified and contrary

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[88] Reporting from New York for the *Daily Mail* on Doctor Death's involvement in the death of Briton Austin Barnstable in Michigan on May 10th 1996, 25, Tony Gallagher quotes Jack Kevorkian as stating that this was "the 28th time he had assisted a suicide"; he was on bail following an earlier case of assisted suicide on this occasion.

to the letter of the criminal law but they have satisfied the morality of a significant proportion of American society.

Euthanasia can offer the opportunity to select the time and manner of one's dying in order to secure a peaceful death, unencumbered by intrusive medical technology and such a death is perceived by many as inherently dignified. However it is important to identify what is meant by dignity in this context. Human dignity is a quality with different connotations for different people and in the context of dying many consider it more dignified to take the opportunity to experience every second that life has to offer. The complex arguments around dignity and the way it relates to euthanasia will be expanded in Chapter Six which will discuss the similarities and differences between perceptions of dignity in dying in different cultures. It will also consider the alternative to euthanasia offered by the hospice movement which regards palliative medicine and good terminal care to be a more dignified option than euthanasia.

Whether a perceived need for death with dignity can be met through euthanasia and whether this should be achieved by legal reform to give people the legal right to opt for euthanasia and assisted death is the central theme of this work. The conclusion of Chapter Six will draw together the threads of the argument and review the possibilities for legal reform which might provide individuals with the opportunity to select euthanasia. It will also describe some of the uncertainties that surround the outcome of the possible introduction of legislation permitting euthanasia, particularly for people who may subsequently discover that euthanasia has become a duty rather than a right.

Chapter Two

Euthanasia and Clinically Assisted Death: From Caring to Killing[1]

Introduction

This chapter defines and describes the various types of clinically assisted death presently associated with euthanasia, and the response of the law to them. In so doing it examines the medical circumstances in which clinically assisted death seems appropriate to some patients, and the methods by which it might be achieved. The legal and ethical issues exposed by this analysis are relevant to all clinical situations where patients or doctors can select a course of medical treatment which has potentially life-limiting consequences. Principally they hinge upon the role of patient autonomy, the practical treatment options available, and the role of the criminal law: these will provide the foundations of this discussion.

The advent of advanced medical technology and its ability to prolong living and dying has, together with greater patient autonomy, inspired increasing awareness of voluntary euthanasia and assisted death. Doctors confronted by distressed patients seeking treatments which may be construed as euthanasia, can experience a profound moral dilemma that emanates from the conflict between their ethical duty to relieve suffering, and the responsibilities imposed upon them by the law. Respect for individual autonomy is central to modern medical practice, such that all patients have the right to autonomy and self determination with regard to medical treatment.[2] The legal expression of this right is enshrined in the concept of consent, which enables a patient to determine what medical treatment she will receive.

Patients have an absolute right to exercise their autonomy by giving or withholding consent to treatment. It is a right which persists even if death will result from refusing treatment,[3] and can endure after a patient loses the mental

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[1] This chapter formed the basis of an article published under the title "Decisions and Responsibilities at the End of Life: Euthanasia and Clinically Assisted Death" (1996) 2 *Medical Law International*, 229-245.

[2] Numerous cases endorse this right, see for example, *Schloendorf v Society of New York Hospital* (1914) 105 N.E. 92, (N.Y.), *Sidaway v Bethlem Royal Hospital Governors* [1985] 1 All E.R. 643 at 666, *Re T* [1992] 4 All E.R. 649 at 652-3.

[3] This right was reiterated in *Airedale NHS Trust v Bland* [1993] 1 All E.R. 821 at 860 per Lord Keith, and in *Re C (Adult: Refusal of Treatment)* [1994] 1 W.L.R. 290.

capacity to consent.[4] However, the right to give or withhold consent, either contemporaneously or in advance, does not extend to requesting that a physician assist a patient to die by performing an act which may be contrary to professional ethics and could lead to criminal prosecution. Kennedy and Grubb argue that a reasonable clinical judgement cannot be overridden by the patient or the law,[5] and *Re J*[6] suggests that the principle of respect for patient autonomy does not entitle patients to demand treatments which are not clinically indicated. Yet there might be circumstances where a doctor feels an ethical responsibility not to reject such a request. Arguably Dr Nigel Cox felt such a responsibility when he responded to the repeated pleas of his long term patient Lillian Boyes to be released from pain by hastening her death.[7] Similarly with the Dutch doctor Boudewijn Chabot who controversially assisted a physically healthy but clinically depressed patient to commit suicide.[8]

Recently greater public awareness of patient's rights has developed through the publicity surrounding cases such as these, current political ideology, which has promoted consumerism through *The Patients Charter*,[9] and the accompanying expansion of doctors' accountability. Together these have emphasised the practical role of individual patient autonomy in the provision of health care, particularly at the end of life. But the absolute endorsement of the patient's right to autonomy may compromise the clinician's professional and ethical integrity if it results in euthanasia.

The pleas of patients and relatives for an end to suffering may be compelling, when a caring physician is confronted by the disturbing realisation that conventional medicine is unable to assuage a patient's distress and symptoms. The doctor's aim and duty is always to provide treatment which is in the patient's "best interests" but the patient's understanding of "best interests" may be at odds with conventional medical wisdom and the law.[10] The patient or relatives may be convinced that only the immediate ending of suffering through death

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[4] *Re T (Adult: Refusal of Treatment)* [1992] 4 All E.R. 649, endorsed the patient's right to refuse medical treatment in advance of that treatment becoming necessary, and *Re C (Adult: Refusal of Treatment)* [1994] 1 W.L.R. 290, held that this right persists even in the event of supervening incapacity.

[5] I. Kennedy, A. Grubb, *Medical Law: Text with Materials* (2nd. ed.) (1994) London: Butterworths, at 1278.

[6] *(A Minor)* [1992] 4 All E.R. 614 CA.

[7] *R v Cox* (1992) 12 B.M.L.R. 38.

[8] Supreme Court of the Netherlands, Criminal Chamber, 21 June 1994, nr 96.972.

[9] *The Patients Charter* (1991) London: HMSO.

[10] A full discussion of the concept of *best interests* is included in Chapter 4.

represents the best interests. The result is either a request for deliberate action or a refusal to consent to treatment.

In these circumstances, are patients and relatives entitled to expect compliance with their requests for a humane and dignified, but permanent, resolution? Or, should they exhibit a greater degree of moral responsibility by not placing the doctor in the position of being forced to choose between legal and professional suicide, and the ultimate act of compassion? If, the exercise of patient's rights compromises the professional integrity of those responsible for the provision of medical care the advancement of those rights becomes problematic. Celia Wells defines the problem precisely when she argues that "refusal of life-saving treatment cannot always be an individual prerogative".[11] The impact of such a refusal on others must always be considered because in some circumstances the demands of patient autonomy may place the doctor in a position almost as intolerable as that occupied by the patient.

The present legal position concerning life-limiting treatment decisions is unsatisfactory for patients and doctors alike. Patients, and their relatives, often demand clinically assisted death in order to curtail what they perceive as the futile suffering associated with protracted dying. Yet doctors who comply with these requests expose themselves to criminal and professional sanction. Hence, the law often fails to afford either group the degree of protection to which they should be entitled. Often therefore, a compromise is necessary to protect the right of the individual to autonomy and bodily integrity, within the defined responsibilities of the doctor in respect of that right.

Tensions occur in clinical situations where the clinician believes it to be in the patient's best interests to discontinue therapy but the patient or relatives disagree, and where the relatives or patient wish the treatment to be discontinued against the advice of the doctor. As a result clinicians may find themselves coerced into taking decisions which are contrary to their ethical or clinical judgement. In situations where the patient is unable to speak for herself the views of relatives should be considered as a part of good medical practice, but legal precedents suggest that these views should not be decisive.[12] The dilemma for the doctor,

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[11] C. Wells, "Patients, Consent and Criminal Law" (1994) 1 *Journal of Social Welfare and Family Law*, 65, at 65.

[12] See for example, *Airedale NHS Trust v Bland* [1993] 1 All E.R. 821 per Lord Goff at 872 where the concept of substituted judgement was discussed and dismissed as having no part to play in English law. In the USA however, the principle has been recognised and used, e.g. in *Cruzan v Missouri Department of Health* (1990) 110 US Supreme Court 2841.

lies in attempting to respect the wishes of patient and family while maintaining legal and ethical standards of care. It is a dilemma which is particularly apparent in clinical situations where the continued provision of medical treatment affords little more than a prolongation of the dying process. Where this is the case, the possible treatment options include;

- the indefinite continuation of palliative treatment,
- selective non-treatment,
- the administration of increasing doses of pain relieving medication until respiratory suppression occurs (the principle of *double effect*),
- the provision of drugs to assist the death of the patient (i.e. physician-assisted suicide), and;
- mercy killing.

These options will be scrutinised in turn, in order to assess the medical, legal, ethical, and social implications of each. The section on selective non-treatment will include a detailed analysis of the legal aspects of causation, acts and omissions and the duty to provide care, while criminal intention and its relationship with motive will be scrutinised alongside the discussion of the principle of *double effect*.

The indefinite continuation of palliative treatment

The terms "palliative care" and "palliative medicine" describe a treatment regime which recognises cure as impossible but aims to alleviate suffering wherever practicable. The indefinite continuation of palliative care can become contentious if patients, or their relatives and carers, consider it to be a futile prolongation of life. Yet for some patients indefinite palliative treatment is the only available therapy. Where this is the case, the aim of palliative medicine is to maintain the patient in a comfortable pain free condition and, as far as is feasible, to comply with the patient's wishes regarding the administration of treatment. The most compelling dilemmas concerning the indefinite continuation of palliative treatment can be illustrated by considering the position of patients with the condition known as persistent vegetative state (PVS).[13]

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[13] This condition was first described by B. Jennet and F. Plum, "Persistent Vegetative State After Brain Damage" (1972) 1 *The Lancet*, 734-7, and has been distinguished from other medical conditions in R. Cranford, H. Smith "Some Critical Distinctions Between Brain Death and Persistent Vegetative State" (1979) 6 *Ethics in Science and Medicine*, 199.

PVS was first legally defined in the American case *Re Karen Quinlan*[14] where the court recognised that the condition dictates that the brain "no longer has any cognitive function" but that despite this it retains "the capacity to maintain the vegetative parts of neurological function".[15] It is arguable that, because cognitive function and social interaction have been irretrievably lost, patients in this condition are devoid of many, if not most, of the attributes which define each of us as distinct human personalities. The unique reasoning character of the individual has been destroyed together with all capacity for awareness and memory. These patients have periods when they appear to be awake, though unaware, and others when they seem to be sleeping despite being unconscious. There is no observable cognitive perception of pain or discomfort although they do exhibit local reaction to painful stimuli. They survive as purely physical beings.[16]

It has become established medical practice not to confirm the diagnosis of PVS until one year after the onset of brain damage[17] but, with continued palliative care it is possible for patients to survive in this condition for many years. In a Japanese study of 110 PVS patients, approximately half the patients died within the first year, while more than a quarter survived for over three years. Four patients continued to live for ten years or more, but generally the possibility of recovery remains slight,

> Vegetative patients have a consistently poor prognosis. During the three year follow up period, more than 60% of the patients died, despite attentive medical care. On the other hand, some patients regained awareness and were able to speak a little but were unable to resume activity as a social human being. Persistent recovery has been attained in three cases ... only one patient regained nearly normal brain function.[18]

Since true PVS offers no scope for recovery, though long term survival is possible, the term "recovery" used in this context may simply express survival. The criteria adopted by this study for the diagnosis of PVS are also questionable in the light of more recent research which suggests that the incidence of true PVS is lower than previously thought and that some level of actual recovery

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[14] (1976) 70, NJ10, 355 A 2nd 647.

[15] *ibid*, at 650.

[16] J. Fletcher, "Medicine and the Nature of Man" (1973) 1 *Science, Medicine and Man*, 93.

[17] See BMA Committee for Medical Ethics discussion paper *The Treatment of Patients in PVS* September 1992.

[18] Higashi, Sakato, Hatano "Epidemiological Studies on Patients with a Persistent Vegetative State", (1977) 40 *Journal Neurology, Neurosurgery, and Psychiatry*, 876.

may indeed be possible even after considerable periods of time have elapsed.[19] The methods adopted by this research team are themselves open to critique however. The research results were based on a retrospective study of 40 patients admitted to a specialist unit who had been referred with a diagnosis of PVS. Of these 40 patients it was claimed that 17 had been incorrectly diagnosed because they later exhibited signs of awareness. Yet 10 of the 17 were admitted to the unit less than 12 months after their initial injury and hence failed to meet the established criteria for diagnosing PVS to begin with.[20,21] Despite the controversy, it has been estimated that at any one time there are at least 1500 PVS patients in the United Kingdom who have been diagnosed using established diagnostic criteria[22] and, contrary to Andrews work which suggests high levels of false positive diagnoses, earlier studies cautioned that due to inaccurate underdiagnosis there are potentially many more.[23]

Patients survive in a PVS without the assistance of artificial life support systems and do not conform to criteria for diagnosing brain stem death. They remain clinically and legally alive, although concerns have been expressed as to what kind of life they live,

> What is meant by "life" in the moral precept which requires respect for sanctity of human life? If the quality of life of a person ... is non-existent since he is unaware of anything that happens to him, has he a right to be sustained in that state of *living death* and are his family and medical attendants under a duty to maintain it?[24]

The queries here expressed imply that the human condition of a person in PVS may be so awful that perhaps actual death would be preferable to living death. It must be recognised however, that the physical being that the PVS patient has become is in many respects inseparable from the intact personality who existed before. The patient does not exist in a vacuum; she has a social history which persists beyond the hospital bed and the body which she now occupies and dictates that treatment decisions cannot be taken in isolation. It "is not simply a

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[19] K. Andrews, L. Murphy, R. Munday, C. Littlewood, "Misdiagnosis of the Vegetative State: Retrospective Study in a Rehabilitation Unit" (1996) 313 *British Medical Journal*, 13-16.

[20] R. Cranford, "Misdiagnosing the Persistent Vegetative State" (1996) 313 *British Medical Journal*, 5.

[21] For an overview of the issues see Adam Nicolson, "Caught Between Life and Death", *Sunday Telegraph Review*, May 26th 1996, 1-2.

[22] "Institute of Medical Ethics Working Party on the Ethics of Prolonging Life and Assisting Death. Withdrawal of Life Support from Patients in PVS" (1991) 337 *The Lancet*, 96-98.

[23] K. R. Mitchell, I. H. Kerridge, T. J. Lovat, "Medical Futility, Treatment Withdrawal and the Persistent Vegetative State" (1993) 19 *Journal of Medical Ethics*, 71.

[24] *Airedale NHS Trust v Bland* [1993] 2 W.L.R. 316, per Lord Brown-Wilkinson.

technical medical issue".[25] However, decisions to continue with palliative care indefinitely also have implications beyond those associated with the individual patient, "the burden is great on patients who suffer permanent loss of intellect, on their families, on the hospitals, and on those in need of hospital beds already occupied".[26] The impact of the indefinite continuation of palliative care upon each of these groups is worthy of further scrutiny.

The patient in PVS is devoid of understanding but nonetheless is subjected to the indignity of a helpless existence where she is dependent upon intrusive medical care for survival. A regime of palliative care for such a patient can involve her carers in many months, or years, of burdensome and stressful toil performed in the knowledge that it is unlikely to impact upon the prognosis of the patient. Therefore, a decision to continue indefinitely with palliative care carries with it social and emotional costs, particularly to the carers and family. Observing the steady decline of a person for whom medicine offers no hope is demanding for professional and emotional carers alike and inevitably exacts a heavy toll. The result may be requests to discontinue treatment: but these requests carry costs in themselves, particularly for relatives, who may feel uneasy and guilty about advocating a decision to curtail treatment, knowing that the consequence will be death for the patient. However, the impact upon others who require hospital care may be equally great if the continuation of futile palliative care effectively denies them treatment.

Determining which patients, or which conditions, have the most worthy or most just claim to any particular facility is a complex process, especially where the funding for medical care is centrally distributed. The provision of scarce resources is readily conceived of in terms of competing claims to be assessed according to a variety of preordained criteria.[27] Most of the methods used to decide how resources should be allocated include a comparative assessment and many are controversial both conceptually and in their application.[28]

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[25] P. D. G. Skegg, *Law, Ethics and Medicine* (1988) Oxford: Clarendon Press at 144.

[26] H. K. Beecher, "A Definition of Irreversible Coma" (1968) 205 *Journal of the American Medical Association*, 337-340 at 338.

[27] C. Newdick, *Who Should We Treat?* (1996) Oxford University Press, examines the issue in terms of the legal response to the competing claims of patients, doctors, and managers to NHS resources.

[28] The issues are clearly outlined and discussed in, P A Lewis and M Charney, "Which of Two Individuals Do You Treat When Only Their Ages are Different and You Can't Treat Them Both?" (1989) 15 *Journal of Medical Ethics*, 28.

For example, the allocation could be made by assessing the patient according to a test that calculates the probable medical benefit that will result from treatment. Clearly the prognosis for a patient diagnosed as suffering from PVS is poor by comparison with other patients whose conditions are either temporary or allow scope for recovery,[29] so the claims of a patient with PVS are always likely to be less favourably assessed. Another method involves making a comparison on the basis of the individual patients' value to society. This calculation is also highly subjective, resulting at best in inconsistency and at worst in discrimination. How, for example, is it possible to distinguish between the value to society of any two individuals? Consider the situation where a gifted doctor has a confirmed diagnosis of PVS and a convicted murderer has recently sustained a severe head injury from which she may or may not recover. Which is in greater need of treatment? Which is likely to be of the most, or least, value to society? And, what if one has several children in need of support and guidance while the other has none?

The concept of *quality adjusted life years* (QALYs), which is essentially an economic indicator, has been developed as a mechanism to help resolve some of these issues.[30] QALYs are a numerical calculation of life expectancy and quality. Scores are attained on a scale which values each year of healthy life as one, death as zero, and each year of unhealthy life as less than one. The scale allows for the degree of the reduction in quality of life to be accounted for in the extent to which the score falls below one. Therefore, "a life considered to be worse than death can be afforded a minus score."[31]

QALYs are dependent upon medical personnel judging the potential quality of life of other people. Such assessments are inherently value laden and subjective. Patients may themselves intrinsically value some aspects of their lives more than others and the opinions of those who are responsible for allocating resources may run counter to these values. A stereotypical example presents the scenario where the patient relishes the opportunity to sit and smoke all day while watching television, but the clinician making the assessment is appalled by the prospect. Moreover QALYs are inherently disadvantageous to certain groups of patients, specifically the elderly and those whose prognosis is poor. If the

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[29] Higashi, Sakato, Hatano "Epidemiological Studies on Patients with a Persistent Vegetative State" (1977) 40 *Journal Neurology, Neurosurgery, and Psychiatry*, 876, demonstrated a recovery rate of below 3%.

[30] See A. Williams, "The Economic Role of 'Health Indicators'", in G. Teeling-Smith (ed) *Measuring the Social Benefits of Medicine* (1983) Oxford University Press.

[31] J. K. Mason & R. A. McCall Smith, *Law and Medical Ethics* (4th ed) (1994) London: Butterworths, at 261.

treatment concerned is purely palliative and the patient has no prospect of recovery, regardless of whether or not treatment is provided, decisions made by applying the quality adjusted life years standard can never be beneficial. Consequently, as a method of allocating scarce resources QALYs seem to offer little more than a third party assessment of an individual patients best interests.

Other methods of determining how resources should be allocated have been suggested,[32] but most frequently medical treatment decisions are still taken on the basis of the clinical assessment of the individual patient's medical condition and its prognosis. This can be contentious if a treatment described as "not clinically indicated" is the only treatment maintaining life. Where the issue for the clinician becomes not simply a determination of the best interests of an individual patient, but also an assessment of the needs of other, as yet anonymous, patients the interests of one must inevitably be weighed against those of the other.[33] A patient in PVS can be described as having no interests,[34] so the continuation of treatment would not be clinically indicated; but a decision to discontinue treatment on this basis may be construed as euthanasia through the back door.

However, if a patient's condition is such that any prospect of improvement due to the provision of sustained medical treatment is minimal or non-existent, all the costs of indefinitely continuing to provide that treatment must inevitably be weighed against the remoteness of securing a beneficial outcome. Dan W Brock offers a useful analogy here stating that "it is *not* considered any requirement of justice to continue to search for those lost at sea or trapped in mines so long as there is any possibility of saving them, no matter how small".[35] The application of this reasoning to decisions to discontinue the treatment of PVS patients suggests that they are not inherently unjust; yet these perplexing decisions about whether or not to continue with palliative treatment are often complicated by the concerns of distressed relatives. Families may be anxious for the treatment to be either continued or terminated in opposition to the beliefs of the clinician responsible for the decision. Whether the decision is to continue or discontinue palliative care, doctors need to be "tactfully resistant" in order to avoid

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[32] E. Nord, "An Alternative to QALYs: The Saved Young Life Equivalent (SAVE)" (1992) 305 *British Medical Journal*, 875, R. Klein, "Dimensions of Rationing: Who Should Do What?" (1993) 307 *British Medical Journal*, 93.

[33] T. Hope, D. Springings and D. Crisp, "Not Clinically Indicated: Patients Interests or Resource Allocation?" (1993) 306 *British Medical Journal*, 379.

[34] See comments to this effect in *Airedale NHS Trust v Bland* [1993] 1 All E.R. 821 per Lord Mustill.

[35] D. W. Brock, *Life and Death* (1993) Cambridge University Press, at 240, emphasis added.

sacrificing the interests of the patient "to the emotional distress of the relatives".[36] The doctor has no legal obligation to continue with futile treatment. In *Airedale NHS Trust v Bland*, Lord Goff stated that, "... in a case such as the present, it is the futility of the treatment which justifies its termination".[37] As a consequence, all treatment, including hydration and nutrition, may be legitimately terminated if to continue would be contrary to the best interests of the patient. However, because the discontinuation of treatment will result in death, doctors have been advised to seek a High Court declaration that this may be accomplished lawfully.[38] The following discussion explains how the court will apply established criminal law principles in order to determine the lawfulness of withdrawing treatment.

Selective non-treatment

Patients who are incurable or terminally ill usually receive a range of treatments depending on the symptoms and progress of specific diseases. In many cases the treatment administered is little more than palliative, catering for pain relief and basic needs such as nutrition and hydration, and where this is the case there may be circumstances where selective termination of treatment is considered appropriate. The control of symptomatic pain is fundamental to good palliative care but the selective withdrawal of other therapies, such as antibiotics to fight infection and artificially administered nutrition and hydration may allow the patient to die peacefully.

There are innumerable medical conditions that can render a patient incapable of sustaining nutrition and hydration without active medical intervention. They include, PVS, anorexia nervosa, and terminal cancer complicated by intestinal obstruction, amongst others. It is also possible for a patient to be rendered incapable of maintaining her own nourishment and hydration through the imposition of medical treatment. Perhaps most notably, this can occur where a patient who is terminally ill requires heavy sedation, often "in order to relieve intolerable distress where dying is complicated by an agitated delirium or tracheal obstruction".[39] Where patients are receiving only palliative care,

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[36] E. Wilkes, "On Withholding Nutrition and Hydration in the Terminally Ill: Has Palliative Medicine Gone Too Far? A Commentary" (1994) 20 *Journal of Medical Ethics*, 144-5 at 145.

[37] [1993] 1 All ER 821, at 870.

[38] See Practice Note [1994] 2 All E.R. 413, para. 1.

[39] R. G. Twycross "Assisted Death: a Reply" (1990) 336 *The Lancet*, 796-798, at 796.

hydration and nutrition is likely to be the only therapy routinely provided, aside from basic care.[40]

Failure to maintain a patient's nutrition and hydration will inevitably result in death, regardless of the nature of any underlying pathology. Unless the patient has deliberately chosen to decline food, drink, and medication such a death could be considered to have resulted from neglect and may, in some circumstances lead to criminal proceedings against those with responsibility for the patient's care. In a situation like this any potential criminal liability is assessed according to the nature of the conduct involved and in particular whether the death resulted from a deliberate action or from a failure to act. The extent of liability will depend upon an analysis of what was the cause of death; whether the conduct which resulted in death is properly categorised as an act or an omission; and, whether a duty of care demands that treatment be continued in the given circumstances.[41] Hence the criminal law dictates that therapeutic decisions to withhold feeding and hydration must include careful consideration of each of these components if liability is to be avoided. Therefore, the relevance of the criminal law principals of causation, acts and omissions, and the duty of care will be discussed in relation to the outcome of withdrawing nutrition and hydration.

Causation

In any case where a clinician may be criminally liable for the death of a patient, verification of the actual cause of the patient's death will be central to the determination of culpability. Where death occurs following treatment withdrawal the cause of death seems obvious in the light of earlier comments about the certainty of death resulting from lack of nutrition and hydration, but sometimes the apparently obvious cause of death is not the actual cause.

In *R v White,*[42] Mrs White's son decided to kill his elderly mother by placing poison in her bedtime drink. He prepared a hot beverage and took it to his mother before retiring for the night. In the morning the old lady was found dead

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[40] *Basic care* is defined as the therapy required to keep an individual comfortable, generally this will include the provision of general hygiene and pain relief. The Law Commission has reaffirmed the view of the BMA and nursing professional bodies, that no patient should have the right to refuse *basic care* because of the distress that such a refusal would be likely to cause carers and other patients, see Law Commission Report 231, *Mental Incapacity, Item 9 of the Fourth Programme of Law Reform: Mentally Incapacitated Adults*, (1995) London: HMSO, at para 5.34.

[41] The *mens rea* or intentions of the clinician are also relevant but will be analysed in detail in the following discussion of double effect.

[42] [1910] 2 K.B. 124.

in her chair but the drink was only partially consumed. Her death was found to have been caused by a heart attack and she had not ingested sufficient of the poison to kill her. Subsequently White was convicted of attempted murder. He clearly intended to kill his mother and had taken steps so to do, but had not actually caused her death.

Similarly, the circumstances surrounding a patient's death may suggest that a particular feature of the treatment has directly resulted in death, but before criminal liability can be attached the actual cause of death must be established. It is arguable that if a patient dies because treatment is not administered, it is not the failure to treat that has caused death but the condition that made the treatment necessary in the first place. By implication this would mean that medical intervention cannot break the chain of causation between the onset of the condition and the patient's eventual demise; this is not necessarily so.

In *R v Jordan*[43] the defendant was convicted of murder. The victim had sustained serious stab wounds, inflicted by Jordan, and died later in hospital. However, the conviction was quashed on appeal when evidence was presented which demonstrated that the original wound was virtually healed at the time of death. Whilst in hospital the victim was discovered to be allergic to the antibiotic terramycin, but a doctor had administered it erroneously. Coincidentally, negligent treatment also resulted in a fluid imbalance which culminated in the patient's lungs becoming water-logged. In the Court of Appeal it was held that death was caused by the grossly negligent and "palpably wrong" treatment which resulted in pneumonia. It was also recognised that ordinarily, "... death resulting from any normal treatment employed to deal with a felonious injury may be regarded as caused by the felonious injury," but that, "... this was not normal treatment,"[44] therefore the causal link was broken.[45]

Jordan is, however, regarded as an exceptional case in British law and a series of subsequent cases have adopted a contrary stance.[46] *R v Smith*[47] concerned the administration of "thoroughly bad" treatment to the victim of a barrack room brawl. Despite the role played by the poor quality of the treatment, the chain of

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[43] (1956) 40 Crim. App. Rep. 152.
[44] *ibid.*
[45] H. L. A. Hart & A. M. Honere`, *Causation and the Law* (2nd ed) (1985) Oxford: Clarendon Press, at 355.
[46] See *R v Smith* [1959] 2 All E.R. 193, *R v Blaue* [1975] 3 All E.R. 446 and *R v Cheshire* [1991] 3 All E.R. 670.
[47] [1959] 2 All E.R. 193.

causation between the victim and his assailant was held to have remained in tact. Lord Parker C.J. explained why this should be so,

> ... if at the time of death the original wound is still an operating cause and a substantial cause, then the death can properly be said to be the result of the wound, albeit that some other cause is also operating. Only if it can be said that the original wound is merely the setting in which another cause operates can it be said that the death does not result from the wound ... only if the second cause is so overwhelming as to make the original wound merely part of the history can it be said that the death does not flow from the wound.[48]

R v Cheshire[49] further negates *Jordan*'s suggestion that the chain of causation may be disrupted by the intervention of medical treatment. Here the victim died of asphyxiation following the negligent management of a tracheotomy which was performed in the initial stages of treating gunshot wounds inflicted by the defendant. At the time of death the bullet wounds themselves were no longer life threatening but still the court held that,

> Even though negligence in the treatment of the victim was the immediate cause of his death, the jury should not regard it as excluding the responsibility of the accused unless the negligent treatment was so independent of his acts, and in itself so potent in causing death, that they regard the contribution made by his acts as insignificant.[50]

Despite the fact that the treatment administered to this patient was clearly negligent, the Court of Appeal regarded the narrowing of the trachea,[51] as not only a "rare complication" but also "... a direct consequence of the appellants acts, which remained a significant cause of his death."[52] Unlike *Smith*, which can be distinguished on its facts, *Cheshire* and *Jordan* are factually similar. Both concern negligent medical treatment of patients whose injuries were substantially remedied, yet the judgements differ in emphasis and outcome. Two observations can be made with regard to this; first the notion of causation is complex and requires recognition of the concept of multiple causes, and second, these judgements may reflect an inherent reluctance in the courts to acquit obviously implicated defendants at the risk of incriminating doctors.[53]

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[48] *ibid* at 198.

[49] [1991] 3 All E.R. 670.

[50] *ibid* at 678.

[51] A recognised but unusual side effect of tracheotomy.

[52] *Supra* n. 50.

[53] David W. Meyers promulgates this view in *The Human Body and the Law* (1990) Edinburgh

The preceding series of cases demonstrates that where the actions of a defendant can be shown, however unsatisfactorily, to remain operative, substantial or significant causes of death, the intervention of medical treatment is unlikely to damage the chain of causation. Yet in some situations, which are analogous to the present discussion concerning the discontinuation, or failure to provide, nutrition and hydration, it is the failure to receive medical treatment which is the apparent cause of death. These instances are often further complicated by the fact that it is the victim's refusal to consent that has resulted in non-treatment rather than any suggestion that the medical response has been inappropriate, they therefore raise the possibility of death being attributed to more than one cause.

In *R v Holland*[54] the victim was assaulted by the defendant, sustaining severe cuts to one of his fingers. He refused medical treatment and subsequently died of tetanus. The defendant was found to have caused his death, despite the victims refusal of treatment, because the original wound remained an operating and substantial cause of death. Medical treatment would not have been required *but for* the action of the defendant in assaulting his victim. Similarly, in *R v Blaue*[55] where the victim suffered four serious stab wounds, one of which punctured a lung. In hospital she was advised that the nature and severity of her injuries meant that she required a blood transfusion if her life were to be saved. Being a Jehovah's Witness she declined to consent to a blood transfusion and ultimately died from internal bleeding. On appeal the defendant argued that it was the lack of medical treatment that had caused her death but the conviction was upheld because,

> ... the physical cause of death in this case was the bleeding into the pleural cavity arising from penetration of the lung. This was not brought about by any decision made by the deceased girl but by the stab wound.[56]

The reasonableness of the victim's refusal of treatment, and its impact upon the chain of causation and therefore on the defendant's culpability, was also questioned. However, its relevance was denied by Lawton LJ,

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University Press, at 98.

[54] [1841] 2 Mood & R 351.

[55] [1975] 3 All E.R. 446.

[56] *ibid*, per Lawton L.J. at 450.

> ... It has long been the policy of the law that those who use violence on other people must take their victims as they find them. This in our judgement means the whole man, not just the physical man. It does not lie in the mouth of the assailant to say that his victim's religious beliefs which inhibited him from accepting certain kinds of treatment were unreasonable. The question for decision is what caused the death? The answer is the stab wound.[57]

The physical cause of death was the bleeding, and that had been caused by the stab wound inflicted by the accused. The decision of the victim to decline medical treatment was clearly also a cause of her death but it was held to be subordinate to the factual cause of her death. The stab wounds caused the bleeding and therefore continued to be operative and substantial up until she died.

In *R v McKechnie and Others*[58] the victim died in hospital more than four weeks after being assaulted when the defendants broke into his home. On admission to hospital he was found to be unconscious, having sustained acute head injuries as a result of a severe beating and being hit over the head with a television set. While undergoing treatment a bleeding duodenal ulcer was also diagnosed which would require surgical intervention. However, the severity of the head injuries was such that the risk of administering a general anaesthetic was too great and no operation was performed. The victim died when the duodenal ulcer perforated. At issue was whether McKechnie had caused the victim's death since the injuries he inflicted were remote from the ulcer that ultimately killed him. At first instance the jury were directed that, in order to convict, they must be satisfied that the head injuries had significantly contributed to the death; they were. On appeal the direction to the jury and the verdict were endorsed because the decision not to operate was regarded as reasonable in the circumstances and the defendant's actions were more than a minimal cause of death. The Court of Appeal took the view that if the victim's anaesthetic tolerance had not been reduced by the beating he received from McKechnie, his ulcer could have been treated and he would not have died. The head injury was not the only cause of death but it was a significant one without which death would have been avoided.

In all of these cases defendants attempted to define medical intervention as an intervening act with the capacity to break the chain of causation between the injury and the death. With the notable exception of *Jordan*, the courts have

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[57] *ibid.*

[58] (1992) 94 Crim. App. Rep. 51.

consistently rejected an argument which would clearly absolve a culpable assailant from responsibility. This rejection has not however excluded the possibility of medical treatment or non-treatment being *a* causative factor in the death of a patient which could result in criminal culpability. What if the victim is a patient suffering from disease or accidental injury where there is no culpable defendant, and the clinicians decline to treat or commence treatment and subsequently withdraw treatment? Such a scenario occurred in the case of Tony Bland,[59] the innocent victim of the Hillsborough Football Stadium disaster.

Tony Bland never recovered from the trauma he received in the Hillsborough stadium in April 1989. He remained in PVS with no prospect of improvement or recovery for more than three years during which time his parents and the clinicians caring for him resolved to allow him to die by withdrawing nutrition and hydration. What would be the cause of death if Tony Bland was allowed to die in this way? Would it be the conduct of the clinician in withholding treatment or would it be the injuries sustained at the football match?

The situation is not analogous to one where mechanical life support is withdrawn from a patient who is subsequently declared dead. In that example criminal liability does not ordinarily flow as a result of cessation of life support because where a patient is wholly maintained by a mechanical life support system, and is incapable of life independent of the machine, it is demonstrable, using established criteria for the diagnosis of brain stem death, that she is already medically and legally dead prior to the disconnection of the ventilator. As long as the patient has been diagnosed as brain-stem dead before the treatment is discontinued the clinician will not be responsible for causing death; a point which was emphasised by Lord Lane in *R v Malcherek*,[60]

> Where a medical practitioner, using generally acceptable methods, came to the conclusion that the patient was for all practical purposes dead and that such vital functions as remained were being maintained solely by mechanical means, and accordingly discontinued treatment, that did not break the chain of causation between the initial injury and the death.[61]

Hence, a doctor who follows this course of action, "... would simply be allowing the original injury to operate to cause death and would thus be protected from

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[59] *supra*, n. 37.

[60] [1981] 2 All E.R. 422.

[61] *ibid*, at 428-9.

criminal liability."[62] Following *Holland*, *Blaue* and *McKechnie*, where the victims were not treated and the wounds inflicted by their assailants were deemed to have caused their deaths, it might be plausible to conclude that failure to treat would not constitute the cause of death in Tony Bland's case. However, in those cases treatment was never instigated. Therefore to attribute the cause of death to medical intervention would clearly be unsatisfactory. With *Bland*, the treatment had been provided for over three years so it was not a case of simply failing to treat but of deliberately ceasing to treat. In this case the withdrawal of treatment must surely constitute *a* cause of death even if other causes, such as the original injury, co-existed.

Lord Goff however resisted this conclusion, suggesting that as long as the withdrawal of treatment from Tony Bland was lawful, it would not constitute the cause of death, because death would have been caused by the injuries sustained in the Hillsborough football stadium.

> ... The established rule [is] that a doctor may, when caring for a patient who is, for example, dying of cancer, lawfully administer painkilling drugs despite the fact that he knows that an incidental effect of that application will be to abbreviate the patient's life. Such a decision may properly be made as part of the care of the living patient, in his best interests; and, on this basis the treatment will be lawful. Moreover, where the doctor's treatment of his patient is lawful, the patient's death will be regarded in law as exclusively caused by the injury or disease to which his condition is attributable.[63]

However, cause is an objective phenomenon; a matter of fact. As such, causing death may or may not attract criminal liability depending on the presence or absence of the other elements of the crime and it is these which denote the lawfulness or otherwise of the conduct concerned. Lord Mustill offered an interpretation of the relevance of causation which conforms to this model,

> ... the argument presented to the House asserts that for the purpose of both civil and criminal liability the cause of Anthony Bland's death ... will be the Hillsborough disaster. As a matter of the criminal law of causation, this may well be right, once it is assumed that the conduct is lawful ... It does not perhaps follow that the conduct of the doctors is not also causative, but this is of no interest since if the conduct is lawful the doctors have nothing to worry about. If on the other hand

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[62] R. Cooper, Comment "Withdrawal of Life Support - Lawful?" (1993) *Journal of Criminal Law*, 283 at 286.
[63] *supra*, n. 37 at 868.

> the conduct is unlawful, then it is in the same case as active euthanasia or any other unlawful act by doctors or laymen. In common sense they must all be causative or none; and it must be all, for otherwise euthanasia would never be murder.[64]

The doctors may effectively cause the death but in so doing they will not attract criminal liability if the causative conduct is considered lawful. The assessment of the lawfulness of this course of conduct is dependent upon the characterisation of the conduct as an act or an omission and the existence, or otherwise, of a duty of care.

Act or Omission?

Where action is taken which causes death, the commission of that act can be defined as the *actus reus* of murder. Ordinarily the *actus reus* of murder will be a positive action which results in death and criminal liability will arise where the *actus reus* coincides with the intention to kill (the *mens rea* of murder). Where there is no positive action but there is a failure to act, that failure to act is described as an omission and an omission causing death will only give rise to criminal liability where the person who failed to act was under a duty to act in the particular circumstances of the case.

In *R v Gibbins and Proctor*[65] a man, and the woman with whom he lived, omitted to provide food for the man's child who died as a consequence. The woman had been given money to buy food but had neglected to do so, and the man had failed to ensure that his child was fed. The Court of Appeal held that the judge at first instance was correct in directing that they were guilty of murder if their intention in withholding food was to cause grievous bodily harm.[66] The reason given was that the father had a duty towards his child and the woman had assumed a similar duty. Therefore, even though the child's death was caused by an omission, the couple were criminally responsible.

To assess the potential criminal liability of those withdrawing hydration and nutrition from a patient, it is first necessary to determine whether such conduct is properly categorised as an act or an omission. In Tony Bland's case the Law Lords decided that the withdrawal of artificial feeding by the removal of the naso-gastric tube constituted not an act but a mere omission, in spite of

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[64] *supra*, n. 37 at 892.

[65] (1918) 13 Crim. App. Rep. 134.

[66] The required *mens rea* for the offence of murder is the intention to kill or cause grievous bodily harm.

protestations to the contrary by the Official Solicitor. Bland's feeding was administered via a naso-gastric tube which delivered liquid food directly into his stomach. Failure to introduce nutrients through the tube would clearly constitute an omission which would ultimately result in death. However, physically removing the tube so that food could no longer be administered in this way could equally be described as a positive act resulting in criminal liability if it caused the patient's death. This apparently arbitrary distinction between act and omission would determine the extent of criminal liability flowing from this situation. Helen Beynon has considered these issues in depth and concluded,

> ... perhaps the distinction in this context is that if the doctor's course of conduct made the patient's condition worse, it should be described as an "act"; whereas if it failed to make the patient's condition any better, it should be described as an "omission".[67]

The distinction between making a patient's condition worse and failing to make it better is a difficult one to apply when the ultimate consequence of either is death. In relation to this discussion of the withdrawal of nutrition and hydration perhaps it is more germane to assess whether criminal culpability is appropriate in the circumstances. In this case the potential liability of those caring for Tony Bland, and other patients in similar circumstances, will hinge upon the duty of care owed.

The duty to provide medical care

No criminal liability arises for omissions to act unless there exists a legal duty of care. It is important therefore to consider the situations which have the potential to create a legal duty of care.

An obvious example is where a duty to act is imposed upon an individual via contractual obligations. *R v Pittwood*,[68] wherein a gate-keeper at a level crossing failed in his contractual duty to close the crossing gate with the result that a cart driver was hit by a train and killed, clearly illustrates this principle. Pittwood was convicted of manslaughter because he failed to perform the duty he had voluntarily accepted as a part of his contract of employment.

A duty of care can also arise in the absence of a contractual duty if an appropriate relationship exists between the people involved. Such relationships include those of family and domestic proximity, and those where there has been

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[67] H. Benyon, "Doctors as Murderers" (1982) *Crim. L. Rev.* 17.

[68] (1902) 19 T.L.R. 37.

a voluntary assumption of a duty of care as was the situation in *R v Instan.*[69] Here, the defendant was the plaintiff's niece who lived in her aunt's house and consumed food provided by her aunt. The aunt was ill and eventually became immobile. Instan failed to supply food to her aunt who subsequently died. The court held that the niece was under a duty to care for her aunt since she had voluntarily undertaken to do so and had received board and lodging in return. In *R v Stone and Dobinson,*[70] Stone's elderly sister who lived with the couple, refused nourishment and medical care and died; a victim of the defendant's neglect of a voluntarily assumed duty. They were convicted despite the fact that Stone was described as being of below average intelligence, almost blind and partially deaf, while his mistress, Dobinson, was "inadequate". It was held that the couple had voluntarily assumed a legal duty to care for the sister, because they had initially undertaken to do so, and that because they had failed to discharge that duty they were criminally liable for her manslaughter.

A legal duty of care also arises by virtue of a person's position in society and her or his relationships with others. Those who hold public office or occupy a position of trust as a consequence of their profession inevitably owe a duty of care to those for whom they are responsible. Doctors, nurses and other health care professionals fall within this category as Lord Nathan explains,

> The medical man's duty arises then quite independently of any contract with his patient. It is based simply upon the fact that the medical man has undertaken the care and treatment of the patient.[71]

All doctors owe a duty of care to their patients. In each case the duty arises by virtue of the fact that the doctor has undertaken to treat the patient concerned. In the performance of that duty a doctor must act,

> ... in accordance with a practice accepted at the time as proper by a reasonable body of medical opinion even though other doctors adopt a different practice. In short, the law imposes the duty of care; but the standard of care is a matter of medical judgement.[72]

Therefore, a doctor will not be in neglect of the duty of care if it is demonstrable that other doctors are treating patients with the same condition and prognosis in

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[69] [1893] 1 Q.B. 450.

[70] [1977] Q.B. 354, [1977] 2 All E.R. 341.

[71] Lord Nathan, *Medical Negligence* (1957) Oxford University Press, at 8.

[72] *Sidaway v Bethlem Royal Hospital Governors* [1985] 1 All E.R. 643, per Lord Scarman at 649, reiterating the *Bolam* principle as articulated in *Bolam v Friern Hospital Management Committee* [1957] 2 All E.R. 118.

the same way.[73] In *Bland* the extent of the doctor's duty of care became the central issue in determining criminal liability. Their Lordships were in complete agreement that a doctor is under no duty to provide or continue treatment which is not in the patient's best interests. Tony Bland's persistent vegetative state was irreversible, rendering the continuation of treatment "futile". Accordingly continuing to administer the invasive and burdensome treatment would provide no benefit to the patient and was contrary to his best interests. The doctor's duty to provide sustenance was therefore negated.[74]

In general clinicians have a duty to make treatment decisions according to an assessment of the "best interests" of the patient, particularly if the patient lacks the capacity to participate in the decision-making process. Both *Bland,*[75] and later *Frenchay Healthcare NHS Trust v S,*[76] concerned the withdrawal of hydration and nutrition from incompetent patients; a course of action which was endorsed by the courts as representing the individual patients' "best interests".[77] These judgements are necessarily reliant upon the efficacy of the medical evidence presented to the court by doctors, and it has been observed that "no doctor's judgement is infallible when it comes to predicting how close a patient is to death".[78] Aware of this fact doctors themselves may not feel comfortable taking decisions which appear to contradict the central tenet of the medical profession, even when confronted by relatives or friends anxious that suffering is not prolonged. In view of this the House of Lords Select Committee on Medical Ethics[79] endorsed the proposition in *Bland* that all cases where the withdrawal of nutrition and hydration is intended, be referred to the courts, thereby ensuring that doctors should not take life-limiting decisions in isolation.

Some clinical situations dictate that a competent and sensate patient is receiving only basic life sustaining treatment, such as artificial respiration, or feeding and hydration.[80] Here it is possible that the patient herself will take a life-limiting decision by refusing to consent to continued treatment. All mentally competent

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[73] *Bolam v Friern Hospital Management Committee* [1957] 2 All E.R. 118, [1957] 1 W. L. R. 582.

[74] Lord Mustill qualified this contention however by arguing that in fact this particular patient had no interests by virtue of his medical condition.

[75] *supra*, n. 37.

[76] [1994] 2 All E.R. 403.

[77] Decisions were taken based on similar reasoning in, *In the Matter of a Ward of Court* [1995] 2 I. R. L. M. 401, and *Law Hospital NHS Trust v Lord Advocate* [1996] 1 *Scots Law Times* 869.

[78] G. M. Craig, "On Withholding Nutrition and Hydration in the Terminally Ill: Has Palliative Medicine Gone too Far?" (1994) 20 *Journal of Medical Ethics*, 139-143, at 140.

[79] Select Committee on Medical Ethics (1993-4) HL 21-II.

[80] Paraplegia and motor neurone disease amongst them.

patients have an absolute legal right to make such a decision,[81] and to have it upheld, as long as the implications of that decision have been explained and understood.[82] This right was reiterated by Lord Keith in *Bland*, when he said that, "... a person is completely at liberty to decline to undergo treatment, even if the result of his doing so will be that he will die."[83] The legal concept of the duty of care may however be at odds with the professional, clinical, and ethical standards of those responsible for the provision of medical care. Hence the endorsement of patient's rights to autonomy in decisions to withdraw life sustaining treatment may result in tension within the doctor-patient relationship.[84]

The American courts have explicitly addressed the issue of conflict between a patient's right to self-determination and clinical reluctance to endorse decisions that will result in death. Both *Re Farrell,*[85] and *Brophy v New England Sinai Hospital*[86] concerned situations where patients, or their representatives, requested the withdrawal of treatment but this was contrary to the ethical standards of the hospital and personnel responsible for administering clinical care. The rulings held that no individual or health care institution should be compelled to withhold treatments they felt morally obliged to provide. This ensures that patient autonomy is upheld but not to the detriment of the clinician's or the hospital's ethical principles. Practically this may mean that the patients right to refuse treatment is contingent upon which institution and which doctor are responsible for the provision of her medical care. In Britain these issues have often come before the courts amid concerns about an individual's competence to make such a decision. If the competence of a patient to give or refuse consent is in question, the ability of that patient to give or withhold consent may be vitiated which may result in treatment being continued against the expressed wishes of the patient.[87]

In some clinical situations however the withdrawal of nutrition and hydration or medication is not an appropriate option for those seeking relief from the rigours

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[81] See for example *Sidaway v Bethlem Royal Hospital Governors* [1985] 1 All E.R. 643 at 666.

[82] There are exceptions to this general rule, one of which concerns the competent minor, see for example *Re W(a minor)(Medical treatment)* [1992] 4 All E.R. 627 CA.

[83] *supra*, n. 37 at 860.

[84] These tensions were graphically illustrated in Brian Clark's dramatic play, *Whose Life is it Anyway?* (1979) New York: Dodd Mead, wherein the fictional character Ken Harrison requests to be discharged from hospital so that all treatment will be withdrawn.

[85] (1987)529 A 2nd,404.

[86] (1986) 497 NE 2nd 626.

[87] *Re T* [1992] 4 All E.R. 649, is an example of this phenomenon and will be discussed along with issues associated with the capacity to consent in Chapters 3, 4, and 5.

of terminal disease. More often than not patients are receiving medication to control pain and other distressing symptoms alongside nutrition and hydration. Sometimes it will be possible for medication to be selectively withdrawn or withheld so that the patient might die from untreated infection but this too may be inappropriate if the patient is in extreme and intolerable pain. In these circumstances death may result from the principle of *double effect*, whereby increasing doses of pain relieving medication are administered until respiratory suppression occurs.

The principle of double effect

The principle of *double effect* refers to the fact that actions can simultaneously have intentional and unintentional consequences. In general terms, *double effect* suggests that while it is wrong to perform a bad act for the sake of the good consequences that may follow, it may be permissible to perform a good act even if some bad consequences can be anticipated. A graphic illustration of the ambiguities involved in the application of *double effect* is offered by Hart's example concerning the case of a man trapped inside a burning vehicle who implores a passer by to shoot him dead and relieve him of further pain and suffering.[88] Clearly the bystander can foresee that if he does nothing the trapped man will burn to death in agony. Yet if he acts as requested and shoots the man dead he will be criminally liable for causing the man's death. Death is inevitable and the only choice is how it occurs. Which would be the *good* act, shooting the man or allowing him to die in the fire? The criminal law dictates that deliberately hastening the death of another is an action which attracts criminal liability, regardless of the circumstances,

> However gravely ill a man may be ... he is entitled in our law to every hour ... that God has granted him. That hour or hours may be the most precious and most important hours of a man's life.[89]

An alternative for the passer-by might be to simply knock out the trapped man, thereby sparing him from further conscious appreciation of his agony while allowing the fire to inevitably kill him. This can be see as analogous to the situation whereby a doctor uses strong pain-killing medication to relieve the pain that is frequently symptomatic of terminal disease knowing that the patient will inevitably die of the disease. However, although terminal pain can usually

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[88] H. L. A. Hart, "Intention and Punishment" (1967) *The Oxford Review.*

[89] *R v Carr*, *The Sunday Times*, 30th November 1986, per Mars-Jones J, at 1.

be controlled by the administration of narcotic drugs, the effectiveness of the drugs gradually decreases as the body becomes accustomed to them. Simultaneously the disease process tends to lead to ever more severe symptoms, requiring that the dosage be incrementally increased to ensure adequate pain relief throughout a prolonged period of terminal care. Alongside their beneficial, palliative effects, these drugs can produce harmful side effects. In high doses they can dull the responses, cause drowsiness and suppress respiration, ultimately causing death. As a result, the control of pain in terminal care presents a clinical setting where *double effect* may readily be put into effect; narcotics may be used both to relieve symptoms and also to hasten death and thereby avoid further suffering. But the practice of *double effect* raises complex legal and ethical issues.

The Hippocratic Oath articulates an ethical standard which challenges the use of the doctrine of *double effect* in terminal care and is of pivotal importance here. Contained in the Oath is the statement, "I will give no deadly medicine to anyone if asked, nor suggest any such counsel ...".[90] The requirement that physicians exercise their duty to relieve suffering and prolong life is also included, emphasising sentiments expressed earlier in this chapter concerning cure, and the preservation of life as fundamental aims of western medicine. The defence of these ethical principles and their impact upon the practice of *double effect* was central to the notorious case of Dr Bodkin Adams.[91]

Dr Adams was tried for murder following the death of an eighty-four year old patient in his care. The patient had named him as a beneficiary in her will and there was evidence that large doses of heroine and morphine had been instrumental in her death. The drugs were prescribed and administered by Dr Adams who claimed that they were required for symptomatic relief. At issue was the right of the doctor to give such medication in circumstances where it might have a detrimental effect on the patient's longevity.

During the trial it was stated that a doctor "is entitled to do all that is proper and necessary to relieve pain and suffering, even if the measures he takes may incidentally shorten human life."[92] Hence it does appear to be legally permissible for a doctor to use whatever measures she deems appropriate to keep

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[90] See *supra*, n. 31 for a translation of the Hippocratic Oath at 429.

[91] *R v Adams, The Times*, 9th April 1957.

[92] H. Palmer, "Dr. Adams' Trial for Murder" (1957) *Crim. L.R.*. 365, at 375.

the patient comfortable and pain free, even if death may be hastened as an indirect or even inevitable consequence.

More contemporary cases indicate that the courts, and public opinion, are prepared to allow doctors to exercise their considerable discretion in this area. Ognall J. stated in the trial of Dr Cox that,

> ... if a doctor genuinely believes that a certain course is beneficial to his patient, either therapeutically or analgesically, then even though he recognises that that course carries with it a risk to life, he is fully entitled nonetheless to pursue it.[93]

This implies that, while it would be *bad* to give a lethal dose of medication with the intention of killing, it is permissible to perform the *good* act of administering high doses of analgesia to relieve suffering, even if the patient dies as a result. From the perspective of the criminal law the crucial factor is the intention of the actor,

> If the acts done are intended to kill and do, in fact, kill, it does not matter if a life is cut short by weeks or months, it is just as much murder as if it were cut short by years.[94]

The intention, or *mens rea* of the practitioner of double effect must be clearly identified before legal responsibility can be established. The *mens rea* of murder is the intention unlawfully to kill or do serious bodily harm to another person. Therefore, if pain relieving medication is given with the sole intention of alleviating symptoms it is beyond reproach, but the medication may also have unintentional but foreseen consequences. The criminal law of homicide extends the concept of intention to include foresight of the consequences of one's actions,[95] therefore, if it is possible to extrapolate that the drug was given because of its side effects as well as for its therapeutic value, the subjective intention of the clinician is ambiguous and the action may be unlawful. Where the use of *double effect* is concerned, there will surely always be recognition that a consequence of administering high doses of analgesics is death.

Fried has analysed the relevance of foresight in this context, and suggests that it can be permissible to follow a course of action which will foreseeably lead to a

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[93] *supra*, n. 7 at 39.

[94] *supra*, n. 92.

[95] *R v Nedrick* [1986] 3 All E.R. 1.

person's death, so long as death is not the intended result.[96] This would certainly be an argument acceptable to the criminal law since proof of intention is an essential requirement in the successful prosecution of any homicide case. Where death has occurred but it was not the intended consequence the position regarding *mens rea* was clarified in *R v Nedrick* where it was stated that,

> When determining whether the defendant had the necessary intent, it may be helpful for a jury to ask themselves two questions. (1) How probable was the consequence which resulted from the defendant's voluntary act? (2) Did he foresee that consequence?
>
> If he did not appreciate that death or serious harm was likely to result from his act, he cannot have intended to bring it about. If he did, but thought that the risk to which he was exposing the person killed was only slight, then it may be easy for the jury to conclude that he did not intend to bring about that result. On the other hand, if the jury are satisfied that at the material time the defendant recognised that death or serious harm would be virtually certain ... to result from his voluntary act, then that is a fact from which they may find it easy to infer that he intended to kill or do serious harm, even though he may not have had any desire to achieve that result.[97]

Norman echoes this opinion when he argues that if analgesics are administered specifically to relieve pain, and simultaneously to hasten death, life has indeed been *intentionally* terminated and that, if the doctor "says that she is not intentionally ending the patient's life, she is deceiving either herself or others".[98] Yet to endorse this sentiment in the arena of terminal care leaves doctors vulnerable to the rigours of the criminal law.

Where the control of symptomatic pain is the only available treatment, it is desirable that it be provided without reservation, even if death is a recognised side effect, because it is beneficial to the patient. The determination of whether a course of treatment is beneficial to a particular patient incorporates the notion that to proceed with the treatment would be in the patient's "best interests". Some commentators however, have described "best interests" in this context as a "pious fiction" which disguises the fact that the patient's interests cannot be easily divorced from those of the carers.[99] Such an approach may call into question the intentions of a clinician and raise doubts about the efficacy of a particular treatment. Should those doubts include concerns about the cause of a

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[96] C. Fried, *Right and Wrong* (1978) Harvard University Press.
[97] *supra*, n. 95 at 3-4.
[98] R. Norman, *Ethics Killing and War* (1995) Cambridge University Press, at 87.
[99] M. Brazier, *Medicine, Patients and the Law* (1992) London: Penguin, at 109.

patient's death and lead to criminal proceedings, a genuinely held belief that the actions taken were in the patient's best interests will not alone absolve the clinician from responsibility.

The distinction between subjective intention and acting in the patients best interests is, in many respects, analogous to that between intention and motive. Motive can be described as the reason why a person commits an act, this is intellectually distinct from whether the consequences of the act were intended or foreseen. The attitude of the law to this distinction was succinctly enunciated by Farquharson J. in *R v Arthur* when he advised the jury that, "however noble his *(the doctor's)* motives were ... is irrelevant to the question of your deciding what his intent was" (parenthesis added).[100]

The case of *R v Steane*[101] offered a slightly different emphasis however. During the second World War, Steane was alleged to have assisted the Germans by making radio broadcasts. He argued in his defence that his intention in so doing had been to protect his family from the threat of harm, not to assist the enemy. Steane was convicted at first instance but appealed. In the Court of Appeal it was noted that,

> While, no doubt, the motive of a man's act and his intention in doing the act are in law different things, it is none the less true that in many offences a specific intention is a necessary ingredient and the jury have to be satisfied that a particular act was done with that specific intent, although the natural consequences might, if nothing else was proved, be said to show the intent for which it was done.[102]

The judgement recognised that some actions may be "equally consistent with an innocent intent as with a criminal intent" and accordingly it was held that Steane did not possess the specific intention to assist the enemy as was required for the offence with which he was charged.[103]

A different construction of these events suggests that in fact although Steane's intention was to help his family he did so by intentionally assisting the Germans. Complying with the enemy's demands was the only way he could save his

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[100] *The Times,* November 6th 1981, [1986] *Crim. L.R.* 383.

[101] [1947] 1 All E.R. 813.

[102] *ibid*, at 820.

[103] Today it is widely believed that *Steane* is been better categorised as a case of duress of circumstance, See C. Clarkson & H. Keating, *Criminal Law: Text and Materials* (1994) London: Sweet & Maxwell, at 147.

family therefore it was his intention so to do,[104] even though he did not make the broadcast with the purpose of assisting the enemy.[105] These comments reveal that in criminal law "the concept of "intention" has a chameleon-like character and changes its meaning according to its context".[106]

Following the dicta in *Nedrick* therefore, doctors who use *double effect* and are "virtually certain" that death will result have the *mens rea* of murder, while adopting the reasoning employed in *Steane* would provide an acquittal due to the lack of "specific" intent. Price argues that, because of the inconsistency it promotes in the law, the doctrine of double effect is "the prime catalyst for jurisprudential distortion"[107]. He asserts that "life-shortening pain relieving measures are justified but *intentional* killings..." and suggests that a new defence justifying killing in these circumstances would be a more appropriate way for the law to legitimate the proper use of these techniques.[108]

Harris offers an ethical perspective which is in accord with Price's argument. He contends that the actual intention to produce a consequence is of lesser significance than being responsible for causing that consequence,

> If you know that as a result of what you deliberately choose to do, the patient will die, then that death is your responsibility. The question you must address is: ought this patient to die in these circumstances? If they should, then it doesn't matter whether you intend it or not, if they shouldn't you should neither intend it nor allow it to happen as a second effect.[109]

His interpretation suggests that the most important aspect of a case like Dr. Arthurs is not whether he carried out the act without intending for the patient to die, but whether or not he was actually responsible for the action that caused the death of the patient.[110] But the approach of the courts to cases where death has occurred following the application of the doctrine of *double effect* demonstrate

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[104] A. Halpin, "Intended Consequences and Unintentional Fallacies" (1987) 7 *Oxford Journal of Legal Studies*, 104.

[105] A. Duff, "Intentions Legal and Philosophical" (1989) 9 *Oxford Journal of Legal Studies*, 76.

[106] C. Clarkson & H. Keating, *Criminal Law: Text and Materials* (1994) London: Sweet & Maxwell, at 144.

[107] D. Price, "Euthanasia, Pain Relief and Double Effect" (1997) 17 (2) *Legal Studies*, 323, at 324.

[108] *ibid*, at 341-2.

[109] Professor John Harris speaking during *Hypotheticals: Kill or Cure*? broadcast on BBC 2 television, July 1994, transcript published by Broadcasting Support Services.

[110] Similar views were expressed by The British Humanist Society in evidence presented for the *Report of the Select Committee on Medical Ethics* HL Paper 21-I London: HMSO, (1994) at para 76.

that the assessment of criminal intention is endowed with greater significance than is the philosophical concept of moral responsibility.

The difference between the legal and ethical response to the use of *double effect* may explain the tension in the relationship between those who wish doctors to use it to end a life of suffering (patients and relatives), and those who must perform it (doctors). Legally medication may be justifiably administered, even if it has the side effect of causing death, so long as the stated intention of the doctor prescribing and giving the drug is therapeutic and beneficial, but morally the practice is less easily justified. Distinctions must surely also be drawn between the unintentional use of *double effect* which results in death and its deliberate application which is a manipulation of its current legal status. Where a patient specifically asks the doctor to prescribe drugs for the express purpose of causing death, the practice cannot be easily legitimated and may be better defined as assisted suicide.

Physician assisted suicide

Faced with an intolerable medical condition some people might prefer to take their own life rather than endure a period of prolonged dying. But when a patient in a hopeless clinical situation has suicidal tendencies and is physically unable to secure her own death, the person often seen as best able to assist is her doctor. She may then implore the clinician to collaborate in her suicide, usually by prescribing the appropriate drugs and advising on their use.

The relationship between doctor and a terminally ill patient is usually long term and founded on caring and trust, therefore it is wholly understandable if the doctor is seen as the best and most obvious person from whom to seek assistance. In Britain, any deliberate action performed with the intention of helping a person to kill herself which results in that persons death is a criminal offence.[111] However, it has been argued that in some instances it can be morally acceptable for a physician to assist a patient to commit suicide, as long as it is done with an entirely compassionate motive.[112]

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[111] s.2 (1) Suicide Act 1961.

[112] R. Weir, "The Morality of Physician-Assisted Suicide" (1992) 20 *Law Medicine and Health Care*, 116.

Assisted suicide is distinguishable from mercy killing because it is the patient who acts to bring about her own death, rather than the doctor or other carer. The person who provides a patient with the means to secure her own demise will not therefore be guilty of homicide or unlawful killing. Neither will the patient, should she survive, be liable for prosecution as it has not been an offence to attempt to commit suicide since the enactment of the Suicide Act 1961. However, it is an offence to aid, abet, counsel or procure the suicide or attempted suicide of another.[113] Accordingly, even if the patient acts with clearly motivated self-determination, the doctor who intentionally provides the means to enable a patient to commit suicide will be culpable.

Despite this, a doctor suspected of assisting in a suicide will be liable to prosecution only if sufficient clear and unequivocal evidence is available to establish that an offence has been committed. The difficulties of obtaining such evidence are demonstrated by *Attorney-General v Able*[114] where a court declaration was sought that it was an offence for the Voluntary Euthanasia Society to sell a booklet detailing various methods of committing suicide.

The evidence presented suggested that fifteen cases of suicide were associated with the booklet and that the Society saw no alternative, in the absence of legislation allowing euthanasia, to providing its members with information as to the various ways and means of securing their own "deliverance". It was held that in order to convict, it must be shown that the booklet was distributed with the intention of assisting the recipient to commit suicide using the information contained therein. Furthermore the individual must have actually committed suicide as a consequence of reading the booklet. A lack of evidence demonstrating that the suicides had occurred as a consequence of reading the booklet prevented conviction in this instance. However, where evidence is available the courts will reflect the gravity of the offence in the sentence.[115]

Some doctors have openly assisted their patients to kill themselves and defended themselves by arguing that their actions were compassionate and caring.[116] The

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[113] *supra*, n. 111.

[114] [1984] Q.B. 795.

[115] In *R v Beecham*, reported in the *Daily Telegraph*, February 18th 1988, a father assisted his daughter, who suffered with persistent pain from cancer and multiple sclerosis, to commit suicide and was given a twelve month suspended sentence. The judge said that "offences of this nature must in all circumstances be met with a term of imprisonment". See J, Horder, "Mercy Killings - Some Reflections on Beecham's Case", (1988) 52 *Journal of Criminal Law*, 309.

[116] Timothy E. Quill, "Death and Dignity: A Case of Individualized Decision Making" (1991) 324 (10) *New England Journal of Medicine*, 691-4.

basis for this argument seems to be; if it is not a crime for people to take their own lives then why should it be a crime to help those who wish to pursue this course of action but are prevented from so doing by disease? Dr. Timothy Quill has written of his patient known as Diane,

> It was extraordinarily important to Diane to maintain control of herself and her own dignity during the time remaining to her. When this was no longer possible, she clearly wanted to die ... When the time came, she wanted to take her life in the least painful way possible. Knowing of her desire for independence and her decision to stay in control, I thought this request made perfect sense.[117]

Diane was dying from incurable leukaemia and sought help in committing suicide so that she could be certain that she would die when she decided the time was right. In reviewing this case, Peter Singer states that "not all patients are fortunate enough to have a doctor like Timothy Quill".[118] In a similar vein, Dr Jack Kevorkian, who has used a home made suicide machine to help at least 28 people to commit suicide has been hailed as "a medical hero",

> No one has demonstrated any discernible motives from him except that he believes his work is right. Greed for money is absent because he has charged no fees. Greed for fame, too, seems unlikely because he has shunned the media except to explain his position. And no one has accused him of sadism in ending the lives and, according to him, the suffering of his patients.[119]

Despite such veneration Kevorkian has been repeatedly tried for helping people to commit suicide although, when he defends his actions by describing his motives as purely compassionate the juries persistently decline to convict him. Other doctors have also openly practised assisted suicide but not all are respected. An example is the Dutch doctor Boudewijn Chabot who has been widely criticised, and indeed criminally convicted but not sanctioned,[120] for assisting a patient suffering only from clinical depression to end her life.[121]

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[117] *ibid.*

[118] P. Singer, *Practical Ethics*, (2nd ed) (1993) Cambridge University Press, 198.

[119] J. Roberts, C. Kjellstrand, "Jack Kevorkian: A Medical Hero" (1996) 312 *British Medical Journal*, 1434.

[120] Assisting suicide can attract a three year prison sentence in the Netherlands.

[121] *Netherlands Juristen Blad* (1994) 26: 893-5, Sheldon T. "Judges make Historic Ruling on Euthanasia" (1994) 309 *British Medical Journal*, 7.

In 1996 Australia's Northern Territory enacted legislation permitting doctors to provide assistance for terminally ill patients who wish to end their own lives.[122] The Federal Parliament has now overruled the legislation but not before four patients took the opportunity to end their lives with the help of their doctor. On September 22nd 1996, Bob Dent became the first person to die by "legal" assisted suicide when he used specially designed computer software, to kill himself. The computer program, called "Final Exit", was developed by Dr. Philip Nitschke to enable patients to end their own lives in a clinical and reliable manner. The process takes a minimum of nine days and involves the participation of up to six medical professionals including a GP and a psychiatrist. The patient must respond to a series of twenty two questions prompted by the computer program beginning with "does the medical practitioner wish to give assistance?". The questions must be answered in the affirmative for the "countdown" to continue. Once the final stages of the program are reached it is necessary for a doctor to fit a cannula which will facilitate the injection of intravenous drugs. The final communication states "If you press "YES", you will cause a lethal injection to be given within 30 seconds and you will die". A positive response results in the administration of a lethal cocktail of drugs inducing unconsciousness and then death. There has been both support and condemnation of the Northern Territories legislation from groups on either side of the euthanasia lobby, but what seems certain is that people seeking assisted suicide welcomed the provisions contained therein and were prepared to travel to Northern Australia to take advantage of them.[123]

A patient's request for assisted suicide may be wholly understandable in the rare cases where orthodox medical techniques are unable to alleviate the anguish imposed by intolerable illness, as may compliance with the request. In some circumstances the act of enabling a patient to commit suicide could be viewed as the supreme act of compassion. This is particularly true where a patient articulates a desire to maintain autonomy over her living and dying which will be denied by the inevitable progress of disease, and when conventional medical therapy has been exhausted.[124] But to assist suicide is contrary to the ethos of the medical profession and exposes the clinician to the potential of criminal and professional sanctions. Furthermore, a doctor who decides not to comply with a request for assistance may come to feel that her inability to provide such

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[122] Rights of the Terminally Ill Act 1996.

[123] C. Zinn & S. Potts, "Australians to log on for the Final Exit" *The Observer* 9th June 1996 at 23.

[124] New York internist Dr. Timothy Quill received much public and media sympathy after publishing an account of how he came to assist his patient "Diane" to commit suicide in 1991.

ultimate care is a failure of her moral responsibility as a clinician. Respect for individual autonomy does not include the right to place another in a position where they feel morally obliged to perform such an act. However, those who are prepared to comply with a request to assist suicide may be perceived as exploiting the vulnerable[125] and sliding down the slippery slope towards mercy killing.

Mercy killing

The term *mercy killing* describes the situation where a person (in practice this will often be a medical professional) deliberately takes the life of another in order to alleviate suffering. In Britain and all other Western jurisdictions, any doctor who intentionally terminates the life of a patient is morally and criminally culpable, whether or not the "victim" complies. The law takes no account of compassionate motives or of the status or profession of the individual concerned, "it always treats mercy killing as murder".[126] As has been shown, the doctrine of *double effect* means that if a patient dies as a result of the administration of medication which was vital for symptomatic relief a prosecution for homicide would probably be unsustainable. But, if the drug given has no therapeutic value, as in the case of Dr Cox,[127] criminal responsibility is irrefutable,

> If he [Dr. Cox] injected her with potassium chloride with the primary purpose of killing her, of hastening her death, he is guilty of the offence charged[128]

Dr Cox's patient was an elderly woman, suffering from severe rheumatoid arthritis, who had been in his care for a number of years and who was believed to be in the terminal moments of her life. The extreme nature of her disease dictated that all conventional methods of pain relief were ineffective. Both the patient and her family, whom Dr Cox had come to know well, made it clear that they wished her suffering to be rapidly concluded. Eventually the doctor

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[125] Doctors Chabot and Kevorkian have been placed in this category by some commentators, see for example, A. D. Ogilvie, S. G. Potts, "Assisted Suicide for Depression: the Slippery Slope in Action?" (1994) 309 *British Medical Journal*, 492, H. Biggs, K. Diesfeld, "Assisted Suicide for People with Depression: an Advocate's Perspective" (1995) 2 (1) *Medical Law International*, 23, and, S. Gutmann, "Dr. Kevorkian's Woman Problem: Death and the Maiden" 24th June 1996, *New Republic*, 1.

[126] G. Williams *Textbook on Criminal Law* (2nd ed) (1983) London: Stevens, at 580.

[127] *supra*, n. 7.

[128] *ibid* at 39, parenthesis added.

administered an intravenous dose of undiluted potassium chloride in order to ease her passing. In this form the drug has no beneficial therapeutic value, its only purpose was to shorten life. The patient expired soon after receiving it, to the great relief of her family who believed that her misery had been brought to a dignified end. However, because of the methods he used, Dr. Cox was charged and convicted of attempted murder. A murder conviction was not possible because Mrs Boyes had been cremated before the murder investigation began, and since she was dying anyway, it was impossible to determine whether it was the drug or the disease that had caused her death.

After convicting him of attempted murder the court went on to temper justice with mercy by imposing a sentence of twelve months imprisonment, suspended for twelve months, in recognition of the dilemma he had experienced. This benevolence was reflected in the subsequent disciplinary hearing of the General Medical Council, which declined to remove his name from the professional register, but compelled him to attend a training course and to work under supervision in future. The GMC's judgement expressed sympathy for the predicament faced by doctor and patient, echoing the perception of a significant section of public opinion, and was revered as entirely just by the patient's son, who gave supportive evidence on the doctor's behalf at the disciplinary hearing.

It has been suggested that if Dr. Cox had given his patient an overdose of narcotics, in the guise of relieving pain, he would have safeguarded himself against criminal responsibility,[129] an observation resting upon the assumption that *double effect* can be used to shorten life, so long as the motive is pain relief.[130] Dr Cox made the decision to end his patient's suffering, at her request, with a lethal injection, and furthermore to take responsibility for his actions by chronicling his conduct in the patient's medical records. As a consequence he was subjected to the full force of the criminal law and the scrutiny of the doctor's professional body.

More recently, in two unreported cases, others have been more generously treated by the criminal justice system. In March 1996 care worker Rachel Heath appeared before Winchester Crown Court charged with the murder of a 71 year old woman. The "victim" was in Rachel's care and had been suffering from cancer. Rachel Heath had accelerated her death while she was in hospital following a suicide attempt. After declaring that the initial decision to prosecute

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[129] *supra*, n. 11 at 74.

[130] P. Devlin, *Easing the Passing* (1985) London: Bodley Head.

was correct Ognall J. instructed the Crown Prosecution Service to reconsider its decision stating that prosecution in such a case was not in the public interest. The trial was abandoned.[131] In the High Court in Glasgow charges of murder against Paul Brady for the killing of his brother James were reduced to culpable homicide. James Brady had been slowly dying from Huntingdon's disease, the same ailment that had killed his mother. He had repeatedly appealed to his family to help him die and eventually, on Boxing day 1995, his brother Paul had acceded to his request. Lord McFadyen explained that the Court's reduction of the charge to culpable homicide allowed for the exercise of discretion in sentencing and that a custodial sentence was considered inappropriate.[132] These cases are illustrative of the gradually changing public and judicial attitude towards mercy killing which are the impetus for calls for legal reform in this area.

Conclusion

The various types of clinically assisted death described in this chapter demonstrate the tension that exists between the criminal law and the demands now commonly made by patients and their relatives for death with dignity. The criminal law places great significance on the cause of death and the intentions of the actors involved. Conversely, medical training and clinical practice emphasises treatment, cure, and caring. Care must be taken to avoid criminalising those whose motives are benevolent, particularly when they have simply responded to a request for mercy.

Clinically assisted death is possible and legally permissible in some forms, but, as this discussion demonstrates, its availability is largely determined by the medical circumstances relating to each specific patient. Therefore, decisions concerning terminal medical care often bring into sharp focus the divergence between the rights of patients and the responsibilities of doctors, and the distinctions between killing and caring.

The development of the concepts of consent and patient autonomy has allowed patients greater involvement in treatment decisions, but legal and ethical constraints prevent doctors from complying with requests for treatment options which will result in death. Many patients wish to retain autonomy to the very

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[131] A. Mollard, "Nurse Cleared of Mercy Killing" 28 March 1996, *Daily Mail*, 1.

[132] See B. Christie, "Man Walks Free in Scottish Euthanasia Case" (1996) 313 *British Medical Journal*, 961.

end of their lives, but because the law dictates the circumstances in which life limiting treatment decisions may be taken, this does not presently extend to the right to request active euthanasia. The increased use and recognition of advance directives is valuable in the promotion of patients rights at the end of life, but careful analysis of individual consent and the capacity to give consent is required before their usefulness can be fully assessed. Attention must also be paid to defining the legal and ethical responsibilities held by medical practitioners and the precise nature of death with dignity.

Chapter Three

Autonomy, Self-determination, and the Ability to Choose Death

Introduction

Chapter Two considered the practical and legal options available to doctors and patients making decisions at the end of life. It demonstrated that the legality of the practical options discussed is largely defined by drawing distinctions between killing and allowing to die. Taking active steps to bring about death is proscribed by the criminal law while passively allowing death to occur through withholding or withdrawing treatment is permissible in some circumstances. The object of this chapter is to analyse the significance of individual autonomy for those seeking death with dignity through euthanasia and assisted death. It will begin by examining the concept of autonomy and the principle of respect for individual autonomy, and go on to explore the scope of individual autonomy in everyday medical situations. The final section will scrutinise the relationship between respect for individual autonomy and the availability of euthanasia and assisted death, with particular emphasis on assisted suicide.

Autonomy and respect for autonomy

The ability to exercise choice and maintain control is widely considered to be fundamental to the preservation of human dignity in dying,[1] and the notion that individuals should have the opportunity to decide for themselves the manner and timing of their own deaths links euthanasia with the concepts of individual autonomy and self-determination. Ian Kennedy has stated that,

> Perhaps the most fundamental precept of the common law is respect for the liberty of the individual. In a medical context this means that a person's right to self-determination, to deal with his body as he sees fit, is protected by the law.[2]

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[1] See C. Seale, J. Addington-Hall, "Euthanasia: Why People Want to Die Earlier" (1994) 39 *Social Science and Medicine*, 647-54.

[2] I. Kennedy, *Treat Me Right: Essays in Medical Law and Ethics* (1991) Oxford University Press, 320.

The fundamental right of self-determination is, in the context of medical care, equivalent to the right of each person to exercise personal autonomy. It is the right to act as an sovereign individual and as such, to exercise autonomous choices. Further, the concept of personal autonomy is often seen as being made up of three separate categories; autonomy of thought, of will, and of action.[3] Together these encompass the notion that individuals are able to think for themselves, make decisions, and act accordingly.

According to Raanan Gillon, the eighteenth century classical philosopher Immanuel Kant argued that "both autonomy and respect for the autonomy others were necessary features of any rational agent in so far as their exercise conformed to the 'categorical imperative'".[4] A necessarily simplistic explanation of Kant's metaphysics reveals that everything that exists is divided between two realms and works in accordance with universal laws. The two realms can be categorised as the world of reason, or the intelligible world, and the world of sense perception which is the phenomenal world. A rational agent has the power to act according to her own perception of the universal laws while non-rational agents are acted upon and their conduct tends to be determined by external causes. Human beings are seen as exhibiting elements of both the rational and the non-rational world, possessing the ability to act as rational agents to influence both the non-rational world around them, and the non-rational aspects of themselves. Where human beings are ruled by their own will and thus act independently of other causes, they can be considered rational and autonomous agents, subject to universal moral laws and simultaneously the authors of those moral laws. It has been suggested therefore, that "Kant wrote that free and equal human beings rationally impose, and therefore accept, moral principles and constraints."[5] And Gillon himself argues that,

> For Kant, then, self-rule - autonomy - is a fundamental and logically necessary feature of being a rational agent: 'Autonomy is therefore the ground of the dignity of human nature and of every rational nature'[6]

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[3] R. Gillon, *Philosophical Medical Ethics* (1985) Chichester: Wiley.

[4] R. Gillon, "Autonomy and Consent" in M. Lockwood (ed) *Moral Dilemmas in Modern Medicine* (1985) Oxford: Oxford University Press, 114, cited in J. McHale, M. Fox, *Health Care Law: Text and Materials* (1997) London: Sweet & Maxwell, at 77-9.

[5] M. Norden, "Whose Life is it Anyway? A Study in Respect for Autonomy" (1995) 21, *Journal of Medical Ethics*, 179, at 180.

[6] *Supra*, n. 4.

John Stewart Mill also argued the merits of the moral importance of autonomy but he approached it from a utilitarian viewpoint whereby personal autonomy was regarded not so much as a moral condition but rather as a social and political one.[7] He contended that respect for the autonomy of others is required in order to maximise human welfare generally. This can be interpreted as meaning that autonomy is fundamental to the principle of utility and therefore essential for the good of society as a whole. He concluded therefore that the autonomy of the individual should always be respected because, "the only purpose for which power can be rightly exercised over any member of a civilised community, against his will, is to prevent harm to others."[8]

The contemporary philosopher and medical ethicist Raanan Gillon gives an informative definition of autonomy,

> Autonomy (literally self-rule) is in summary the capacity to think, decide and act on the basis of such thought and decision, freely and independently and without as it says in the British passport *let or hindrance*.[9]

Autonomy therefore, enables people to make choices and decisions about the shape of their own destinies while respect for autonomy ensures that individuals are not subjected to the arbitrary imposition of any body else's wishes or ideals. There are however, moral limits on how far respect for individual autonomy should extend, and Kant and Mill agree, despite their difference in emphasis on the basis of autonomy, that respect for autonomy of action should only apply so long as the action does no harm to others and hence does not impinge upon their personal autonomy.

In western culture one practical consequence of respect for personal autonomy is that any physical touching of one person by another without the authorisation of the person concerned is proscribed by the criminal and the civil law. The contact need not be hostile or intend injury. The proscription is merely designed for the protection of personal bodily integrity based on respect for individual autonomy. However, in practice individual autonomy is often not absolute. No person is an island and everyone is influenced in their decisions by considerations relating to their social surroundings and relationships with others. Inevitably this will

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[7] J. S. Mill, *On Liberty,* in M. Warnock (ed.) *Utilitarianism* (1974) Glasgow: Collins/Fontana.

[8] *ibid*, at 135.

[9] *Supra*, n. 3 at 61.

impact upon personal autonomy and the ability to make autonomous choices and act upon them.

In the context of general medical treatment the principle of respect for autonomy is given legal expression through the law of consent which operates as a means of safeguarding physical integrity.[10] Where a person is capable of participating in the medical decision-making process the principle of respect for autonomy means that she has a fundamental right to accept or reject any form of treatment offered. This right was upheld in *Airedale NHS Trust v Bland* where Lord Keith held that,

> ... it is unlawful, so as to constitute both a tort and the crime of battery, to administer medical treatment to an adult, who is conscious and of sound mind, without his consent ... such a person is completely at liberty to decline to undergo treatment, even if the result of his doing so will be that he will die.[11]

Respect for patient autonomy therefore dictates that a doctor "has a duty to respect the integrity and individuality of the person before him",[12] and normally may not proceed with therapeutic or diagnostic procedures without the consent of the patient. The practical effect of upholding respect for autonomy in this way was spelled out in *Re T (Adult: Refusal of Medical Treatment)* where it was held that a patient's choices must be respected in all circumstances, regardless of the substance or perceived morality of the decision made,

> An adult patient who ... suffers from no mental incapacity has an absolute right to choose whether to consent to medical treatment, to refuse it or to choose one rather than another of the treatments being offered.[13]

The common law therefore endorses the principle that to reject a persons ability to dictate the management of their own life and body is, in Harris's words, "the most profound of insults".[14] Unconditional respect for autonomy assumes that the individual whose autonomy is being respected has the capacity to make autonomous decisions. However, in everyday medical situations the ability of

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[10] The general law relating to consent and its application is the subject of Chapter Four.

[11] [1993] 1 All ER 821, at 860.

[12] I. Kennedy, *The Unmasking of Medicine* (1983) Paladin: London.

[13] [1992] 4 All E.R. 649, at 652-3.

[14] J. Harris, *The Value of Life* (1985) London: Routledge, 85.

any individual to exercise autonomy rests on the provision of full information and the capacity to understand and act upon that information by giving or refusing consent. The conviction that autonomy should and will always be respected is therefore necessarily contingent upon the fact that not everybody is competent to exercise it.

Conflict may occur concerning decisions, and the outcomes of those decisions, where a person either lacks, or appears to lack, the competence to decide for herself. For example, a child may resist decisions made by her parents concerning her medical care because she fears pain, this can be particularly evident in the case of vaccination. Paradoxically, Kennedy asserts that in a situation like this, where the child does not have the capacity to act autonomously, failing to act on her wishes is actually autonomy enhancing. The logic behind his assertion is that if an individual is unable to make decisions in her own best interests then allowing somebody else to do so in order to preserve her long term well-being is a way of affording respect and protecting that person from harm.[15] However, exercising this principle may be acceptable for small children in some circumstances, perhaps once reasoning has tried and failed, but a general acceptance of this attitude walks dangerously close to the edge of paternalism.

General issues relating to the autonomy of people who are not competent to give or withhold consent will be addressed in chapters Four and Five. The remainder of this chapter will concentrate on concerns for the autonomy of mentally competent people who, for a variety of reasons, may fail to exercise their autonomy in practice, particularly which regard to decisions at the end of life.

Autonomy and general medical care

The right of individual autonomy and self-determination is a fundamental right reflected in every patient's legal right to decide whether or not to agree to medical treatment.[16] The valid giving or withholding of consent to medical

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[15] *Supra*, n. 2 at 177.

[16] See for example, *Schloendorff v Society of New York Hospital* (1914) 105 N.E. 92, 93, per Cardozo J., *Sidaway v Bethlem Royal Hospital Governors* [1985] 1 All E.R. 643 at 666. *Re T (adult: refusal of treatment)* [1992] 4 All E.R. 649, at 652-3, and *Airedale NHS Trust v Bland* [1993] 1 All E.R. 821, at 860. This right is also endorsed in the Government policy document "*A Guide to Consent for Examination and Treatment*" issued by Dept. of Health and the Welsh

treatment is the manifestation of any patient's autonomy over her personal bodily integrity. Yet the circumstances within which medical care is administered may effectively undermine the patient's right to self-determination.

In an institutional setting individuals may be unusually insecure due to the idiosyncrasies of the group or establishment with which they are associating. Unfamiliar surroundings with unknown personnel and routines will almost inevitably impact on a person's ability to act as an autonomous agent. Where medical treatment is concerned, this is often compounded by illness, lack of understanding, and fear and may provoke insecurity in the patient. In considering these influences O'Neill has recognised that when stripped of clothing, familiarity of surroundings, and emotional support, some patients can find it difficult to express doubts and fears about the efficacy of proposed forms of treatment,

> One patient can indeed be expected to come to an informed and autonomous (if idiosyncratic) decision; another may be too confused to take in what his options are. A third may be able to understand the issues but too dependent or too distraught to make decisions.[17]

Clearly some people are more assertive than others and those who are will be able to grasp and control the situations where their awareness and consent is required. Others however do not posses the ability or comprehension to challenge the received wisdom of those who can determine their immediate medical future. Furthermore, because of the complexity of the situation, the personnel responsible for providing medical care may be ill equipped to recognise the patients to whom this applies. The result may be that consent is given despite the patient's taciturn scepticism or ignorance and the patient's ability to act as an autonomous agent is compromised.

In these circumstances Len Doyal has described respect for autonomy as an indeterminate morality because he believes that in the clinical setting respect for autonomy is often imperfect and the exercise of autonomy is ill-defined. Doyal argues that autonomy generally is made up of weak and strong elements. Weak autonomy is possessed by all who have the ability to make ordinary everyday decisions in their lives, while strong autonomy attaches only to those who are

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Office, and *The Patient's Charter*.

[17] O. O'Niell, "Paternalism and Partial Autonomy" (1984) 10 *Journal of Medical Ethics*, 177.

able to scrutinise the information they receive in terms of impact and outcome, and thereby make a fully informed choice.[18] Accordingly some patients might never be able to make autonomous decisions while others will achieve autonomy in some situations but not others.

The application of Doyal's theory suggests that in the clinical context the effectiveness of consent as an exercise of individual autonomy and self-determination, can be invalidated for many reasons. Firstly, patients may not possess a level of understanding of their medical condition, or the procedures involved, to enable them to fully participate in decisions concerning the treatments offered. Secondly, the patient may be resistant to learning the full implications of the proposed treatment or the illness and may defer to the knowledge of the medical staff. Thirdly, these shortcomings may be compounded by medical paternalism, often exercised through the expression of clinical judgement, and fourthly, by the paternalism of the law via the application of the concept of *best interests*. These limitations on the effectiveness of patient autonomy will be considered in turn.

Lack of understanding by the patient

Understanding disease and therapy requires an awareness of anatomy, physiology, and pharmacology, not normally possessed by people without medical qualifications. Consent forms require that medical professionals provide patients with the information necessary to anticipate the implications and complications of the proposed treatment in recognition that they are entitled to all relevant information. However, many patients encounter illness without the knowledge or expertise to understand and address the issues raised by treatments proposed by their doctors, and clinical practice often precludes any more than the most superficial notification process. Moreover, the shortcomings of the rudimentary knowledge of the workings of the human body which many patients exhibit, may be exacerbated by the specialised language used by medical professionals. It is likely therefore that, in the absence of understandable and detailed explanations from medical professionals, many patients will give consent while unaware of all the potential implications and complications of the therapy or investigation that is proposed.

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[18] L. Doyal, "Medical Ethics and Moral Indeterminacy" (1990) 17 (1) *Journal of Law and Society*, 1.

Modern consent forms do appear to provide the opportunity for patients to glean complete information prior to giving consent. The standard form for use in the NHS which was issued by the Department of Health in 1990 provides a useful example.[19] The form invites patients to question information they do not understand or would like explained more fully as a means of protecting their autonomy. However, in order to avail themselves of this safeguard patients need a level of understanding about their own medical conditions and the procedures and techniques likely to be adopted in treating or diagnosing them, which is beyond many people's experience. It is simply not possible to know whether you have been provided with sufficient information to make an informed decision if you are ignorant of the details involved and are reliant on somebody else furnishing good advice. Unsurprisingly, comments like, "... I don't understand what is happening so I just let them get on with it",[20] are not uncommon in doctor's surgeries and hospital wards. Similarly a voyeuristic investigation of the waiting room at any general practice or hospital outpatients department will garner evidence of the ignorance with which many people approach health care.[21] As a consequence many patients may appear to give autonomous consent to medical procedures but the consent given could later prove to be invalid because the patient did not fully comprehend the information upon which the consent was based.

Patient's deference to the doctor, and preference not to know

To be confronted by a situation where one is at the mercy of an institution and its personnel because of ill health can be very disconcerting. People who find themselves in hospital and redefined as patients can experience profound insecurity when they are weakened by illness and in an alien environment. Even when fully fit some patients may be afraid or reluctant to discover the full ramifications of their disease and its management, or may just prefer to remain ignorant. As a result, many patients defer unconditionally to the judgement of the doctor responsible for their care. Two weeks as a patient in a local NHS hospital ward provided this author with several verbal examples of patient deference to the professional integrity of doctors and nurses. Comments like, "the doctors are all so busy ... I was lucky that my particular doctor had the time

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[19] A facsimile of the form appears in Appendix A.

[20] Taken from an interview with a fellow patient, conducted by this author at Lipscomb surgical ward, Kent and Canterbury Hospital in July 1994.

[21] A survey of this type conducted by this author in a local general practitioners waiting room revealed innumerable misunderstandings about illness, investigations and treatments which could potentially invalidate the consent given for the procedures involved.

to explain",[22] and, " ... the doctor knows best ... I don't like to ask too much, in case I'm interfering",[23] provide some evidence of a phenomenon which can be wholly destructive of patient autonomy and which has important implications for the validity of consent.

However, as Doyal comments, it can be "wrong to conceive of respect for autonomy as being just a matter of honouring an individual's right to choose without coercion".[24] In situations where patients "positively and deliberately delegate doctors to manage their case"[25] an autonomous choice has been exercised. These patients have chosen to distance themselves from clinical decision making and to place themselves in the hands of their doctors because that is where they feel most comfortable. Consent given in these circumstances is likely to be entirely valid given that the judgement in *Sidaway v Bethlem Royal Hospital Governors*[26] and the standard NHS consent form,[27] allow that a doctor's duty is to answer questions about particular treatments as fully as the questioner requires,

> ... when questioned specifically by a patient of apparently sound mind about risks involved in a particular treatment proposed, the doctor's duty must, in my opinion, be to answer both truthfully and as fully as the questioner requires.[28]

Clinical judgement and medical paternalism

It has long been recognised that consent, as the legal expression of respect for individual autonomy, can be undermined by the paternalistic attitudes of the medical profession.[29] Raanan Gillon demonstrates the potential scale of medical paternalism in his authoritative work *Philosophical Medical Ethics* with the comment that,

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[22] Taken from an interview with patient A. T. conducted by this author while a patient at Kent and Canterbury Hospital in July 1994.

[23] Taken from an interview with patient D. K. conducted by this author while a patient at Kent and Canterbury Hospital in July 1994.

[24] *Supra*, n.18 at 12.

[25] *Supra*, n.3 at 119.

[26] [1985] 1 All E.R. 643, the case is considered in detail in Chapter Four.

[27] See Appendix A.

[28] *supra* n. 26, per Lord Bridge at 662.

[29] See for example, R. E Sartorius, (ed.) *Paternalism* (1983) Minneapolis: University of Minnesota Press, M. M. Shultz, "From Informed Consent to Patient Choice: a New Protected Interest" (1985) 95 *Yale Law Journal*, 219, M. Brazier, *Medicine Patients and the Law* (1987) Penguin, chapters 1-4, and S. A. M. McLean, *A Patient's Right to Know* (1989) Dartmouth.

> Sometimes one has as a doctor to be paternalistic to one's patients - that is, to do things against their immediate wishes or without consulting them, indeed perhaps with a measure of deception, to do what is in their best interests.[30]

His opinion appears to reflect an established conviction amongst some in the medical profession that, "a certain amount of authoritarianism, paternalism and domination are the essence of the physician's effectiveness".[31] But should the physician's effectiveness ever be secured by failing to respect the patients right to self-determination through the exercise of autonomy?

Doctors have an obligation to treat patients according to their assessment of what constitutes each patient's best interests. However, the range of investigations and treatments offered in any given clinical situation will be limited by what the doctor considers to be clinically appropriate in the given circumstances. This assessment of what is clinically appropriate may conflict with the patient's expectation of how they wish their treatment to proceed and what is best for them. It will also be influenced by the clinician's own perceptions of how each clinical situation should be managed.

Clinical judgement is based upon the calculation and understanding of the available medical data and the application of each physician's expertise and experience. The doctor is in a unique position to evaluate the available information and to make judgements about prognosis and potential therapies. Yet the same doctor has responsibility for providing the patient with the information she requires before she can give valid consent to any proposed treatment. The determination of what information is relevant in order to make a rational decision about treatment in any given clinical situation is therefore the prerogative of the medical personnel concerned. Hence, the patient's decisions about whether and which treatment options to accept are inevitably governed by the amount of information provided and the way it is presented.

Kennedy has described how doctors, often unwittingly, introduce their own value judgements into treatment decisions so that clinical or technical decisions can become inherently moral in nature.[32] Frequently therapeutic decision making cannot be accomplished without considering wider social and moral issues but

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[30] *Supra*, n. 3 at 67.

[31] F. J. Ingelfinger, "Arrogance" (1980) 303, *New England Journal of Medicine,* 1507-11.

[32] *Supra*, n. 12, especially Chapter 4.

this has profound implications for the exercise of patient autonomy. Decisions to terminate a pregnancy, or not; to provide contraception to a fifteen year old girl, or not; to confine a person suffering from mental illness involuntarily, or not; are just a few examples of clinical situations which cannot be considered in isolation. The implications of the decisions and the treatments are such that they cannot and should not be determined in a vacuum. But neither should they be unduly influenced by the experience and morality of the clinician responsible for patient care at the expense of the need of the patient concerned to make an autonomous decision. The biggest impact of any treatment decision is on the life of the patient receiving the treatment so it should be for that individual to consent or not autonomously and on the basis of her own morality, not that of the doctor.

In situations where tension exists between the patient's wishes and what clinical judgement declares to be the *best* treatment option, the law of consent is designed to provide the patient with a safeguard against medical paternalism. Therefore, patients are entitled to reach their own decisions, even if the choices they make do not seem rational to medical staff or the disinterested onlooker.[33] But there are bound to be occasions when doctors feel "justified in going to great lengths to persuade a patient to undergo a procedure",[34] especially if the patient is apparently too overwrought, afraid, and confused, to be competent to make an autonomous choice. As a result it should be recognised that medical paternalism occurs not because of any conspiracy by doctors to overrule the autonomy of any given patient, but usually because of a well intentioned desire to provide the best possible treatment regime in the circumstances. What is certain is that,

> Attempts to provide uniform guidelines for treating patients as persons, respecting their autonomy and avoiding unacceptable medical paternalism are bound to be insensitive to the radical differences of capacity of different patients.[35]

However, any undermining of patient's wishes by paternalistic interventions will usually occur in situations where clinical judgements and the application of best interests criteria are crucial to the decision making process, and often where there is doubt about the patient's capacity to decide for herself. It is in those situations,

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[33] See *Re T (Adult: Refusal of Treatment)* [1992] 4 All E.R. 649, where Lord Donaldson explained that patients choices are not limited to those which others may regard as sensible or rational, at 652-3.

[34] P. D. G. Skegg, *Law, Ethics, and Medicine* (1988) Oxford: Clarendon Press at 98.

[35] *Supra*, n. 17.

where the value judgements of medical practitioners conflict with those of the patient, that legal mechanisms may be invoked in order to achieve a clinically desirable outcome. This is where medical paternalism can give way to legal paternalism.

Paternalism of the law

The legal resolution of tensions arising when a doctor's clinical judgement conflicts with a patient's decision about whether to consent to treatment affords many illustrations of paternalistic legal attitudes. Such disputes are particularly likely to arise in relation to emergency treatment that has been refused by a patient, or by a parent on behalf of a minor. Celia Wells has eloquently described the dilemma experienced by all who are involved in this decision making process,

> On the one hand the image of the surgical team bearing down on an unwilling patient with its spectre of naked self-defence in the face of coercion is offensive. On the other, there is the competing thought of the sense of despair that must affect those seeking to help, to do that which is both a natural and in this instance a professional reflex, to preserve the life of another.[36]

Thus, in a clinical emergency where medical attendants confront a patient who has apparently irrationally refused to consent to the available treatment, legal clarification may be sought, especially if the failure to treat has life threatening consequences. At issue are respect for the patient's autonomy (the right to give or withhold consent to treatment), the rationality of the decision to refuse consent and treatment, and the efficacy of proceeding with treatment in the absence of consent. *Re T (adult: refusal of treatment)*,[37] describes one situation where these tensions existed and the expressed wishes of a patient were overridden by the court in an unfolding clinical emergency.

The case arose when *T*, was twenty years of age and thirty-four weeks pregnant. She had been injured in a car accident and required treatment in hospital, although her injuries were not life threatening. During the course of treatment for these injuries however, she developed pneumonia and became more seriously unwell. *T's* mother, who was a Jehovah's Witness, visited her daughter in

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[36] C. Wells, "Patients, Consent and Criminal Law" (1994) 1 *Journal of Social Welfare and Family Law*, 65 at 69.

[37] *supra*, n. 13.

hospital and shortly afterwards *T* declared her intention to refuse a blood transfusion should she need one. *T* had been brought up by her father since the age of three and was not herself a practising Jehovah's Witness. At this time there was no clinical indication, that a blood transfusion would be required.

A short time later *T* went into premature labour for which she required a Caesarean section. She again stated that she did not want a blood transfusion and signed a form which recorded her refusal of consent for a transfusion. She was advised that it was not ordinarily necessary to carry out a transfusion following a Caesarean section but no explanation was given of the fact that, should the need for a transfusion arise, it might be the only way to save her life.

The Caesarean section was performed and the baby was stillborn. *T's* condition then deteriorated to the point where she required intensive therapy and a blood transfusion. Her father and boyfriend made an emergency application to the High Court to obtain authorisation for a transfusion to be given against *T*'s expressed wishes. Ward J. authorised the procedure on the grounds that it was in *T's* best interests, that she was not fully *compos mentis* when she had signed the refusal of consent and that, *T* did not appreciate how serious her situation could become when she withheld her consent. Clearly she was unlikely to be aware of how serious the situation might become because this had not been explained to her.

The decision was upheld in the full court hearing, after the event, on the basis that the refusal of consent did not apply to the particular emergency situation which developed later. The *compos mentis* element of the judgement was withdrawn. The Court of Appeal affirmed the decision of the lower court but was uneasy with the reasoning behind the judgement and held that *T's* consent was effectively vitiated by the undue influence exerted by her mother. Had this not been the situation however, the Court of Appeal also determined that refusal of consent may be invalid if it was not relevant to the specific circumstances in which the treatment became necessary especially where the treatment concerned was essential to save life or avoid permanent damage to health. Alternatively, in a case like *T's*, temporary incapacitation due to drug therapy or other circumstances was recognised as a legitimate argument.

The judgement displays a degree of paternalistic irrationality in its analysis, if not in its outcome. The patient's right to give or withhold consent was recognised and upheld by the court,

> An adult patient who ... suffers from no mental incapacity has an absolute right to choose whether to consent to medical treatment, to refuse it or to choose one rather than another of the treatments being offered ...[38]

But, far from being an absolute right, as a right founded upon respect for individual autonomy ought to be, *Re T* shows this right to be highly contingent. As a consequence refusal of consent can be overridden in emergency situations or translated into a debate as to the patient's competence to decide, and this in spite of Lord Donaldson's statement in *Re T* that, "This right of choice is not limited to decisions which others might regard as sensible."[39]

The case of *Re S (Adult: Refusal of Medical Treatment)*[40] later in the same year illustrates that the patient's right to refuse consent to treatment may also depend on whether or not she is a pregnant woman. Here the patient was a thirty year old woman at full term in her third pregnancy. After she had been labouring for two days doctors decided that the transverse lie of the foetus would prevent normal delivery and that there was a very real risk that the uterus might rupture. Delivery by Caesarean section was proposed but *S* and her husband were religiously opposed to it and *S* refused to give her consent. The Health Authority immediately sought a court declaration that to proceed with the surgery without consent would be in the best interests of *S* and her unborn baby and therefore lawful. The declaration was granted and the operation was performed. *S* survived but the child did not.

At issue here is when will the courts exercise discretion to overrule a patient's right to decline consent to medical treatment, and on what basis are the decisions made? Both *Re T* and *Re S* appear to have been decided according to the application of best interests criteria where the courts have determined that they are in a better position to assess the best interests of a person than is the person herself. However, both cases were complicated by the fact that the women were pregnant and the lives of their unborn children were also at stake. The decisions

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[38] *ibid*, at 652.
[39] *supra*, n. 37 at 653.
[40] [1992] 4 All ER 671.

of pregnant women to decline proposed treatments have been particularly susceptible to legal paternalism because the courts have considered not only the best interests of the patient but also those of the unborn child. The application of best interests criteria has thereby permitted legal paternalism to overrule an individual's autonomous refusal of consent in order to protect the interests of the unborn. The pregnant woman's right to bodily autonomy is esteemed in these judgements but the outcomes demonstrate that while the right exists it is not absolute. Therefore, the exercise of autonomy and respect for autonomy by medicine and the law are conditional upon the particular circumstances of each individual case. Notwithstanding this, the constraints upon the individual autonomy of those who seek death with dignity through euthanasia and assisted dying are more widely accepted and always legally enforceable.

Autonomy and death with dignity

The relationship between death with dignity and respect for individual autonomy is complex and intriguing. Those who advocate legal reform in order to permit euthanasia and assisted death tend to do so on the basis of arguments in favour of enabling people to maintain independence and control of their lives up to and including the moment of death. For many this means being able to decide the time place and manner of dying and to make autonomous choices in relation to these decisions. However, the law prohibits such decisions being acted upon when they require the assistance of others. Consequently active euthanasia, whereby deliberate steps are taken by one person to bring about the death of another, amounts to murder, and assisting suicide is prohibited by statute.[41] Arguably neither of these phenomena should be construed as true expressions of individual autonomy since they require the active participation of other people, although where they do occur interesting tensions exist between the autonomy of the recipient of euthanasia and that of the actor. Suicide, or self-murder, is not defined as a crime.[42] It is, however, for a coroners court to return a verdict of suicide having determined that the death has been intentionally caused by the victim's own hand. These criteria for defining the death as the result of suicide satisfy the criminal law requirements of *actus reus* and *mens rea* and

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[41] s2 (1) Suicide Act 1961 imposes a maximum penalty of 14 years imprisonment for those who aid, abet, council or procure the suicide of another.

[42] In Britain attempted suicide was a criminal offence until the enactment of the Suicide Act 1961.

demonstrate the tensions which still exist between the social perception of suicide and its legal status. Hence suicide may be described metaphorically as the vampire in the mirror of murder; it is invisible as a crime since it is not proscribed by law but must be defined by a court of law within the same parameters as murder. Suicide and assisted suicide will provide the focus of this discussion since the issues associated with autonomy and dignified dying are perhaps most clearly observed here.

Suicide has existed in all social settings throughout history but in different cultures and across time it has been differently regarded. Social, legal, and philosophical approaches to suicide across the ages inform modern day perceptions of the phenomenon through theological and philosophical theory, references in literature and more latterly depictions in the media. Biblical references to suicide apparently contain no condemnatory remarks[43] and throughout the Roman empire suicide was considered honourable where it reflected a commitment to ideals.[44] Similarly, in medieval society, suicide was sometimes accepted as a noble conclusion in the aftermath of sexual assault or rape. More often though it was considered to be an offence against God and the State, and categorised as criminal.

> ... the law of England wisely and religiously considers, that no man hath a power to destroy life ... and as the suicide is guilty of a double offence; one spiritual, in evading the prerogative of the Almighty ... and the other temporal, against the King ... the law has ranked this among the highest crimes, making it a peculiar species of felony, a felony committed on oneself.[45]

Modern day Judaeo-Christian taboos on suicide reportedly stem from Saint Augustine's description of it as a "mortal sin" in his fourth century work, *City of God*.[46] The pronouncement seems to have been based on anxieties within the Church at the time about false martyrdom and led to practices such as the prohibition on burying the bodies of those who had committed suicide in hallowed ground.

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[43] B. Barraclough, "The Bible Suicides" (1990) 86 *Acta Psychiatrica Scandinavia*, 64-69.

[44] M.G. Velasquez, "Defining Suicide" (1987) 37 (3) *Issues in Law and Medicine*, 40.

[45] Blackstone, *Commentaries on the Laws of England* (1769) 4 at 189.

[46] C. Pritchard, *Suicide - The Ultimate Rejection* (1995) Buckingham: Open University Press, at 10.

Even after these concerns had faded the religious and social sanctions against suicide persisted so that it carried enormous social stigma. In England attempted suicide was considered a felony from the fourteenth century onwards. As a result, anyone who survived a suicide attempt would face the death penalty and have their assets seized by the state.[47] The primary purpose behind the criminalisation and punishment appears to have been to raise income for the Government since there can be little point in censuring someone who has tried to kill themselves by executing them. The property and possessions of successful suicides would also be forfeited. Their bodies would have stakes driven through them before being placed at a cross-roads. In France the body of a suicide may have been put on trial before being publicly crucified.[48] Attempted suicide remained a crime in England until 1961 when it was decriminalised.

Despite the stigma attached to it suicide has often been romanticised in popular culture. Shakespeare's Romeo and Juliet typifies a rather sentimental portrayal of suicide as an ultimate act of love. Cleopatra's suicide has been similarly idealised as a noble and honourable death. Even where a character contemplates suicide in tragic circumstances the contemporary audience frequently admires the courage and logic if not the motivation. The reverence with which the Hamlet soliloquy is regarded typifies this response,

> To be or not to be, that is the question:- Whether 'tis nobler in the mind to suffer the slings and arrows of outrageous fortune; Or take up arms against a sea of troubles, And, by opposing, end them? ... To die, - to sleep; - To sleep! - Perchance to dream; ay, there's the rub; for in that sleep of death what dreams may come, when we have shuffled off this mortal coil ... (Hamlet III. i)

The lines were written at a time when suicide was generally regarded as a mortal sin and stigmatised even more profoundly than today. Yet then, as now, these words evoke the misery of the dilemma and provoke sympathy and perhaps admiration. Similar sentiments often surround the publicity concerning cases where individuals seek to terminate lives they consider to be intolerable through declining further medical treatment. Brian Clark's play *Whose Life is it Anyway?*[49] epitomises the plight of many who are condemned by modern medicine to a life of dependence and indignity. The play's main character, Ken

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[47] G. Williams, *The Sanctity of Life and the Criminal Law* (1957) Faber and Faber at 274-5.
[48] *supra*, n. 46.
[49] B. Clark, *Whose Life is it Anyway?* (1979) New York: Dodd Mead.

Harrison, has been paralysed in a road accident and is fighting a legal battle to have his decision to be discharged from hospital upheld. Leaving hospital will inevitably result in his death because he is physically incapacitated and needs assistance with food and fluids and to keep his lungs functioning. Harrison bases his argument on notions of autonomous choice and human dignity,

> I know that our hospitals are wonderful. I know that many people have succeeded in making good lives with appalling handicaps. I'm happy for them and respect and admire them. But each man must make his own decision. And mine is to die quietly and with as much dignity as I can muster.[50]

Ken Harrison's plight is profoundly disturbing and raises real dilemmas concerning the ability of any person to act as a truly autonomous agent within contemporary society. It recognises the significance of social interaction and the fact that people's choices and hence their autonomy are necessarily constrained by the needs, preferences and reactions of others.[51] The play also makes important comments about the nature of suicide, and especially calculated suicide within the context of terminal or incurable illness,

> Perhaps we ought to make suicide respectable again. Whenever anyone kills himself there's a whole legal rigmarole to go through ... and it all seems designed to find something to blame. Can you ever recall a coroner saying something like: 'We've heard all the evidence of how John Smith was facing literally insuperable odds and how he made a courageous decision. I record a verdict of noble death?[52]

Today suicide represents the highest cause of death in young people in all developed western countries and tends to be regarded as a tragic waste of life rather than a noble death. The actual statistical incidence of suicide is hard to determine since it remains socially stigmatised and is consequently thought to be underreported, with many deaths recorded as accidental when they may have been the result of misadventure or suicide. This may in part be due to the methods selected by those who attempt to kill themselves. Men tend to be impulsive and choose drastic methods which are likely to succeed but may be recorded as accidental death, especially if the impulse allowed no time for the traditional suicide note. Women, on the other hand, tend to favour less dramatic

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[50] *ibid*, at 76-7.

[51] See S. Jinnet-Sack, "Autonomy in the company of Others" in A. Grubb (ed) *Choices and Decisions in Health Care* (1993) Chichester: Wiley.

[52] *supra,* n. 49, at 102.

methods, like self-poisoning, which are less likely to be misconstrued.[53] World Health Organisation figures point to a suicide rate of 121 per million head of population in the United Kingdom for the year 1992. That year 4,628 were suicides recorded. Pritchard explains that this amounts to more than ten times the homicide rate, even taking into account terrorism in Ireland, and that this has enormous resource implications. The figures are similar in other western countries.[54]

Within these statistics most suicides are characterised by mental illness, with the suicide rate amongst people with mental illness being equivalent to more than eighty times that of the general population.[55] Where this is the case concerns arise as to whether the individuals concerned have taken their lives as a means of exercising their autonomy. People who have been diagnosed as suffering from mental illness may not be competent to make free and independent moral decisions . In these circumstances it has been suggested that respect for autonomy may be overridden, for example if such a patient is admitted to hospital requiring emergency life saving treatment.[56]

The suicide that is the object of this analysis generally falls outside of these categories however, being confined to the actions of those who seek release from a life they perceive as intolerable; not because of despair due to "community or circumstance, which shatters [one's] hold on the value of life"[57] and questions one's competence, but because life and medicine has nothing left to offer but a prolongation of the dying process which will inevitably lead to dependence and loss of control. In these circumstances those who bring about their own demise through suicide may succeed in preserving their autonomy and dignity until the end of their lives. They can apply the independence of thought, will and action described by Gillon as fundamental to autonomy and human dignity in choosing to bring about their own death.

But against this analysis are concerns that in fact such a suicide may not be autonomous if the person concerned has a hidden agenda behind her desire to end her life. She may be acting altruistically to try to avoid family and friends

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[53] *supra*, n. 46 at 55-6.

[54] *ibid*, at 2.

[55] Department of Health, *The Health of the Nation: A Strategy for England and Wales* (1992) London: HMSO.

[56] See M. Brazier, M. Lobjoit, *Protecting the Vulnerable* (1991) New York: Routledge.

[57] *supra*, n. 46 at 2.

experiencing distress and suffering at witnessing her gradual demise, or she may simply want to prevent others being burdened by having to care for her. Janet Adkins, Dr Kevorkian's first "victim", seems to typify this sentiment. Diagnosed as suffering from Alzheimer's Disease she is reported to have planned her death at a time which would be least disruptive to her family, particularly by avoiding spoiling Christmas. She also selected a time that enabled her to organise her own memorial service and is said to have "arranged for a therapist to mediate final 'closure' sessions with her family".[58] Where choosing suicide amounts to one person wanting to sacrifice herself for the good of others because she feels socially pressured serious doubts are raised about whether that person is making an autonomous decision. These doubts persist regardless of whether that pressure is real or imagined, covert or overt.[59]

There are people who, in the absence of any kind of external pressure, would fervently desire to take their own lives but are prevented from so doing. Many people are physically constrained by the nature of their disease while others desire a clinical and certain suicide which they cannot achieve without assistance. The issue of the physical disability being destructive of autonomy has been discussed by Carole Smith.[60] She contrasts the fact that legal mechanisms have been formulated to protect the autonomy of those with mental disability in order to provide freedom from exploitation and abuse, with the poorly addressed issue of the impact of physical disability on people's autonomy. Her thesis is that where physical disability is concerned a positive notion of autonomy is required so that people can be free to act autonomously, and that the inequity between the provision of this freedom and the negative freedom which safeguards against exploitation in the mentally disabled is the result of policy decisions.

An example of a case concerning a person whose potential physical disability would ultimately prevent her from taking her own life is provided by the 1993 case of Canadian born Sue Rodriguez.[61] A detailed analysis of the case is given in Chapter Six which emphasises Rodriguez' contention that barring her from

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[58] S. Gutmann, "Dr. Kevorkian's Woman Problem: Death and the Maiden" 24th June 1996, *New Republic*, 3.

[59] See R. M. Cole, "Communicating with People who Request Euthanasia" (1993) 7 (2) *Palliative Medicine*, 139-43.

[60] C. Smith, "Disabling Autonomy: The Role of Government, the Law, and the Family" (1997) 24 (3) *Journal of Law and Society*, 421-39.

[61] *Rodriquez v A-G British Columbia* [1993] 3 WWR 553.

receiving assisted suicide was destructive of her dignity. In essence Rodriguez argued that her autonomy was compromised by the Canadian Criminal Code and by the physically disabling nature of her disease. She was able to make an autonomous choice that she wished to take her own life when she decided that the time was right, but would be unable to act upon it in much the same way as the fictional Ken Harrison was. Her case failed in the Supreme Court where it was held that such fundamental decisions could only be taken by the legislature.

In England Annie Lindsell who suffered from motor neurone disease also sought a legal right to die by assisted suicide. Her case went to court in October 1997 and is comparable with that of Sue Rodriguez in that the disease was the same and her reasons for seeking assisted suicide were similar. Lindsell believed that when she reached the terminal stages of her disease she would welcome the opportunity to end her own life but would be prevented from so doing by the nature of the disease. She therefore wished her autonomy to be respected and her decision to be acted upon by someone else. Annie Lindsell dropped her case after being assured that she could legally be given any medication required to keep her comfortable in the terminal stages of her disease, even if that meant her life would incidentally be shortened. She died in December 1997.

In the American state of Oregon a decision to permit assisted suicide was taken by the legislature in 1994. Subsequent legal challenges held the law to be unconstitutional and appeals against this ruling have now resulted in a decision to allow the people of Oregon to vote in a referendum on the issue. In Australia's Northern Territory The Rights of the Terminally Ill Act 1996 permitted medically assisted suicide and four patients successfully exercised the autonomous right to die by assisted suicide granted by the Act before the legislation was challenged and ultimately overruled by Australia's Federal Parliament.

Similarly in the cases of *State of Washington et al v Glucksberg et al* and *Vacco et al v Quill et al*,[62] which were discussed in Chapter One in the context of a constitutional challenge to New York State's ban on assisted suicide as a violation of the Fourteenth Amendment's Equal Protection Clause, the prohibition was said not to have been a violation however because anyone can refuse treatment while nobody is entitled to assist suicide.

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[62] The decision of the Supreme court was published on June 26th 1997 and is available on LEXIS.

It is interesting to compare this interpretation of American constitutional rights with women's constitutionally protected right to have a previability abortion. Like the illusive right to die with dignity, the right to a previability abortion is often viewed as a right to terminate life, albeit a potential life rather than a life in being. Furthermore, neither assisted suicide nor the termination of pregnancy can be achieved without the help of medical professionals. Yet the right to previability abortion has been described as being entitled to constitutional protection because it, "... falls within the constitutionally protected sphere of liberty requiring medical assistance".[63] It is difficult to differentiate this right, which has been said to represent a unique thread of individual liberty and is justified by concerns for the woman's suffering,[64] from claims for a constitutional right to assisted suicide in order to relieve individual suffering. One way to explain this apparent inequity is by considering the interests that the state is protecting.

With the previability abortion the interests of the living woman are protected by the law and her liberty to make an autonomous decision to abort her pregnancy takes priority over the unprotected "rights" of the unborn child.[65] The individual who dies has no legal rights and therefore no interests to be protected by the State. The individual who dies as a result of assisted suicide possesses a right to life which the State considers worthy of a degree of protection. This protection extends to guarding against the potential for unlawful killing that allowing assisted suicide may open up. However, classifying assisted suicide as a criminal act akin to unlawful killing is in some respects anomalous because to assist in the suicide of another amounts to aiding and abetting the commission of an action which is not in itself a crime.

For most criminal offences aiding and abetting counselling and procuring are the actions of an accomplice who participates, to some degree, in the commission of a crime. In recent years suicide has been recognised more as, either an expression of self-determination and individual autonomy, or the result of mental illness neither of which require the attention of the criminal justice system

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[63] B. Geobel, "Who Decides if there is 'Triumph in the Ultimate Agony?' Constitutional Theory and the Emerging Right to Die with Dignity" (1995) 37 (2) *William and Mary Law Review*, 827, at 879.

[64] *Planned Parenthood v Casey*, 112 S. Ct. 2791 (1992) at 2810-11.

[65] The term "unprotected rights" is used here to express the lack of legal protection for the moral rights of the unborn child which are recognised by some.

because of the absence of *mens rea*. But when a person wants to kill herself and cannot do so without help her adjutant is regarded as a criminal accomplice and can be sentenced to a maximum penalty of 14 years imprisonment. Ashworth argues that this is necessary in order to guard against the potential for subversion of the right to self-determination if "vulnerable people who do not desire death, despite their suffering, might be killed by others for reasons of their own".[66] He goes on to recognise that the legal prohibition on assisted suicide is likely to be manifested in a sympathetic response for doctors while friends and relatives "must run the gauntlet of a legal process which affords no formal recognition to the circumstances under which they killed."[67]

Conclusion

This chapter has considered the right of every individual to make autonomous choices regarding the medical care they receive, a right which is enshrined in the law governing consent to examination and treatment. Many cases have endorsed this as an absolute right but the examples shown here demonstrate that where informed consent, the right to refuse treatment, assisted death and euthanasia are concerned, it is a highly contingent right. As John Harris states,

> ... perfect autonomy, decisions taken without any defect at all either of information or reasoning or of control, is, like any ideal, unattainable. But the fact that autonomy, like many important and desirable things, is a matter of degree does not make it any the less worth striving for, nor does it make it any the less important to have as much of it as possible.[68]

It is important that all patients are enabled and encouraged to exercise autonomous choice but,

> To make an optimally informed choice, patients require active help ... when, for whatever reason, they are confused or think they know more than they do, the duty not to coerce in the long term tells doctors little about how to help them to be more critically autonomous in the short term.[69]

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[66] A. Ashworth, *Principles of Criminal Law* (1995) Oxford University Press, 286.
[67] *ibid.*
[68] *supra*, n. 14 at 200.
[69] *supra*, n. 18 at 12.

In other words, "there is no such thing as informed consent unless there is equal knowledge",[70] but all patients should be helped to make their own choices even if they later prefer to leave the decisions to the clinician.

In order to allow this to happen, it is as important that the law relating to consent respects patient autonomy when it is called upon to determine outcomes in cases concerning consent and clinical care. Many have rightly argued that "the law relating to consent pays little more than lip service to patient autonomy."[71] Autonomy presently extends only as far as legal and medical paternalism allows it to, being contingent upon clinical and legal assessments of patient's best interests and professional competence measured against standards accepted within the medical fraternity, as enshrined within *Bolam*,[72] *Sidaway*,[73] and *Re F*,[74] which will be discussed fully in Chapter Four.

This is a degree of paternalism which is becoming unacceptable in many other western jurisdictions[75] and has been particularly strongly criticised in the Australian case *Rogers v Whitaker*.[76] The judgement in that case determined that when providing advice and information to a patient, prior to that patient giving consent to treatment, the clinician's duty was to give the information which a reasonable person in the patient's position would require. This would not be ascertained by comparing the practitioner's conduct with that of other similar practitioners, but according to an analysis of many different factors, including, the type of therapy involved, the individual patient's thirst for information about the procedure and the general comportment of the patient. In short *Rogers v Whitaker* upheld the judgement of King L. J. in an earlier authoritative Australian case which formulated a more progressive and patient orientated test than that laid down in *Bolam*, namely that,

> It is for the court to decide what a careful and responsible doctor would explain to the patient in the circumstances, and I do not regard as decisive the opinions of the medical witnesses on the point or the

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[70] The words of Professor Max Hamilton cited in, C. Pritchard, *Suicide - The Ultimate Rejection* (1995) Buckingham: Open University Press, 166.

[71] M. Brazier, *Medicine, Patients and the Law* (1992) London: Penguin, 92.

[72] [1957] 2 All E.R. 118.

[73] *supra*, n. 26.

[74] [1989] 2 All E.R. 545 (HL).

[75] K. Tickner, "*Rogers v Whitaker*-Giving Patients a Meaningful Choice" (1995) 15 (1) *Oxford Journal of Legal Studies*, 110 at 118, suggests that this is the case in Australia, Canada, New Zealand and more than half of the jurisdictions of North America.

[76] (1992) 67 ALJR 47 (High Court of Australia).

> existence of a practice of non-disclosure in a section of the profession.[77]

Unless and until the English courts adopt a similar approach to the disclosure of information, enabling patients to make fully informed decisions concerning consent to medical treatment, patient autonomy will continue to be contingent upon medical and legal paternalism and the right to choose, particularly to choose to decline treatment will only be of limited practical value. Similarly, while assisted suicide continues to be outlawed, many people's measured, autonomous decisions to kill themselves will be nullified by the absence of the physical autonomy to act for themselves.

It is not enough simply to consider the impact of the present legal situation on the autonomy of those who would want the right to assisted suicide and euthanasia however. The potential impact of legal reform permitting assisted suicide on the autonomy of those who would have to assist the suicide must also be considered. The central tenet of medical ethics is to do no harm but providing a patient with the means to kill herself clearly contravenes this ethic. Therefore some clinicians may find their personal and professional ethics compromised by allowing patients to request assisted suicide.[78] Anecdotal evidence suggests that many of the Dutch doctors who have assisted with suicide do so only once because of the trauma involved. Hence, if assisted suicide were to be permitted as a means of protecting patient autonomy doctors would need to be enabled to exercise their own autonomous choice not to participate if they so desired.

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[77] *F v R* (1983) 33 SASR 189, per King CJ at 192-3.

[78] These issues will be addressed more fully in Chapter Six.

Chapter Four

Consent to Treatment but not to Death

Introduction

Consent is central to understanding the relationship between medicine, the law, and the right to die with dignity. Based on respect for individual autonomy, the law of consent enables people to decide whether or not to accept any medical treatment that may be offered and thereby retain some control over clinical management. Those who advocate the right to die with dignity tend to predicate their opinions on respect for autonomy, choice and the maintenance of control as the means of achieving dignity in dying. Consequently it appears likely that the law of consent may be useful to those who seek legal reform in favour of euthanasia and assisted death in the name of dignity. In practice however, the law of consent has only been successful in the pursuit of dignity in dying where it has been possible for individuals to withdraw or withhold consent so that treatment ceases and death results.

For our hypothetical patient, confined to her hospital bed, clinging to life but with little prospect of recovery, the outlook is bleak. Respect for autonomy and the law of consent allow her an absolute right to give, or withhold, consent to medical treatment which may enable her to influence the way in which events unfold. But whether or not she can depends largely on the individual circumstances of her case and more particularly on whether she has the legal capacity to participate in the medical decision-making process by giving or withholding consent.

This chapter will investigate the role of consent in everyday medical treatment. In respect of competent adults it will analyse why consent is necessary through a discussion of the consequences of administering treatment in the absence of valid consent, and discuss the different types of consent. Some consideration will also be given to the methods for obtaining consent and ensuring that consent is valid. Finally there will be some analysis of the special consent issues that arise in relation to incompetent adults and minors. After this, Chapter Five will discuss the significance of advance directives in achieving death with dignity by declining consent to some or all treatment in advance of those treatments becoming necessary, and Chapter Six will consider whether such a death can in fact be dignified.

Consent and the competent adult

Chapter Three described how the law requires that no person should be touched by another without authorisation and that, in the context of medical care, no therapy should be given in the absence of consent in order that every individual's right to autonomy is respected. Cardozo J's statement that,

> Every human being of adult years and sound mind has the right to determine what shall be done with his own body.[1]

reflects this right and the need for consent wherever deliberate physical contact is made by one person on another. As the manifestation of the patient's autonomy over her personal bodily integrity, this principle applies whether the contact occurs in everyday life or during examination by a medical professional intent on diagnosis or treatment.[2] Hence the law relating to consent, as a means of validating physical contact, is informed by cases involving all kinds of human conduct.

Both Cardozo J's statement, and the general law relating to consent refer specifically to adults who are of sound mind, excluding minors,[3] and adults who lack the mental capacity to make their own health care decisions. The implications of imposing medical treatment without consent are the same for all patients regardless of their mental capacity, but the focus of the opening discussion of the law relating to consent will be confined to its implications for a competent adult. Such a person is able to comprehend and retain treatment information, believe that information and weigh the information given in the balance to reach a decision. The specific legal mechanisms for legitimating the

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[1] *Schloendorff v Society of New York Hospital* (1914) 105 N.E. 92, 93 (N.Y.) per Cardozo J.

[2] *Schloendorff v Society of New York Hospital* (1914) 105 N.E. 92, 93 (N.Y.), *Sidaway v Bethlem Royal Hospital Governors* [1985] 1 All E.R. 643 at 666, and *Airedale NHS v Bland* [1993] 1 All E.R. 821, provide examples of prominent cases that include statements emphasising this right. It is also endorsed in the Government policy document "*A Guide to Consent for Examination and Treatment*" issued by Dept. of Health and the Welsh Office, and *The Patient's Charter*.

[3] Technically all those who are below the age of 18 years are minors.

provision of medical treatment in the absence of valid consent for people who lack capacity, will be discussed later in this chapter.

Consent in the context of general medical treatment may be implied or express, oral or written. As long as the consent is validly obtained each type of consent is equally as valid and there are no formal requirements as to how consent is obtained only that it is necessary.

For most routine medical treatment verbal consent is considered sufficient, but the Department of Health recommends in its *Guide to Consent for Examination or Treatment*,[4] that written consent be obtained for procedures or treatments which carry with them substantial risks or side effects. A wide variety of consent forms which relate to specific forms of treatment are available.[5] Procedures for which the *Guide* considers written consent appropriate include, surgery, general anaesthesia, and treatments utilising ionising radiation or cytotoxic drugs (chemotherapy).[6] Obtaining written consent is however, a matter of convention as much as legal necessity, since the availability of a signed consent form will only constitute evidence that the patient has agreed to the procedure concerned. The forthcoming discussion of negligence and informed consent makes it clear that unless the procedure has been explained to the patient, along with its purpose, nature, and side effects, even a signed consent form may not render the contact involved in the administration of treatment valid.

In practice the written consent form is often regarded as little more than a formality. It will frequently be the most junior doctor on the team who is assigned the task of obtaining the patient's consent, and the nature of the task is that of a chore which must be completed before the *real* (meaning important) work can commence. Patients will generally regard the signing of the consent form similarly, since their primary interest is in getting the necessary procedure over with as quickly and effortlessly as possible. This has implications for both the validity of the consent given and also for the patient's ability to act as an autonomous agent, as was discussed in Chapter Three. In order to safeguard

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[4] NHS Management Executive, 1990, (HC (90) 22).

[5] The standard form for use in the NHS issued by the Department of Health in 1990 is reproduced in Appendix A.

[6] The omission of vaccination against childhood diseases in this list is interesting in view of the controversy surrounding the potential adverse effects of some of the vaccines. It is arguable that as one of the most routine procedures formal consent is unnecessary, and may be less than practical, but given the gravity of the consequences of vaccine damage perhaps more attention should be given to providing information and obtaining specific valid consent.

individual autonomy through gaining valid consent to medical treatment it is essential that wherever possible express consent should be obtained. Regardless of whether the consent is obtained verbally or in writing, the process involved should be recorded in the patient's notes as a means emphasising the importance of valid and informed consent.

In some clinical situations it may be impractical, or inappropriate to obtain written consent to medical examination or treatment and in these cases consent may be expressed verbally, or implied by conduct. Where a patient presents[7] for a procedure or investigation, and acquiesces with the medical staff, for example by undressing or offering her arm for venepuncture, consent is implied by conduct. The nineteenth century American case of *O'Brian v Cunard SS Co.*[8] illustrates this point. The case concerned a young man who understood little English and had just arrived in America as a potential immigrant worker. He was confused by the immigration procedures with which he had to comply and later claimed that he had not consented to receive the small-pox vaccination that was administered to him. It was held that because he rolled up his sleeve and presented his arm to the attending clinician, specific verbal consent was not necessary, his consent was implied by conduct.

Today this procedure can be readily observed in general practices and hospitals throughout the country. If a patient presents to the doctor complaining of a chesty cough or a sore throat, formal consent to examine the relevant body part is rarely sought. It is simply a matter of unbuttoning a shirt or opening a mouth. Similarly, wherever mothers and children attend clinics offering vaccination against childhood diseases, mere attendance at the clinic and presentation of the child to the doctor or nurse, is considered sufficient to assume or imply that consent has been given.

The concept of assumed or tacit consent was established in *Beatty v Illingworth* in 1896,[9] where a surgeon performing an operation to remove one unhealthy ovary actually removed both, after discovering that each was similarly diseased. The patient took legal action because, prior to undergoing the procedure, she had

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[7] Medical personnel use the term *patient presents* to denote that a person has come forward to receive medical attention. Accordingly the descriptive term, "*a patient presented with*", refers to the condition or symptoms which provoked the individuals first attendance at the medical facility concerned.

[8] (Mass. 1891) 28 NC 266.

[9] (1896) *British Medical Journal* 21st November, 1525.

expressly informed the doctor of her impending marriage, and of her desire that she should not be rendered infertile. Her case failed because her consent was considered to be implicit in the fact that she had agreed to undergo surgery.

In America *Mohr v Williams*[10] also raised the issue of implied or assumed consent in a case where surgical intervention went beyond that to which the patient had expressly agreed. Brown J. stated that,

> if in the course of an operation to which the patient consented, the physician should discover conditions not anticipated ... and which if not removed, would endanger the life or health of the patient, he would, though no express consent was obtained or given, be justified in extending the operation.

He also argued that,

> if a person should be injured to the extent of rendering him unconscious, and his injuries were of such a nature as to require prompt surgical intervention ... consent on the part of the injured person would be implied.[11]

Similar reasoning was employed in the English case of *Wilson v Pringle,*[12] which concerned a patient who arrived unconscious in the accident and emergency department. Here, the Court of Appeal interpreted emergency treatment as falling within the category of "all physical contact which is generally acceptable in the ordinary conduct of daily life",[13] which thereby implied consent and legitimacy. This approach had previously been disapproved of in the Canadian case *Marshall v Curry,*[14] where it was described as a legal fiction, and subsequent British judgements have re-interpreted the issue,

> ... in situations where a patient of full mental competence is unable to give consent, an operation necessary for the preservation of life or for the preservation of health ... not only can but should be performed. It does not appear to me to be based on implied consent

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[10] (1905) 104 NW 12 (Sup Ct Minn).

[11] *ibid.*

[12] [1986] 2 All E.R. 440.

[13] *Re F (A Mental Patient: Sterilisation)* [1990] 2 A.C. 1, [1989] 2 All E.R. 545 (HL), per Lord Goff.

[14] [1933] 3 D.L.R 260 at 275.

> but on public policy that it is in the public interest that unconscious patients requiring emergency treatment should be able to receive it.[15]

Implied consent does not therefore, validate extending one procedure to include another without the patient's knowledge, or against the patient's expressed wishes as in *Beatty v Illingworth*, unless the situation is one of emergency.

Any bodily contact without consent, including that which occurs in relation to medical treatment, can attract criminal or civil legal action. Criminal and tort liabilities resulting from non-consensual treatment will be considered here, although in practice health care personnel who act without obtaining consent are more likely to be found liable in the law of torts, than guilty of a crime. This is largely because a civil action offers the plaintiff the potential to receive financial compensation and also because the police are unlikely, other than in truly exceptional circumstances, to view the imposition of medical treatment without consent as a inherently harmful and therefore worthy of criminal prosecution.

Nevertheless, the law relating to consent is heavily influenced by both tort and criminal law, and a detailed analysis of each is required to fully explore the necessity for consent and the potential consequences of treatment without consent.

Criminal Liability

Unauthorised physical contact which results in harm will usually attract criminal sanction. However, the complexities of the relationship between consent and crime dictate that physical contact which in some circumstances would be considered unlawful, can in others be legitimated by the giving of valid consent by the victim.[16]

> ... activities carried on with consent by or on behalf of the injured person have been accepted as lawful, not withstanding that they involve actual bodily harm or may cause serious bodily harm. Ritual circumcision, tattooing, ear piercing and violent sports including boxing are lawful activities.[17]

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[15] *supra* n. 13, per Lord Butler-Sloss.

[16] The word 'victim' is used here to denote the recipient of the harm.

[17] *R v Brown* [1993] 2 W.L.R. 558, per Lord Templeman.

Where a person actively seeks any of these types of activity she does so in anticipation of the hurt that will inevitably result and often welcomes its effect. Because of its consensual nature society considers this to be an acceptable kind of harm which is therefore lawful. Consent can however be negated by the nature of the harm involved or by issues which question the validity of the consent given, such as fraud, or mistaken identity.

For example, participants in physical sports expect a degree of contact and give their implied consent by voluntarily engaging in the game and, as Lord Templeman suggests above[18] the law offers no opposition. But, if a footballer is injured as a result of an "off the ball" incident the player who caused the injury is potentially criminally liable. The action was not lawful since it formed no part of the game and therefore did not occur with the valid, implied consent of the victim.

Even if the consent given had been valid, the fact that the injured party consented to the action which caused her injury will not always render that action lawful.

> As a general rule to which there are well established exceptions, it is an unlawful act to beat another person with such a degree of violence that the infliction of bodily harm is a probable consequence and, when such an act is proved, consent is immaterial.[19]

Some types of harm will only rarely be legitimated by the giving of consent. These include,

> ... any hurt or injury calculated to interfere with the health or comfort of the prosecutor. Such hurt need not be permanent but must no doubt, be more than trifling.[20]

The harms which tend to result from medical diagnosis and treatment, such as venepuncture, incisions and strenuous palpation of parts of the body, would certainly fall within this description, yet in the medical context they can be legitimated by the giving of valid consent. This appears to be because of a presumption that any physical contact occurring in the course of medical treatment will be for the benefit of the recipient and is therefore, ultimately in the

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[18] *ibid.*
[19] *R v Donovan* [1934] 2 K.B. 498, at 507, per Swift J.
[20] *ibid.*

public interest.[21] The giving of consent in this context does not license the commission of what would otherwise be a crime. The crime of battery would generally apply in circumstances where unauthorised physical contact occurs but it only becomes relevant where the contact happens without legally valid consent. Consequently consent to medical treatment represents a necessary and sufficient defence to the crime of battery.

Therefore, even though medical treatment may involve contact which in another context could constitute bodily harm, it is not ordinarily seen as criminal behaviour. Similarly with the blows to the head and body during boxing or puncturing the earlobes in ear piercing. Conduct which is not ordinarily considered lawful however, cannot be legitimated by gaining the victim's consent,

> If an act is unlawful in the sense of being in itself a criminal act, it is plain that it cannot be rendered lawful because the person to whose detriment it is done consents to it. No person can license another to commit a crime.[22]

An example from the medical arena is *R v Flattery*,[23] where Dr. Flattery made the false representation to his patient that sexual intercourse was a legitimate method of medical examination. Consent was apparently given but was invalid due to the doctor's misrepresentation of the facts. Dr Flattery was convicted of rape because he had sexual intercourse with this patient without obtaining her consent. Had he not mislead his victim so that she had given informed consent to have sex with him he would have committed no crime[24] since rape is only committed where sexual intercourse occurs in the absence of valid consent.

Clearly therefore, criminal liability can flow from misconduct in the medical arena, albeit rarely, and there are many crimes for which a medical practitioner may be criminally liable, depending on the kind of conduct involved. Outside the medical context criminal responsibility for bodily contact which results in

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[21] It should be noted however that some medical procedures appear to provide little or no physical benefit to the individual patient concerned. The removal of organs for transplantation or the extraction of bodily tissues or fluids for donation are obvious examples.

[22] *A-G's Reference (No.6 of 1980)* [1981] 2 All E.R. 1057 at 1059.

[23] (1877) 2 Q.B.D. 410, *R v Williams* [1923] 1 K.B. 340, provides a similar example where a music teacher persuaded his student that sexual intercourse was an exercise to improve her breathing.

[24] Other than serious professional misconduct.

injury but is not fatal will usually be determined according to the Offences Against the Person Act 1861. The offences range from assault and battery, through actual bodily harm to grievous bodily harm and, if death results, murder or manslaughter charges may be brought. These offences could apply to very many diagnostic and therapeutic procedures. However, Kennedy and Grubb suggest that where medicine is practised in good faith there is in reality no likelihood of criminal prosecution.[25] The example of Dr Flattery is one wherein medicine was obviously not being practised in good faith and criminal prosecution was appropriate.

Medical procedures that involve bodily touching can theoretically give rise to allegations of criminal battery. In terms of general criminal liability the words assault and battery are frequently used interchangeably although they are distinct statutory offences with separate common law definitions.[26] Assault does not require physical contact with the victim,[27] while battery involves intentional or reckless infliction of unlawful physical contact. Kennedy and Grubb consider where the crime of battery may apply to cases concerning consent to treatment and conclude that,

> The scope of the crime of battery, should it ever arise, is likely to be held by the courts to be the same as the tort of battery, apart from the fact that the doctor's intention will be relevant in determining whether he has the necessary *mens rea* for the crime.[28]

The Offences Against the Person Act (1861) defines the more serious aggravated criminal assaults[29] which cannot generally be legitimated by reference to the victim's consent. The criminal law has however been inconsistent in it's approach to examples of these kinds of assaults. Perhaps the least serious of these offences is defined in s.47 as assault occasioning actual bodily harm. Here the harm caused by the assault is construed as, "any hurt or injury calculated to interfere with health or comfort," so long as the injury is not "so trivial as to be

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[25] I. Kennedy, A. Grubb, *Medical Law: Text with Materials* (2nd ed.) (1994) London: Butterworths, at 90.

[26] *Taylor v Little* (1992) 95 Crim. App. R. 28.

[27] *R v Mansfield Justices (ex parte Sharkey)* [1985] Q.B. 613, [1985] 1 All E.R. 193, per Lord Lane.

[28] *supra* n. 25.

[29] Offences Against the Person Act 1861, s.18, s.20, and s.47, define the offences of causing grievous bodily harm, inflicting grievous bodily harm and, assault occasioning actual bodily harm, respectively.

wholly insignificant".[30] s.18 and s.20 of the Act deal with the more serious crimes of causing and inflicting grievous bodily harm respectively, where grievous bodily harm is defined as serious bodily harm.[31]

The type of physical contact involved in the provision of medical care will frequently fall within these definitions but, being considered an exception to the general rule, will not attract criminal sanction.[32] The 1861 Act does not provide that the commission of grievous bodily harm will automatically be unlawful, implying that if grievous, or serious, bodily harm is caused unintentionally or lawfully it will not be an offence. In *R v Hogan,*[33] Lawton J. construed "unlawfully" in s.18 as meaning "without lawful excuse",[34] hence in the context of harm resulting from proper medical treatment, the giving of valid consent can provide a lawful excuse as it does with the previously mentioned exceptions of violent sports, tattooing and piercing. Yet many commentators believe there are inconsistencies in the way the law has approached these issues.[35] These perceived inconsistencies have resulted in the publication of two consultation papers by the Law Commission,[36] one of which contained the following summary of the law of consent,

> In short, the consent of the injured person does not normally provide a defence to charges of assault occasioning actual bodily harm or more serious injury. On to this basic principle the common law has grafted a number of exceptions to legitimise the infliction of such injury in the course of properly conducted sports and games, lawful correction, surgery, rough and undisciplined horseplay, dangerous exhibitions, male circumcision, religious flagellation, tattooing and ear piercing.[37]

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[30] *R v Donovan* [1934] 2 K.B. 498.

[31] *DPP v Smith* [1961] A.C. 290, *R v Hyam* [1975] A.C. 55, and *R v Cunningham* [1982] A.C. 566, have all adopted this interpretation of grievous bodily harm.

[32] *supra* n. 17, especially the dissenting judgements of Lord Mustill and Lord Slynn.

[33] (1973) 59 Crim. App. R. 174.

[34] *ibid* at 176.

[35] See for example, L. Bibbings and P. Alldridge, "Sexual Expression, Body Alteration, and the Defence of Consent" (1993) 20 (3) *Journal of Law and Society*, 356, M. Allen, "Consent and Assault" (1994) 58 (2) *Journal of Criminal Law*, 183, and, R. Leng, "Consent and Offences Against the Person: Law Commission Consultation Paper No. 134" (1994) *Criminal Law Review*, 480.

[36] *Consent and Offences Against the Person*, Law Commission Report, No. 134 (1993) London: HMSO, and *Consent in the Criminal Law*, Law Commission Report, No. 139 (1995) London: HMSO.

[37] *Consent in the Criminal Law*, Law Commission Report, No. 139, (1995) HMSO, at para 1.11.

The extensive list of exceptions to the basic common law principles of when consent can provide a defence causes concern to many commentators since there is no logical reason given why these practices should be exceptions, other than that they represent behaviour that is considered to be socially acceptable. Alongside these objections is the fact that the list itself is by no means comprehensive since various other body altering practices such as nipple and navel piercing are today commonplace and many types of medical procedure other than surgery fall within the definitions of the 1861 Act. One of the most obvious examples of medical procedures which are not immediately evident as beneficial to the patient, is the removal of body tissues and organs for transplantation which certainly fall within the scope of s.18. It has been suggested however, that the altruistic motivation for these operations will avoid the imposition of criminal liability.[38]

Overall then it seems that there is a great deal of support for Kennedy and Grubb's assertion that criminal liability is unlikely to arise from the proper practice of medicine. However, should death result from the inappropriate practice of medicine, of which euthanasia and assisted death may be considered examples, criminal liability is the most likely form of legal response.

Any deliberate action by one person which causes the death of another is categorised as homicide, murder or manslaughter, under the common law. The fact that such an action was performed with the consent of the "victim" is of no relevance, neither would be the fact the actions were performed by a medical professional. The criminal liability of a health care professional who deliberately causes the death of a patient is the same as for any other person who causes the death of another. Essentially, mercy killing at the request of the "victim" is as much murder as any other intentional killing,

> ... 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.[39]

Several examples of doctors acting to shorten the lives of patients with compassionate motives are given in Chapter One which discusses euthanasia as

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[38] For example *A..-G.'s Reference (No. 6 of 1980),* [1981] Q.B. 715, refers at 719D to the removing kidneys from living donors for transplantation as being done for "good reason" and therefore legitimate.

[39] *Airedale NHS Trust v Bland* [1993] 2 W.L.R. 316, per Lord Goff.

homicide.[40] Conduct such as this is presently outside the scope of the legal duty owed by the doctor to her patient even where the patient requests euthanasia, and is therefore always unlawful.

In the context of medical care criminal liability for causing death can also arise out of negligence. This will occur when the performance of a duty falls so far below the expected standard as to suggest liability beyond that of the civil law. Here a perpetrator will usually be charged with manslaughter because the death has not been caused intentionally and the required *mens rea* for murder is absent. Such a case was *R v Adomako*[41] where an anaesthetist was found liable for the death of a patient in his care after he failed to observe and respond to the patient's deteriorating condition. In the appeal court it was held that, in cases arising from a breach of duty, the correct test to apply in determining liability was that of gross negligence, as opposed to recklessness. The test applied here because Dr Adomako was considered to have missed signs that should have been obvious to any competent anaesthetist, and there was some doubt on the evidence as to whether he had provided adequate safeguards for monitoring the patient when he may have been absent from the room.

While this case did not strictly revolve around the issue of consent it is pertinent to consider that the patient in Dr. Adomako's care had consented to be anaesthetised on the understanding that the doctor would exercise his professional duty with an acceptable level of expertise. This duty was grossly breached and Dr Adomako's conviction was upheld. However, as has been mentioned, it is not usual for criminal liability to arise in the context of medical care because the imposition of civil liability is usually considered more appropriate since it provides a potential remedy for the victim.

Tortious Liability

Tortious, or civil liabilities are of limited relevance to the discussion of euthanasia and assisted death but are of particular importance to determining the validity and scope of consent. They are therefore pertinent to the general discussion of the right to withdraw or withhold consent which might be a patient's only means of attempting to achieve death with dignity.

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[40] See *R v Adams* [1957] Crim. L.R. 365, *R v Arthur* (1993) 12 B.M.L.R. 1, *R v Carr The Sunday Times*, 30th November 1986, 1, and *R v Cox* (1992) 12 B.M.L.R. 38.

[41] [1991] 2 Med. L.R. 277.

Two separate torts are relevant to liabilities emanating from issues concerned with consent to medical treatment. These are, the intentional tort of battery and the non-intentional tort of negligence. Battery will be considered first as it is of limited application, followed by negligence which incorporates a discussion of the concept of informed consent.

Tortious battery is a form of trespass which results from intentionally causing offensive or harmful contact with another which,

> ... serves the dual purpose of affording protection to the individual not only against bodily harm but also against any interference with his person which is offensive to a reasonable sense of honour and dignity. The insult of being touched is traditionally regarded as sufficient, even though the interference is only trivial and not attended with actual physical harm.[42]

In effect the tort of battery is a legal representation of the right of an individual to dictate what is done to her body as is embodied in the principle of respect for personal autonomy. The significance of this is that no consequential physical harm needs to be demonstrated by the plaintiff, the harm is in the insult to bodily integrity.

Illustrative of this is the fact that the consent should be specific to the treatment or procedure involved. The Canadian case *Allan v Mount Sinai Hospital*[43] demonstrates the principle. The patient involved was injected in her left arm, after giving explicit instructions that she wished to be injected only in the right arm. She later successfully sued in the tort of battery. Such judgements are rare in the British courts however,[44] with only a handful of cases being brought and even fewer being successful on the rationale that as long as consent is given to physical contact of some kind there can be no battery. Furthermore, in *Wilson v Pringle*,[45] it was postulated that touching must be hostile in order to impose tortious liability for battery, but that judgement has since been discredited,

> ... In the old days it used to be said that, for a touching of another's person to amount to a battery, it had to be a touching 'in anger' ... and

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[42] Fleming, *Law of Torts* (8th edition) (1992) at 24.

[43] (1980) 109 DLR (3d) 536.

[44] See for example, *Cull v Royal Surrey County Hospital* (1932) 1 B.M.J. 1195, and *Hamilton v Birmingham RHB* (1969) 2 B.M.J. 456.

[45] *supra* n. 12.

> it has recently been said that the touching must be 'hostile' to have that effect (see *Wilson v Pringle*). I respectfully doubt whether that is correct.[46]

Nevertheless, *Wilson v Pringle* does demonstrate the stringent efforts that have been made in attempts to avoid finding in favour of battery, particularly if the factual situation presents the possibility of liability in negligence where the availability of damages is more restricted.[47] In a successful claim for battery, damages can be recovered for all direct consequences of the tort whether or not they were foreseeable. But the level of damages available in negligence is more restricted because awards are limited to reasonably foreseeable consequences. Moreover, successful actions in negligence also require the plaintiff to demonstrate that the injury or harm for which damages are sought was caused by the negligent action of the tort feasor.

The seminal case defining negligence in terms of a clinician's responsibility towards her patients is that of *Bolam v Friern Hospital Management Committee*.[48] The case was brought by a voluntary patient in a mental hospital who suffered fractures during electro-convulsive therapy. The patient had not received an anaesthetic before the procedure, which was in accordance with a prominent opinion at the time that to do so might pose increased risks. There was however another school of thought which held that muscle relaxing anaesthesia ought to be used.

Mr Bolam's case was that the attending doctor had been negligent in the performance of his professional duty by failing to ensure that the therapy was performed safely. He claimed that insufficient restraints were placed upon him during the treatment to prevent his limbs from flailing about, and that inadequate warnings had been provided as to the potential risks involved.

The judgement drew on ancient and informative decisions to describe and define the nature of the doctor's obligations in the performance of his professional duty,

> Every person who enters a profession undertakes to bring to the exercise of it a reasonable degree of care and skill. He does not

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[46] *supra* n. 13, per Lord Goff.

[47] M. Brazier, *Medicine, Patients and the Law* (1992) London: Penguin, at 74.

[48] [1957] 1 W.L.R. 582, [1957] 2 All E.R. 118.

> undertake ... that he will perform a cure; nor does he undertake to use the highest possible degree of skill.[49]

The standard has been held to apply to all professional people, not just to doctors,

> The *Bolam* test is not confined to a defendant exercising or professing the skill of medicine ... the *Bolam* test is rooted in an ancient rule of common law applicable to all artificers.[50]

In respect of medical care the *Bolam* test of professional competence provides only that a doctor is not negligent if she acts "in accordance with the practice accepted by a responsible body of medical men skilled in that particular art."[51] It does not relate to the standard of the reasonable person or the man on the top of the Clapham omnibus, but to that of the ordinary man endowed with special skills. Therefore, the standard of skill exercised by a given member of a professional body must simply be "the standard of the ordinary skilled man exercising and professing to have that special skill."[52] It need not be the highest possible level of expertise. The standard is one which weighs the professional competence of doctors against the practices of their peer group rather than one which imposes a minimum standard of professional practice or provides any expectations as to the level of care that should be incorporated into the performance of a professional duty.

In recent years, it has been recognised that negligence liability in the context of medical care is not only germane to the physical provision of diagnostic, surgical, or medical skills, but also to the provision of information in relation to obtaining a patient's consent to treatment. Hence in many jurisdictions the law of negligence has developed towards defining the concept of informed consent. Initially this grew out of a perceived need to protect patients engaged in clinical research and the concept of informed consent was first mentioned in the American case of *Salgo v Leland Stanford Junior University Board of Trustees,*[53] which concluded that a doctor has a duty to inform her patient of, "... any facts

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[49] *Lamphier v Phipos* (1838) 8 C & P 475, per Tindall CJ, at 478.

[50] *Gold v Haringay Health Authority* [1987] 2 All E.R. 888, [1987] 3 W.L.R 649, per Lord Lloyd.

[51] *supra* n. 48.

[52] *ibid* at 121.

[53] 317 P 2d 170 (Cal, 1957).

that are necessary to form the basis of an intelligent consent ... to the proposed treatment."[54]

Chapter Three raised doubts about whether a consent given by a patient who does not understand or has not been made aware of the full implications of a particular course of treatment will be legally valid. The doctrine of informed consent challenges the validity of a consent given in ignorance of some, or all, of the implications of any treatment or investigation, and patient's advocates argue that unless people are enabled to make fully informed decisions about whether or not to proceed with proposed forms of treatment or investigation, any consent obtained will be invalid. In order to take such decisions patients need to be made aware of all the ramifications of the proposed treatment, whether they pertain to the procedure itself, or to its potential side effects.

These issues were first raised in England in *Chatterson v Gerson*[55] and later became the focus of *Sidaway v Bethlem Royal Hospital Governors.*[56] In that case a patient who underwent a surgical operation to relieve pressure on a nerve root in her neck alleged that her surgeon was negligent for failing to inform her of the possible side effects. After the operation, and as a result of known complications, Mrs Sidaway suffered partial paralysis and became severely disabled. She claimed that had she been aware of the potential risk of this particular outcome she would not have given her consent to the operation. She sued in battery and negligence.

Evidential problems arose during the case because the neuro-surgeon responsible for Mrs. Sidaway's diagnosis and operation died before the court action commenced. The case went ahead based on the assumption that Mr. Falconer (the neuro-surgeon) would have given general warnings about the kind of damage that might occur, but not about the specific damage that did result since there was a less than one per cent risk of this materialising.

The claim in battery failed at first instance, where it was affirmed that providing a patient is cognisant of the nature of the surgery in general it will not constitute a battery. The negligence claim also failed both at first instance and in the Court of Appeal, but a further appeal was made to the House of Lords.

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[54] *ibid* at 172.
[55] [1981] All E.R. 257.
[56] [1985] 1 All E.R. 643.

The Law Lords confirmed that the *Bolam* test is equally applicable to diagnosis[57] and treatment,[58] and that it applies similarly to the provision of advice and information. However, the test was not endorsed without reservation. Lord Bridge, supported by Lord Keith, considered that there are some situations where the courts might intervene even though accepted medical practice suggests there is no necessity to disclose specific information. He remarked,

> I am of the opinion that the judge might in certain circumstances come to the conclusion that disclosure of a particular risk was so obviously necessary to an informed choice on the part of the patient that no reasonably prudent medical man would fail to make it.[59]

But his comments were somewhat diluted in the light of his earlier statement that,

> ... when questioned specifically by a patient of apparently sound mind about risks involved in a particular treatment proposed, the doctor's duty must, in my opinion, be to answer both truthfully and as fully as the questioner requires.[60]

As a result the way was left open for the exercise of clinical judgement in determining exactly how detailed an answer the patient needs. Lord Diplock's judgement reflects these sentiments in its support for the use of the *Bolam* test,

> To decide what risks of the existence of which a patient should be voluntarily warned ... is as much an exercise of professional skill and judgement as any other part of the doctor's comprehensive duty of care to the individual patient, and expert medical evidence on this matter should be treated in just the same way. The *Bolam* test should be applied.[61]

Earlier discussions about the validity of consent have suggested how this approach can be problematic. Allowing too much latitude in the exercise of clinical discretion can enhance the existing paternalism in many medical relationships, and be destructive of patient autonomy.[62] Lord Bridge's comments

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[57] *Maynard v West Midlands Health Authority* [1984] 1 W.L.R. 634.

[58] *Whitehouse v Jordan* [1981] 1 W.L.R. 246.

[59] *supra* n.56, per Lord Bridge at 663.

[60] *ibid* at 662.

[61] *supra* n. 56, per Lord Diplock at 658.

[62] See Chapter Three for a detailed discussion on medical paternalism, autonomy and the

above[63] recognised the importance of enabling patients to make informed choices and opened up the potential to develop the concept of informed consent, but the courts have been slow to respond.

It was, for example, argued in *Gold v Haringey Health Authority*,[64] that the *Bolam* test did not apply, on the facts of the case, to the provision of contraceptive advice. Mrs Gold had undergone a sterilisation operation and subsequently become pregnant. She had not been warned that the operation could fail, that the consequences of failure could be that she would become pregnant, or that there were alternative forms of contraception available, namely that her husband could have undergone a vasectomy. At first instance it was held that the *Bolam* test did not apply to information given in non-therapeutic medical situations such as the provision of contraceptive advice. This meant that the surgeon was found to be negligent even though there was evidence that a significant body of doctors, one witness said 50%, would also not have issued a warning. But, in the Court of Appeal, Lord Lloyd held that the *Bolam* test is equally applicable to this kind of clinical environment as any other so the doctor had not been negligent.[65]

In *Blyth v Bloomsbury Area Health Authority*[66] the patient concerned was also a qualified nurse. She sued the health authority, in negligence arguing that it was in breach of a duty owed to her by failing to inform her of all the known potential consequences of the treatment administered to her. Ms Blyth had asked numerous detailed questions concerning potential side effects before she was injected with the contraceptive Depo-Provera. After beginning the treatment she experienced prolonged vaginal bleeding, a potential side effect of which she had not been informed and was unprepared for. At first instance the trial judge found in her favour, but in the Court of Appeal it was held that the doctor had not been negligent because the amount of information given to a patient is a matter of clinical judgement, even where the patient specifically requests it. Any suggestion that *Sidaway* implied that patients should be given *all* available information on a particular form of treatment was rejected[67] and the *Bolam* test

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validity of consent.

[63] See *supra* n. 59.

[64] *The Times* 17th June 1986.

[65] *Gold v Haringey Health Authority* [1987] 3 W.L.R. 649, at 656-7.

[66] [1993] 4 Med. L.R. 151.

[67] *ibid*, per Neill L.J.

was endorsed as being generally applicable to the provision of information, even if the patient makes specific enquiries.[68]

This judgement was one in a line of similar decisions that received criticism from both the medical fraternity and academic lawyers.[69] Subsequently the case of *Smith v Tunbridge Wells Health Authority*[70] has demonstrated a more patient centred approach to negligence in respect of consent and the provision of full information. Mr Smith was a 28 year old married man who had suffered from rectal prolapse for a number of years and had undergone a surgical operation intended to correct this condition. After the surgery Mr Smith experienced bladder dysfunction and impotence which were recognised complications of this particular operation. He brought an action in negligence against his surgeon, claiming that he had not been warned of the risks inherent in the operation and that had he known of them he would not have consented to the procedure.

Evidence was presented in the case that although the side effects Mr Smith suffered were recognised they were not mentioned in the leading text book on this type of surgery at the time. Professor Golligher, the author of the book, gave evidence to this effect but also claimed that he considered the non inclusion to be an oversight which may have misled many surgeons. The surgeon, Mr Cook, himself said in evidence that he could not remember warning the patient of these particular risks, and had not noted that he did so, but he considered that he would have been in breach of his duty to the patient had he failed so to do.

Morland J. accepted that a young man like Mr Smith would not have consented to the operation without further enquiry or information about alternative treatments, had he been aware of the risk of impotence, and he held,

> In my judgement Mr Cook, in stating that he considered that he owed a duty to warn, was reflecting not only the generally accepted standard practice, but also the only reasonable and responsible standard of care to be expected from a consultant in Mr Cook's position faced with the plaintiff's situation. On this issue the plaintiff succeeds applying the *Bolam* test as elucidated in *Sidaway*.[71]

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[68] *supra* n. 66, per Neill L.J and Kerr L.J.

[69] See for example, I. Kennedy, "The Patient on the Clapham Omnibus" in *Treat me Right: Essays in Medical Law and Ethics* (1991) Oxford: Clarendon, 210-212, and S. McLean, *A Patient's Right to Know* (1989) Aldershot: Dartmouth.

[70] [1994] 5 Med. L.R. 334.

[71] *ibid*, at 338.

This judgement goes some way towards demonstrating that the law is now beginning to question the traditional and paternalistic attitudes to medical negligence reflected in *Bolam* and *Sidaway.* Yet the impact of the decision in *Smith* may be limited if its relevance is confined to its particular facts.

Evidence of the growing concern that patients be supplied with full information about what is to be done to them is provided by the wording of the Department of Health's standard form for routine surgery, investigation, or treatment. This document now emphasises the patient's right to know and to demand explanations. That the medical profession is also concerned that patients should be fully apprised of all the implications of proposed treatments, so that they can make informed choices gives an indication of a trend within the medical profession for greater openness and awareness. Perhaps this will amount to a body of responsible medical opinion which considers the provision of full information a necessity? The judgement in *Smith* certainly appears to represent a departure from decisions in previous English cases while reflecting decisions reached in many other jurisdictions. Some commentators have therefore suggested that a move towards a fully evolved legal concept of informed consent is inevitable.[72]

The controversy surrounding the doctrine of informed consent, and the negligent failure to disclose relevant information is central to the ability to obtain valid consent to medical treatment. It can also play an important role in decisions taken by patients who decline treatment, particularly where treatment refusal will result in death. Here it seems certain that a competent patient will be given every opportunity to fully reflect upon the consequences of her refusal to consent to treatment. Refusal to consent to treatment considered medically necessary to preserve life has in some circumstances led to a patient's competence to decide being questioned. The following discussion will consider the special procedures that can be applied to legitimate the provision of medical treatment for a patient who lacks the mental capacity to give consent.

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[72] See *Rogers v Whitaker* (1992) 67 ALJR 47 (High Court of Australia), K. Tickner, "*Rogers v Whitaker*-Giving Patients a Meaningful Choice" (1995) 15 (1) *Oxford Journal of Legal Studies*, 110 at 118, and, C. Newdick, *Who Should We Treat? Law, Patients and Resources in the NHS*, (1995) Oxford: Oxford University Press, at 297.

Consent and the incompetent adult

With regard to consent to treatment, an incompetent adult can be broadly defined as someone over the age of 18 who lacks the mental capacity to participate in the process of medical decision making. There is a legal presumption that every adult has the capacity to consent unless the contrary has been demonstrated, and an adult patient is the only person who can give legally valid consent to a medical procedure on herself. In practice the assessment of an adult's capacity to give or withhold consent is largely a matter of clinical judgement,[73] although ultimately the assessment of an individual's capacity is a legal question for a court to decide.[74]

A person may be temporarily or permanently incompetent to give consent to treatment depending on her medical condition, but, while the practical implications may be different, the legal position is similar for each. When an incompetent adult requires treatment the situation is one where the clinicians appear to face two choices; either administer the treatment without consent, or don't give any treatment.

There are some situations where treatment without consent is legitimate, these are largely concerned with emergency treatment where the patient is temporarily incapacitated and a doctor can act out of necessity, and there are some situations where special mechanisms apply, and these tend to apply to patients who are permanently incapacitated or can be treated under the provisions of the Mental Health Act 1983. This section will describe the procedure for providing treatment to a patient who cannot consent firstly in an emergency situation and secondly in respect of permanently incompetent patients. The provisions available under the Mental Health Act have little application in respect of this analysis of the role of consent to treatment in respect of euthanasia and death with dignity so only scant reference will be made to them.

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[73] The BMA with the Law Society, *Assessment of Mental Capacity: Guidance for Doctors and Lawyers*, (1995) BMA: London, 66.

[74] *Richmond v Richmond* (1914) 111 LT 273.

Temporary incapacity / emergency / necessity

The need to provide treatment for a patient who is unable to give consent but urgently requires medical care provokes a dilemma for clinicians. To go ahead and administer treatment raises the potential to invade a person's body in neglect of her autonomy, something which should always be approached with caution. But not to treat with potentially deleterious consequences, is contrary to the ethic of medicine.[75] Therefore, wherever a patient is in urgent need of medical treatment, the attendant doctors usually have little hesitation in defining the situation as one of clinical emergency and the law is sympathetic to the notion that an emergency obviates the need to obtain consent. Neill LJ explained this position, and the reasons for it, in *Re F (Mental Patient: Sterilisation)*,

> ... if a patient is unconscious and therefore unable to give or to withhold his consent, emergency medical treatment, which may include surgical procedures, can lawfully be carried out ... The treatment which can be so given, however, is, within broad limits, confined to such treatment as is necessary to meet the emergency and such as needs to be carried out at once.[76]

The popular perception of an emergency situation is one where a person is admitted to an accident and emergency department in a condition which prevents communication with the medical staff. The incapacity may be due to a range of symptomatic responses including, unconsciousness, and severe disorientation caused by an underlying medical condition. The kinds of situations that constitute a clinical emergency for the purpose of legitimating treatment without consent are however, strictly legally defined. Most importantly, the situation must be one of authentic emergency, whereby "...it would be unreasonable, as opposed to merely inconvenient, to postpone until consent could be sought",[77] although, as we have seen, the definition of emergency treatment can be extended to include additional treatment that becomes clinically indicated after a patient has been anaesthetised for a procedure to which prior consent has been given. It is not the emergency itself which sanctions treatment without consent, but the urgency of the need for treatment; the emergency is relevant because, "it

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[75] See C. Wells, "Patients, Consent, and Criminal Law" (1994) 1 *Journal of Social, Welfare and Family Law*, 65 at 69, for a graphic illustration of the dilemma.

[76] *supra* n. 13.

[77] P. D. G. Skegg "Justifications for Medical Procedure Performed without Consent" (1974) 90 LQR 512, also the Canadian case of *Murray v McMurchy* [1949] 2 D.L.R. 442, and *Devi v West Midlands Regional Health Authority* [1981] (CA Transcript 491) both reiterate this point.

gives rise to a necessity to act in the interests of the assisted person, without first obtaining his consent".[78]

In all cases it is the urgency of the situation which legitimates medical treatment without consent. Only if the procedure is necessary for the preservation of life and health may the doctor waive the requirement of gaining prior consent, but this cannot be done simply for convenience. The mere fact that the medical situation is one of emergency does not permit a doctor in proceeding to treat a patient without consent, the treatment must always be imperative and of a type which, in the circumstances, cannot be delayed.

There are some clinical situations that do not fit easily into this understanding of an emergency but whose circumstances nevertheless apparently suggest that doctors have a duty to act, even in the absence of consent. These situations are both rare, controversial, and subject to reinterpretation, as *Leigh v Gladstone,*[79] illustrates.

Marie Leigh was a member of the Suffragette movement who went on hunger strike while detained in prison. She brought an action for damages against Gladstone *et al* claiming that the forcible feeding she had been subjected to amounted to an assault because it had been against her wishes. It was argued that only minimal force was used, and Mrs Leigh agreed with this, and that the action was necessary to save the woman's life. The court held that "... it was the duty ... of the officials to preserve the lives and health of the prisoners, who were in the custody of the Crown".[80]

The judgement in *Leigh v Gladstone* appears to disregard the principle that a person's bodily integrity should not be violated without express or implied consent; and to assume that the existence of a duty of care allows the imposition of treatment upon an individual in order to keep him or her in good health. The judgement no longer represents the law however, even with regard to those in the custody of the Crown.[81] Conversely a number of criminal cases have been tried

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[78] *supra* n. 13, per Lord Goff.

[79] (1909) 26 T.L.R. 139 (King's Bench Division).

[80] per Lord Alverstone CJ in, *Leigh v Gladstone* (1909) 26 T.L.R. 139 (Kings Bench Division).

[81] *A-G of British Columbia v Astaforoff* [1983] 6 WWR 322, and, in the British Columbia Court of Appeal, [1984] 4 WWR 385, expressly rejected the notion that the state had a duty to force feed an individual on hunger strike to prevent her suicide. Similarly, in *Airedale NHS Trust v Bland* [1993] 1 All E.R. 821, at 861, Lord Keith, while discussing the principle of the sanctity of life, confirmed that "it does not authorise the forcible feeding of prisoners on hunger strike." See

on the basis of a failure to act where a duty of care exists, even though the alleged victim has declined to consent.[82]

In *R v Stone,*[83] a case of manslaughter, the defendant was held to have voluntarily assumed a duty to care for his sister, the victim, by providing sustenance and assisting her with personal hygiene while she lived in his house. The deceased was ill but declined medical aid and refused food and drink. She was ultimately found dead in her bed. Despite the defendant's below average mental capacity, it was held that he and Dobinson, his common law wife, were aware of the victim's deteriorating condition and carried out ineffectual attempts to secure medical treatment for her. They had thereby neglected their duty to care for her and so were responsible for her death.

Like *Leigh v Gladstone*, *Stone* assumes that the presence of a duty negates the need for individual consent. It offers no recognition of the fact that even if the ineffectual carers had found a doctor to attend the victim was at liberty to refuse treatment, and that she had already insisted that she was hostile to medical intervention. Clearly the couple were in dereliction of their duty because they failed to summon a doctor, although it should also be noted that a competent adult has an absolute right to refuse to be treated or diagnosed by a doctor. But, in the absence of evidence that the sister would have then consented to any treatment offered, or that it would have been legally permissible for treatment to be imposed without consent, should their failure have generated liability for homicide? Perhaps the court was implying here a principle enunciated in *R v Smith,*[84] namely that, "if she appeared desperately ill then whatever she may say it may be right to override",[85] but this statement is clearly contrary to the obligation to respect individual autonomy and not to breach another's physical integrity without their consent. At issue in these cases is whether the individuals concerned were competent to decide for themselves? If they were, medical intervention cannot be justified in the absence of consent, and if they were not on what basis could treatment be legitimately administered?

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also *Home Secretary v Robb* [1995] F.L.R. 412, which upholds this position.

[82] *R v Stone* [1977] Q.B. 354, *R v Wilkinson*, *The Times*, 19th April 1978, 5, and *R v Smith* [1979] Crim L. R. 251, are the most notable.

[83] [1977] Q.B. 354, [1977] 2 All E.R. 341, (CA).

[84] [1979] Crim L.R. 251.

[85] *ibid*, at 252-3.

In some clinical situations, particularly emergencies where an adult patient is temporarily incapacitated, consent is often sought from relatives or next-of-kin. This practice has no legal authority, its only significance is as a method of determining the supposed wishes of the patient regarding the unfolding medical situation. Medical treatment performed without consent may be more easily legitimated in any subsequent legal dispute if relatives have been consulted, but only because the opinions of relatives can provide evidence as to the presumed wishes of the patient, not because proxy consent has been obtained from the relatives.[86]

However, in the past some judges have erroneously assumed that valid consent to treat an incompetent adult may be acquired through the agency of relatives.[87] The American case of *Canterbury v Spence*[88] has been cited as authority for the proposition that relatives consent should be sought as a substitute where the patient is unable to comply. However, that judgement referred to the earlier case of *Bonner v Moran*,[89] which apparently supports the contention that a patient's relatives are eligible to give consent in circumstances where the patient is prevented from so doing. But *Bonner v Moran* concerned the eligibility of an adult relative to give consent on behalf of a child patient and is therefore distinguishable on its facts from *Canterbury v Spence*. Consequently, *Canterbury v Spence* cannot provide the authority claimed for it.

In general the courts are concerned that medical professionals, acting from laudable motives, should not be subjected to legal sanction if they treat incompetent patients without consent. This has sometimes been expressed in terms of protecting the public interest, in that it should be permissible as a matter of public policy, for doctors to legitimately give emergency treatment to patients, even in the absence of consent,

> ... I would prefer to explain the emergency cases on the basis that it is in the public interest that an unconscious patient who requires treatment should be able to receive it and that those who give this treatment in an emergency should be free from any threat of an action for trespass to the person.[90]

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[86] P. D. G. Skegg, *Law, Ethics, and Medicine* (1984) Oxford: Clarendon at 72-3.

[87] See for example Johnson LJ in *Wilson v Pringle* [1987] Q.B. 237, who makes this assumption but offers no legal authority to support it.

[88] (1972) 464 F 2d 772 per Judge Robinson at 789.

[89] (1941) 126 F 2d 121.

[90] *supra* n. 13, per Neill LJ.

However, there are some adult patients who are permanently incapacitated and therefore require medical treatment in routine situations which cannot be defined as emergencies. Incapacitated patients inevitably suffer from the same range of minor and major ailments as the rest of the population but are unable to give consent for the treatment of these conditions. In the absence of special mechanisms to authorise treatment even the pain and distress associated with something as trivial as a toothache or an ingrowing toe nail could not be remedied.

Permanently incapacitated adults

Whether the patient is temporarily incapacitated in a situation where treatment can be justified on the basis of emergency, or permanently incapacitated where even routine treatment must be legitimated because consent cannot be illicited, the overriding legal principle which governs the provision of care is that at all times the patient must be treated according to her own best interests,

> ... not only must (1) there be a necessity to act when it is not practicable to communicate with the assisted person, but also (2) the action taken must be such as a reasonable person would in all the circumstances take, acting in the best interests of the assisted person.[91]

A patient with the capacity to consent can choose whether or not to accept the treatment offered according to her own understanding of what constitutes her own best interests. But a patient who needs treatment and lacks the competence to give consent will be treated according to somebody else's interpretation of her best interests. Simultaneously, the duty owed by a doctor to her patient lies in providing treatment according to that patient's best interests. These factors are clearly important for the general health and well-being of incompetent adults but they hold particular significance for people who may have previously expressed a wish not to be treated in pre-determined circumstances. These issues will be specifically addressed in the context of advance directives in Chapter Five, but much of that analysis is underpinned by the concept of best interests which will be discussed here.

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[91] *supra* n. 13.

The best interests approach has been a founding principle in family law and has provided a framework within which the courts have adjudicated cases according to the merits of their individual facts. A range of criteria can and have been used to determine what constitutes the best interests of a particular patient in particular circumstances. This has often rendered the best interests test imprecise in its application and its definition reducing it, in Kennedy's terms, to "... a somewhat crude conclusion of social policy".[92]

Re F,[93] was concerned with the definition of the circumstances under which it is lawful to treat an adult patient who is incapable of giving consent and was determined according to the best interests test. The judgement sought to clarify the circumstances under which the test's application is germane. The House of Lords held that the best interests test is apposite where a person is unable to consent to medical treatment, and described the type of criteria which should be used to define the patient's best interests. It also affirmed that referral to the judiciary for a declaration that a particular therapy was in the best interests of a patient, and therefore lawful, was appropriate and necessary because,

> ... no court now has jurisdiction either by statute, or derived from the Crown as *parens patriae*, to give or withhold consent to ... an operation in the case of an adult as it would in Wardship proceeding in the case of a minor[94]

The *Bolam* test of professional competence provided the initial framework for the House of Lords' analysis of the patient's best interests. Accordingly, it was held that once it had been ascertained that a doctor had acted "in accordance with the practice accepted by a responsible body of medical men skilled in that particular art,"[95] she would not be in breach of the duty owed to her patient. Thereafter, careful consideration should be given to the reasonableness of the proposed treatment, in the light of the circumstances of the case, and with regard to the certain procedural guidelines.

To be reasonable the procedure involved must be necessary, due to the medical circumstances, and ideally the carers and relatives of the patient should have

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[92] Ian Kennedy, *Treat Me Right: Essays in Law and Ethics* (1994) Oxford University Press, at 395.
[93] *supra* n. 13.
[94] *ibid*, per Lord Bridge.
[95] *supra* n. 48.

been consulted. Where appropriate, the opinions of other specialists should also be obtained, so that decisions are not taken in isolation. Factors specific to each case should also be considered which, in *Re F*, included the woman's right to control her own reproduction, and the fact that she was physically healthy but would be subjected to an invasive and serious operation. The reasonableness of the proposed treatment should be assessed by the clinicians considering whether and what treatment to administer, with the consequence that proceeding with any treatment subsequently shown to be unreasonable will attract liability for battery.

The procedural guidelines dictate that the person responsible for the care and proposed treatment of the patient, should make an application to the court for a declaration that the treatment concerned can be lawfully undertaken in the absence of consent. The patient should normally be the respondent in the case with representation by a guardian *ad litem* who where possible should be the Official Solicitor. Hearings should ordinarily be conducted in private, subject to the court's discretion, with the decision being given publicly.[96]

Ian Kennedy has argued that medical and judicial decisions determined according to the consideration of *best interests* alone, will often disregard fundamental issues of human rights and may therefore result in unsatisfactory outcomes.[97] The judgement in *Re F* did not explicitly refer to human rights but it appears that these rights have none the less been afforded some protection since it did address some of the human rights issues pertinent to the sterilisation of an incompetent adult woman. The fact that the controversial nature of sterilisation raises emotional and moral issues, and that it is permanent and should never be performed involuntarily without the clearest justification was closely considered. Furthermore the inclusion of the requirement that patients have a right to representation and privacy indicates a recognition of the importance of these human rights.

The procedural guidelines and assessment of best interests criteria contained in *Re F* have subsequently been applied in cases where the courts have been required to issue declarations as to the lawfulness of proposed medical treatments.[98] Most notable amongst these cases is *Airedale NHS Trust v Bland*,[99]

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[96] *supra* n. 13, per Lord Brandon.

[97] *supra* n. 92, at 392.

[98] See *Airedale NHS Trust v Bland* [1993] 2 W.L.R. 316, and *Frenchay NHS Trust v S* [1994] 2 All E.R. 403.

[99] *supra* n. 39.

which concerned the discontinuation of treatment for a patient in persistent vegetative state. Here it was decided that the best interests test was also appropriate in cases where it is necessary to determine the extent of a doctor's duty of care to a particular patient. However, the merging of the principles of the *Bolam* standard for assessing medical negligence with criteria legitimating non-consensual treatment of incompetent adults in *Re F*, is problematic. Reference was made to the kinds of issues which ought to be considered when determining the best interests of a patient who is unable to consent, but no guidance was explicitly included explaining how to assess what actually constitutes a patient's best interests. Anxiety about this matter was expressed in the evidence presented to the House of Lords Select Committee on Medical Ethics,

> ... one of the things that is not very good is that the phrase *best interest* has been put into play without any description of what it means. This ... actually increases the difficulties for the doctors rather than helps to solve them.[100]

The issue of defining the meaning of *best interests* has since been specifically addressed however, by the Law Commission in its Report on *Mental Incapacity* which considered "the ways in which decisions may lawfully be made for those who are unable to make decisions for themselves".[101] The purpose of the Report was to provide certainty for medical and legal decision makers, while offering protection to patients. Clause 3(1) of the Draft Bill proposed in the Report contains the general recommendation that, "any thing done for, and any decision made on behalf of, a person without capacity should be done or made in the best interest of that person" thereby adopting the best interests standard as pivotal in the decision making process.

During it's consultation process the Law Commission was made aware of the inadequacies of the legal position following *Re F*, and of the expressed desire of it's consultees for "clear and principled guidance" about the assessment of best interests.[102] Consequently the Report outlines a "checklist of factors" to be considered in determining the best interests of any particular individual, in order that the standard be judiciously applied to all health-care decisions made on

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[100] Select Committee on Medical Ethics (1993-4) HL 21-II, Oral Evidence at page 21 para 41 per Lord Mustill.

[101] The Law Commission Report No. 231 *Mental Incapacity. Item 9 of the Fourth Programme of Law Reform, Mentally Incapacitated Adults* (1995) London: HMSO at para 1.1.

[102] These comments are made in Consultation Paper No.119, paras 2.22-2.24.

behalf of those who lack the mental capacity to consent for themselves. These factors are contained in Clause 3(2) of the Draft Bill proposed in the Report which recommends that,

> ... in deciding what is in a person's best interests regard should be had to:-
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> (1) the ascertainable past and present wishes and feelings of the person concerned, and the factors that person would consider if able to do so;
>
> (2) the need to permit and encourage the person to participate, or to improve his or her ability to participate, as fully as possible in anything done for and any decision affecting him or her;
>
> (3) the views of other people whom it is appropriate and practicable to consult about the person's wishes and feelings and what would be in his or her best interests;
>
> (4) whether the purpose for which any action or decision is required can be as effectively achieved in a manner less restrictive of the person's freedom of action.

The Report stresses the importance of any known views of the individual patient in respect of the decisions to be made in the reference to "ascertainable past and present wishes" which recognises the fact that some people have never had the capacity to consent while others may have been able to anticipate their present incapacity and recorded their opinions in advance of it. Consideration should therefore be given to the factors that the individual herself "would consider" and any known convictions and preferences of the previously competent individual. If however a person has never attained the capacity to decide or express an opinion the court will imply the standard of "a normal decent person, acting in accordance with contemporary standards of morality."[103]

Where "other people" are to be involved in the decision making process the Report is careful to point out that no one class of person is designated as any more appropriate than any other. It may be practicable and appropriate to consult relatives, or carers, or anyone nominated in advance by the patient to be involved in decision making.[104] Clearly any or all of these types of people should be

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[103] *Re C (A Patient)* [1991] 3 All E.R. 866,at 870.

[104] *supra* n. 101, at paras 3.33-3.36.

consulted in an effort to determine the wishes of the incapacitated person and his or her best interests. The inclusion of the requirement to investigate less restrictive treatment options is in line with established medical and legal practice.

These recommendations about the definition and assessment of best interests criteria have been made by the Law Commission in response to the inadequacies of the common law position in Britain which offers scant guidance to clinicians as to how they should proceed in practice. Other jurisdictions however, have attempted to address the problem of legitimating medical treatment without consent by adopting the principle of substituted judgement as an alternative method of decision making.

Substituted judgement is founded on the principle of autonomy, as opposed to the best interests standard which is based upon beneficence and nonmaleficence. Substituted judgement involves a designated proxy, or a court acting as proxy, making decisions on behalf of the patient so that the decisions made reflect what the wishes of the patient would have been, had she been able to respond. Arguably therefore substituted judgement is an expression of the patient's best interests "as that patient would have defined them",[105] and provides a means by which the best interests standard can be executed. However, as an autonomy based standard and as a measure of an individual's own assessment of her best interests, substituted judgement can be an imperfect device.

Firstly, proxy decision makers bring with them their own idiosyncrasies and prejudices which will necessarily influence the decisions they make. Autonomy is worthless if a proxy consents to a procedure believing it to be in the patient's best interests but knowing that the incompetent individual would not have consented in the circumstances. The objectivity of the proxy decision maker is crucial to the efficacy of the process of substituted judgement but is not easily guaranteed or verified. Hence, when the applicability of the substituted judgement test in English law was discussed in *Bland*[106] it was rejected by Lord Goff, "I do not consider that any such test forms part of English law", and by Lord Mustill, "the idea is simply a fiction, which I would not be willing to adopt". However, both here and in the earlier case *Re T,*[107] it was held to be

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[105] P.S. Applebaum, C.W. Lidz, A. Meisel, *Informed Consent: Legal Theory and Clinical Practice* (1987) Oxford University Press, New York.

[106] *supra*, n. 39 at 365-366.

[107] *Re T (Adult: Refusal of Treatment)* [1992] 4 All ER 649.

appropriate to consider the opinions of relatives while compiling evidence about the patient's best interests.

Secondly, the substituted judgement test is not appropriate in all circumstances, specifically, it is not appropriate to apply such a test to patients who have never been competent to make decisions for themselves, such as permanently mentally disabled adults and minors. Much of the discussion of the principle of substituted judgement in English cases has centred on cases where the test was inappropriately applied. For example, *Belchertown State School Superintendent v Saikewicz*,[108] *Re Moe*,[109] and *Re Jane Doe*,[110] all of which purported to apply the principle of substituted judgement to patients who had never been competent and whose wishes therefore could never have been known or expressed. These examples have been responsible for much confusion as to its application and appropriateness. As a consequence English courts continue to be reluctant to adopt it despite the fact that, in some high profile cases substituted judgement has clearly played a valuable role in determining the preferences of patients who become incompetent.[111]

In some clinical situations statutory authority enables a guardian, appointed under the Mental Health Act 1983 s.7, to consent to treatment on behalf of an incompetent adult. However, in *T v T* [112] Wood J. correctly concluded that under this provision the power of a guardian to give consent is limited to psychiatric treatment as defined in s.8 of the same Act. The proposals for legal reform within Law Commission Report 231[113] do go some way towards better defining the mechanisms of legitimately providing treatment to permanently incompetent adults. New forms of decision making are considered and recommendations are made concerning the introduction of a continuing power of attorney to deal with matters such as admission to hospital,[114] the appointment by the court of managers to manage property and financial matters,[115] and the expansion of the use of advance statements about health care.[116] Essentially however, the

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[108] 373 Mass 728 (1977).

[109] 432 NE 2d 712 (1982).

[110] 583 NE 2d 1263 (1992).

[111] *Re Quinlan* 70 NJ 10 (1976) is illustrative of the successful operation of substituted judgement.

[112] (1988) 1 All ER 613, [1988] Fam. 52.

[113] *supra* n. 101.

[114] *ibid* at para 7.1.

[115] *ibid* at para 8.41.

[116] *ibid* at paras 5.1 - 5.39.

recommendations centred around defining what constitutes the best interests of any individual while leaving the existing legal framework largely in tact. The introduction of many of these recommendations would be valuable in terms of providing guidance for the medical profession but may also lead to a degree of inflexibility which the present common law approach of considering individual cases according to their particular facts tends to avoid.

Children

Ordinarily minors, below the age of majority[117] have limited legal rights compared with adults and would be deemed unable to consent to medical treatment if they were not sufficiently mature. In general this means that if medical treatment is necessary consent must be provided by an adult who has parental responsibility for the child. Any medical therapy or investigation can be authorised by such an adult as long as that treatment is in the child's best interests. A child's parents will usually have parental responsibility by virtue of their relationship with the child but exceptionally, the natural father of a child who was not married to the mother at the time of birth may not have parental responsibility.[118] Where a child has no parent or legal guardian and consent for medical treatment is required, Wardship proceedings can be instituted to enable the courts to decide. Similarly, in situations where the efficacy of a proposed treatment is questionable or is not demonstrably in the child's best interests, the Family Courts are empowered to give or withhold consent if the child is made a ward of the court. In the alternative, the court possess the constitutional prerogative of *parens patriae* which provides it with the authority to consent to treatment on the child's behalf.

Under The Family Law Reform Act 1969,[119] a person reaches maturity for the purposes of consent to medical treatment at the age of 16, but the ability to give legally valid consent to medical treatment is not determined solely according to chronological age, it also depends on an individual's demonstration that she has the capacity to decide for herself. Therefore a child below the age of 16 may be regarded as competent to consent to treatment if she has attained a level of

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[117] This is 18 years of age, in Britain.

[118] Under s.4 of The Childrens Act 1989 such a father may acquire parental responsibility by agreement with the mother or by court order.

[119] s.8 (1), (2), and (3).

maturity which her doctor considers enables her to make an informed decision. In this situation the minor may be described as *Gillick competent*, a term which is derived from the name of the case brought by Mrs Victoria Gillick which was ultimately decided in the House of Lords in 1985.[120]

The case turned upon the legal status of advise and guidance issued to doctors by the Department of Health and Social Security (DHSS) in 1974 and revised in 1980. There was a perceived need for contraceptive services to be made more accessible following the collation of statistics revealing a high incidence of teenage pregnancy and abortion. The DHSS issued circulars concerning the provision of contraceptive advice to teenagers even if they were below 16 years of age. The advice to doctors did not simply facilitate the provision of contraception to girls in this group it also allowed that, while the child should be encouraged to notify her parents, if she preferred not to involve her family her confidentiality should be respected.[121]

Mrs. Gillick, a devout Catholic and, at that time, mother of four daughters under 16, argued that doctors should not be permitted to offer contraceptive advice to children under sixteen without the consent of their parents. She disputed the assumption that medical treatment of the under sixteens could be lawful in the absence of parental consent, and asserted that it would signify that a crime was being condoned if the treatment provided was contraceptive advise, since it is a criminal offence for man to have sexual intercourse with a girl below the age of consent.

The House of Lords held that the advice given to doctors was not unlawful and that children below the age of sixteen can lawfully receive medical advice and treatment, in the absence of parental consent, provided that the particular child has achieved a degree of maturity which enables her to comprehend fully the implications of the treatment being proposed. The judgement recognised that people mature at different rates and that consequently flexibility in the

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[120] *Gillick v West Norfolk and Wisbech AHA* [1985] 3 All E.R. 402, HL.

[121] s.8 (3) of The Family Law Reform Act 1969 makes provision for situations such as this, stating as it does that "Nothing in this section shall be construed as making ineffective any consent which would have been effective if this section had not been enacted". This is a reference to the assumption which had existed before the act that individuals between 16 and 18 could consent in particular circumstances, and was considered pertinent to those under 16 once the legal position regarding the over 16s was clarified.

application of legal principles is essential to uphold the autonomy of those who attain maturity at a younger age. In Lord Scarman's words,

> If the law should impose upon the process of growing up fixed limits where nature knew only a continuous process, the price would be artificiality and a lack of realism in an area where the law must be sensitive to human development and social change.[122]

Thereby *Gillick* is thought to have decided that incompetence should not be assumed simply because an adolescent has not yet attained the chronological age of consent. However, this proposition has subsequently been seriously undermined by both medical and legal paternalism,[123] perhaps demonstrated most visibly in *Re W*.[124] Here a girl of sixteen was transferred to a psychiatric hospital against her will, to undergo treatment for anorexia nervosa to which she had declined to consent. The court relied on *Re R*[125] which interpreted *Gillick* as deciding that, while minors under sixteen could consent to treatment, if they refused to consent others may do so on their behalf. *Re W* extended this principle further by including minors over the age of sixteen, even though the rights of these persons to give or withhold consent, had been apparently firmly established by the Family Law Reform Act 1969.[126] The judgements in these cases turn upon the minor's capacity to consent and the distinction between giving and withholding consent, especially when the result of refusal to consent will be death. Further analysis of these decisions will be included in Chapter Five's discussions of living wills and anticipatory decisions.

Conclusions

This chapter has discussed consent to medical treatment as the legal expression of individual autonomy. It has analysed the legal and medical principles of consent to medical treatment as they relate to competent adults and people who are unable to make their own health care decisions and has considered the potential legal consequences for clinicians who administer treatment in the absence of consent. The focus of the chapter has been on the ability to give

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[122] *supra* n. 120 at 421.

[123] J. Murphy, "W(h)ither Adolescent Autonomy?" (1992) *Journal of Social Welfare and Family Law*, 529.

[124] [1992] 4 All E.R. 627.

[125] (1992) Fam. 11.

[126] s.8.

consent and how consent can be obtained, or when treatment can legitimately go ahead without consent, particularly in circumstances where a person needs medical care but lacks the capacity to consent. In theory the same legal mechanisms and rules apply to withholding or refusing consent and to giving consent. The following chapter will show that there are practical and ethical differences between giving and refusing consent, especially if refusing consent will lead to death, and that consequently the legal response to these issues is, at best in need of clarification, and at worst riddled with inconsistency.

Chapter Five

Living Wills and the Will to Die

Introduction

Living wills are variously described and defined as advance directives, advance declarations and anticipatory decisions about medical treatment. Within the confines of this chapter a living will is defined as a statement giving an indication of a person's preferences and intentions regarding the type of medical treatment she wishes to receive at the end of her life. The term 'living will' is also "... sometimes used for advance directives which are concerned with other situations or which can be used to express a willingness to receive particular treatments".[1] It is important to note however that in practice any advance directive about future medical care may appear to operate as a living will if respecting its provisions will inevitably result in death. Advance refusals of blood transfusion and particular types of surgical intervention which may be necessary to preserve life illustrate the profound dilemmas present in these situations. These dilemmas are often absent where living wills defining terminal medical care are concerned because the patients involved are already terminally ill or incurable and inevitably dying, while in the former case, the treatment, if given, could restore health and prolong life. As a consequence the law concerning the applicability and validity of living wills is largely informed by cases defining the scope of advance directives which do not directly refer to terminal care and these will provide a focus for this discussion.

A living will is a mechanism whereby people can make known their aspirations regarding the type and extent of medical treatment they will accept if they become incapacitated and can no longer participate in the therapeutic decision making process. Through a living will decisions regarding future treatment can be taken in consultation with medical professionals in advance of the treatment being required and while the person concerned still has the mental capacity to decide for herself. Family and friends can also be included in the decision making process so that the patient's wishes are clearly understood, and decisions can be anticipated by all concerned. Thus, even if the hypothetical patient of this

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[1] The Law Commission Consultation Paper No. 129, *Mentally Incapacitated Adults and Decision Making: Medical Treatment and Research* (1993) London: HMSO, 29 n. 18.

study remains unconscious and unable to communicate her concerns about how her treatment should proceed, she could impress her opinions upon the clinicians responsible for her care through a previously executed living will.

The concept of the living will originated in America and is now gaining currency in most Western countries as a device which can enable people to retain control of their lives until they die.[2] The idea is that, just as people can make a will to stipulate their intentions concerning the dispersion of their property and assets after they have died, so they might construct a living will defining their wishes regarding their medical care especially if they become incapable of any other form of medical decision-making at the end of their lives. Frequently this will involve an advance refusal of medical care which could lead to death, so that living wills are commonly associated with euthanasia and assisted death. Indeed, in those jurisdictions where legislation has been enacted to support the development of living wills they were initially regarded as appropriate only for people who were terminally ill.

Some people who make living wills do so because they would prefer a quick dignified end to protracted dying and therefore do not wish to be kept alive once any hope of cure or improved quality of life is lost. Others simply wish to spare their loved ones from the potential trauma of having to make life-limiting medical decisions on their behalf or having to sanction such decisions made by clinicians. Similarly, a person may prepare a living will because she seeks to avoid adding to the distress of loved ones who might otherwise have to care for her during a lengthy period of physical deterioration.[3] Alternatively a person may hold a philosophical objection to the prolongation of futile treatment, perhaps because of a sense that the resources needed to delay the inevitable death of one who cannot be saved could be better used for people with more optimistic prognoses. Regardless of the motivation for formulating a living will those who do so expect that their decisions will be respected in the appropriate circumstances. This chapter will consider whether that is a legitimate expectation.

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[2] For example, living wills have been recognised by statute in America since the introduction of the Natural Death Act in California in 1976, and in South Australia since the Natural Death Act 1983. The Patient Self Determination Act 1990 now requires that all federally funded hospitals in America advise their patients of their right to make a living will.

[3] R. Pearlman, K. Cain, D. Patrick, M. Appelbaum-Maizel, H. Starks, N. Jecker, R. Uhlmann, "Insights Pertaining to Patient Assessments of States Worse than Death", in L. Emanuel (ed) *Advance Directives: Expectations, Experience and Future Practice* (1993) 4 (1) *Journal of Clinical Ethics*, 33.

The preceding chapter described how every competent adult has a legal right to give or withhold consent to treatment. This principle is founded upon respect for the autonomy of individuals and, in the context of medical care, operates to protect patients from unfettered medical paternalism.[4] However, so far as this protection exists, it is only available to those who have the capacity to express their desires and give, or withhold, their consent.[5] Ordinarily the mental capacity necessary for full participation in an interactive decision making process develops with maturity, but the acquisition of this capacity may be prevented by mental handicap, mental illness, or trauma before attaining competence to consent. Other situations dictate that competence to decide is lost at some time after it has been acquired, so that a person who was once competent to make decisions no longer has the capacity so to do. Such a loss of capacity may result from trauma, degenerative disease, or mental illness and may be temporary or permanent.

Chapter Four described the special mechanisms that exist to legitimate the provision of medical treatment in the absence of consent from the patient. In summary they allow treatment to be administered if it is medically necessary and in the patient's best interests.[6] Those who are incapacitated are not ordinarily afforded the luxury of participation in the decision making process. They become the object of decisions made about them rather than interested contributors and, while no-one else has authority to consent on behalf of another, treatment that has commenced with consent may continue even after the individual concerned has lost the capacity to withdraw consent.

A living will can enable a person who has become incompetent to exert an influence over medical decisions taken on her behalf in these circumstances. Such a directive may take the form of a generalised expression of the patient's wishes and aspirations, or it may encompass actual decisions about specific prospective therapies. Where decisions are recorded in advance of the patient becoming incapacitated they usually take the form of refusal of particular forms

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[4] But see, Sally Sheldon, "Subject Only to the Attitude of the Surgeon Concerned: The Judicial Protection of Medical Discretion" (1996) 5 (1) *Social and Legal Studies*, 95, which suggests that in many clinical situations, perhaps most notably those concerning women's reproductive rights, medical paternalism appears to remain unfettered and is frequently upheld by the courts.

[5] J. Montgomery, "Power Over Death: The Final Sting" in R. Lee, D. Morgan (eds) *Death Rites: Law and Ethics at the End of Life* (1996) London: Routledge, 37-53, at 37.

[6] *Re F (Mental Patient : Sterilisation)* [1990] 2 A.C. 1, [1989] 2 All E.R. 545 (HL).

of treatment, although some stipulate that specific treatments are acceptable while others are not,[7] and some insist that all available appropriate medical resources should be utilised to maintain life.[8]

In general the purpose of the living will is to promote individual autonomy and choice for the patient; characteristics which have long been associated with euthanasia as a means of achieving death with dignity. As a consequence, the living will is the mechanism through which some forms euthanasia will become more socially and legally available.[9] Therefore advance statements about medical care hold significance for both patient autonomy and clinical responsibility. They may offer a reassurance for the patient or pose a threat to clinical freedom, particularly where treatment decisions that are likely to culminate in the death of the patient are endorsed and encouraged. In this situation an advance directive may represent a stark choice between "prior personal choice and immediate well-being".[10] Clinicians may experience this choice as a tension between the obligation to respect individual autonomy and the duty to treat the patient according to her best interests. As a result a living will can present professional and ethical dilemmas.

Living wills are usually promoted on the assumption that they enhance patient autonomy and individual choice. However, some commentators have identified situations where rigid adherence to the provisions contained in an advance directive may limit choice and consequently be less than beneficial to the patient concerned.[11] Specific criticisms relate to the perceived inability of a living will to adequately cater for a person's complex care requirements,[12] and the possibility that the period between the composition and the execution of the provisions within the directive may witness the development of new therapies which could be advantageous to the author. The patient may then effectively

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[7] For example, *The Watch Tower: Bible and Tract Society of Pennsylvania* issues a directive for use by its members that states that the transfusion of blood and blood products is refused in all circumstances, but the administration of non-blood volume expanders such as saline and Ringer's solution is acceptable.

[8] The Terrence Higgins Trust and King's College London, Living Will (2nd edition) in M. Molloy, V. Mepham, *Let Me Decide* (1993) London: Penguin.

[9] Euthanasia in the form of selective non-treatment or treatment refusal are particularly relevant here.

[10] D. Lamb, "Refusal of Life-prolonging Therapy" (1995) 1 (2) *Res Publica*, 147 at 156.

[11] J. Lynn, "Why I Don't Have a Living Will" in A. Capron (ed) "Medical Decision Making and the 'Right to Die' After Cruzan" (1991) 19 *Law Medicine & Health Care* 101, and, Law Commission Report 231, Mental Incapacity. *Item 9 of the Fourth Programme of Law Reform: Mentally Incapacitated Adults* (1995) London: HMSO, para 5.4, at 66-67.

[12] See J. Lynn, *ibid.*

deny herself the opportunity of receiving a valuable, even curative therapy, which was unknown when the advance directive was formulated.[13]

This chapter will describe some common forms of living wills and the kinds of provisions often included in them. It will examine their practical significance and legal standing through a discussion of when they become operative and the factors that determine their scope and validity. Finally it will consider the responsibilities of health care professionals to patients who have composed living wills so that some conclusions may be drawn about the effectiveness of advance directives in safeguarding autonomy and providing death with dignity.

What form of will?

An advance directive can take the form of a formal document evidenced in writing, or an informal statement of intentions made orally. It could represent an anticipatory decision about a specific form of treatment, or it may constitute an expression of a person's preferences and opinions regarding future therapy. Where the former is true distinctions can be drawn between those decisions which favour particular types of treatment, and those which effectively withhold consent in opposition to specific therapies. A comprehensive advance directive has been formulated by *The Terrence Higgins Trust* which incorporates examples of both of these elements in the statements, "I wish to be kept alive for as long as reasonably possible using whatever forms of medical treatment are available" and,

> If I become permanently unconscious with no likelihood of regaining consciousness, I wish medical treatment to be limited to keeping me comfortable and free from pain, and I *REFUSE* all other medical treatments.[14]

Some advance directives also nominate others to whom the power of decision making is to be delegated when the patient can no longer decide for herself.[15]

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[13] Law Commission Report 231, Mental Incapacity, *Item 9 of the Fourth Programme of Law Reform: Mentally Incapacitated Adults* (1995) London: HMSO, para 5.4, at 66-67.

[14] *Supra* n. 8.

[15] See *infra*, proxy decision makers, for expansion of this point.

The simplest form of advance directive is a statement made by a competent person in respect of medical treatment which will occur at some time in the future rather than contemporaneously with the declaration. Kennedy and Grubb therefore correctly assert that the commonest form of advance directive is the surgical consent form which takes the form of an anticipatory decision about future surgical intervention.[16] This kind of anticipatory decision is designed largely as a means of protecting medical professionals from legal action by authorising in advance the physical contact involved in medical treatment. Properly executed and exercised, advance directives of this type are largely uncontroversial and unremarkable.

However, advance directives can become contentious when they stipulate an anticipatory refusal of some or all treatment and effectively become living wills. Directives which have this effect usually relate to specific medical circumstances which their author has anticipated and regards as intolerable. Consequently, observance of the provisions included in such a directive will usually culminate in the death of the patient. An example of a comprehensive advance directive which operates as a living will is the one which has been formulated by the *Voluntary Euthanasia Society*.[17]

This particular living will provides a detailed schedule of the kinds of medical conditions which should trigger the application of the directive if the signatory is unable to speak for herself. These are,

A) Advanced disseminated malignant disease,

B) Severe immune deficiency,

C) Advanced degenerative disease of the nervous system,

D) Severe and lasting brain damage due to injury, stroke, disease or other cause,

E) Senile or pre-senile dementia,

F) Any other condition of comparable gravity.

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[16] I. Kennedy, A. Grubb, *Medical Law: Text with Materials* (2nd edition) (1994) London: Butterworths, at 1325.

[17] Published by *The Voluntary Euthanasia Society*, 13 Prince of Wales Terrace, London W8 5 PG, 1995.

Although detailed, the list exhibits a degree of uncertainty about exactly when the provisions of the living will come into force and each element allows for clinical discretion in determining when the advance directive will become operative. There is, for example, no precise clinical definition of when disseminated malignant disease, or degenerative disease of the nervous system becomes *advanced*, or how extensive brain damage or immune deficiency must be before it is classified as *severe*. "Any other condition of comparable gravity" is similarly imprecise. In practice these apparently minor interpretative discrepancies could result in a failure to safeguard the patient's wishes and may become a source of discord between the patient's clinicians and representatives. However, the following declaration which is also included in the *Voluntary Euthanasia Society* living will should assist in the interpretation of the schedule,

> I declare that if at any time the following circumstances exist, namely:
>
> 1) I suffer from one or more of the conditions mentioned in the schedule; and
>
> 2) I have become unable to participate effectively in decisions about my care; and
>
> 3) two independent physicians (one a consultant) are of the opinion that I am unlikely to recover from illness or impairment involving severe distress or incapacity for rational existence.
>
> Then and in those circumstances my directions are as follows;
>
> 1) that I am not to be subjected to any medical intervention or treatment aimed at prolonging or sustaining my life;
>
> 2) that any distressing symptoms (including any caused by lack of food or fluid) are to be fully controlled by appropriate treatment, even though that treatment may shorten my life.

This clarifies when the provisions should be acted upon, and specifies what action is to be taken if and when any of the conditions mentioned in the schedule applies. This particular living will also contains a compelling statement of opinions and intentions,

> I wish it to be understood that I fear degeneration and indignity far more than I fear death. I ask my medical attendants to bear this in mind when considering what my intentions would be in an uncertain situation.

The *Voluntary Euthanasia Society* living will is designed to operate in conjunction with a medical emergency card which functions in a similar way to the organ donors card. The card incorporates the patient's signature, some medical information, the name of the next of kin, and, details of where the advance directive is lodged. Individuals carry the card with them in case they require emergency treatment and are unable to express their wishes. In such a situation the reader of the card is advised that the individual named does not wish resuscitation or artificial prolongation of life, if there is no "reasonable prospect of recovery." While self-explanatory, these provisions may be of limited value in a genuine medical emergency.

Physicians are trained to react to emergencies with speed and skill; their strategy is usually confined to overcoming the initial crisis and observing the therapeutic duty of care owed to the patient. For these reasons scant attention may be paid to whether or not the patient has a "reasonable prospect of recovery". Managing an emergency situation requires different skills to those necessary for accurately assessing prognosis and recovery. Such assessments are neither practically feasible nor appropriate in the emergency room where the clinical emphasis is on resuscitation and stabilisation.

The phrase "reasonable prospect of recovery" itself allows for a variety of interpretations. Recovery is a value laden assessment which be defined in complete or partial terms. Some people would consider the prospect of recovery with full mental capacity but physical disability to be unreasonable, while others would tolerate, even relish, physical survival, despite the impairment of cognitive function. Similarly, does the prospect of recovery need to be reasonable or the recovery itself? Without a subjective understanding of what constitutes a reasonable prospect of recovery for the individual concerned those responsible for the provision of medical care are bound to exercise a wide discretion.

Despite these shortcomings, the living will of the *Voluntary Euthanasia Society* is likely to be as effective in practice as an advance directive can be. The document takes a legalistic form, incorporating a formal declaration to be signed by two witnesses. It makes provision for updating, confirmation of its applicability, and for its revocation. Signatories are also urged to discuss the stipulations within the directive with their general practitioner and to lodge a copy of it at their doctor's surgery. These provisions offer the maximum possible security that the desires espoused within the living will will be acted upon at the appropriate time.

However, not all living wills are in writing or made as formally as the last example. A verbal declaration of a patient's opinions and wishes should be equally influential in determining future medical care. In its Report No. 231, *Mental Incapacity*, the Law Commission of England and Wales was anxious to stress the importance of both written and oral advance health care statements, as expressions of individual preferences.[18] However, unless oral statements are recorded in such a way that all those responsible for the provision of medical care to the patient are aware of their existence and validity, their practical value is likely to be limited. Even though verbal statements represent an equally valid expression of a person's views concerning future medical treatment, they are less easily evidenced and therefore less readily confirmed as valid and applicable in whatever circumstances subsequently arise. If, for example, a patient explains her wishes and preferences regarding future medical care in a particular set of circumstances, she is reliant on those wishes being accurately recorded and made available to others who might subsequently become responsible for her care. Such a statement made to a general practitioner would probably have greater impact than if it were made to a friend or family member but only if it were recorded and accessible to other medical personnel. The American case of *Cruzan v Missouri Department of Health,*[19] illustrates this point since it was held that, while a patient's wishes should be respected in order to uphold self-determination, "clear and convincing" evidence was required before such wishes could be acted upon. Only a formally executed living will was considered sufficient for this purpose.

Regardless of the format of a living will, other factors are important in determining how effective it will be at protecting the autonomy of a patient and ensuring that her views are considered and respected. It is therefore necessary to establish when a living will comes into operation, what its scope will be and the clinicians' responsibility relative to it? These questions will be addressed in turn.

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[18] *supra* n. 13 at para 5.1.

[19] (1990) 110 S Ct 2841 (U.S. Supreme Court).

When does a living will become operative?

The primary purpose of a living will is to ensure that a person's wishes and convictions about her medical treatment at the end of life are upheld, even after she is no longer able to voice an opinion. It is imperative for patient autonomy that a living will designed to take effect in this way will become operative once its author's ability to decide is so diminished that she has become mentally incompetent. Therefore, the definitive answer as to when a particular living will becomes operative usually depends upon an assessment of when the individual to whom the directive relates is no longer competent to participate in medical decision-making. An alternative to this model however, may include the provision that some other "trigger" stimulates the operation of an advance directive. The triggering factor may be a specific deterioration in the patient's medical condition, or a particular medical occurrence which the author considers to be significant for her prospects of survival. This type of living will is gaining in popularity in jurisdictions where advance statements about health care are supported by legislation, but they are not commonplace in Britain where loss of mental capacity is the event which would usually be expected to trigger the initial introduction of the provisions of a living will.

It has been stated that, "the right to decide one's own fate presupposes a capacity to do so",[20] suggesting that individual personal autonomy is only available to people who are intellectually competent. This is doubly significant for the operation of living wills. Firstly because a living will does not usually become operative until its author becomes incompetent, and secondly, because the validity of a living will is largely dependent upon the competence of its author to make anticipatory health care decisions. Therefore it is important to examine how the competence of any individual patient is assessed.

A Test for Competence

In most instances there is no doubt about a person's competence to give or decline consent to treatment. For example, an adult patient who is fully conscious and suffering no mental impairment will usually be competent to decide. Similarly, an unconscious patient is clearly devoid of the mental capacity and physical ability required to make a competent medical decision. However, another person may be mentally ill, or suffering from an impairment in

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[20] *Re T (Adult: Refusal of Treatment)* [1992] 4 All E.R. 649, per Lord Donaldson at 653.

her mental capability, yet still be considered competent for some purposes. Competence is assessed according to the type of decision to be made and it is widely recognised that competence can be "both partial and fluctuating".[21] Indeed it is possible for a person to have the capacity to marry, but, on the same day, to be incompetent to make a detailed will.[22]

In the medical context the capacity to consent is assessed differently according to the type of treatment involved and the reasons why the treatment is necessary. The patient must be able to comprehend the nature of the treatment and any potential complications, as well as the implications of not undergoing the treatment.[23] Some treatment decisions require complex analysis and powers of reasoning in the determination of whether or not to consent, while others are relatively simple and straight forward. Therefore an assessment of competence to consent must be made for each decision and does not confer an overall status of competence or incompetence on the patient.[24] Furthermore, because the assessment of an individual's competence to consent to treatment is presently based on clinical and legal criteria, and determined in relation to each particular clinical situation, there are bound to be uncertainties and inconsistencies in the evaluative process. *Re C,*[25] clearly illustrates this point.

C was a 68 year old man who had been diagnosed as having chronic paranoid schizophrenia and had been an inpatient of Broadmoor secure mental hospital for 30 years. Part of his condition was that he suffered from the delusion that he had been a world renowned vascular surgeon who had pioneered techniques to avoid amputating limbs. Ironically *C*'s leg became gangrenous after he sustained a minor injury, and surgeons recommended amputation in the belief that without it *C* would die. *C* refused to consent to surgical intervention. The questions for the court to decide were firstly, was *C* competent to refuse consent, and secondly, if

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[21] *supra* n. 13 para 3.5.

[22] *In the Estate of Park, Park v Park* [1954] P. 112, the particular facts of this case are explained in M. Brazier, *Medicine, Patients and the Law* (1992) London: Penguin at 100-101.

[23] The Mental Health Act 1983 Code of Practice discusses the issue of capacity to make medical treatment decisions in great detail.

[24] This principle is enshrined in the Mental Health Act 1983 which permits some patients to be treated against their will but only for conditions which relate to their mental illness. The assessment of capacity is also relevant in Part VII of the Act, which deals specifically with the issue of competence to manage "property and affairs" and again illustrates that while a person may be considered incompetent for the purposes of this provision she may retain capacity in respect of other decisions.

[25] *Re C* (Adult: Refusal of Treatment) [1994] 1 W.L.R. 290.

his refusal was valid would it also be valid in respect of the same treatment at any time in the future, even if *C* later became incompetent?[26]

The central issue in the case was the necessity to determine the competence of a mentally ill patient who refused consent for a potentially life-saving treatment. Varying opinions and assessments of *C*'s mental capacity were offered by three separate consultant psychiatrists, a surgeon, and the court, before it was eventually decided that *C* was competent for these purposes. The difficulties encountered in *Re C* in assessing the patient's competence to decide are reflected in the tests and standards proffered as mechanisms of determining competence in the case law and legislation in this area. Three types of assessment are in common usage.

The first is a cognition-based test which involves an assessment of the patient's ability to understand information. Sections 57 and 58 of the Mental Health Act 1983 include such a test and require that a patient who is competent to consent to treatment should be, "capable of understanding the nature, purpose and likely effects" of the treatment in question. In *Re C* Thorpe J. applied a modified form of this type of test to determine *C*'s competence. He held that the patient would *not* be competent if he failed to "sufficiently understand the nature, purpose and effects of the proffered amputation".[27] His test assessed the patient's subjective understanding rather than with his *ability* to understand, which distinguishes it from the cognition test in the Mental Health Act 1983.

The second type of test recognises that cognition alone is often an insufficient assessment of a person's competence to make health care decisions, and reflects the reasoning applied in *Gillick v Norfolk and Wisbech Area Health Authority*.[28] It was held there that children under the age of sixteen can attain competence but to do so they must demonstrate maturity together with intelligence and understanding.[29] There is no presumption of competence for minors in this situation; they must effectively prove that they are competent to make health-care decisions on their own behalf. The assessment of the competence of people

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[26] See also, R. Gordon, C. Barlow, "Competence and the Right to Die" (1993) 143, *New Law Journal*, 1719-20, E. Roberts, "*Re C* and the Boundaries of Autonomy" (1994) 10 (3) *Professional Negligence*, 98-101.

[27] *supra* n. 25, at 295.

[28] [1985] 3 All E.R. 402.

[29] In *Re E* [1993] 1 Fam. Law Reports, 386, Ward J. endorses the notion that a minor may be both intelligent and well-informed but may, nevertheless lack the maturity to attain *Gillick* competence.

who have experienced long term institutional care raises similar concerns since there may in practice be a presumption that these people are not competent to make their own choices. Combined with this the simple fact of being institutionalised and isolated from every-day decision making, due to mental illness or instability can seriously impair a person's ability to function autonomously.[30]

The doctors who presented evidence in *Re C* disputed *C*'s understanding of the information given to him regarding the proposed amputation. *C* expressed his disbelief in their assertions that he might die without the treatment. The clinicians contended that if he understood but nevertheless failed to believe that he could die, he was not competent to decide. Fennell argues that this test poses particular practical difficulties;[31] if a patient believes the assessment of her situation and the suggested treatment must she accept the treatment offered in order to demonstrate her belief in it, or can she still decide for herself in the face of the information provided, thereby implying an element of disbelief?

Thorpe J. based his assessment of *C*'s competence largely on the patient's reactions and responses at the court hearing, and found that *C* was cognisant of his situation and was therefore was competent to decide. This assessment was made regardless of the psychiatrist's diagnosis of paranoid and delusional schizophrenia, and the thirty years *C* had spent as an inpatient of Broadmoor, demonstrating that the fact that a person is mentally disordered is not in itself sufficient to destroy her decision making capacity. The operation of the test has subsequently been clarified in *B v Croydon District Health Authority*[32] where Thorpe J. explained that absolute disbelief amounts to being "impervious to reason, divorced from reality, or incapable of judgement after reflection" and that this can be distinguished from,

> ... the tendency which most people have when undergoing medical treatment to self assess and then to puzzle over the divergence between medical and self assessment.[33]

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[30] *Kaimowitz v Michigan Dept. of Mental Health* 42 USLW 2063 (1973), Law Commission Consultation Paper No. 128, "Mentally Incapacitated Adults and Decision-Making" (1993) at 31.

[31] P. Fennell, *Treatment Without Consent* (1996) London: Routledge, at 257.

[32] [1995] 2 W.L.R. 294.

[33] *ibid.*

The third test of competence is perhaps the most contentious and the most difficult to demonstrate as a test. It focuses on the rationality of the decision made, and is contentious because respect for individual autonomy dictates that the rationality of any one person's decision should not be challenged on the basis that it fails to conform with accepted norms or the opinions of those required to assess competence. As long as the patient is legally competent to decide she has an absolute right to choose whether to give or refuse consent to medical treatment. The choice made is not limited to,

> ... decisions which others might regard as sensible. It exists notwithstanding that the reasons for making the choice are rational, irrational, unknown or even non-existent.[34]

Legal precedent therefore suggests that any decision made by a competent patient will be binding, irrespective of whether or not that decision appears rational or sensible to others. Yet, a series of cases concerning young adults appears to show that individual autonomy can indeed be devalued by other people's perceptions of what would constitute a rational or sensible choice in a given situation.

Re R[35] concerned a girl aged fifteen years and ten months with a history of depressive mental illness and violent outbursts. It demonstrates that the autonomy of a minor who is *Gillick* competent may only be upheld as long as to do so would secure an outcome that corresponds to what others with the ability to consent on behalf of the minor (the parents or court) believe to be in the *child's* best interests. *R* was resident in a secure home and those responsible for her care were concerned that at some future time it might be necessary to administer drugs to restrain her. She had refused to give consent in anticipation of this circumstance and it was felt that because of her unpredictable mental condition she could not safely continue in residence at the home unless the contingency of the use of such medication was available. Although considered to be competent at the time the issue was raised in the court, *R* had been incompetent at various times during her illness and the potential existed for her refusal of consent to apply to a time when she would be incompetent again and present a danger to herself and others. The judgement distinguished *Gillick* on the basis that it applied to minors who display consistent and developing maturity rather than to

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[34] *supra* n. 20.

[35] *Re R (A Minor) (Wardship: Medical Treatment)* [1991] 4 All E.R. 177.

those whose mental condition was unpredictable. The Court of Appeal also held that in cases concerning *Gillick* competent minors, refusal of consent could be overridden by those with parental responsibility if the treatment proposed is considered to be in the minor's best interests. Autonomy must be respected but it is by no means absolute.

This view was affirmed in the later case of *Re W*,[36] where a sixteen year old girl with a diagnosis of anorexia nervosa, refused consent to be transferred to a psychiatric unit for specialist treatment. Under the Family Reform Act 1969 minors between the ages of 16 and 18 years are deemed competent to consent to medical treatment for themselves.

> The consent of a minor who has attained the age of sixteen years to any ... medical ... treatment which, in the absence of consent, would constitute a trespass to the person, shall be as effective as it would be if he were of full age[37]

However, *W*'s carers believed that the psychiatric nature of her illness prevented her from making a rational decision and the Court of Appeal agreed. Furthermore, it reiterated the view articulated in *Re R* that, while *Gillick* competent minors are able to give consent to treatment their autonomous refusal of consent will not be valid if others with the power to consent on their behalf do so,

> No minor of whatever age has power by refusing consent to override a consent to treatment by someone who has parental responsibility for the minor and a fortiori a consent by the court.[38]

The court overruled *W*'s refusal by giving consent on her behalf, denying her competence and subverting her autonomy to paternalism at a stroke.

Apparently then, the competence of the individual making the decision may be otherwise firmly established but the substance of the decision can raise doubts as to their mental capacity, particularly in the case of minors. So it was in *Re E*[39] where a fifteen year old boy declined consent to a blood transfusion on the basis of his religious beliefs. The boy was admired by the judge for his intelligence

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[36] *Re W (A Minor) (Medical Treatment)* [1992] 4 All E.R. 627.

[37] Family Reform Act 1969, s. 8 (1).

[38] *supra* n. 36 at 639.

[39] *Re E* [1993] 1 Fam. Law Rep. 386.

and composure but none the less it was felt that he had failed to comprehend the full significance of the process of dying he would confront if his decision were upheld. Implicit in the judgement is the suggestion that although the boy was competent the irrationality inherent in his decision negated its validity. However, the level of understanding and insight described in this judgement as necessary to demonstrate competence has

> effectively set the test of competence so high that it was not only beyond the range of a 15 year-old boy but arguably beyond the range of most adults[40]

The Law Commission recognised the problems associated with the assessment of mental capacity in the face of apparently irrational decision making. Describing what it defined as the "outcome" approach to the assessment of capacity, Law Commission Report 231 states,

> An assessor of capacity using the 'outcome' method focuses on the final content of an individual's decision. Any decision which is inconsistent with conventional values, or with which the assessor disagrees, may be classified as incompetent ... A number of our respondents argued that an 'outcome' approach is applied by many doctors; if the outcome of the patient's deliberations is to agree with the doctor's recommendations then he or she is taken to have capacity, while if the outcome is to reject a course which the doctor has advised then capacity is found to be absent.[41]

As a consequence of its analysis of the issue of the assessment of mental capacity the Law Commission concluded that a legislative definition of incapacity is needed:

> *We recommend* that legislation should provide that a person is without capacity if at the material time he or she is:
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> (1) unable by reason of mental disability to make a decision on the matter in question, or
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> (2) unable to communicate a decision on that matter because he or she is unconscious or for any other reason.[42]

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[40] E. Roberts, "*Re C* and the Boundaries of Autonomy" (1994) 10 (3) *Professional Negligence*, 98-101.

[41] *supra* n. 13, para 3.4.

[42] *supra* n. 13, Draft Bill Clause 2 (1).

The expression "mental disability" is defined as meaning,

> ... any disability or disorder of the mind or brain, whether permanent or temporary, which results in an impairment or disturbance of mental functioning.[43]

Further provision was included in the Draft Bill concerning the link between a person's competence to decide and her understanding of the likely consequences of that decision,

> *We recommend* that a person should be regarded as unable to make a decision by reason of mental disability if the disability is such that, at the time the decision needs to be made, he or she is unable to understand or retain the information relevant to the decision, including information about the reasonably foreseeable consequences of deciding one way or another or failing to make that decision.[44]

The recent case of *Re MB (Caesarian section)*,[45] decided after the Law Commission Report and recommendations, apparently expands the nature of incompetence further. The case concerned a woman's refusal to consent to a caesarian section which her doctors believed would save her life and that of her child. The patient was apparently fully cognisant of the consequences of her action but was held to lack the capacity to decide because she had undergone a painful and protracted labour and had received pain relieving medication. Stress, fatigue and medication were considered to have temporarily impaired her reasoning capabilities in what looks like a further example of an assessment of capacity based on the rationality of the potential 'outcome'.

In the absence of a legislative framework of the kind outlined by the Law Commission, common law holds that adult patients with the capacity to give consent are also competent to refuse or withhold consent, and may do so "even if a refusal may risk personal injury to (his) health or even lead to premature death."[46] Also, "a refusal of treatment can take the form of a declaration of intent never to consent to that treatment in the future, or never to consent in some

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[43] *supra* n. 13, Draft Bill Clause 2 (2).

[44] *supra* n. 13, Draft Bill Clause 2 (2)(a).

[45] *The Times* 18th April 1997.

[46] *supra* n. 20.

future circumstances."[47] Accordingly, any refusal of consent made by a competent adult patient should also be valid in respect of the same treatment at any time in the future, priority being given to the patient's competence at the time of making the decision and not at the time when the treatment is required.

Therefore, competence is crucial to the efficacy of anticipatory consent or refusal of consent to treatment, and to the determination of when a living will becomes operative and therefore, when the provisions contained therein should commence. The mental capacity of the patient is also central to the appraisal of the validity of a living will since no advance health care statement will be considered valid its author was not competent at the time it was formulated. This will necessarily impact upon the scope of the advance directive in practice.

What is the scope and validity of a living will?

It is settled law that if a patient is devoid of the capacity to give or refuse consent, the clinicians, or the courts, will decide for her on the basis of a determination of her best interests. If, in similar circumstances the patient has executed a living will, her own wishes about the kind of care she desires will be known and can be given effect. However, in some situations the provisions contained within a person's living will may be considered, by those responsible for her medical care, as contrary to her best interests. The living will may include anticipatory decisions with which the carers disagree, or decision-making health care proxies may have been appointed whose opinions differ from those of the professionals involved. In order to dispel conflict in these circumstances it will become necessary to determine the scope and validity of the particular living will and this will normally be achieved by examining the provisions contained in it, and their legal status.

The authority of a living will does not extend to requests or demands for treatment which is not clinically indicated.[48] A reasonable medical judgement that a certain treatment regime is inappropriate, cannot be overridden by interjection from the patient or anyone else,

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[47] *supra* n. 13, para 5.14.

[48] See *Re J (A Minor) (Wardship: Medical Treatment)* [1992] 4 All E.R. 614 (CA), where the court refused to insist that a doctor should treat a child in a way that was contrary to clinical judgement. See also, *R v Secretary of State for Social Services ex p Hincks* [1992] 1 B.M.L.R. 93.

> ... where a doctor has formed a reasonable and responsible clinical judgement that treatment is not called for, the law will not second-guess him by ordering him to provide the treatment.[49]

This may however, be a cause of conflict between others who are privy to the contents of the patient's living will, and those responsible for medical care. Patients and their representatives may be under the impression that any requests for treatment made within a formally executed living will must be complied with. Doctors, on the other hand, have expressed concerns that they may be required to perform treatments which are contrary to their clinical judgement, or even against the law, because they have been specified in a patient's advance directive.[50] Both viewpoints are clearly misinformed in a way which the Law Commission explains thus,

> Since no contemporaneous or oral statement by a patient can have this effect, this may be another example of excessive influence being attributed to the fact that "advance directives" are often written down and signed.[51]

As the introduction to this chapter suggests, living wills usually include anticipatory decisions about future medical care and most of those concern the refusal of some or all forms of treatment. Where this is the case its scope is largely dependent upon the validity of the provisions it contains. If any of the stipulations within the living will are considered to be invalid its scope will be limited accordingly. It is therefore, important to ascertain when and why the provisions are valid. This can best be achieved by first considering the legal status of anticipatory decisions specifically and then extrapolating the implications of this for the validity of living wills generally, paying particular attention to the status of proxy decision-makers, the refusal of basic care,[52] and finally, the possibilities for alteration and revocation of an advance directive.

Anticipatory Decisions

Anticipatory decisions relating to the acceptance of treatment where consent is *given* in advance have generally not been problematic. Those which concern decisions to refuse consent to specific kinds of treatment which, in the unfolding

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[49] *supra* n. 16, at 1278.

[50] See *supra* n. 1, para 3.12.

[51] *supra* n. 13.

[52] Basic care is defined as pain relief and basic hygiene.

medical situation would lead to the patient's death, have however been the subject of intense legal and ethical debate. The legal status of anticipatory decisions in Britain has been informed by several leading cases,[53] but these cases have tended to be confined to the discussion of the status of anticipatory decisions in general, rather than with the operation of living wills specifically.

Re T,[54] *Re S*,[55] and *Re MB*[56] all concerned pregnant women who declined particular types of treatment; *T* signed a form refusing a blood transfusion while S and *MB* objected to a Caesarian sections to deliver their babies. The wishes of each were overruled in clinical decisions which were legitimated by the courts. *Bland*[57] considered the potential status and usefulness of advance directives but largely as a hypothetical analysis, and *Re C*[58] referred explicitly to anticipatory decisions and the nature of prior refusals of medical treatment which may result in death.

In all of these cases the absolute right of the individual to make autonomous and binding choices about medical treatment was recognised. For example, in *Re T* Lord Donaldson MR explained that,

> An adult patient ... has an absolute right to choose whether to consent to medical treatment, to refuse it or to choose one rather than another of the treatments being offered.[59]

These sentiments were reiterated in *Bland* where Lord Keith said, "... a person is completely at liberty to decline to undergo treatment, even if the result of his doing so will be that he will die."[60]

These judgements apparently confirm the validity of anticipatory decisions where the individual concerned was competent to consent to treatment at the time of their formulation. Yet, the outcomes of these cases belie the effectiveness of apparently valid anticipatory decisions, prompting Jonathan Montgomery to protest,

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[53] *Re T* [1992] 4 All E.R. 649, *Re S* [1992] 4 All E.R. 671, *Airedale NHS Trust v Bland* [1993] 1 All E.R. 821, and *Re C* [1994] 1 W.L.R. 290.

[54] *supra* n. 20, facts outlined in Chapter Four.

[55] *Re S* [1992] 4 All E.R. 671.

[56] *Re MB (Caesarian section)*. *The Times* 18th April 1997.

[57] *Airedale NHS Trust v Bland* [1993] 1 All E.R. 821.

[58] *supra* n. 25.

[59] *supra* n. 20, at 652.

[60] *supra* n. 57, at 860.

> The law represents that they [patients] may choose to die, but allows this power over their dying to be withheld from them at the very point at which its exercise is sought.[61]

Only anticipatory decisions appertaining to the specific circumstances of the patient's condition will be valid. If a patient refuses a specific form of treatment in advance but there is no evidence that at the time of making her declaration she was aware that, in the circumstances that have subsequently arisen, this would result in her death, the refusal will be invalid.[62] Similarly the effectiveness of a living will, as a mechanism for enhancing patient autonomy, can be significantly impaired if the provisions within it are couched in general terms. Andrew Grubb addresses the issue in his discussion of *Re T*,

> ... the requirement in *Re T* that the patient be as specific as possible may well mean that a 'living will' is less comprehensive than would be a general statement of the patient's wishes. Provided that the specific situation contemplated arises, there is no legal problem ... If a different situation arises, however, the 'living will' may miss the mark and the patient's more general intention to, for example, forego life-sustaining treatment will be frustrated.[63]

It seems that a living will which contains anticipatory decisions that are either too general or too specific could be considered inapplicable, depending on the particular circumstances of the individual case.

The Law Commission considered the problem and how it might be overcome. It concluded that primary legislation would be unlikely to overcome the problem concluding that,

> The technique (adopted by the THT/King's College model form) of referring to treatments with particular purposes rather than any particular treatments may be one way of avoiding some of the difficulties.[64]

A further difficulty concerning the scope and validity of anticipatory decisions in living wills certainly cannot be avoided by this mechanism and impacts

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[61] *supra* n. 5, at 38.
[62] *Re T* [1992] 4 All E.R. 649.
[63] A. Grubb, "Commentary on *Re T (Adult: Refusal of Treatment)*, (1993) 1 *Med. L.R.* 83, at 87.
[64] *supra* n. 13, para 5.22.

specifically upon women. The Law Commission Report 231,[65] identified a tension between the dicta of *Re C*, which endorsed the validity of anticipatory decisions, and *Re S*, which related to a contemporaneous decision.

S made her decision to refuse consent for a Caesarian section in response to the clinical emergency which gave rise to its necessity. Even so, in a ruling which has been widely discredited,[66] the patient's decision was overruled because of the imminent danger to the life of her unborn child. Protection of the interests of unborn children was thereby afforded greater importance than respect for the autonomy of pregnant women. Following *Re S*, any anticipatory decision with life-limiting implications could be legitimately invalidated, simply because the author was a pregnant woman; a situation which has generated considerable unease amongst advocates of patient autonomy, and prompted the Law Commission to comment,

> We do not, however, accept that a woman's right to determine the sorts of bodily interference which she will tolerate somehow evaporates as soon as she becomes pregnant.[67]

Nevertheless, the Law Commission went on to acknowledge the probability that any advance directive relating to a pregnant woman, which might endanger the life of her foetus, would be invalid, unless it specifically addressed the circumstances in question. Therefore,

> Women of child bearing age should ... be aware that they should address their minds to this possibility if they wish to make advance refusals of treatment.[68]

The "possibility" referred to here appears to be the possibility that pregnancy may occur and that if it does it will impact upon the validity of any anticipatory decisions contained within the living will. Women of child bearing age and pregnant women are thereby distinguished as a separate class to whom special rules relating to the formation, application, and validity, of advance directives

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[65] *ibid* at para 5.24-5.26.

[66] D. Morgan, "Whatever Happened to Consent?" (1992) 142 *New Law Journal,* 1448, J. Bridgeman, "Medical Treatment: The Mother's Rights", [1993] Fam Law, 534, I. Kennedy & A. Grubb, *Medical Law: Text with Materials* (2nd ed) (1994) London: Butterworths, at 359, M. Thomson, "After *Re S*" (1994) 2 Med. L.R. 127.

[67] *supra* n. 13, para 5.25, at 75-6.

[68] *ibid.*

will apply.[69] Any person's anticipatory decisions about health care must relate to the specific circumstances which arise, but if the person making the declaration is a pregnant woman, the threat to the life of the unborn child as well as that to the patient must also be considered.

Furthermore, the Law Commission's Draft Bill includes the general recommendation that, unless there are contrary indications, a presumption will operate that an anticipatory refusal of treatment does not apply if it threatens the life of the author or, if the author is a pregnant woman, if it threatens the life of her unborn child.[70] Effectively this recommendation amounts to a "presumption in favour of the preservation of life,"[71] so that unless a living will makes specific reference to the potential for an advance refusal of treatment to result in death its provisions may be invalidated.

A further reason for the anticipatory decisions contained in a living will to be invalidated is that they can appear irrational and therefore cast doubt upon the competence of the decision-maker. The implications of refusing consent are often far greater than those of giving consent. Therefore, the mere fact that a patient has refused a potentially life-saving form of therapy may in itself be sufficient to question the integrity of her decisions. Accordingly, some commentators have argued that a higher degree of comprehension is required to make an informed refusal than is necessary for a competent consent.[72] Giving consent calls for little more than an acceptance of an opinion proffered by an experienced medical professional as to the efficacy and necessity of the treatment proposed, particularly in the absence of an established doctrine of informed consent. Refusal of consent in similar circumstances takes on the appearance of a rejection of the same expertly formed opinion, ostensibly from a position of relative ignorance. Consequently, a decision to refuse life sustaining treatment may appear irrational and could be challenged on the basis of the questionable competence of the individual concerned.

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[69] Similar distinctions have been included in other models for living wills, for example, the first legislative provision for living wills, the Californian Natural Death Act 1976, and, Age Concern Institute of Gerontology and Centre of Medical Law and Ethics King's College London, *The Living Will: Consent to Treatment at the End of Life* (1988) London: Edward Arnold, at 60.

[70] *supra* n. 13, Draft Bill, clause 9(3), 76.

[71] *supra* n. 13, para 5.26, at 76.

[72] J. A. Deverereux, D. P. H. Jones, D. I. Dickenson, "Can Children Withhold Consent to Treatment?" (1993) 306, *British Medical Journal*, 1459.

With regard to advance directives, Kristina Stern has raised concerns that such decisions may be taken as evidence of a patient's incompetence simply because they fail to comply with expert opinion and are idiosyncratic.[73] Where a treatment refusal is made in advance and remote from the clinical situation to which it is relevant, the appearance of irrationality may be compounded. Stern suggests that in cases where a diagnosis of incapacity is disputed, perhaps by the patient, the family, or carers, an independent assessment of competency could be required to clarify the situation. This was not considered by the Law Commission as a possible solution to the problem but has been addressed in other jurisdictions.[74] Such a requirement would certainly assist in ascertaining the validity of anticipatory decisions where a diagnosis of incapacity was challenged and may be similarly useful in the determination of when a living will becomes operative.

Proxy Decision-makers

The appointment of health-care attorneys, or proxy decision-makers, is seen by many patients and potential patients as a way to facilitate easier decision-making once their capacity to decide is lost. Therefore, many living wills designate a trusted friend or relative as a surrogate decision maker who is authorised to give or refuse consent when the patient is no longer competent.[75] This is done in the expectation that the proxy will use personal knowledge of the patient's convictions and beliefs to reach decisions which would be in keeping with the patient's own principles. Although this sounds like an ideal solution for a patient who wants to be certain that the provisions contained in her living will are upheld, many potential problems can be anticipated.

A proxy nominated in a living will would clearly be able to demonstrate that it was the patient's intention that she be involved in the decision-making process, but what about the substance of the decisions taken? How could those responsible for patient care verify that the decisions made by the proxy were in keeping with the views of the incompetent patient? Carers, whether professional or voluntary, usually favour treatment which corresponds to their understanding of the best interests of the patient. This ethos may strongly conflict with

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[73] K. Stern, "Advance Directives" (1994) *Medical Law Review*, 57-76 at 62.

[74] The Manitoba Law Reform Commission refers to independent assessment of competence in its Report No. 74, June 1991, *Self-determination in Health Care (Living Wills and Health Care Proxies)*.

[75] An example of this can be seen in the advance directive drawn up by the *Voluntary Euthanasia Society* (1995) 13, Prince of Wales Terrace, London W8 5PG.

decisions made by a proxy, particularly if the proxy is inclined towards a course of treatment, or non-treatment, which will culminate in the death of the patient. Furthermore, what if the patient, though now incompetent, were to deny the authority of the proxy to decide for her, or challenge the efficacy of the proxy's decisions? How could valid treatment decisions be made in such circumstances?

The appointment of proxy decision-makers or health-care attorneys, conforms to the substituted judgement model which was discussed in Chapter Four. However, as that discussion emphasises, where previously competent adult patients are concerned, British law does not facilitate the giving or withholding of consent by anyone other than the patient herself. Andrew Grubb considers that the introduction of a valid system for proxy decision making "is beyond the role of the courts and could only be done by Parliament."[76] All treatment decisions concerning incompetent adults will be taken according to the application of *best interests* criteria, as they would for minors or those of adult years who had never attained competence. The views of significant others, including anybody who had been appointed as a proxy decision maker, can be considered in the assessment of the patient's best interests[77] and the Law Commission recommend that others should be consulted where it is "appropriate and practicable" so to do.[78]

In other jurisdictions, where the use of advance directives has become more commonplace than it is in Britain, the appointment of proxy decision-makers is now an established practice. Indeed the twenty years since the first Natural Death statute was enacted in California in 1976, has seen America legally recognise and endorse the authority of proxy health care decision-makers.

American living will legislation was originally designed to enable people to forgo life sustaining medical care in their final days and die unencumbered by intrusive medical technology. In practice the statutes were limited in their application. Many of them allowed only those who were terminally ill to gain the protection of living wills, and defined "terminally ill" so narrowly that many people died before completing the required waiting period between being diagnosed as terminally ill and signing their living will. Seemingly however, the

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[76] *supra* n. 63.

[77] See *Airedale NHS Trust v Bland* [1993] 2 W.L.R. 316, and *Re T (Adult: Refusal of Treatment)* [1992] 4 All E.R. 649, and Chapter Four.

[78] *supra* n. 13, para 3.33 - 3.36, and Clause 3(2) of the draft Bill.

greatest difficulty was that many people wanted to give power of attorney to others who could then make health related decisions for them. This was problematic because ordinarily a power of attorney does not endure once the principal becomes incompetent. As a consequence statutes were passed in several states enabling the appointment of powers of attorney over health care decisions which would persist even after the onset of incompetence. Subsequent legislation has incorporated the provisions in the living will and the enduring power of attorney statutes and, more recently, twenty states have passed acts enabling family members to make health care decisions when the patient has no advance directive. This pattern is being reflected in Australia and Canada.

In Britain there is still no specific legislation relating to living wills. The Enduring Powers of Attorney Act became law in 1985 and allows that those with power of attorney could continue to administer the affairs of a person after she has lost mental capacity. However, decisions about medical treatment are excluded from the scope of the act so that advance directives which appoint proxy decision-makers in respect of medical treatment decisions are presently ineffective. The Law Commission has considered the issues surrounding the appointment of continuing power of attorney in conjunction with advance directives and recommends it in appropriate circumstances, as an alternative strategy for medical decision making.[79]

Advance Directives and Basic Care

Basic care has been defined by the Law Commission as the alleviation of severe pain, the maintenance of bodily hygiene, and the provision of direct oral hydration and nutrition.[80] The Consultation Paper which preceded the Report included the proposal that no advance directive which declined either the provision of pain relief or, basic care, would be valid, but this was revised following consultation with the British Medical Association. The BMA considered the revision to be necessary because to effectively outlaw all anticipatory decisions which refused pain relief would mean that those individuals who sought to remain alert, through abstention from certain types of medication, might be denied that opportunity. Therefore it was more pertinent to prohibit the refusal of treatment to alleviate *severe* pain than to deny patients who consider the side effects of strong pain relief to be inappropriate the opportunity to refuse it. The Consultation Paper also originally referred to

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[79] *ibid*, para 7.1.

[80] *ibid*, para 5.34, and Draft Bill, clause 9(7)(a) and (8).

spoon-feeding as an element of basic care but this failed to take account of the practicalities of nursing care which often dictate that nutrition and hydration are administered via spouted cup or syringe, signalling the change to "direct oral hydration and nutrition".

The prohibition on any refusal of basic care in an advance directive is clearly destructive of individual rights of self-determination and autonomy and was recognised as such by the Law Commission.[81] However, it was felt that the denial of this right was necessary to protect the interests of others who had to have contact with the patient concerned. To endorse the provisions of a living will which stipulated the complete withdrawal of basic care, including elementary hygiene and symptomatic pain control, would be too traumatic for medical staff and other patients who would have to observe its effects. The responses to the Law Commission's consultation paper prompted the determination that, "... a patient's right to self-determination could be properly limited by considerations based on public policy"[82] and that the definition of basic care contained within the Report "reflects a level of care which it would be contrary to public policy to withhold from a patient without capacity".[83] Public policy however takes no account of the fact that a patient with full mental capacity may decline the provision of this kind of basic care, and that no patient who is conscious and physically able can be compelled to submit to efforts to wash and nourish her.[84]

Alteration and Revocation of advance directive / anticipatory decisions

Once a living will has been executed it will stand, in that form, unless altered or revoked by its author. As long as the author retains the required mental capacity she can alter, or revoke, the provisions contained within her living will as she chooses. The Law Commission has adopted a "policy favouring maximum flexibility"[85] with regard to the formation, alteration, and revocation, of advance directives, which is designed to enable patients to review the provisions contained within their living wills in the light of developing medical circumstances and changes in their own values and opinions. Of particular concern to the Law Commission was that people should be able to change their

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[81] *ibid.*

[82] *ibid.*

[83] *ibid.*

[84] I am indebted to the doctors at Watling Street Surgery, Canterbury, for their practical insights into this situation.

[85] *supra* n. 13, para 5.32.

minds about anticipatory decisions to refuse life prolonging treatment without being constrained by the need to formally repudiate their advance directive,

> It would seem entirely wrong to stipulate that an advance refusal must stand until, for example, paper and pencil and an independent witness can be found.[86]

Concerns were also expressed that patients should not inadvertently deprive themselves of "professional expertise or of beneficial advances in treatment".[87] Since new therapies are continually being developed and people often revise their opinions about what kinds of treatment they find acceptable once they confront the practicalities of illness such a concern is, of course, appropriate. However, because advance directives generally only become operative once the signatory becomes incompetent they are of minimal relevance while the person to whom they relate is able to speak for herself. So long as the author of an advance directive retains the capacity to stipulate which treatments she is prepared to consent to, she cannot be overruled by an advance directive she has previously drawn up. She is also at liberty to change any of the provisions included in the directive at any time.

Moreover, a living will made before the development of new treatments that could be of benefit to the patient would be likely to be considered invalid. Existing law requires that for a living will to be valid its author must have been sufficiently informed and to have intended any anticipatory decisions to apply in the circumstances which had subsequently arisen.[88] If there had been clinical developments which were not envisioned when the advance directive was formulated, the circumstances would have changed and the provisions of the directive would not apply to the specific situation. It would therefore be invalid.[89] As a result, in most situations there seems to be little need for specific guidelines relating to the revocation and alteration of advance directives. Yet it is possible to foresee situations where a patient, or her relatives, challenge the clinical interpretation of a directive.

One example is a case where the continuation of treatment is clinically assessed as futile. The medical staff may seek to reinforce a decision to discontinue

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[86] *supra* n. 13, para 5.31.
[87] *supra* n. 13, para 5.4.
[88] *Re T* [1992] 4 All E.R. 649, *Airedale NHS Trust v Bland* [1992] 1 All E.R. 821.
[89] *Re T* [1992] 4 All E.R. 649.

treatment by reference to a previously enacted living will which suggests that the patient, if she were able, would have endorsed this course of action. In this circumstance the provisions contained in the living will could be taken as evidence that such a course of action would indeed be in the patient's best interests. Even so, such an assessment may be contrary to the wishes and expectations of the patient's relatives and the result is tension between professional and emotional carers. Decisions concerning specific forms of therapy, including those concerning the discontinuation of futile treatment are of course a matter of clinical judgement, but good clinical practice dictates communication and shared decision making which may not be possible if there is discord between professional and emotional carers.

Conflict may also occur if the competency of an individual is called into question. The professional carers may determine that a person has lost the capacity to participate in medical decisions and consequently the provisions contained in an advance directive are to be invoked. The patient herself, or her representatives, may challenge the clinical diagnosis of incompetence and accordingly the need to proceed with the provisions of the advance directive. In such circumstances they may consider that the best course of action is to revoke the advance directive.

These situations clearly demonstrate the need, anticipated by the Law Commission, for specific legal guidelines regarding the revocation of advance directives. They also go some way towards illustrating the necessity for clarification of the responsibility of clinicians in relation to living wills.

The living will and clinical responsibility

Members of all medical professions, and the professions supplementary to medicine, may have responsibilities relating to the operation of living wills. The patient's general practitioner, and any doctor by whom the patient is treated in hospital, will have particular obligations since it is they who must ensure that valid consent for medical treatment is given. Other health-care professionals also have a role to play. For example, hospice nurses and district nurses tend to develop close, long term relationships with patients and may be aware of anticipatory decisions which are unknown to other carers. Medical workers, such as ambulance drivers and para-medics, may encounter a patient for the first time in an emergency situation and be completely unaware of that individual's concerns or preferences. The legal and practical significance of living wills and their impact upon the clinical responsibilities of each of these groups will be considered in turn.

Doctors

In Britain the care and treatment of the population is divided between primary and secondary care under the umbrella of National Health Service. General practitioners, or family doctors, are responsible for the primary care, operating as family doctors who have responsibility for all initial consultations, and for referring patients to hospitals or clinics for specialist secondary care. Superimposed on this system is the facility for people to self refer to hospital accident and emergency departments without having to involve a general practitioner. The impact of living wills on the clinical responsibility of the doctors in each of these settings differs according to the practicalities of the role they play within the health service.

General practitioners are the clinical group most likely to be involved with the formulation of living wills and will often be responsible for holding a copy of a patient's living will in her medical records. Historically patients have tended to have long standing professional relationships with their family doctors, who would usually have been aware not only of their medical history but also of their social circumstances and background. As a consequence patients may seek advice from their general practitioner concerning how to make a living will and what provisions to include in it, or may verbally express their opinions and wishes about future medical treatment which can also constitute a valid advance directive.

Within a hospital setting responsibility for obtaining consent to medical treatment rests with the clinician who will be carrying out the procedure concerned. In Chapter Four it was shown that doctors are authorised to treat patients who are unable to consent so long as the treatment is necessary and in the patient's best interests. A previously executed living will becomes clinically significant when the exact medical circumstances anticipated by the patient arise, and a specific course of action is authorised by an anticipatory decision. It was recognised in *Re C*[90] that an adult patient with the capacity to decide can express

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[90] *supra* n. 25.

opinions regarding consent, or refusal of consent, which will remain valid even after the mental capacity to give consent is lost. Therefore, if a doctor is aware that a patient has made an advance directive which is relevant to the unfolding clinical situation, its contents should be considered prior to taking treatment decisions on behalf of a patient who has become incompetent. A living will that is applicable in the clinical circumstances should be regarded as "the settled wishes of the patient" and the doctor should "act upon it if the clinical situation requires".[91]

The existence of a living will may also be significant even it does not relate to the specific clinical situation that has arisen. If a proposed treatment regime is not clearly defined as being in the best interests of a particular patient, or if there is some dispute between clinicians, or between carers and relatives as to how to proceed, opinions expressed within an advance directive drawn up by the patient may provide evidence as to the patient's own perception of her best interests and thereby assist with the decision.

In its Report No 231 the Law Commission endorsed the recommendation of the House of Lords Select Committee on Medical Ethics that a Code of Practice be developed as a guide to health-care professionals concerning their responsibilities towards patients with advance directives.[92] The British Medical Association, in conjunction with the Royal College of Nurses, has subsequently published guidelines for its members which include many of the provisions contained in the Law commission's Draft Bill, and are intended to operate as a Code of Practice for practitioners dealing with advance directives.[93] In summary the guidelines state that,

Advance directives refusing some or all medical procedures must be followed where valid and applicable;

- The validity of statements refusing life-prolonging treatments should be checked to ensure that the wishes expressed are those of the patient, made of the patient's own volition, free from undue influence;

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[91] The MDU, *Problems in General Practice: Consent to Treatment*, July 1996, London: The Medical Defence Union, 10.

[92] *supra* n. 13, paras 5.39,and 5.4, and the House of Lords Select Committee on Medical Ethics para 265.

[93] The BMA, *Advance Statements about Medical Treatment* (1995) London: BMA publications.

- GPs may be contacted by other health professionals to clarify patient wishes;
- If patient intentions are in doubt or absent, appropriate treatment in their best interests must be given;
- If made when patients were competent and informed, oral objections to treatment may constitute an advance directive.

These provisions hold considerable practical significance for patients and medical personnel in the determination of how effective living wills can be, and how they are administered within the health care system. Consider the stipulation that advance directives refusing some or all medical procedures must be followed where valid and applicable. The intention seems to be that this provision will ensure that the autonomous wishes of patients are respected. However, given the tension that exists in the doctor-patient relationship concerning the refusal of life prolonging treatment it is possible that this clause could operate in an entirely different way. For example, in a clinical situation where the doctors or carers believe that a refusal of treatment is inappropriate, perhaps because it appears to be irrational, or because it is contrary to their own beliefs, the living will may be considered inapplicable.

Unless an advance directive is sufficiently detailed to apply to the specific situation that has arisen, its validity will always be vulnerable to challenge. And a clinician who is concerned for the well-being of her patient can disregard the provisions contained within an otherwise valid living will if its applicability is questionable. This chapter has demonstrated the increasing number of British cases where refusals of medical treatment, whether contemporaneous or anticipatory, have been overruled on the grounds that they are invalid in the specific clinical situation that has arisen.[94] Many of these cases are informed by decisions taken in America and Canada where similar issues have been raised.

The American case of *Werth v Taylor*[95] illustrates the controversy. The patient, Cindy Werth, was a Jehovah's Witness who developed medical complications immediately following the birth of twins. Mrs Werth suffered severe haemorrhaging which dictated that a dilation of the cervix and curettage of the uterus lining (D & C) was required to try to stop the bleeding. When she had

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[94] *Re R* [1991] 4 All E.R. 177, *Re W* [1992] 4 All E.R. 627, *Re T* [1992] 4 All E.R. 649, *Re S* [1992] 4 All E.R. 671.

[95] (1991) 474 NW 2d 426 (Michigan CA).

registered at the hospital for prenatal care Cindy Werth had informed the staff that she was a Jehovah's Witness and did not wish to receive blood transfusions. Her husband had signed a similar statement when she was admitted to the hospital in labour and together they had verbally reiterated their opinion to the doctor who explained the D & C procedure to them.

The D & C failed to stem the bleeding however, and Mrs Werth's condition deteriorated to the point where, without a transfusion of blood, she would have died. At this time the anaesthetist, Dr. Taylor, administered a blood transfusion even though he was aware of the unconscious patient's religious convictions. Mr. and Mrs. Werth brought an action alleging medical malpractice, negligence and battery, against Dr. Taylor.

In his defence Dr. Taylor claimed that the refusal of blood was not valid because it did not apply to the situation that subsequently arose. All the refusals were made when the procedure concerned was thought to be routine and not life threatening. The plaintiffs, therefore, were not made aware that a blood transfusion might be necessary in order to preserve Mrs. Werth's life. Furthermore, Mrs. Werth was unconscious by the time the urgent decision became necessary and it was Dr. Taylor's understanding that consent, or refusal of consent, could be given only by the patient herself.

The Court relied on the judgement in the earlier case of *In Re Estate of Dorone*,[96] which includes the passage,

> ... in a situation ... where there is an emergency calling for an immediate decision, nothing less than a fully conscious contemporaneous decision *by the patient* will be sufficient to override evidence of medical necessity.[97]

In these circumstances, *Werth v Taylor* held that,

> ... it is the patient's fully informed contemporaneous decision which alone is sufficient to override evidence of medical necessity ... Cindy was unconscious when the critical decision regarding the blood transfusion to avoid her death was being made. Her prior refusals had not been made when her life was hanging in the balance or when it appeared that death might be a possibility if a transfusion

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[96] *In Re Estate of Dorone* 517 pa 3, 543 A 2d 452 (1987).

[97] *Ibid.*

> was not given. Clearly her refusals were, therefore, not contemporaneous or informed.[98]

The judges went on to hold unanimously that, "... without contemporaneous refusal of treatment by a fully informed, competent adult patient, no action for battery lies."[99]

Analysis of the British cases concerned with treatment refusal[100] indicates that, while endorsing the general principle that every competent patient has the right to refuse treatment, whether contemporaneously or in anticipation, the efficacy of such a decision is dependent upon the refusal relating precisely to the specific medical circumstances that subsequently arise. The judgements in *Re T*[101] and *Re S*[102] in particular, are certainly informed by the judgements in *Dorone*[103] and *Werth v Taylor*,[104] and have been the subject of much academic debate because they appear to subjugate the decisions of the patients in favour of a paternalistic clinical response. However, the Canadian case *Malette v Shulman*[105] offers a judgement which is rather more sympathetic to the desires of patients formulating advance directives.

The case arose after Mrs Georgette Malette and her husband were involved in a road accident in which Mr Malette had been killed. Mrs Malette was rushed unconscious to hospital, where she was found to be suffering from head and facial injuries and was "bleeding profusely". The bleeding had induced severe clinical shock for which Ringer's Lactate and glucose were immediately administered. This is the usual treatment for shock resulting from blood loss with whole blood being transfused if the patient's condition fails to improve after this initial treatment.

Mrs Malette's condition did not improve but before any further treatment decisions were made a card was discovered in her belongings which identified

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[98] *supra* n. 95.

[99] *ibid.*

[100] *Re R* [1991] 4 All E.R. 177, *Re W* [1992] 4 All E.R. 627, *Re T* [1992] 4 All E.R. 649, *Re S* [1992] 4 All E.R. 671.

[101] *supra* n. 89.

[102] *Re S* [1992] 4 All E.R. 671.

[103] *supra* n. 96.

[104] *supra* n. 95.

[105] (1990) 67 DLR (4th) 321, [1991] 2 Med. L.R. 162 (Ont CA).

her as a Jehovah's Witness. The card was written in French, Mrs Malette was a French speaking Canadian; on translation it read,

> NO BLOOD TRANSFUSION!
> As one of Jehovah's Witnesses with firm religious convictions, I request that no blood or blood products be administered to me under any circumstances. I fully realise the implications of this position, but I have resolutely decided to obey the Bible command: 'Keep abstaining ... from blood.' (Acts 15:28, 29). However, I have no religious objection to the use of nonblood alternatives, such as Dextran, Haemaccel, PVP, Ringer's Lactate or saline solution.

Dr Shulman, the clinician in charge of Mrs Malette's care in the Emergency Room, was informed of the contents of the card. A surgeon had also examined Mrs Shulman and both doctors had formed the opinion that her blood volume must be maintained to avoid irreversible shock. While undergoing further diagnostic tests the patient's condition deteriorated and Dr Shulman personally administered the transfusions of blood he believed were necessary to preserve her life. He was fully aware of the card and its contents but was not entirely satisfied that the opinions expressed represented Mrs Malette's steadfast opinion in this life threatening situation. The doctor took responsibility for disregarding the instructions on the card and later raised questions concerning its validity, in defence of his actions. Robins JA articulated these queries in the Ontario Court of Appeal,

> ... he did not know whether she might have changed her religious beliefs before the accident; whether the card may have been signed because of family or peer pressure; whether at the time she signed the card she was fully informed of the risks of refusal of blood transfusions; or whether, if conscious, she might have changed her mind in the face of medical advice as to her perhaps imminent but avoidable death.[106]

The concerns expressed by Dr Shulman are not dissimilar to those voiced in *Dorone, Werth v Taylor* or indeed in *Re T* and *Re S*. However, Robins JA responded to them quite differently. He argued that,

> ... there was no reason not to regard this card as a valid advance directive. Its instructions were clear, precise and unequivocal, and

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[106] *ibid*, per Robins JA.

> manifested a calculated decision to reject a procedure offensive to the patient's religious convictions.[107]

Furthermore, he expressed the view that, because the opposition of Jehovah's Witnesses to blood transfusions is well known and the card carried by Mrs Malette explicitly referred to her understanding of the implications of such a refusal in all circumstances, the doctor could not defend his actions with the argument that he held a "reasonable belief that the patient would have consented had she been in a condition to do so." The fact that the situation was one of emergency was similarly dismissed,

> A doctor is not free to disregard a patient's advance instructions any more than he would be free to disregard instructions given at the time of the emergency. The law does not prohibit a patient from withholding consent to emergency medical treatment, nor does it prohibit a doctor from following his patient's instructions. While the law may disregard the absence of consent in limited emergency circumstances, it otherwise supports the right of competent adults to make decisions concerning their own health.[108]

Robins JA stated categorically that Dr Shulman's conduct in transfusing Mrs Malette despite the objections raised in her card was not authorised, even though she was unconscious and could not verify that the views described on the card were an expression of her firmly held beliefs. He described the doctors actions as contrary to the principles of individual autonomy and self-determination, "violating" the patient's right to control her own body and disrespectful of her religious beliefs. According to him, the very fact that Mrs Malette carried a card in anticipation of an emergency situation where she would be unable to communicate her wishes was evidence of her continuing commitment to the opinions stated on the card. Therefore her stated opinions should have been respected by the clinical staff and in disregarding them Dr Shulman's action constituted a battery.

The facts of *Malette v Shulman* clearly demonstrate the tension that often exists between established, and well intentioned, medical practice, and the kind of provisions contained within advance directives. With the exception of those whose advance directives are designed to ensure that they obtain every possible medical advantage, people usually construct their advance directives because

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[107] *ibid.*

[108] *supra* n.106.

they wish to decline certain forms of treatment in certain situations. Often this will amount to a declaration that the individual concerned does not wish to be kept alive beyond what they consider to be dignified bounds. This of course, conflicts with the ethos of using all available resources to save life that exists within the medical profession.

Malette v Shulman also illustrates the difficulties that exist within the BMA guidelines for the administration of advance directives. The level of scrutiny necessary to ascertain the validity and applicability of advance directives is outside the ordinary experience of most medical practitioners. Doctors do not routinely need to interrogate statements made by patients concerning their present or future health care. The absence of a legal doctrine of informed consent in Britain means that even decisions made by patients concerning their consent to medical intervention rarely require detailed scrutiny. Hence, practitioners may not possess the skills required to determine the validity of an advance directive, particularly where the presence or absence of duress or undue influence is concerned. To expect doctors to seek to ascertain that patients have executed their advance directives of their own volition and free from external pressure is to encumber them with a burden which can only compound the pressures they bear in everyday clinical practice. Dr Shulman raised this issue with his concerns about whether Mrs Malette had signed her refusal of blood transfusion card because of family or peer pressure and his concerns were overruled by the court. It is also uncertain whether the requirement in the BMA guidelines that doctors must ensure that the wishes expressed are those of the patient, made freely and without undue influence, refers to the time when the advance directive is executed or to the time when its provisions are put into effect. Clearly it will be difficult for a doctor to ascertain whether an advance directive was made freely and in the absence of duress if, as is probable in an emergency setting, her first contact with the patient and the living will, occur simultaneously. This is the situation where living wills could perhaps most benefit patients and where they will in practice be of the least benefit.[109]

The provision that general practitioners may be contacted by other health workers to verify the existence or the terms of an advance directive dictates that family doctors must devise a mechanism for identifying which patients have composed living wills so that they are available for easy retrieval from the notes

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[109] See D. Morgan, "Odysseus and the Binding Directive: Only a Cautionary Tale?" (1994) 14 *Legal Studies*, 411, at 423.

at any time. Also, because verbal statements may constitute valid advance directives, any statements made by a patient that may be considered an advance directive should also be recorded and similarly identifiable.

Yet practically, the guidelines do not significantly improve the chances of a patient's living will being upheld by a clinician who is unfamiliar with the patient's medical and social history such as when family doctors use deputising or co-operative systems to provide emergency services outside of normal surgery hours. Anecdotally, some general practitioners make provision for these circumstances by ensuring that their deputising or co-operative administrators are aware of all of their patients who have living wills and the contents of those wills, but this appears to be an uncommon practice. The BMA guidelines include the provision that if there is doubt as to the patient's intentions, treatment should be given according to a determination of the patient's best interests. Therefore any patient who is incapacitated upon presentation and is not known to the doctor concerned is likely to be treated according to best interests criteria, whether or not there is an existing advance directive, particularly in an emergency situation. This may provide a safeguard for those doctors who can demonstrate genuine doubts as to the validity of a living will, or it may offer a clinician the opportunity to disregard a directive that does not correspond with her assessment of clinical need. The result may be that a properly executed directive fails to operate in the way its author intended because a clinician is uncertain about it's validity. However, a doctor who wrongly assesses the validity of an advance directive and disregards it, as did Dr Shulman, may not be authorised to treat the patient and may incur tortious or criminal liability as a consequence.

The patient's expectation is that if she has gone to the lengths necessary to formulate and record an advance directive then the provisions contained within that document will be acted upon. However, doctors may be reluctant to act upon an advance directive whose validity they cannot verify because they do not personally know the patient, particularly in circumstances which might lead to the death of a patient. Consider the hypothetical situation where a patient arrives in an emergency room unconscious but in a condition which is immediately treatable. The accompanying family members insist that the living will they have with them should be observed and no treatment should be administered so that the patient is allowed to die. Is the attending clinician going to examine the document to ascertain its authenticity and validity while the patient's condition deteriorates, or is she going to treat the patient according to best interests criteria and ask questions later?

Nurses and other clinical carers

The guidelines formulated by the BMA are effectively a Code of Practice for health care professionals treating patients who have living wills. The guidelines were formulated in consultation with the doctor's Royal Colleges of medicine and surgery and with the Royal College of Nursing. All medical personnel with responsibility for the treatment and care of patients have similar responsibility with respect to the provisions contained within properly executed living wills.

Members of the professions supplementary to medicine (nurses, para-medics, radiographers, physiotherapists, inter alia) are not usually primarily responsible for obtaining consent from patients who are undergoing diagnosis and treatment. This responsibility rests with the doctors who request diagnostic procedures and authorise the administration of treatment. The doctors take overall clinical responsibility for the actions of staff in their unit, ward or department. They are usually involved with the appointment of staff, and it is usually part of their role to ensure that their staff practice safely and competently. Therefore it is doctors who will be mainly concerned with ensuring that the preferences expressed in a patient's living will are upheld. However, there are some situations where the doctor may not be available to make a decision, or, where the health care worker has to react to a situation which was not foreseen. This is particularly relevant to para-medics, who may be confronted with a patient they have never seen before who is obviously in need of immediate treatment.

Most para-medics are ambulance staff or nurses who have been specially trained to provide emergency care and life-sustaining treatment until such time as medical assistance is available. If confronted with an unconscious patient who is not competent to give consent the para-medic will administer treatment as the clinical situation dictates. Frequently this will involve first aid, resuscitation and maintenance while a patient is transported to hospital. If the patient is competent and can give or refuse consent the para-medic must act accordingly; like doctors they are not authorised to treat a patient in the absence of consent unless it is an emergency and the patient is not competent but needs urgent treatment.

Faced with a situation where the patient is not conscious but the relatives or friends insist they have made a valid living will refusing treatment in the situation that has occurred, the para-medic must judge whether or not treatment is appropriate.[110] However, just as for doctors, if there is any doubt about the validity or applicability of a living will the para-medic is authorised by the Code of Practice to administer treatment in accordance with the patient's best interests. Para-medics are likely to take this course rather than risk neglecting the duty of care they owe to their patients by failing to treat in an emergency.[111]

Conclusion

Living wills can include anticipatory decisions consenting to as well as rejecting therapy, but it is advance treatment refusals leading to death that are the most contentious form of living will. The close association between refusal and withdrawal of treatment, and voluntary euthanasia, means that living wills are frequently seen as an expression of a person's will to die. This may ultimately lead to their inability to provide people with the degree of autonomy they seek at the end of life.

Fundamental distinctions exist between respecting the autonomy of declarations of beliefs and wishes, and binding decisions concerning future medical treatment. Furthermore, decisions which give consent to treatments have been legally distinguished from those refusing treatment. In practice, as the cases referred to in this chapter demonstrate, anticipatory decisions made by patients about their future medical care have often been overruled or disregarded, and decisions which decline consent in circumstances where non-treatment is likely to result in a patient's death are less readily complied with than those which give consent. As Derek Morgan suggests, considering the nature of the doctor-patient relationship and the responses of the courts to it, the assessment of advance directives by doctors and the courts can not be "value- neutral".[112]

In America and Canada, where there is a significant body of legislation protecting the right to make an advance directive, a number of cases have been brought concerning the application of the provisions contained within living

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[110] K. V. Irerson, "Forgoing Hospital Care: Should Ambulance Staff Always Resuscitate?" (1991) 17 *Journal of Medical Ethics*, 19-24.

[111] This conclusion was reached following consultation with ambulance crews and para-medics attending the accident and emergency department at Kent and Canterbury Hospital, in August 1996.

[112] *supra* n. 109, at 422 and n. 73.

wills. Most of these have revolved around the issue of treatment being given in the absence of consent.[113] However, the Voluntary Euthanasia Society reports that more recently, civil cases concerning 'wrongful life' have been brought by patients who did not wish to be resuscitated or treated. Edward Winter brought such a case after he was resuscitated by a nurse following a heart attack. Prior to this he had witnessed the lingering death of his wife and expressed his wish that if ever he should need to be resuscitated no action should be taken and he should be allowed to die. He was left in a severely debilitated condition and later sued the hospital, but for whose action he believed he would have died with dignity.[114]

In Britain the Law Commission, the BMA, and the common law, all now support the principle of patients being enabled to make advance declarations and decisions about the medical treatment they will receive if they become incapacitated. The Law Commission has recommended that advance refusals of care should be presumed to have been validly made, if they are "in writing, signed and witnessed" and there is "no indication to the contrary"[115] and this is reiterated in the BMA Code of Practice relating to advance statements about medical care. However, the BMA guidelines associated with the Code of Practice, and the common law interpretation of the issues involved in the cases concerning refusal of treatment in life threatening circumstances, suggest that, to paraphrase Sally Sheldon, the effectiveness of a living will is subject to the discretion of the doctors and courts involved.[116]

Living wills should be valuable in enhancing individual autonomy in the context of medical care. They could also be useful as a means of protecting doctors from litigation in circumstances where treatment is withdrawn. But how effective they can be in promoting death with dignity by "... protecting patients from the final sting, the broken promise which leaves them powerless to control their last days,"[117] remains uncertain.

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[113] *In Re Estate of Dorone* 517 pa 3, 543 A 2d 452 (1987), *Werth v Taylor* (1991) 474 NW 2d 426 (Michigan CA), *Malette v Shulman* (1990) 67 DLR (4th) 321, [1991] 2 Med L.R. 162 (Ont CA).

[114] Voluntary Euthanasia Society, *Your Ultimate Choice: The Right to Die with Dignity*, (1992) London: Souvenir Press, at 16.

[115] *supra* n. 13, Draft Bill clause 9 (5).

[116] *supra* n. 4.

[117] *supra* n. 5, at 39.

Chapter Six

Is Euthanasia a Dignified Death?

> I have had a good life and I would dearly like a good death ... my last wish is to die with dignity.[1]

Introduction

The opportunity to die before experiencing loss of independence and control, and unencumbered by the intrusion of medical technology, appears to many to extend the promise of a dignified death. Hence, because modern medicine has developed the ability to maintain life and prolong the dying process, euthanasia and dignity have become inextricably linked. Science and nature have become rivals in a contest where death represents the ultimate failure of medicine so that,

> The quality of life remaining to many terminally ill people has been tragically compromised by an ideology driven by the medical technical imperative to treat, ... where curative medicine is prioritised at the expense of individuals.[2]

When medical technology intervenes to prolong dying it does not do so unobtrusively, it does so with needles and tubes, noise, pain, and discomfort. Often these will be accompanied by the bright lights, odours, and loss of privacy associated with institutional caring. In this environment death represents, "the ultimate form of consumer resistance, ... natural death is now that point at which the human organism refuses any further input of treatment".[3]

Death and dying are elements of life over which human beings can exert only limited control. Death itself is not an experience that can be recounted or shared with others, but dying is an observable phenomenon whose contemplation shapes peoples perceptions of their own lives and their expectations for their own

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[1] C. Taylor-Watson in Margarette Driscoll "After a Good Life, Why Can't we Choose a Good Death?" *The Sunday Times*, Jan 15th 1995.

[2] B. McNamara, C. Waddell, M. Colvin, "The Institutionalisation of the Good Death" (1994) 39 (11) *Social Science and Medicine*, 1501-8 at 1505.

[3] I. Illich, *Medical Nemesis: The Exploration of Health* (1975) Rupa, Delhi at 149.

demise. "Fear of dying, fear of the possible mode of dying, fear of death itself are part of the human condition"[4] and the combining of these fears with new anxieties about the excesses of inappropriate medical care has fostered the convergence of euthanasia and death with dignity that is now well established in Western culture.

Ronald Dworkin describes belief in human dignity as "the most important feature of Western political culture."[5] For him respect for human dignity means respecting the inherent value of human life. The ability to govern one's own conduct according to self-formulated rules and values underpins the concept of individual autonomy and is pivotal to the perceived quality of a person's life. Overriding autonomy and insisting on utilising every available therapy can compromise people's quality of life and is inherently destructive of human dignity. This has meant that concerns about excessive treatment have generated much of the debate about and support for euthanasia.

The euthanasia debate is therefore gaining momentum, fuelled by the increasing longevity of the population and the further development of medical expertise.

> Sophisticated new medical and psychotherapeutic technology can constitute a threat to the physical and intellectual integrity of the individual minimising the degree of control and choice he has over his own life.[6]

Furthermore, it has been acknowledged that individual choice and self-determination are central to this debate.[7] Surveys of patient's attitudes to terminal care suggest that the possibility of choosing an alternative to becoming dependent upon medical carers and burdensome to family is fundamental to dignity in this context.[8]

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[4] J. Sanders, "Medical Futility: CPR", in R. Lee, D. Morgan, *Death Rites: Law and Ethics at the End of Life* (1994) London: Routledge, 72-90, at 77.

[5] R. Dworkin, *Life's Dominion: An Argument about Abortion and Euthanasia* (1993) London: Harper-Collins, at 166.

[6] L. Sampaio, "To Die with Dignity" (1992) 35 (4) *Social Science and Medicine*, 433-41, at 433.

[7] M. Kelner, I. Bourgeault, "Patient Control Over Dying: Responses of Health Care Professionals" (1993) 36 *Social Science and Medicine*, 757-765.

[8] See P. J. Van Der Mass, J. J. M. Van Delden, L. Pijnenborg and C. W. N. Looman, "Euthanasia and Other Medical Decisions Concerning the End of Life" (1991) 338 *The Lancet*, 669, C. Seale, J. Addington-Hall, "Euthanasia: Why People Want to Die Earlier" (1994) 39 *Social Science and Medicine*, 647-54, and, R. Hunt, I. Maddocks, D. Roach, A. McLeod, "The Incidence of Requests for a Quicker Terminal Course" (1995) 9 (2) *Palliative Medicine*, 167-8.

Euthanasia is practised openly in the Netherlands and is legally permissible subject to established procedural guidelines.[9] In 1990 the Dutch Government requested a nationwide study of "Euthanasia and Other Decisions Concerning the End of Life" as part of its preparation for a discussion about the legalisation of euthanasia.[10] Three distinct studies were undertaken. Firstly, detailed interviews were conducted with 405 physicians; secondly, questionnaires were sent to the doctors of a sample 7000 deceased persons, and thirdly, the 405 doctors interviewed provided information about the 2250 deaths that occurred in their collective practices in the six months following the interviews.

The study considered three types of medical decision at the end of life (MDEL). These were, non-treatment decisions, the administration of high doses of opioids to relieve pain and control symptoms, and active euthanasia. The results showed that MDEL were taken in 38% of all deaths and in 54% of non-acute deaths. Life was shortened by the use of high doses of opiates in 17.5% of all deaths and by non-treatment in a further 17.5%. Euthanasia by the administration of a lethal dose of medication at the request of the patient was estimated to occur in 1.8% of all deaths annually.[11]

The participants in the study were questioned about the reasons patients gave for requesting euthanasia. Their responses showed that;

- 57% mentioned loss of dignity;
- 46% mentioned pain;
- 46% mentioned unworthy dying;
- 33% mentioned being dependant on others, and;
- 23% mentioned tiredness of life.

In less than 5% of the cases was pain given as the primary reason for requesting euthanasia which illustrates the close link between euthanasia and dignity in the minds of patients. Retaining dignity and control was considered more important than relief from terminal pain as a reason for requesting euthanasia.

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[9] J. Griffiths, "The Regulation of Euthanasia and Related Medical Procedures that Shorten Life in the Netherlands" (1994) 1 *Medical Law International*, 137-58, at 143.

[10] P. J. Van Der Mass, J. J. M. Van Delden, L. Pijnenborg and C. W. N. Looman, "Euthanasia and Other Medical Decisions Concerning the End of Life" (1991) 338 *The Lancet*, 669.

[11] R. Fenigsen, "The Case Against Dutch Euthanasia" (1989) *Hastings Centre Report*, Special supplement, 22-30, claims that the incidence of active euthanasia in Dutch AIDS patients is 11.2%, suggesting that the incidence of active euthanasia is variable according to the disease group.

Similar findings were recorded in a survey of 3,696 people in 20 health authorities in England.[12] The participants were questioned about relatives and friends who had recently died, of whom 3.6% were shown to have requested euthanasia at some time during their final year of life. As in the Dutch sample, fear of dependency and the indignity associated with it was more prominent than fear of pain amongst this group. The preservation of dignity through the avoidance of dependency and the maintenance of autonomy was of greater significance to those surveyed than was relief from pain. For these people euthanasia represents an attractive alternative to conventional medical therapy which suggests that perhaps the issue of dependence and indignity needs to be more fully appreciated and catered for,

> If good care is to obviate the desire to die sooner, it needs to address the problem of dependency as well as to provide the symptom control in which hospice practitioners have developed such impressive expertise.[13]

In the post war period patients have become consumers of health care services and have come to be recognised by medical professionals as people first and patients second.[14] Today many patients demand more than just a right to health care in general, they seek a right to choose specific types of treatment. They want to be able to retain control throughout the entire span of their lives and to exercise autonomy in all medical decisions concerning their welfare so that they maintain control over what happens to them. This is evidenced by the results of a survey of members of the Voluntary Euthanasia Society in which the reason most often given for joining was "to be able to control myself in the circumstances of my own death."[15] The concepts of autonomy, self-determination, and control at the end of life are therefore, key factors in conflating euthanasia and dignity but the concept of dignity itself remains esoteric and difficult to define.

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[12] C. Seale, J. Addington-Hall, "Euthanasia: Why People Want to Die Earlier" (1994) 39 *Social Science and Medicine*, 647-54.

[13] *ibid.*

[14] W. Arney, B. Bergen, "The Anomaly, the Chronic Patient and the Play of Medical Power" (1983) 5 *Sociology of Health and Illness*, 12.

[15] See R. Lam, "Who is Concerned about the Right to Die with Dignity? A Postal Survey of Exit Members" occasional paper (1981) London: Institute for Social Studies in Medical Care.

The Oxford English Dictionary defines dignity as, "true worth, excellence, high estate or estimation, honourable office, rank or title; elevation of manner, proper stateliness", so that to dignify is to, "make worthy; confer dignity upon, ennoble". In the context of dying, the word dignity engenders a sense of serenity and powerfulness, fortified by "qualities of composure, calmness, restraint, reserve, and emotions or passions subdued and securely controlled without being negated or dissolved".[16] This being so, a person possessed of dignity at the end of life, can induce in an observer a sense of tranquillity and admiration which inspires images of power and self-assertion.

In Britain dignity is not a concept that is presently recognised by the law although it has been alluded to in cases concerning medical decisions at the end of life. For example, in *Airedale NHS Trust v Bland*[17] Lord Goff stated that, "... account should be taken of the indignity to which ... a person has to be subjected if his life is to be prolonged by artificial means", and in *Re A (A Minor)*[18] Johnson J. held that, "... it would be wholly contrary to the interests of that child ... for his body to be subjected to what would ... be the continuing indignity to which it is subject."[19] Dignity is also gaining currency through the language of human rights in other jurisdictions, and not always in respect of decisions at the end of life.

In France the principle of safeguarding human dignity was recently identified within the preamble to the 1946 constitution. It first came to light when the French Constitutional Council was reviewing proposed new laws on bio-ethics to ensure their conformity with the constitution. Since then the principle has been referred to in a case concerning the constitutionality of legislation on housing and again in a case concerned with deciding the morality of the bizarre practice of dwarf throwing.[20]

In America the 1991 Natural Death Act of California refers specifically to the, "recognition of the dignity and privacy that a person has a right to expect", in its endorsement of a person's right to "make a written declaration instructing his or

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[16] A. Kolnai, "Dignity", in R.S. Dillon (ed.) *Dignity, Character, and Self-Respect* (1995) London: Routledge.

[17] *Airedale NHS Trust v Bland* [1993] 1 All E.R. 821.

[18] *Re A (A Minor)* [1992] 3 Med. L.R. 303.

[19] *ibid* at 305.

[20] S. Millns, "Dwarf-throwing and Human Dignity: A French Perspective" (1996) 18 (3) *Journal of Social, Welfare, and Family Law*, 375-80.

her physician to withhold or withdraw life-sustaining treatment ... in the event that the person is unable to make those decisions ..."[21] The Act does not condone mercy killing or assisted suicide, but it does acknowledge that a person's dignity may be preserved through the availability of the choice to decline treatment, even if the exercise of that choice results in death.

The concept of human dignity was also central to the case of *Sue Rodriguez v Attorney General of Canada and Others*[22] where the plaintiff argued that her constitutional right to basic human dignity was nullified by s. 241 (b) of the Canadian Criminal Code. Sue Rodriguez was 42 years old and suffering from motor neurone disease.[23] She had requested the assistance of a doctor to commit suicide because her physical condition prevented her from acting alone, but was denied help because aiding and abetting suicide is contrary to section 241(b) of the Canadian Criminal Code. She therefore applied for an order declaring section 241(b) invalid, on the grounds that it violated her rights under sections 7,12, and 15(1) of the Canadian Charter of Rights and Freedoms.

The Court of British Columbia dismissed her application, as did the Court of Appeal of British Columbia. She appealed to the Supreme Court of Canada, arguing that Section 7 of the Canadian Charter of Rights and Freedoms, which refers to "security of the person" encompasses autonomy as well as "control over one's physical and psychological integrity", and that these principles are essential to dignity. This was said to be pivotal to her case since she was seeking a right to die with dignity. The dissenting judgements of L'Heureux-Dube and McLachin agreed as to the significance of dignity in dying while Cory J declared that "any prohibition that would force a dreadful, painful death on a rational but incapacitated terminally ill patient is an affront to human dignity".

However, the majority opinion accepted that while Section 241(b) did impinge on the security of her person as defined in section 7, and thereby encroached upon her dignity, this was not contrary to the principles of fundamental justice under section 7. It argued that the state has an interest in the protection of life and the avoidance of any devaluation of human life which could result from permitting lives to be deliberately terminated. As a means of protecting vulnerable individuals from potential abuse the measures in section 241 (b) were

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[21] Natural Death Act California, 1991, 7185.5, Legislative Findings and Declaration (d).

[22] Supreme Court of Canada [1993] 7 WWR 641.

[23] Also known as amyotrophic lateral sclerosis or A.L.S.

not unfair or arbitrary. Hence the correlation between dignity and the ability to make choices concerning the time and manner of one's own death was recognised but ultimately not endorsed by the court.

This case was decided according to the need of the state to protect the interests of those for who may suffer abuse if euthanasia were legally permitted. The argument rested on the dichotomy of dignified and undignified dying, but the ability of euthanasia to provide a dignified death was not an issue. The close association between euthanasia and dignified death is one which remains firmly established within western society because euthanasia is seen as a way to curtail futile suffering by enabling people to control their own destinies. Yet opponents of euthanasia also speak of the centrality of dignity in dying arguing that there are alternative methods of achieving the same goal.

This chapter will consider whether death by euthanasia is indeed dignified. It will describe the approach to death with dignity advocated by the hospice movement and reflect on the alternative forms of death with dignity offered by Buddhism, Jainism and Hinduism. The preservation of autonomy through consent to treatment and living wills has been considered in Chapters Four and Five and this final chapter will consider whether dignity in dying can be achieved through these mechanisms or if there is a need to permit active euthanasia in the quest for dignity. Elements of the preceding chapters will be drawn together to discuss the need for legal reform and the form that any legislative changes might take. In conclusion the potential dangers of euthanasia for some groups of people will be explored to determine whether any legal reform can truly safeguard the interests of vulnerable groups.

Death with dignity without euthanasia

Arguments in favour of euthanasia are frequently advanced on the basis that it provides a dignified alternative to the traditional medical approaches to death and dying because, rather than endure prolonged suffering associated with protracted dying, a person could opt to bring her life to an end when and where she chose. Euthanasia is not however the only alternative to the techniques of modern Western medicine. The ancient religions of Buddhism, Jainism, and Hinduism, and the hospice system of terminal care all embrace the concept of the *good death* as a means of achieving dignity and spiritual fulfilment at the end of life.

The good death in ancient eastern religions

The cultural framework of Indian religion encompasses many different cultural traditions. Buddhism, Jainism, and Hinduism will be used here to illustrate some of their different approaches to death, dying and euthanasia. Contemporary Buddhists have extensively questioned whether euthanasia has a role to play within Buddhist philosophy,[24] and as a result it is suggested that "... there is much more to Buddhist thinking on euthanasia than a purely pragmatic concern to keep the First Precept - not to take life - while practising the virtue of compassion."[25] It has, for example, been argued that in Buddhism "volition constitutes a man's essential *beingness*" which implies that the intrinsic value of human life lies in the capacity for conscious choice. So in principle, the Buddhist should be in favour of "*voluntary* euthanasia, provided it applied within narrowly defined limits".[26]

An opposing argument has been made however, based on the doctrine of *karma*. The doctrine of *karma* asserts that positive acts and thoughts bring good *karma* while the opposite is true for evil or negative thinking and conduct. These goods and evils are carried over into subsequent lives. On this basis Phillip Lecso argues that,

> ... if the complete evolution of a karmic debt were to be disrupted by an active intervention on the part of a physician, it would then need to be faced again in another existence.[27]

Accordingly Lecso favours the hospice model for coping with the needs of the terminally ill because it appears to allow calm and controlled dying without active intervention. Yet both of these conclusions are problematic for other Buddhists, the first because it, "is only doubtfully Buddhist in its account of the human person" while the second, Lecso's analysis, "begs the question by failing

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[24] See for example, M. Barnes, "Euthanasia: Buddhist Principles" (1996) 52 (2) *British Medical Bulletin*, 369-75, P. A. Lecso, "Euthanasia: a Buddhist Perspective" (1986) 25 *Journal of Religion and Health*, 51-7, and Louis van Loon "A Buddhist Viewpoint", in G C Oosthuizen, H. A. Shapiro, S. A. Strauss (eds) *Euthanasia* (1978) 65 Human Sciences Research Publication, Cape Town: OUP 73-79.

[25] M. Barnes, "Euthanasia: Buddhist Principles" (1996) 52 (2) *British Medical Bulletin*, 369-75, at 369.

[26] Louis van Loon "A Buddhist Viewpoint", in G C Oosthuizen, H. A. Shapiro, S. A. Strauss (eds) *Euthanasia* (1978) 65 Human Sciences Research Publication, Cape Town: OUP 73-79.

[27] P. A. Lecso, "Euthanasia: a Buddhist Perspective" (1986) 25 *Journal of Religion and Health*, 51-7.

to acknowledge that *any* treatment will have karmic consequences".[28] These opinions demonstrate the absence of an established Buddhist position on euthanasia, which some commentators regard as entirely appropriate.[29]

Jainism similarly emphasises the autonomy of the moral subject and reveres a practice called *ahimsa* which extends the notion of non-violence to include positively wishing well to all beings. Jainism also acclaims the custom known as *sallekhana* as the ultimate act of heroism. *Sallekhana* involves fasting to the death in a manner which is reminiscent of religious martyrdom or suicide. The process takes the form of personal penance which is believed to purge the body of all pernicious, detrimental, and negative factors as the moment of death approaches. It is not however considered to be a form of euthanasia or suicide because it is constrained and legitimated by religion. Instead the practice of *sallekhana* is described as a kind of "self-willed death" that better resembles a religious sacrifice.[30]

While similar to Jainism in many respects, Buddhism forbids the taking of ones own life. The distinction seems to be that the Jains believe people are shaped by their history so that the Karmic process is ongoing and the causes of Karma can be identified and eliminated, but for Buddhists *Karma* cannot be destroyed. A person's volition or intention determines the moral status of her act such that, "the moral quality of the act is to be determined by the interior state of the individual."[31] Actions motivated by greed or hatred for example will always be an immoral act and the opposite will apply for pure actions and deeds. Buddhists believe that human existence is rare and rebirth as a human is rarer still therefore it is best to approach death cautiously without attempting to exert control over the dying process. Ideally, at the point of dying a Buddhist should be conscious rational and alert, prompting the Dalai Lama to comment,

> ... from a Buddhist point of view, if a dying person has any chance of having positive virtuous thoughts, it is important -and there is a purpose- for them to live even just a few minutes longer.[32]

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[28] *supra*, n. 25.

[29] See A. Sumedho, cited in M. Barnes, "Euthanasia: Buddhist Principles" (1996) 52 (2) *British Medical Bulletin*, 369-75, at 370, n.4.

[30] P. Dundas, *The Jains* (1992) London: Routledge, at 155.

[31] *supra*, n. 25, at 372.

[32] In P. Anderson, "Good Death: Mercy Deliverance and the Nature of Suffering" (1992) *Tricycle, the Buddhist Review*, 36-42.

It is therefore crucial for Buddhists to prepare for the moment of death because the quality of that moment will dictate the prestige of the new birth.

> Whichever of the two kinds of karma dominates at the time of death determines one's next life ... By forgetting or ignoring death one is unworthy of human existence, thinking only of the pleasures of this life. Lack of death awareness affects one's way of life and leads to regret at the time of death.[33]

Thus Keown's statement that "any affirmation of death or choice in favour of death is a rejection of the vision of human good"[34] explains why the self-willed death revered by the Jains appears to Buddhists as a kind of escapism which cannot succeed because the *Karma* will have to be relived.

Traditional Hindu religious culture is informed by both the Jain and the Buddhist religions and also emphasises the *good death* as a reflection of the quality of the life which preceded it. If a good, dignified death is attained, it is perceived as evidence of having lived a worthy life, "the manner of one's passing out-weighs all previous claims and intimations of one's moral worth".[35] Both ancient and contemporary Hindu religious philosophers acknowledge death as an ordinary occurrence which is of extraordinary significance in that "a good death certifies a good life".[36]

But a *good death* does not happen automatically. It is a goal to be accomplished, one which must be striven for and attained. The *good death* is achieved when death occurs in full consciousness, in a chosen place and at a chosen time. The chosen location will ideally be the home, or alternatively a holy place. As with Buddhism great significance is attached to the element of choice and the maintenance of control,[37] so that ideally, "one must be in command and should not be overtaken by death. To be so overtaken is the loss of dignity".[38] The final moments of life should be calm, easy and peaceful if dignity is to be preserved. This provides a sharp contrast to the kind of institutional death which many in

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[33] Geshe Ngawang Dhargyey, *Tibetan Tradition of Mental Development*, (1974) Dharamsala: Library of Tibetan Works and Archives, 54-5.

[34] D. Keown, *Buddhism and Bioethics* (1995) London: Macmillan, at 187.

[35] T. N. Madan, "Dying with Dignity" (1992) 35 (4) *Social Science and Medicine*, 425-32.

[36] T. N. Madan, "Living and Dying", in *Non-Renunciation: Themes and Interpretations of the Hindu Culture* (1987) New Delhi: Oxford University Press.

[37] J. Parry, *Death and the Regeneration of Life* (1982) Cambridge University Press.

[38] *supra*, n. 35.

the West would seek to avoid through euthanasia and many more expect and fear.

The modern Western understanding of euthanasia, as a means of achieving death with dignity, echoes many of the insights of these traditional religions in its insistence on avoiding dependence and loss of control. Choosing to deliberately end one's life allows control over the time, place and method of one's dying and explains why euthanasia appears to offer death with dignity. The ancient religions however advocate calm, control and compassion as a means of achieving dignity rather than active euthanasia. Those who favour good palliative care in British hospices espouse very similar convictions.

The hospice movement

As an alternative to euthanasia the hospice movement is applauded for providing dignity in dying without deliberately ending life. The aim of the hospice movement is to provide a holistic approach to terminal care in response to the depersonalisation of traditional medical techniques. They treat total pain with total care in order to overcome the physical and psychological trauma of terminal disease. Dying patients, and their families are treated as individuals whose particular needs are related to their terminal condition rather than simply as the recipients of symptomatic therapy and a positive attitude to the dying process is encouraged. Cicely Saunders explains it thus,

> To talk of accepting death when its approach has become inevitable is not mere resignation or feeble submission on the part of the patient, nor is it defeatism or neglect on the part of the doctor. For both of them it is the very opposite of doing nothing. Our work ... is to alter the character of this inevitable process so that it is not seen as a defeat of living but as a positive achievement in dying; an intensely individual achievement for the patient.[39]

The network of hospices was established by Dame Cicely Saunders in 1967 after an inspiring encounter with a terminally ill cancer patient. The patient shared her vision of a caring environment for the dying and left £500 in his will so that she could begin fund-raising to transform the vision into a reality. There are now more than two hundred hospices around the country.

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[39] Ciceley Saunders in S. du Boulay, *Ciceley Saunders* (1994) London: Hodder & Stoughton, at 174.

Advocates of the hospice ideal are vociferous in their defence of good palliative care for relief of the pain and distress associated with terminal illness. As an alternative to euthanasia such therapy is invaluable in assuaging distressing symptoms and strongly defended as a means of achieving a *good death.* The comments of Dr Thomas Nicholson-Lailey, following his participation in a survey of general practitioners on the subject of terminal care and euthanasia, demonstrate of the success of the hospice ideal, "the priority should always be to provide palliative care of the highest quality rather than legalise euthanasia".[40] The development of the specialism of palliative medicine is directly attributable to the hospice movement[41] and hospices continue to carry out extensive research in the field of palliative care and the relief of pain. Nevertheless the availability of good palliative care does not necessarily eliminate the appeal of euthanasia for the terminally ill.

Until recently Britain hospices have been run on a voluntary basis with minimal Governmental financial support. They offer terminal and respite care to those suffering from cancer, motor neurone disease and recently AIDS but hospice care is not universally available to terminally ill and incurable patients. People dying from a range of commonplace diseases like, multiple sclerosis, chronic heart or lung disease have until very recently not been eligible. Moreover the availability of hospice places is constrained geographically because not all eligible patients reside in the immediate vicinity of a hospice. The provision of hospice care may offer death with dignity to its recipients, but its limited availability means that it is unable to negate the need for euthanasia felt by many people suffering from terminal and incurable illness.

Furthermore, the nature of the hospice movement is changing as it is incorporated into mainstream medical services. Initially hospices were funded from the voluntary sector through charities and donations and their staff were employed independently of the National Health Service. However the need for accountability and standardisation of care and services that has accompanied the growth of consumerism within health care and society in general has inevitably brought changes. "The initial hand-to-mouth financing of hospices has had to

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[40] J. Coulson, "G. P.s Oppose Legal Mercy Killing for the Dying" *BMA News Review*, March 8th 1995, at 24.

[41] N. James, "From Vision to System: the Maturing of the Hospice Movement", in R. Lee, D. Morgan, *Death Rites: Law and Ethics at the End of Life* (1994) London: Routledge, 102 - 130 at 125.

become more systematic"[42] in order to provide the increasingly formalised network of terminal care. Nicky James considers the implications of these changes at length,

> With growing professionalism comes careerism and professional development. Inevitable though these may be, they bring about a change in emphasis. The early hospice pioneers who believed in the importance of their mission took it up without any assurances for their futures. These pioneers are being, and will be replaced by those who, albeit committed to their specialist discipline, work in a now established specialism and look for peer credibility and recognition in pay, status research and career prospects. Traditionally the biomedical system emphasises the physical. Hospice services which initially strived for a balance of 'total care' may observe the primacy of physical interventions re-emerge.[43]

Some research already indicates that the *good death* ideals of the hospice movement are beginning to be subverted by its institutionalisation and the consequent encroachment of mainstream medicine.[44] Similar concerns have been expressed about the hospice movement in North America.[45] The infiltration of hospice care by medical technology emphasising treatment and cure may result in failure to achieve the *good death* that those who advocate palliative care as an alternative to euthanasia seek. The methods employed by conventional medicine to give symptomatic control of pain usually involve sedation, and require a level of compliance which necessarily negates the patient's control and choice. The intrusion of medical technology into terminal care is precisely what those pursuing death with dignity wish to escape and explains why some consider euthanasia to be an appropriate alternative. However, those who do rarely question the ability of euthanasia to achieve dignity.

Is euthanasia dignified?

Whether or not euthanasia can provide a dignified death depends on how euthanasia is performed in practice, both within present legal constraints and

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[42] *ibid*, at 117.

[43] *ibid*, at 123.

[44] N. James, D. Field, "The Routinisation of Hospice: Chrisma and Bureaucratisation", (1992) 34 *Social Science and Medicine* 1363-1371.

[45] E. K. Able, "The Hospice Movement: Institutionalising Innovation" (1986)16 *International Journal of Health Services*, 71.

under any potential legal reforms. This discussion considers euthanasia and dignity within the existing legal framework and is followed by an inquiry into possibilities for law reform, and the likely impact of those reforms on the ability of euthanasia to provide death with dignity.

The dignity of those who might die by euthanasia tends to be regarded as of primary importance in debates about the efficacy of euthanasia. Advocates of euthanasia as a means of achieving death with dignity locate their arguments within the dialogue of respect for individual autonomy, the need to provide alternatives to conventional modes of therapy, and the desire to enable people to exercise choice in deciding when, where, and how to die. Yet the debate is incomplete and inconclusive if it focuses solely on these notions because the dignity of those who are, or might be, instrumental in performing euthanasia, and the wider implications for the dignity of society as a whole are of no less significance.

Earlier discussions described how some communities favour different methods of attaining dignity in dying and consider euthanasia an insult to human dignity, but these too may provide an inadequate response to the perceived need for dignity in dying. Preserving the dignity of some may be achieved only by compromising the dignity of others, most notably carers who perform euthanasia. To paraphrase Jinnet-Sack, emphasising euthanasia, which must be performed in the company of others, may fail to recognise the potential sacrifice of the dignity of the practitioner.[46] According to Sampaio, "to die with dignity should be a very private decision"[47] but, to die with dignity by euthanasia in the present legal environment, often involves complicity and subterfuge to avoid criminal liability. The Voluntary Euthanasia Society graphically describe the effects of subterfuge,

> ... even when patients beg them for it - doctors tend to kill only when the dying are too far gone to consent. Thus, because voluntary euthanasia is taboo, a doctor makes the decision himself - and the patient is killed involuntarily in the night with a syringe. That is one price of keeping euthanasia secret.[48]

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[46] S. Jinnet-Sack, "Autonomy in the Company of Others", in A. Grubb, (ed) *Choices and Decisions in Health Care* (1993) Chichester: Wiley, at 97.

[47] *supra*, n. 6 at 434.

[48] The voluntary Euthanasia Society, *Your Ultimate Choice: The Right To Die With Dignity* (1992) London: Souvenir Press, at 106.

Others acknowledge a that a conspiratorial duplicity often exists between doctor and patient,

> Surveys suggest the practice of active euthanasia occurs covertly, most likely involving assertive patients who are able to convince the doctor to perform euthanasia in a private setting ... [49]

Active voluntary euthanasia occurs when its 'victim' requests or consents to an intentional action that leads to her death. Mercy killing and assisted suicide fall within this category.[50] Both are proscribed by the criminal law. Mercy killing is defined as murder and attracts a mandatory life sentence. Assisted suicide is contrary to s 2 (1) The Suicide Act 1961 and carries a maximum sentence of 14 years imprisonment. The consent or request of the victim offers no defence in either crime, neither does the fact that the action was performed for compassionate motives.

For a person who seeks relief from the anguish of terminal or incurable disease active voluntary euthanasia may appear to be the most appropriate means of achieving death with dignity. Reason and emotion cannot be easily separated by those involved in terminal care since each is significant in treatment decisions. This leads to compassion which can elicit empathy and imaginative insight into the condition of a patient and may provoke an active response, especially if assisted dying is requested. Calman and Downie distinguish this response from that of pity which they argue is less than dignified because it is paternalistic.[51]

The case of Dr Nigel Cox[52] illustrates how this can occur in practice. Dr Cox cared for Lillian Boyes for 13 years, he knew her and her family well. When she became desperately ill and repeatedly appealed to him end her suffering, he empathised so completely with her that his compassionate reaction to her pleas took the form of direct action. He injected Mrs Boyes with strong potassium chloride, knowing that it had no therapeutic value and that it was likely to cause death. Shortly afterwards she died. Her family believed that Dr Cox had provided her with a merciful release from the terrible pain and distress she was

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[49] R. Hunt, "Approach of the GP to End-of-Life Decisions" (1997) *The RCGP Members' Reference Book 1997/8*, 266, at 267.

[50] Mercy killing can also be performed involuntarily, particularly where the 'victim' is incompetent.

[51] R. S. Downie, K. S. Calman, *Healthy Respect: Ethics in Health Care* (1994) Oxford University Press, at 51-53.

[52] *R v Cox* (1992) 12 B.M.L.R. 38.

enduring and allowed her to die with dignity. However, Cox then suffered the indignity of a criminal prosecution which resulted in his professional integrity being questioned in court and by the General Medical Council.

Two cases from 1996 further illustrate the impact of the criminal justice system on the dignity of those who kill with compassion. They also raise the debate about the appropriateness of criminalising euthanasia. Rachel Heath was a care worker who had witnessed the anguish of an elderly woman in her care. Kathleen Corfield, the 71 year old patient, had always been independent and lived alone until she became infirm and housebound because of lung cancer. Finding this existence too undignified she tried unsuccessfully to starve herself to death and succeeded only in being hospitalised. Rachel Heath visited her in hospital and hastened her death by administering an overdose of diamorphine through her drip infusion. Heath was charged with attempted murder and was scheduled to appear for trial at Winchester Crown Court in March 1996. However, on the first day of the trial the Crown Prosecution Service offered no evidence after Ognall J. requested that it reconsider. The case was abandoned amidst comments from the judge that prosecution would not be in the public interest.[53]

In Scotland in October 1996 Paul Brady appeared before Glasgow High Court charged with the murder of his brother James. Brady had given his brother five times his usual dose of temazepam with alcohol and later smothered him with a pillow after James, who was dying from Huntingdon's disease had pleaded for help to die. The charge was later reduced to culpable homicide and Brady received a non-custodial sentence. Referring to the details of the case Lord McFadyen is reported to have decided that,

> ... a custodial sentence would be neither appropriate nor necessary and would have the effect of adding to the considerable suffering already experienced by the family.[54]

The criminal proceedings and media reporting of them which exposed the details of the family's private life to the world which they thought was destructive of their dignity and the dignity of the memory of their brother.[55]

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[53] See A. Mollard, "Nurse cleared of Mercy Killing", *The Daily Mail*, 28th March 1996, 1, and "Euthanasia Charge Dropped", *The Guardian*, 28th March 1996, 3.

[54] Cited in, B. Christie, "Man Walks Free in Scottish Euthanasia Case" (1996) 313 *British Medical Journal*, 961.

Other carers may suffer the indignity of guilt, self-reproach, and remorse because they are unwilling or unable to perform the ultimate act of compassion. When a loved one or a respected patient professes to prefer the solace of euthanasia to enduring dependence, those who are unable to assist may suffer emotional turmoil which is destructive of their own dignity. Zoe Wanamaker has described being incapable of helping someone you care for to die as "being on an undignified, emotional and moral rack."[56] Jim Brady's sister reported similar feelings,

> ... it was awful. He was crying and I was crying but I just could not do it. I used to try to fob him off and say, "What if they find a cure?"[57]

Euthanasia is seen by many as an immoral act which is an affront to the sanctity of life and humanity. The fact that it is also an illegal act prevents many professional and emotional carers from performing it even if they perceive it as a compassionate and otherwise appropriate response.

In some circumstances the law does permit passive euthanasia, whereby a patient dies as a result of selective non-treatment, but that does not mean that death with dignity is necessarily forthcoming. Chapters Three, Four, and Five, described the legal mechanisms designed to enable patients to endorse their autonomy by withholding consent to some or all forms of medical treatment, either contemporaneously or in advance through a living will. Hence, where a patient is competent and physically able to express a wish not to be treated she is, "... completely at liberty to decline to undergo treatment, even if the result of his doing so will be that he will die."[58] The Canadian cases of *McKay v Bergstedt*,[59] and later, *B (Nancy) v Hotel-Dieu de Quebec*[60] demonstrate this principle in practice.

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[55] See, H. Mills, "The Courage to Kill", *The Guardian*, 15th October 1996, 6-7, also, B. Christie, "Man Walks Free in Scottish Euthanasia Case" (1996) 313 *British Medical Journal*, 961.

[56] Zoe Wanamaker, *Woman's Hour*, BBC Radio Four, 16th May 1995, and *The Long Goodbye*, BBC 2 TV, 17th May 1995.

[57] Margaret Currie, in H. Mills, "The Courage to Kill", *The Guardian*, 15th October 1996, 6-7, at 6.

[58] *supra*, n. 17, per Lord Keith at 860.

[59] *McKay v Bergstedt* (1990) 801 P 2d 617 (Nev Sup Ct).

[60] *B (Nancy) v Hotel-Dieu de Quebec* (1992) 86 DLR (4th) 385, (Quebec Supreme Court).

Kenneth Bergstedt was 31 and had been a quadriplegic since he was injured in a swimming accident at the age of ten. He had been cared for by his devoted parents since the accident but his mother had died and at the time of the case his father was terminally ill. Kenneth requested that his artificial life support be withdrawn because he feared that his already poor quality of life would further deteriorate after his father died. He requested also that a sedative be administered when the ventilator was removed and that a court declare that his death was not from suicide but the result of his medical condition. Kenneth's right to die in this way was upheld.

Nancy B, was 25 years old and permanently paralysed from the neck down due to Guillain-Barre Syndrome. She was unable to even breath without mechanical life-support, and had been maintained by artificial respiration for two years when she petitioned the court to order her doctors to disconnect the ventilator. Like Kenneth McKay, *Nancy B* was not dying and could have survived for many more years. Endorsing the decision in *McKay*, Mr. Justice Dufour granted her request, and affirmed that people have the right to decline treatment, or demand that it be withdrawn, if they perceive the conditions under which they survive to be intolerable The right exists even if the person concerned will die as a result of withdrawing the treatment but would not otherwise be considered terminally ill. A series of cases have defined the conditions under which courts will allow the selective non-treatment of people who are not competent to decide for themselves

The American case of *Re Quinlan*[61] concerned a young woman who was in a persistent vegetative state (PVS). The court decided that "there comes a point at which the individual's rights overcome the state's interest" and life support was discontinued on the basis that Quinlan herself would have sought this had she been able. Despite switching off the respirator however, Karen Quinlan survived for a further ten years. *Cruzan v Missouri Department of Health*[62] addressed similar issues and allowed life support to be terminated, also on the principle of self-determination. In Britain *Airedale NHS Trust v Bland*[63] also concerned a decision to discontinue treatment for a patient who was not competent to decide for himself, but here the problem was solved through the application of the principle of *best interests* to determine the extent of a doctor's duty to this

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[61] (1976) NJ 355 A. 2d. 647.
[62] (1990) 110 US Supreme Court 2841.
[63] *supra* n. 17.

particular patient. The treatment was invasive by its nature, and futile because Tony Bland had no prospect of recovery. Allowing the patient to die by withdrawing treatment would amount to an omission which would only be unlawful if a duty of care existed between doctor and patient. The nature of the treatment involved allowed the House of Lords to determine that it would not be in Bland's *best interests* for it to continue. Therefore no duty of care existed and the withdrawal of treatment was not unlawful. But is it dignified to die in this way?

Decisions like these have been applauded as examples of preserving individual dignity by saving the respective patients from indefinite futile and degrading medical treatment. It seems certain that further indignity through worthless treatment has been avoided but whether the nature of the dying that resulted was dignified is open to question. A patient who needs a ventilator to survive will suffocate if it is removed and those who are deprived of food and fluid will die from the effects of dehydration. Kenneth McKay was aware of the fate that awaited him and requested medication to sedate him and ease his path, that was his choice. Karen Quinlan, Nancy Cruzan and Tony Bland were incapable of appreciating either the details about the manner of their demise, or the plight of the condition they existed in. This being the case it is difficult to ascribe human dignity to either their living or the method of their dying. Both appear inherently undignified for the patient.

Unlike active euthanasia, which exposes its practitioners to the potential indignity of criminal prosecution and sanction, passive euthanasia through selective non-treatment, can appear to preserve the dignity of the practitioner but perhaps at the expense of the patient's dignity. If death results from double effect it may be more dignified for all concerned. Hunt discusses the practice in the following terms,

> The administration of sedatives for refractory symptoms and distress is common practice in terminal care. ... It should be made clear that the treatment is likely to hasten death, the patient is less able to eat, drink, interact, mobilise, cough to clear secretions, and is prone to infections. ... Terminal sedation which hastens death can be justified using the principle of double effect, or it can be regarded as slow euthanasia.[64]

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[64] *supra*, n. 49, at 267.

He recognises that double effect may be a less dignified option because "in some situations it is kinder to end the patient's life quickly", but considers it to be good medical practice in the present legal climate. He may however, be mistaken in his assumption that a doctor can be justified in *using* the doctrine of double effect to hasten a patient's death.

It has been established that a doctor "is entitled to do all that is proper and necessary to relieve pain and suffering, even if the measures he takes may incidentally shorten human life",[65] but to *use* double effect is to imply that the effects are not purely incidental or anticipated, they are desired, purposeful and therefore intended. Should a criminal prosecution be brought against a doctor in these circumstances she may confront not only the indignity of a criminal prosecution and trial but also a conviction for murder or manslaughter.

Some of these indignities might be avoided if the law were to be reformed to permit euthanasia, yet legal reform would need to safeguard against other indignities and potential abuses in order to protect those who may fall victim to non-voluntary euthanasia in the guise of mercy killing. Death with dignity could be equally illusive if the law were to be relaxed too far in favour of euthanasia. Nevertheless the controversy surrounding the legal status of euthanasia, and the need for carers who kill with compassion to be shielded from the mandatory life sentence for committing murder, has prompted various suggestions concerning how the law may be reformed.

Possible legal reforms

One method of overcoming concerns about people who perform euthanasia being regarded as murderers would be to create an entirely new offence of mercy killing. In 1980 the Criminal Law Revision Committee[66] discussed this possibility within the terms of a proposal made two years previously in the Twelfth Report of the Committee. That proposal suggested that a person who unlawfully killed another out of compassion, believing them to be either "subject to great pain or suffering", or "permanently helpless from bodily or mental incapacity", or "subject to rapid and incurable bodily or mental degeneration",

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[65] H. Palmer, "Doctor Adams' Trial for Murder" (1957) *Crim. LR* 365, per Lord Devlin at 375.

[66] Criminal Law Revision Committee, 14th Report, *Offences Against the Person* (1980) Cmnd 7844, section F, at 53.

should be liable for a maximum of two years imprisonment. However, a significant level of public dissent had resulted from the proposal leading the committee to conclude in the Fourteenth Report that,

> When we came to examine our suggestion again for the purposes of this report, we decided unanimously that we should withdraw it, if only on the ground that it is too controversial for the exercise in law reform on which we are engaged. We do not recommend that there should be an offence of mercy killing ...[67]

The 1994 House of Lords Select Committee on Medical Ethics, considered a similar possibility for the creation of a new offence of mercy killing, and also failed to recommend it.[68] Their position was endorsed in the Government Response to the Report of the Select Committee on Medical Ethics.[69]

In the alternative, euthanasia could become the subject of a special defence to homicide, described as mercy killing or legal euthanasia which would operate so that culpability could be defined without the necessity to analyse issues of causation or to distinguish between acts and omissions.[70] Were this type of option to be adopted it could operate in one of two ways; it might reduce a charge of murder to manslaughter, allowing for flexibility in sentencing, or it might provide a complete defence.

A further possibility for legal reform is that the mandatory life sentence for murder could be abolished to facilitate greater discretion in the sanctions imposed upon those involved in euthanasia.[71] Such a reform could operate for all cases of murder so that the mandatory life sentence was abolished absolutely, or it might operate selectively whereby judges were given the option to dispense with the mandatory life sentence only in murder cases where a mercy killing had occurred.[72]

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[67] *ibid.*

[68] House of Lords Select Committee on Medical Ethics, (1994) HL 21-II Para 260.

[69] Government Response to the Report of the Select Committee on Medical Ethics Cmnd 2553 (1994).

[70] T. Helme, N. Padfield, "Setting Euthanasia on the Level" (1993) XV (1) *Liverpool Law Review* 75.

[71] The Select Committee on Medical Ethics strongly endorsed the recommendations of an earlier select committee that the mandatory life sentence for murder be abolished, at *Para 294*, but the Government Response to the Select Committee Report was equally vociferous in its opposition to this suggestion.

[72] M. Otlowski, "Active Voluntary Euthanasia" (1994) 2 *Medical Law Review* 161.

Chapter Five described how the preservation of dignity through autonomous choice has in recent years been the stimulus for much comment, which in some jurisdictions has resulted in the introduction of legislation supporting the use of advance directives or living wills. These provide a mechanism whereby individuals can record their wishes concerning future medical treatment before that treatment becomes necessary in case they are incapacitated at the relevant time. The Law Commission has given careful consideration to living wills, following their discussion in a number of judgements concerning their use in specific medical circumstances.[73] Comprehensive recommendations have subsequently been made about their potential operation and legal status and a code of practice has been formulated by the British Medical Association and the Royal College of Nursing.[74] Increased use of advance directives would certainly help clarify the position concerning the status of anticipatory decisions by patients, and facilitate easier decision making regarding selective non-treatment or passive euthanasia, but their impact on the position of clinicians accused of homicide following deliberate action or double effect would be limited.

Each of these proposed reforms could facilitate greater dignity for some or all of the participants in the dying process. The dying may benefit if reform allowed for greater openness so that they felt more able to voice their concerns about dying or to request assistance, and the carers could benefit from increased protection against criminal conviction. However, it is feared that people who might already be vulnerable to abuse could be placed in greater jeopardy if the law were relaxed in favour of euthanasia. Opponents of euthanasia argue that no legislative framework could provide the necessary safeguards to protect the vulnerable from abuse and society from a decline into moral decay. George Fletcher's concerns about the ability of individuals to resist the corrupting influences of performing actions that society has regarded as taboo are relevant here,

> ... the self-destructive individual who induces another to kill or mutilate him implicates the latter in the violation of a significant social taboo. The person carrying out the killing or mutilation crosses the threshold into a realm of conduct that, the second time,

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[73] *Airedale NHS Trust v Bland* [1993] 1 All E.R. 821, *Re T (Adult: Refusal of Treatment)* [1993] Fam. 95, *Re C(Adult Refusal of Treatment)* [1994] 1 W.L.R. 290.

[74] Law Commission Report 231, "Mental Incapacity" *Item 9 of the Fourth Programme of Law Reform: Mentally Incapacitated Adults* (1995) London: HMSO, Paras 5.1 - 5.39.

> might be more easily carried out. And the second time it might not be particularly significant whether the victim consents or not.[75]

And Cicely Saunders expresses a view that permitting voluntary euthanasia would pose dangers for particular groups within society,

> To make voluntary euthanasia lawful would be an irresponsible act, hindering help, pressuring the vulnerable, abrogating our true respect and responsibility to the frail and old, the disabled and the dying.[76]

Regardless of the apparent dangers however, the need for dignity in dying continues to be expressed through the demands of patients for greater autonomy to select the time and method of dying which conventional medical treatment is failing to adequately address. While the arguments for and against the legalisation of euthanasia are polarised on the basis of religion, ethics, and politics, dignity in dying remains inexplicably linked with euthanasia in the public consciousness. Physical pain constitutes just one factor in the equation, with emotional pain assuming greater significance for those who wish to avoid dependence and therefore pursue death with dignity through euthanasia.

Conclusions

This thesis has argued that the issue of euthanasia has created a tension between the criminal law and social and medical ethics. Euthanasia is widely regarded as offering scope for providing a dignified alternative to the protracted dying which is perceived as the legacy of modern medicine but the preceding chapters have shown that the law absolutely prohibits active euthanasia and uses inconsistency and sophistry to restrict and define passive euthanasia. Consequently, within the law as it stands, neither those who seek euthanasia for themselves nor those who help others to achieve it are obtaining justice.

Alan Norrie has considered the limitations on the ability of the criminal justice system to deliver justice.[77] He argues that the theoretical basis of the criminal justice system and the practicalities of modern life have diverged in such a way

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[75] G. P. Fletcher, *Rethinking Criminal Law* (1978) Boston: Little Brown, 770-71.

[76] Quoted in, Lord Goff "A Matter of Life and Death" (1995) *Medical Law Review* 1-21 at 17.

[77] A. Norrie, "The Limits of Justice: Finding Fault in the Criminal Law" (1996) 59 *Modern Law Review* 540-556.

that the accepted rationale that crime deserves punishment may not always be legitimate. It may not always be appropriate simply to apportion blame and allocate punishment to the individuals involved in criminal conduct. Society as a whole may be required to shoulder some of the responsibility through what Norrie describes as "relational justice", whereby the social, moral and political context of the conduct in question is considered alongside its criminal definition. This conception of justice involves,

> ... a sense of the particularity of human life, a sense of social engagement, and a sense of responsibility that is contextualised both in terms of looking at the wrongdoer's past acts and their provenance, and to his relationship with a community that includes his victim.[78]

The issue of euthanasia presents a perfect example of conduct which is decontextualised by the law and demonstrates the inability of the law to reflect and respond to the moral and political contexts within which changes in social attitudes occur.

Recent technological advances have provided a context within which many ordinary people have called for legal reform because they fear that they may be robbed of their autonomy and dignity as their lives draw to an end. Ronald Dworkin argues that we emphasise the importance of death accompanied by dignity because it "shows how important it is that life ends *appropriately*, that death keeps faith with the way we want to have lived".[79] He observes that death is "not only the start of nothing but the end of everything"[80] and therefore it should be accomplished in a manner compatible with the ideals sought during life. Dworkin's interpretation reflects the *good death* ideal of the religious philosophies discussed earlier and those of the founders of the hospice movement. Both are contrary to the kind of death often achieved through the practice of modern medicine and within the law, yet Dworkin's proposals for solutions are more in accord with those of Derek Humphry and The Voluntary Euthanasia Society than with Buddhism and the Christian tradition of the hospice movement. James marvels at the fact that these quite distinct approaches have developed simultaneously and comments that,

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[78] *ibid* at 555.
[79] *supra*, n. 5, at 179.
[80] *ibid.*

> It will be interesting to see how history interprets the morality of a society in which two contrasting groups, each with deeply committed views on human dignity, develop in parallel.[81]

Perhaps the diversity of opinions and approaches is due to the complex relationship between dignity and dying which cannot be explained simply in terms of medical care or symptomatic relief. The dignity debate revolves around questions of how, where, and when to die as much as to die or not to die? People fear a slow lingering death because such a death tends to be associated with a gradual loss of control and dignity and some will respond by wishing for an immediate release in an effort to retain their dignity. Others consider the process of dying over an extended period of time as providing, "a chance to be able to come to terms with dying and with yourself, and other people, to sort things out in your life over a period of time; to round off your life",[82] which may be dignity enhancing. Of course, if euthanasia were available one could make dignified plans about the time and place of dying in advance, which in itself might facilitate the opportunity to make financial and emotional preparations for the inevitable death, as well as avoiding unwelcome suffering.

It is the fluidity of the concept of human dignity that enables the hospice movement and the pro euthanasia lobby to share the common goal of avoiding pointless pain and suffering at the end of life. The solutions they offer remain poles apart however and euthanasia remains an intractable problem which apparently defies social or legal resolution. The need for individual dignity in dying is strongly felt within society but can be achieved in vastly different ways depending on the medical, religious, and philosophical imperatives of those concerned. Individualistic solutions however focus on the needs of the dying, often to the detriment of others who share the experience. Sampaio articulates the nature of the problem of death with dignity very eloquently,

> Guidelines of how to die with dignity cannot be built on the individualism of John Locke or the humanitarianism ideals of Jean Jacques Rousseau but rather on a sense of civil responsibility to oneself and to others. Most of all, they must be based on never losing sight of the fact that their basic 'raison d'etre' is not to leave the helpless to their misery.[83]

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[81] *supra*, n. 41, at 125.

[82] N. Kfir, M. Slevin, *Challenging Cancer - From Chaos to Control* (1991) London: Tavistock, at 53.

[83] *supra*, n. 6, at 433.

One conclusion to draw from Sampaio's inference is that legal reform permitting euthanasia is necessary so that society as a whole can take responsibility for easing people gently into that good night. However even to do so from his altruistic motivation may present dangers for some groups within society.

In the context of euthanasia Fletcher's words above warn against crossing the Rubicon that separates mercy from killing, suggesting that once a practice that was stigmatised becomes accepted it presents dangers for society as a whole, not just for individuals. Cicely Saunders is more precise in her fears, believing that legalising euthanasia will undermine the position of particular groups. This is also a theme which recurs in Sampaio's analysis of euthanasia and death with dignity. He concludes that whether or not euthanasia will ultimately gain legitimacy is likely to be determined by economic imperatives,

> In the industrialized part of the world there is the danger that as the economic problems worsen the powers that be might undergo an overnight 'conversion' and encourage the death of those who are not economically productive.[84]

Such a conversion is, he believes, likely to be informed by the kind of arguments made here and based upon notions of enhancing the dignity of the dying and protecting those who help others to die. With escalating costs placing market pressures on over extended health-care services this concern is only too valid. Euthanasia could become a method of resource led population control in much the same way as infanticide has been practised in various societies throughout the ages.[85]

Furthermore the impact may well be greater on some groups within society than others. Life expectancy in the United Kingdom has increased by 25 years during this century, and in the 37 years between 1951 and 1988 the number of people aged 80 and over nearly trebled.[86] The numbers of people suffering disabling, chronic, and terminal disease has also risen[87] and "the ageing of the population alone means that the overall number of new cancer patients will increase at an

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[84] *ibid.*

[85] For an exposition of the prevalence of infanticide see M. Harris, *Cannibals and Kings: The origins of Culture* (1978) London: Collins.

[86] *Social Trends*, 1990, Table 1.2, Age sex structure of the population, London: HMSO, at 24.

[87] E. Grundy, "Future Patterns of Morbidity in Old Age", in F. I. Caird, J. Grimley-Evans, (eds), *Advanced Geriatric Medicine* (1987) Bristol: John Wright.

estimated 0.5% a year over the next 20 years".[88] Simultaneously statistics demonstrate that women live longer than men so that in 1992 for example, 25% of men who died did so in their own homes compared with only 19% of women with 13% of men dying in communal establishments as opposed to 25% of women.[89]

Recent cuts in welfare impact crucially upon the elderly who are now required to provide for more of their own care, either through contributions during their working lives or by the clawing back of assets they have accumulated. The indignity of dependence coupled with the financial burden to family and the state may be sufficient to encourage "the frail and old, the disabled and the dying"[90] to consider euthanasia as an alternative. If active euthanasia were to be permitted as a right because of social pressure what is to prevent the endorsement of this *right* being translated into a social duty? How long will it be before those who seek euthanasia in order to avoid being a burden lose the right to continue living until the natural end of their lives?

Despite these concerns the pressure to relax the law and permit euthanasia for individuals remains, with patients and their emotional carers feeling that like Karen Quinlan, they are dying in an age of eternal life.[91] The ability of medicine to maintain life beyond what many perceive to be dignified bounds raises questions that go to the root of defining what kinds of human behaviour ought to be criminalised.[92] Killing is rightly proscribed but voluntary euthanasia may be slipping beyond the scope of the criminal law if society's morality is no longer opposed to its practice. Yet the law needs to protect the vulnerable at the same time as enabling the dying to exercise their autonomy through euthanasia and protecting those who compassionately assist them.

Earlier in this chapter various types of reforms were discussed ranging from a new statutory offence of mercy killing, through the introduction a special defence to homicide to the abolition of the mandatory life sentence for murder. Either a new offence or a new defence would require a legislative resolution which would

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[88] *Review of National Cancer Registration System*, Series MBI (1990) No.17, London: OPCS.

[89] Office of Population Census and Surveys, *Mortality Statistics, General: Review of the Registrar General on Death in England and Wales 1992,* (1994) London: HMSO, Table 7.

[90] *supra*, n. 76.

[91] B. D. Cohen, *Karen Ann Quinlan; Dying in an Age of Eternal Life* (1976) New york: Nash Publications.

[92] See, Jean Davies, "Raping and Making Love are Different Concepts; so are Killing and Euthanasia" (1988) *14 Journal of Medical Ethics*, 148-9.

be entirely dependent upon political will. The emotive nature of the euthanasia debate and the voracity of its opponents dictate that Parliamentary intervention of this nature is unlikely to be forthcoming. Equally the rigidity of statutory composition may not provide the most accessible format for sympathetic judicial interpretation of the issues arising from euthanasia.

The introduction of judicial discretion in sentencing would appear to offer the most socially acceptable solution at the present time. It would enable the strengths of the common law to facilitate the degree of flexibility required in order to safeguard the needs of the vulnerable while combining maximum individual autonomy with compassionate caring. Ultimately this could provide a dignified alternative to the present position for those who seek euthanasia for themselves and those who practice it.

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Appendix A

DOCTORS OR DENTISTS
(This part to be completed by doctor or dentist. See notes on reverse)

TYPE OF OPERATION INVESTIGATION OR TREATMENT

....

I confirm that I have explained the operation investigation or treatment, and such appropriate options as are available and the type of anaesthetic, if any (general / regional / sedation) proposed, to the patient in terms which in my judgement are suited to the understanding of the patient and / or to one of the parents or guardians of the patient.

Signature... Date........./.........../.........

Name of doctor or dentist...

PATIENT / PARENT / GUARDIAN
1. Please read this form and the notes overleaf very carefully.

2. If there is anything that you don't understand about the explanation, or if you want more information, you should ask the doctor or dentist.

3. Please check that all the information on the form is correct. If it is, and you understand the explanation, then sign the form.

Name... I am the patient / parent /guardian

(delete as necessary)

I agree to..............................
a) what is proposed which has been explained to me by the doctor / dentist named on this form.

b) the use of the type of anaesthetic that I have been told about.

I understand that....................
a) the procedure may not be done by the doctor / dentist who has been treating me so far.

b) any procedure in addition to the investigation or treatment described on this form will only be carried out if it is necessary and in my best interests and can be justified for medical reasons.

I have told the doctor or dentist about any additional procedures I would *not* wish to be carried out straight away without my having the opportunity to consider them first.

Signature...

NOTES TO :

DOCTORS, DENTISTS
A patient has a legal right to grant or withhold consent prior to examination or treatment. Patients should be given sufficient information, in a way they can understand, about the proposed treatment and the possible alternatives. Patients must be allowed to decide whether they will agree to the treatment and they may refuse or withdraw consent to treatment at any time. The patient's consent to treatment should be recorded on this form (further guidance is given in HC(90) 22 - *A Guide to Consent for Examination or Treatment).*

PATIENTS
* The doctor or dentist is here to help you. He or she will explain the proposed treatment and what the alternatives are. You can ask any questions and seek further information. You can refuse the treatment.

* You may ask a relative, or friend, or nurse to be present.

* Training health professionals is essential to the continuation of the service and improving the quality of care. Your treatment may provide and important opportunity for such training, where necessary under the careful supervision of a senior doctor or dentist. You may refuse any involvement in a formal training programme without this adversely affecting your care and treatment.