THE LAW, DEATH, AND MEDICAL ETHICS

Comment on *Re B (Adult: Refusal of Medical Treatment)* [2002] 2 All England Reports 449

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The judgment handed down in the case of Ms B confirms the right of the competent patient to refuse medical treatment even if the result is death. The case does, however, raise some interesting legal points. The facility for conscientious objection by doctors has not previously been explicitly recognised in case law. More importantly perhaps is that the detailed inquiry by the court into Ms B's reasons for refusing treatment, apparently as a precondition for finding her competent, seems to contradict earlier case law where it has been asserted that competent patients can refuse treatment for no reason at all.

In terms of legal principle, there is, at first sight, little in this judgment (handed down by Dame Elizabeth Butler-Sloss, the president of the family division of the High Court) to cause surprise to the medical lawyer. The primacy of patient autonomy—that is, the competent patient's right to decide for himself whether to submit to medical treatment, over other imperatives, such as his best interests objectively considered, had been clearly established in a number of decisions prior to Ms B's case. The autonomy principle will prevail even in cases of refusals of life-saving treatment, notwithstanding the perturbation caused to the sanctity of life principle. As Lord Donaldson MR stated in *Re T (Adult: Refusal of Treatment)*, a Court of Appeal decision from 1992: "This situation gives rise to a conflict between two interests, that of the patient and that of the society in which he lives. The patient's interest consists of his right to self-determination—his right to live his own life how he wishes, even if it will damage his health or lead to his premature death. Society's interest is in upholding the concept that all human life is sacred and should be preserved if at all possible. It is well established that in the ultimate the right of the individual is paramount".[1]

Having cited this and other *dicta* to similar effect (including from the House of Lords in the *Bland* case[2]), the president turned to the issue of Ms B's capacity: was the latter competent on the facts to refuse the treatment in question? In the case of an adult patient, there is a presumption in favour of such capacity, however, this can be rebutted. In this regard, the president reiterated the test she had previously applied in *Re MB (Medical Treatment)*, which was itself modelled on Thorpe J's approach in *Re C (Adult: Refusal of Treatment)*[3]: "A person lacks capacity if some impairment or disturbance of mental functioning renders the person unable to make a decision whether to consent to or to refuse medical treatment. That inability to make a decision will occur when, (a) the person is unable to comprehend and retain the information which is material to the decision, especially as to the likely consequences of having or not having the treatment in question; [or] (b) the patient is unable to use the information and weigh it in the balance as part of the process of arriving at a decision."[4] As the president noted, though, the application of these principles to individual situations, "especially in an intensive care unit [as in Ms B's case] is infinitely more difficult to achieve".[5] In fact much of the remainder of the judgment is taken up with a detailed recital of the evidence, from the doctors and psychiatrists involved, and from Ms B herself, which pointed fairly conclusively to the latter's capacity in this case. Having decided that Ms B was indeed competent, the president held that her continuing treatment, in the face of her clear objection to the same, amounted to an unlawful battery and awarded nominal damages (of £100). The president concluded by summarising the applicable principles and procedural steps that should be followed when patients refuse apparently beneficial medical treatment. This included the point that: "The doctors must not allow their emotional reaction to or strong disagreement with the decision of the patient to cloud their judgment in answering the primary question whether the patient has mental capacity to make the decision". Equally, a duty was placed upon the hospital/National Health Service (NHS) trust: "If the hospital is faced with a dilemma which the doctors do not know how to resolve, it must be recognised and further steps taken as a matter of priority. Those in charge must not allow a situation of deadlock or drift to occur". In such cases, "the NHS Hospital trust should not hesitate to make an application to the High Court or seek the advice of the Official Solicitor".[6 7]

Nevertheless, and notwithstanding what has been said so far, there are some respects in which Ms B's case appears to break new legal ground (albeit that this is not explicitly recognised in the judgment itself). In the first place, this is the first time in the UK that a competent, ventilator-dependent patient has sought (and won) the right to have their ventilator turned off. (As the president noted, such cases have arisen previously in Canada and the US.)[8 9] Here, given Ms B's paralysis, the switching-off would need to be performed by a doctor, and this fact might have been thought problematic. In particular, could it not be argued that the doctor in question would be performing an *act* that intentionally brought about

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the patient's death?[10] If that were so, then Ms B's wishes in the matter would be legally irrelevant: one cannot consent to be killed. This would be an example of "active euthanasia", which the law regards as murder.[11 12]

In fact, though, following an *obiter dictum* of Lord Goff in the *Bland* case,[13] it is apparent that, despite the physical appearance of an act, the law will characterise the switching off of a ventilator as an omission. Since it was the doctors who were responsible for instigating the regime of ventilation initially, their conduct at this point amounts simply to a cessation of that previous ongoing treatment. It is immaterial that the mechanics of such a cessation may include elements of positive conduct (in terms of bodily movements by the doctors concerned).[14] Instead, taken overall, the doctors' conduct qualifies as lawful "passive euthanasia" (indeed it was mandatory in this instance, given Ms B's competent rejection of the life-sustaining regime).

Although the above argument does not appear in the judgment in Ms B's case (presumably the point was simply not raised by counsel), its validity would seem to have been taken for granted. On the other hand, the psychological difficulty for Ms B's doctors in taking such a step (one doctor said in evidence that she felt she was being asked to kill Ms B) was recognised. Thus, rather than ordering her own doctors to cease the ventilation, the judgment sanctioned Ms B's transfer to a different hospital where the doctors would be prepared to do this. This aspect of the legal decision, too, may be regarded as setting a new precedent for the UK (though there is some US authority in point).[15] In effect, it amounts to giving doctors who, for certain reasons, feel unable to comply with a course of conduct required by law, a right of conscientious objection. While such a right has been provided for by statute in the context of particular, ethically problematic, medical procedures—notably abortion and fertility treatment,[16] it was not previously recognised at common law (at least not explicitly: it was arguably implicit in a number of earlier decisions, see—for example, *Re J*).[17] This certainly represents a sensitive response by the court to the practical realities of the case, but it is perhaps hard to square with the rules on battery, which in principle are triggered as soon as the non-consensual nature of the interference with the competent patient is made out. Seemingly, these rules will simply be suspended during the period of the patient's transfer, provided that this is carried out reasonably expeditiously (which it had not been in Ms B's case).

Returning, lastly, to the matter of Ms B's capacity, which occupied so much of the president's judgment, it is arguable that the amount of attention directed to this issue is significant in itself. In particular, it may be thought to give the lie to some of the more hard-edged *obiter dicta* from earlier case law in which it had been asserted that competent patients are entitled to refuse medical treatment (including life-saving treatment) for no reason at all.[18 7] Admittedly, near the beginning of her judgment, the president repeated a *dictum* to just this effect from her own previous judgment in *Re MB*.[19] This was immediately followed, however, by an extended and anxious inquiry into Ms B's reasons for wishing to discontinue ventilation in this case, apparently as a precondition for finding her competent. In practice, then, the competent patient who refuses life-saving treatment for no reason may be a legal oxymoron.

REFERENCES

1 **[1993] Family Law 93**, at 113.
2 **Airedale NHS Trust v Bland** [1993] Appeal Cases 789.
3 **[1994] 1 Weekly Law Reports 290**.
4 **[1997] 2 Family Law Reports 426**, at 437 (as Butler-Sloss LJ).
5 **[2002] 2 All England Reports 449**, at 455.
6 **See reference 5: 474–5**.
7 This guidance was based on that previously laid down by the Court of Appeal in the case of *St George's Healthcare NHS Trust v S* [1999] Family Law 26.
8 *Nancy B v* Hotel-Dieu *de Quebec* (1992) 86 Dominion Law Reports (4th) 385.
9 *McKay v Bergstedt* (1990) 801 Pacific Reporter, (2d) 617.
10 **Beynon H**. Doctors as murderers. *Criminal Law Review* 1982; 17–28.
11 **Regina v Cox** (1992) 12 Butterworths Medico-Legal Reports 38.
12 **Similarly**, as illustrated in *R (on the application of Dianne Pretty) v DPP* [2002] 1 All England Reports 1, a patient's consent to be assisted in their suicide will not relieve the assisting person of criminal liability (under section 2 of the *Suicide Act, 1961*).
13 **See reference 2: 866**.
14 **Stauch M**. Causal authorship and the equality principle: a defence of the acts/omissions distinction in euthanasia. *Journal of Medical Ethics* 2000;**26**:237–41.
15 **Brophy v New England Sinai Hospital** (1986) 497 North Eastern Reporter (2d) 626.
16 **Abortion Act 1967**, section 4; *Human Fertilisation and Embryology Act 1990*, section 38.
17 **Re J (A Minor) (Wardship: Medical Treatment)** [1991] Family Law 33, *per* Lord Donaldson MR at 41.
18 **Re MB (Adult: Medical Treatment)** [1997] 2 Family Law Reports 426.
19 **See reference 18: 432**.