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Master Of Jurisprudence

The Persistent Vegetative State: Legal and Ethical Issues

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Rosemary Dobson, July 1995

University Of Durham: Law Department

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The Persistent Vegetative State:
Legal and Ethical Issues

Rosemary Dobson, July 1995

Abstract

Recent advances in technology and medical expertise have enabled doctors to prolong the lives of many severely injured patients who only a few years ago would have died from their injuries. The prolongation of life by such measures has raised many legal, ethical and social issues. When in 1992 the House of Lords determined in *Airdale NHS Trust v Bland* that life-supporting measures, including artificial nutrition and hydration (ANH) might lawfully be withdrawn from Anthony Bland, a patient in a persistent vegetative state (PVS), attention was focused on these issues particularly as they apply to the patient in PVS. Since the PVS patient is neither competent to refuse treatment, nor is he dying or suffering, the reasons normally advanced for withdrawing life-supporting measures do not apply. In *Bland*, their Lordships relied on the best interests test laid down in *Re F (mental patient: sterilisation)* [1989] 2 All ER 545, and, with the exception of Lord Mustill, on the *Bolam* test (*Bolam v Friern Barnet Hospital Management Committee*)[1957] 1 WLR 582. This thesis examines the decision in *Bland* and addresses some of the issues raised. The appropriateness of the best interests test as applied to the patient in PVS is explored and compared with the approach of substituted judgement employed in some other common law jurisdictions. The relevance of the *Bolam* test to decisions regarding the withdrawal of life-supporting measures is considered. The legal requirements for the withdrawal of ANH are discussed, together with the ethical debate and the moral dilemmas posed by its withdrawal. Finally, the question as to whether the decision in *Bland* is good law is addressed, and it will be argued that whilst it may be morally acceptable to withdraw ANH from some patients, as regards a patient in PVS, the moral imperative is that we should not.

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1. Introduction

On March 3rd 1993, Tony Bland, a patient in the Airedale NHS Trust Hospital died after the deliberate withdrawal of life sustaining treatment, including artificial nutrition and hydration. For three years prior to that date, Mr. Bland had lain unconscious after suffering a severe crushing injury which caused prolonged deprivation of oxygen to his brain and resulted in destruction of the cerebral cortex, but left the brain stem intact. Expert medical attention saved Mr. Bland's life. but the consequences were devastating, leaving Mr. Bland in a condition of persistent vegetative state (PVS) from which he had no hope of recovery. Doctors in charge of Anthony Bland came to the conclusion that continuation with artificial measures of life support merely prolonged his life without conferring any benefit to him and that therefore such continuation was not in Anthony's best interests. In order to forestall charges of illegality, the hospital made an application to the High Court to have the proposed course of action legally sanctioned. The Official Solicitor was appointed guardian ad litem to uphold Anthony Bland's interests. The High Court allowed the application, as did the Court of Appeal and the House of Lords on appeal from the lower courts. What made Tony Bland's death legally significant, was that at the time of the withdrawal, Tony Bland was neither "brain dead" nor was natural death inevitable and imminent. He was in a condition known as a persistent vegetative state, a phrase coined by Professors Plum and Jennett in 1972[1]. *Prima facie*, the intentional act of withdrawing medical treatment constitutes both a civil breach of the duty of care and the crime of murder. However in *Airedale NHS Trust v Bland*[2] the House of Lords held, albeit on narrow legal grounds, that in certain circumstances, "medical treatment", including artificial feeding and the administration of antibiotics could lawfully be withheld. Tony Bland fell within that category. Their Lordships however, made clear the narrow grounds of their decision and intimated that any expansion of that decision would be for Parliament and not the Courts to determine. The case of *Bland* raised for the first time in English courts the question in what circumstances if any, may a doctor lawfully discontinue life sustaining treatment? To date the English courts have had to consider the legal issues only in the context of patients with PVS; other jurisdictions however, have addressed them in determining the legality of withdrawal of treatment from patients with other medical conditions, which although significantly different from PVS, present similar legal, ethical and moral dilemmas. Here, it is intended to examine the exact parameters of *Bland*, any deficiencies in the law highlighted by that case, and the basis upon which Parliament might consider appropriate reforms. In doing so, the law prior to

Bland will be examined, together with any changes in the current English law occasioned by *Bland*, and the approaches taken by other common law systems to the dilemmas of the withdrawal of medical treatment from incompetent patients in general. and patients in PVS in particular. To do this it is essential to understand the legally accepted definition of death itself, how the law has attempted to keep pace with advances in medical technology, and the nature and consequences of the condition of PVS, and, where relevant, other similar conditions.

Persistent Vegetative State

Persistent vegetative state is the name coined by Plum and Jennett to describe a particular type of coma. It is essentially different from other types of coma, and from brain stem death, and in legal contexts must be distinguished from them, although some of the legal, issues pertinent to PVS patients may be relevant to patients suffering other medical conditions in which brain function is seriously and permanently impaired [3].

Patients in PVS have permanently lost the function of the cerebral cortex, which is that part of the brain controlling the higher functions of sapience and cognition that is the capacity to feel and to be aware. A differential diagnosis between loss of the cerebral cortex and loss of the brain stem must be made, since loss of function of the latter constitutes brain stem death, whereas loss of the former does not, and the patient is therefore alive and must be treated accordingly. PVS most often arises either as a result of trauma to the cortical tissue in an accident, or following oxygen starvation due to cardiac arrest. In these patients, that part of the brain controlling basic functions such as breathing remains active and the patient is therefore not dependent on artificial ventilation for survival. These patients are neither conscious and alert nor are they brain stem dead. They may have periods of apparent wakefulness and may respond to painful stimuli with eye movement or jerky involuntary limb retraction, but they are unable to make voluntary actions or respond to the environment in any meaningful way. They exhibit wakefulness without awareness, and in short have suffered cognitive death. Research has shown that after extensive trauma or anoxia to the brain, any recovery will invariably occur in the following three months, thereafter the condition is permanent and there is no reasonable possibility of return to a cognitive and sapient state. Whilst in this state a patient can neither enjoy comfort nor suffer pain, hunger thirst or anxiety, and it follows that for these patients the term "quality of life" is meaningless. Further, since voluntary activity is not possible the normal bodily functions of eating, drinking and the

evacuation of bowel and bladder must be accomplished by artificial means involving intrusive medical procedures. However, since the heart and lungs function normally, in the absence of medical complications such as infection, such a patient may live for many years.

Tony Bland had been in this condition since suffering a severe crush injury in the Hillsborough football disaster three years earlier.

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1 Jennett B. and Plum F. The Persistent Vegetative State: a syndrome in search of a name, Lancet, 1972 734.

2 *Airdale NHS Trust v Bland* [1993] 1 All ER 821 (HL), [1993] 2WLR 316

3 Many of the relevant USA cases concern patients not suffering PVS but from other conditions

2. The Relevant Law Prior To *Bland*

In *Bland* the courts were asked to give the answer to two questions; whether the Airedale NHS Trust and the doctors attending Anthony Bland could:-

1. ...lawfully discontinue all life sustaining treatment and medical support measures designed to keep him alive in his existing persistent vegetative state, including the termination of ventilation, nutrition and hydration by artificial means; and
2. ...lawfully discontinue, and thereafter need not furnish medical treatment except for the sole purpose of enabling him to end his life peacefully, with the greatest dignity and the least pain and suffering.

Behind these legal questions lie moral, ethical, medical and social issues which are of fundamental importance, and any legislative criteria for determining such issues must therefore seek to reflect either a consensus view or the legitimacy of conflicting views. As yet insufficient consultation has been carried out to determine such criteria, but in the absence of legislation, judicial decisions based on accepted legal principles must suffice. [1]

The questions posed in *Bland* challenged the legality of the proposed action by the doctors, and in particular raised the following legal points:-

The possibility of:-

1. Criminal liability for murder by either:-

   i) a positive act of commission, or

   ii) an omission where there existed a duty to provide care.
2. Liability for battery by giving medical treatment without consent outwith the best interests of the patient.
3. Civil liability for breach of a duty of care.

In addressing these legal issues regard must be taken not only of legal principles which form the basis of English law, but also moral and ethical values upon which our society is founded. Of these, the principle of the sanctity of human life may be pre-eminent ,but must in some circumstances cede to others such as necessity and the principle of autonomy or self determination.

The Doctor's Duty

Firstly, a doctor, no less than any other person must act within the criminal law. Secondly a fundamental obligation upon a doctor is negative; in the absence of consent, he may administer no treatment to a competent adult patient. To do so is a trespass to the person and may constitute a battery.[2] Lastly, a doctor owes a duty to treat his patient with proper skill and care, which has been accepted by the courts as to act in accordance with a responsible and competent body of professional opinion — the *Bolam* test (*Bolam v Friern Hospital Management Committee*) [3].

The Sanctity of Life and Criminal Liability

Before examining the principle itself, it is essential to determine what exactly can be accounted as life, and at which point death is held to have occurred.

Modern medical technology offers doctors not only the opportunity to treat and cure previously untreatable conditions, but also enables resuscitation and life prolonging measures which have revolutionised the treatment of patients who would hitherto inevitably have died from their injury or illness. As a result, where once cessation of breathing and heartbeat was definitive of death, since both can now be maintained by artificial means, some other criterion is required. Such interventions giving as they do the appearance of continuing life when in reality there may be none, means that the absolute demarcation between life and death may be difficult, but since 1979, the medical profession has accepted that when irreversible brain damage is diagnosed, and it is established by tests that none of the vital centres in the brain stem are still functioning, the patient is to be accounted dead[4]. Ian Kennedy describes death in these terms;

> "The view has been accepted that the state which has traditionally been regarded as death in a human being is reached when the brain stem is destroyed" [5]

Thus the identification of brain death means that a patient is truly dead whether or not some functions such as heart beat are still maintained by artificial means. Loss of function of any other part of the brain, however extensive, which leaves the brain stem intact does not equate with death .But see Stephens J in *Cruzan*:-[6]

> "But for patients like Nancy *Cruzan* who have no consciousness and no chance of recovery, there is a serious question as to whether the mere persistence of their bodies is "life" as that word is commonly understood"

The ability to sustain life is of fairly recent origin but although the determination of death is a matter of law, medical evidence is the only criterion upon which the court can act. Hence, although there is no statutory definition of death, the law has attempted to keep pace with medical advances by accepting a definition reliant on the medical diagnosis of "brain stem" death, which in *Malcherek*[7], the court accepted as the medical criterion for death, although the court did not itself give it as the legal definition.

Thus even though it may be technically possible to maintain respiration and heartbeat in patients who have lost all function of the brain stem almost indefinitely, such interventions merely ventilate what is in effect a corpse and the discontinuation of those "life sustaining" measures is not unlawful (Malcherek[8]). However, in the context of switching off life support machines, a distinction may be drawn between patients who are clinically dead, brain stem death having been demonstrated, and those patients who are alive but death is imminent and inevitable. In the latter category life support may be withdrawn because notwithstanding that the patient is still clinically alive, the doctors in charge consider that there is no therapeutic, or other justification for continuing the life support, and that therefore the patient should be allowed to die. The law has recognised this and in such circumstances applies no sanctions for "allowing to die". Arguably this distinction has been drawn too sharply. In *Bland* Lord Goff himself accepted that although any active intervention to end life crosses the Rubicon between lawful and unlawful action, the law is open to a charge of hypocrisy in precluding positive action to put a patient "out of his misery" where to do so would be more humane than merely allowing him to die. Be that as it may, the law at present sanctions no positive action to end life. However, as regards "allowing to die", the discontinuance of "heroic measures" will take account primarily of the therapeutic value and subsequent quality of life, set against the invasiveness of the treatment and the pain and suffering involved, but may in addition include such considerations as the scarcity of resources and the wishes of the relatives, none of which are relevant in a case of "brain death".

Thus, even though brain stem death is now the medically and legally accepted definition of death, the law recognises that heroic measures may defer death for a significant length of time for patients when there is no hope of recovery, or real benefit to the patient, and has therefore limited the duty of doctors to treatment which is neither

futile nor outwith the "best interests" of that patient, and which therefore allows discontinuance of life sustaining treatment in appropriate circumstances.

It seems then, that advances in medical technology have blurred the old certainties between life and death in that the precept of "life" now encompasses shades of being which may not necessarily require the absolute protection of all human life nor the absolute prohibition of taking life. Both at the very beginnings of life, in the treatment of embryos and the sanctioning of abortions, to the end of life in the balancing of heroic life sustaining measures against the burdens of that treatment for the patient, and his subsequent quality of life, the principle of the sanctity of life meaning life itself, appears to have been has been reinterpreted. If not eroded as such by other principles and considerations, sanctity of life now seems to equate more with human dignity than with mere prolongation of bodily function.

Nevertheless, life represents a deep rooted value immanent in our society and its protection is a fundamental humanitarian precept and a primary function of the criminal law. Indeed, Blackstone declared it to be the first regard of English law[9]. The sanctity or life therefore, is the cornerstone of legal decisions regarding life and death, but it is not absolute and cannot be the overriding principle in all circumstances[10]. However, absent such defences, the law imposes a prohibition on the taking of life. Furthermore there is sometimes a fine line between causing the death of another person and allowing another to die, but *prima facie*, in the absence of a legal defence, an intentional act on behalf of one competent person which brings about the death of any other person constitutes the crime of murder. This principle extends to acts which hasten death, other than those acts which serve to alleviate pain and suffering, but which may also have the dual effect of shortening life provided that death is in any case inevitable and imminent (Adams[11]). In *Adams* Devlin J. unequivocally set out the position-

> "No doctor, nor any man, no more in the case of the dying than of the healthy, has the right deliberately to cut the thread of life"

and

> "If the acts done intended to kill, and did in fact, kill, it did not matter if a life were cut short by weeks or months, it was just as much murder as if it were cut short by years".[12]

However, in his instruction to the jury he included the passage:-

> "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 incidentally shorten life".[13]

Nevertheless it seems clear that other than in the above circumstances, an intentional act by a physician in charge of a living patient which is intended to, and does in fact cause the death of that patient, will amount to the crime of murder if the act is committed with the requisite mens réa (see Cox 1992[14]).

The Criminal Law and Omissions

The law draws a distinction between acts of commission and acts of omission, and in the absence of a duty of care there is no general liability for omissions, but a duty does arise where it is undertaken either voluntarily or as a result of some special relationship Clearly in a doctor-patient relationship, the doctor has assumed the duty to care for his patient, and with the consent of that patient, render such care as accords with that which might be given by a responsible body of medical opinion (the *Bolam* test[15]). This test, relying as it does solely on medical practice, at best differs significantly from the general reasonable care test for negligence, and furthermore appears incompatible with the best interests test set out in *Re F*[16].[17]

Clearly there must be a duty before we can properly speak of an omission, however even where there is a duty does liability arise as much for an omission as for a positive act? There is no doubt that murder and manslaughter by omission are possible, although in such cases the causative link may prove harder to establish than where a positive act is the causation, and manslaughter is the usual conviction in homicide due to omissions (*R v Gibbins and Proctor)*[18], *(Reg v Stone)*[19].

In the field of medicine there is recognised a very important distinction in that, in the words of Glanville Williams:-

> "Whereas killing your patient is absolutely taboo, according to present law and official medical ethics, letting your patient die is qualifiedly permissible, namely when the patient is dying and there is no point in continuing his agony"[20]

The point was determined in *Re B (a minor) (1981) 1 WLR*[21]. Court held that there may be cases where the life of the child would demonstrably be so awful as to justify the withholding of medical intervention; and also in *Arthur (1981)*[22].

It is clear then that the omission of a duty either voluntarily undertaken, or imposed by a relationship, may give rise to criminal or civil liability, and indeed where a failure to provide food or procure medical treatment may indeed result in a conviction for manslaughter *(R v Stone)* but that withholding food and allowing a patient to die is not necessarily unlawful (Re B). However, the act of failing to provide artificial nutrition, as in *Bland* may not be so easily categorised either as a lawful act of omission as inArthur's case or a criminal omission as in *Stone.*[23]

It is clear also that there is overwhelming medical opinion that artificial feeding is a medical procedure, and that for the time being at any rate the courts are content to accept this view. However there is a minority medical opinion to the contrary, expressed in evidence to the court in *Bland,* furthermore there is by no means a consensus amongst commentators.[24] If it is accepted that artificial feeding is medical treatment, there may be a significant moral and legal difference between the withholding of artificial nutrition and the withholding of food, since the former is governed by principles applicable specifically to medical care, and the latter by those of a duty to provide the necessities of life.(For further dscusion on this point see chapter 6)

The withdrawal of a feeding tube is undoubtedly a positive act, but so equally is the switching off of a ventilator, as is the giving of a lethal injection or the cutting of a mountaineer's rope. In some circumstances however, a ventilator may lawfully be switched off to allow a patient to die and is not seen to equate with a positive act of commission, which whatever the condition of or prognosis for the patient is deemed unlawful. If the withdrawal of artificial feeding can properly be classed as a positive act, then undoubtedly it amounts to unlawful killing. It is submitted that withdrawing treatment must be classified as an omission in a similar category of not initiating treatment, and thus, unless there is a positive duty to act, neither withdrawal nor non-initiation is unlawful. Of course equally, where there is such a duty neither is lawful.. Furthermore, the withdrawal of ANH obviously is an omission where the means of delivery is left in situ, but no nutrition is administered. It would seem unduly pedantic to classify this an omission but the removal of any feeding tube, an act of commission, where the intention and result are identical. However, since a doctor will have a duty to his patient, whether withdrawal can be classed as an act or an omission, there is a

possibility that either course might be unlawful .Thus the intentional physical act of withdrawing the means of delivering medical treatment in the form of artificial nutrition and hydration without which the patient will inevitably die, does *prima facie* amount to murder notwithstanding the best motives of the physician in charge (see *R v Cox*). However further matters must be considered.

Tortious Liability and the Issues of Consent

Important as is the sanctity of life principle, it is but one of a number of principles upon which law is founded: One such fundamental principle of English law is that every person's body is inviolate, and in that therefore in the absence of consent, any intentional physical contact is *prima facie* tortious. (*Cole v Turner*[25]). Thus every competent adult has an absolute right to decide what is not done to his body; (the converse however is not true since the law circumscribes the limits of consensual harm — *Brown et al 1992*[26]. This means that in the absence of consent, an intentional act of physical contact by one person upon another, is a trespass against the person (*Wilson v Pringle*[27]). In the context of medical treatment, unlike the position in the United States, where the principle of self-determination is given effect by the doctrine of informed consent, in the UK there is no such doctrine (*Chatterton v Gerson*[28]), and medical care is governed by the tortious principle of consent. The English doctrine thus dictates that an adult patient who suffers no mental incapacity, has an absolute right to choose whether to consent to, or refuse medical treatment. This right is subject only to the qualifications of necessity to undertake lifesaving treatment in circumstances where there is no opportunity to obtain consent, or possibly following *re S*[29], in a case which may lead to the death of a viable foetus. Furthermore, the decision to consent or refuse is not limited to decisions which others might consider sensible (*Sidaway v Bethlem Royal Hospital*[1985][30]), and as regards adult patients, no one other than the patient himself can give valid consent. This applies equally to the competent and incompetent alike (*Re F*[31]). It is clear then that as regards a competent adult, in the absence of consent, any medical treatment requiring physical contact is unlawful. However, what is the position of the incompetent patient?

The Incompetent Patient

Incompetent patients can be divided into three main categories; those adults temporarily incompetent; the permanently incompetent, and children. Issues of consent vary with each category.

The temporarily incompetent may be given such medical treatment as is necessary to save the patient's life on the basis of the principles of necessity and implied consent: the exact parameters of lawful treatment are unclear but fall outside the present discussion.

The Permanently Incompetent.

Medical care of the adult incompetent is now governed by the principle of best interests as laid down in the seminal case of *Re F. Re F* concerned the case of a thirty-six year old mentally retarded woman who had formed a sexual relationship with a fellow patient. It was the opinion of the majority of her carers that she would be unable to cope with either pregnancy, or childbirth, and would be incapable of caring for any child born to her. In all the circumstances it was felt that sterilisation of F was desirable. However, the operation could not be performed without authorisation and since F herself was incompetent to give valid consent, the question thus arose as to who could consent to the operation on her behalf. Had F been a minor no such problem would have arisen since the wardship jurisdiction of the High Court would have sufficed, but in *Re F* the House of Lords confirmed that the courts no longer have any powers either to consent on behalf of an incompetent adult patient, nor to dispense with the need for consent. Such powers would depend either on statutory provision, of which there is none since The Mental Health Act 1983 makes no provision for the giving of medical care, other than such care relating to the treatment of the mental condition of the patient, or on parens patriae jurisdiction. The latter arose from the constitutional responsibility of the monarch for the welfare of any subject suffering such disability as to render him incompetent incapable; such powers could be delegated by Royal Warrant to the courts who then exercised jurisdiction. Unfortunately the last such warrant was revoked in 1960. However, the courts do retain inherent power to make minors wards of court where, on application from an interested party, the court considers it appropriate. This means that although the primary responsibility for a minor, rests with the parent, (or since The Children Act 1989, anyone with parental responsibility), to give consent to medical treatment, where a child is made a ward of the court, the court can thus give or refuse consent on his behalf. The court is no longer able to do this for an adult.

Prima facie then, an adult who cannot consent for himself may receive such treatment as would a temporarily incompetent patient which on a strict interpretation of necessity would be such treatment as is immediately life saving. However, obviously such patient cannot be left without medical care; at the very least, to do so would be in

breach of a duty of care on the part of those charged with that duty. In the absence of either statutory or prerogative power to consent for an incompetent adult, the courts must look to the common law to determine the lawfulness of proposed treatment. It is to be noted that although relatives are frequently consulted, their consent on behalf of the incompetent has no legal validity.

In circumstances where medical treatment is deemed necessary for the health or well-being of an incompetent patient,, but cannot be categorised as immediately life-saving two distinct approaches have been identified ; that of applying the best interest principle, and that of employing the doctrine of substituted judgement. In English law in the seminal case *Re F,* the House of Lords determined that in treating an incompetent adult, a doctor must act in the best interests of his patient, to avoid tortious liability, and in accordance with a recognised body of medical opinion *(Bolam),* to defeat a claim in negligence. In some other common law jurisdictions, notably the USA substituted judgement is the primary approach. In *Re F,* having identified a lacuna in the law regarding consent to medical treatment, their Lordships extended the principle of necessity beyond emergency medical care to cover treatment given to the permanently incompetent. In doing so the concept of necessity appears to have been stretched to the extreme. Lord Brandon in particular gave the principle the alarmingly wide parameters of applying to persons lacking capacity "for whatever reason", to be subject to decision making by person(s) with "the appropriate qualifications" as regards apparently all, or any, medical treatment to be given to them[32]. In other words to hand decision making to carers and/or clinicians. A similar line is taken by the House of Lords in *Bland* who appear to equate necessity with best interests and indeed by allowing determination of best interests by reference to *Bolam* appear also to accept that necessity is governed by acceptable medical practice on the same basis as negligence. This however, is in marked contrast to the approach in both F and *Bland* taken by the Court of Appeal where determination of best interests is taken to consider factors other than mere medical opinion. The relevance of *Bolam* in the best interest test is considered more fully in Chapter 5.

Following *Re F* then in the UK, whereas a child may be treated on the basis of consent given by the parent or the court, medical treatment of the incompetent adult can be undertaken only under the principles of necessity and best interest. As an adult incompetent Tony Bland could therefore receive lawfully only medical treatment which

was in his best interests. The crucial question for patients such as he, is what those best interests are.

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1 The Law Commission has made certain recommendations. Law Com. No. 231, HMSO, 1995.

2 *Wilson v Pringle* [1986] 2 All ER.440

3 *Bolam v Friern Hospital Management Committee* [1971] 1WLR 582

4 1979 1BMJ 332

5 Switching Off Life Support Machines: The Legal Implications. In "Treat Me Right", 1988, p351, Ed Joanne Lynn.

6 Stevens J. in *Cruzan v Director, Missouri Dept. of Health* [1990]110 S.Ct. 2481 @ 2886.

7 *R. v Malcherek, R v Steel* [1981] 2 All ER 422 — Cause of death in a patient suffering brain stem death but whose vital functions are being maintained by artificial ventilation, is the underlying cause of the injury and not the switching off of the ventilator.

8 *Ibid 427*

9 Blackstone: Commentaries on the Laws of England (1978)

10 War, self defence etc.

11 *Reg. v Adams.* (unreported), 8 April 1957, Devlin J.

12 *Ibid.*

13 *Ibid.*

14 *Reg v Cox* (unreported), 18 September 1992. Ognall J. — The intentional giving of a lethal injection which had no therapeutic purpose to a patient in constant and excruciating pain.

15 *Bolam. v Friern Hospital Management Committee* (1957)

16 *Re F (mental patient: sterilisation)* [1989] All ER 545. Sub. nom *F v West Berkshire Health Authority (Mental Health Act Commission intervening.*

17 The appropriateness of the *Bolam Test* is examined more fully in Chapter 5.

18 *R v Gibbins and Proctor* (1918) 13 Cr, App. Rep 134 — man and the woman with whom he was living convicted of the murder of his child by deliberate witholding of food.

19 *Reg. v Stone* [1977] QB 374 — conviction for manslaughter for failure to procure medical treatment for a dependent relative

20 Glanville Williams: Criminal Omissions — The Conventional View 1991 L.Q.R.P

21 *Re B (A Minor) (Wardship: medical treatment)* (1981) [1992] 3 All ER 927 Down's Syndrome baby requiring surgery.

22 Unreported — charge of attempted murder where doctor in charge administered drug to sedate new-born Down's baby and ordered nursing staff to withhold food and give "nursing care only", the question being left to the jury as to whether the *doctor's* action was a culpable positive act or merely allowed the child to die lawfully.

23 In *Bland* Mr. Munby for the official Solicitor attempted to draw an analogy with *Stone* which was expressly rejected by Butler-Sloss LJ — the point is further discussed below under the head The Decision in *Bland*

24 A fuller discussion is undertaken later in Chapter 6.

25 *Cole v Turner* (1704) 6. Mod, 149

26 *Reg v Brown* [1992] 2 All Er 75 — conviction for sado-masochism between consenting adults.

27 *Wilson v Pringle* [1986] 2 All ER 440

28 *Chatterton v Gerson* [1981] QB 432

29 *Re S (adult:refusal of medical treatment)* [1992] 4 all ER 671 — caesarian section performed on a mother in the face of her refusal, to save the life of her unborn child. It is to be noted that although this decision is in conflict with the decision in Re T that a competent adult has an absolute right to refuse medical treatement, unlike T, S was decided at first instance only.

30 *Sidaway v Board of Governors of the Bethlem Royal Hospital and The Maudsley Hospital* [1981] A.C.871.

31 *Re F Sterilisation: Mental patient* [1989] All ER 545.

32 *Re F* [1990] A.C at 55.

3. Best Interests Or Substituted Judgement?

The Best Interests Approach

The genesis of the best interests test, and thus the basis of the decision in *Bland* was the landmark case of *Re F*[1] in which the court was asked to determine whether a doctor would be acting lawfully if he carried out a sterilisation operation on an adult patient who was herself incapable of consenting to treatment. In concluding that in the circumstances of the case, such an operation lawfully could be performed, the House of Lords engendered a novel concept in English law : that of best interests. *Re F* highlighted a lacuna in the law relating to consent to medical treatment, for whereas medical treatment may be given to a child on the basis of consent given by its parent(s)[2], or under the wardship jurisdiction of the court. no-one, other than the patient himself may now consent for an adult patient. Furthermore, consent cannot be dispensed with except for emergency treatment. Their Lordships declared that for an incompetent adult, the proper test for giving medical treatment is that such treatment must be in the best interests of the patient. However, in promulgating this new concept, their Lordships appeared to rely on two well established principles; the welfare test applicable to the treatment of minors, and the *Bolam* test which governs the extent of a doctor's duty to his patient. The application of this latter test in an area where decisions may rest as much on ethical, as medical criteria, has caused no little concern amongst medical and legal commentators alike[3].

Development of The Best Interest Test

The best interests test for all incompetent patients developed through cases in which Courts were requested to use their powers to give consent or refusal to treatment for handicapped neonates. e. g. *Re J* [1990][4], *Arthur*[5], (1981 unreported), *Re B*[6]*(a minor;medical treatment)(19810[1990], Re C*[7]*[1989]*, and *Re J*[1992][8].

In *Re B,* the case of a Downs Syndrome baby with a life threatening but operable intestinal obstruction and a prognosis of a reasonable quality of life thereafter, the court consented to treatment on the grounds that the life of this child would not be "demonstrably so awful" as to condemn the child to death by refusing consent for the operation, but it was made clear that there might well be cases in which the court might be driven to a different conclusion. Shortly after the decision in *Re B,* in the case of *Arthur*[9] a clear distinction was made by the judge between killing and lawfully allowing

to die. Dr Arthur stood trial on a charge of attempted murder after ordering "nursing care only", and prescribing a sedative drug to a Down's syndrome infant rejected by its parents. In *Re C*[10] the court added a further gloss to the framework set out in *Re B*. The case concerned the treatment to be given to an infant born with severe hydrocephalus and brain malformation, together with gross physical deformity. A palliative operation was performed to prevent further pressure in the skull, but it was apparent that no degree of medical intervention could postpone death for more than a very short time. The question arose as to what treatment to give should the child develop an infection or other complication. The High court took the view, *inter alia*, that the doctors should be free to "treat the minor to die" and administer only such treatment as might relieve pain, suffering and distress. Notwithstanding that the original order was reworded prior to the appeal being heard to read, "to treat to allow her life to come to an end peacefully and with dignity", it is clear that this was a case in which the court considered that what little life this infant had before death, would with certainty be "demonstrably so awful" so as to justify the withholding of life prolonging treatment.

Later cases further refined the criteria to be applied in considering decisions whether or not to give or withhold medical treatment from minors. In *Re J* [1990][11], Lord Donaldson said:-

> "In deciding whether to authorise that treatment need not be given, the court had to perform a balancing exercise in the course to be adopted in the best interests of the child, looked at from his point of view and giving the fullest possible weight to his desire, if he were in a position to make a sound judgement and taking into account the pain and suffering and quality of life which he would experience if life were prolonged, and the pain and suffering involved in the proposed treatment".[12]

In these two cases then, the basis was laid down of a "critical equation" between benefits and burdens which must be evaluated when considering whether to consent to treatment which the doctors in charge deemed appropriate.

Apart from these cases dealing with decisions to treat or refrain from treating handicapped babies, a series of cases, notably *Re B*[13] and *Re F*[14], fell to be decided, in which the issue was whether sterilisation was in the best interest of a patient where that patient was legally incompetent. These cases covered both incompetent adults and minors who although if of full mental capacity may have been *Gillick* competent to consent on their own behalf to most medical treatment (although it is unlikely that that would extend

to sterilisation), suffered severe mental retardation[15] .(notwithstanding the provision of s. 8 (3) of The Family Reform Act 1969, which gives minors over the age of 16 the power to consent to medical treatments. A minor below that age has that capacity provided that he has sufficient understanding and intelligence to understand what is proposed.).

In *Re B* the court had no difficulty in deciding that as regards minors, a court exercising its wardship jurisdiction should apply the same principles as would a fully competent and reasonable adult to regulate his own medical treatment, or a reasonable parent in relation to his child that is the test applied by their Lordships was, per Lord Hailsham L. C. , P. 202

> "the well-being, welfare or interests of the human being concerned, that is the ward herself or himself"[16]

and per Lord Bridge

> "It [the appeal] is concerned with one primary consideration and one alone, namely the welfare and best interest of this young woman"[17]

The principles to be applied in the treatment of incompetents were then brought together and clearly set out in *Re F.*[18] Prior to theis case the law as regards the medical treatment of the adult incompetent patient was unclear ; in the absence of consent, other than in an emergency, non-consensual treatment would be at least tortious. and possibly criminal. However. since the leading passage by Lord Bridge, in *Re F* the "best interests" test has determined medical treatment for the legally incompetent. In that case Lord Bridge uttered the famous passage:-

> "It would be intolerable for members of the medical Professions that in caring for those lacking the capacity to consent to treatment, they should be put in the dilemma that if they administer the treatment which they believe to be in the patient's best interests, acting with due skill and care, they run the risk of being held guilty of trespass to the person, but if they withhold that treatment, they may be in breach of a duty of care to the patient... If those who undertake responsibility for the care of the incompetent... administer treatment which they believe to be appropriate... the lawfulness of that treatment should be judged by one standard, not two. It follows that if the professionals have acted with due care judged by the well-known standard in *Bolam* they should be immune from liability in trespass just as they are immune from liability in negligence."[19]

In *Re F,* the question arose whether F, a 35 year old patient in a mental hospital, with a mental capacity of four or five years old, should undergo a sterilisation to prevent her becoming pregnant. F was capable of, and apparently enjoyed, a sexual relationship, but in the opinion of both her mother and medical staff, she would be unable to comprehend either pregnancy or childbirth and would be totally incapable of caring for a child. Furthermore, the psychiatric consequences for F of her having a child would be "catastrophic". For medical reasons contraception was not a viable option.

In considering *Re F* the court took its lead from the sister case of *Re B*[20], where on facts essentially identical ,apart from the age of the patient, their Lordships held that in practising its wardship jurisdiction to determine medical treatment, the welfare of the minor in question is paramount, that welfare being equated with well-being or interests. However in contrast to B, F was an incompetent adult and thus in the absence of parens patriae jurisdiction, in order that F's doctor's might perform the proposed operation without that action being tortious or constituting a criminal battery, some lawful basis for such action was required. In the context of medical care, patient autonomy gives way to paternalism in circumstances of necessity (*Cresswell v Sirl)*[21]. However necessity would appear to be limited to such medical care as is required to safeguard the patient's life or immediate health, and would thus exclude the type of elective treatment to which a normal and prudent competent adult might choose to consent. Such elective treatment would include the type of treatment proposed for B and F viz. sterilisation. In examining the exception of emergency treatment, to the common law rule in *Collins v Wilcock*[22], Lord Donaldson observed:-

> "I do not think that the law does, or should regard adults who are in the position of F simply as permanent emergency cases. [A doctor] must act in the best interests of his patient as he sees them"[23]

Further, he said:-

> "the test to be applied was the same test which would be applied by any competent and reasonable adult to determine his own medical treatment, or by reasonable parents in relation to their child"

That test was:-

> "What course of action is best calculated to promote my true welfare and interests"[24]

In the House of Lords, Lord Goff endorsed this view and Lord Brandon elaborated on, and set the parameters of, the test of best interests by stating:-

> "The operation or other treatment will be in their best interests if, but only if, it is carried out in order either to save their lives, or to ensure improvement or prevent deterioration in their physical or mental health"[25]

The significance of the above statement is that it appears to preclude any considerations other than these (which clearly cannot be correct since that would also preclude all pain relieving measures). This would mean that, as is the case for some severely handicapped infants, and patients for whom further treatment is futile, and who are therefore allowed to die, if any proposed medical treatment can neither improve health, nor prevent deterioration , the best interests of the patient will not be served ,and further treatment therefore would be unlawful. However, even apart from these obvious omissions, this "therapeutic "test seems too restrictive to deal adequately with all considerations likely to be relevant in such cases as sterilisation, termination of pregnancy, or tissue donation (to siblings for instance).

Thus, for the adult incompetent patient, for whom no consent may be given, a doctor must act in the best interests of his patient . Furthermore, it is clear that whereas a competent patient is free to refuse treatment "for reasons which are rational, or irrational, or for no reason at all" (*Sidaway*[26]) — provided that the refusal has not been invalidated by a change of circumstance ,Re *T*)[27], in the case of an incompetent patient, the best interests test is dependent on the welfare of the patient in all the circumstances, and therefore includes a decision not to treat.

As will be explored later, it is significant to note that in the wake of*Re F* and *Bland*, what now constitutes best interests is by no means clear, since whereas the more logical approach favours a benefit/burden evaluation (CA in *Bland*), the other, employed also in *Bland* (HL) relies on the conferring of no benefit, (as determined by the doctors in charge- *Bolam.)* However, what is clear is that whereas best interest in some circumstances, notably neonates, would appear dependent on the "critical equation" of benefits and burdens, best interests in other circumstances appears to rest on futility. It falls to be determined the exact limitation of this exercise, who should perform it, and, if an equation is relevant, which factors may be considered and which should be excluded.

The Substituted Judgement Approach.

The substituted judgement approach has been adopted in some other common law jurisdictions, notably the USA, in order for the courts to determine the medical treatment afforded to adult incompetent patients. It is to be noted that unlike the present situation in the UK, most of the States in the USA, where substituted judgement is the norm in such cases, retain wardship jurisdiction in some circumstances in relation to adult incompetents. The essence of the doctrine of substituted judgement, is that a patient who is incompetent, is to be given such medical treatment as he would himself have chosen, had he been competent to do so. As such, the doctrine is essentially different from the "best interests" principle, in that the latter is an objective test whereas substituted judgement is as far as possible subjective, and may therefore be considered as upholding the right of personal autonomy better than does the best interests principle. Thus, just as a competent patient has the right to refuse treatment for no rational reason, but merely on his own preference, so, by employing the substituted judgement principle, may the presumed actual, wishes of an incompetent patient be followed, (provided that those wishes can be ascertained).

The origins of the doctrine may be found in English trust law in the area of the administration of the estate of an incompetent person, and in particular the early nineteenth century case of *Ex Parte Whitbread In Re Hinde*[28]. The doctrine was utilised to authorise a gift from the estate of a Lunatic (sic) in circumstances where the incompetent owed no duty to support the donee. The court in considering such gifts, set out the principle by which the court must act in sanctioning gifts by incompetent donors in these circumstances, and accomplished the purpose by substituting itself as nearly as possible for the incompetent, and acting on the same motives and considerations as would have moved him, Lord Eldon L.C. said the court should:-

"[apply] the property... in such a manner as the court thinks it would have been wise and prudent of the lunatic himself to apply it, in case he had been capable"[29]

Thus the English court, in making the substituted judgement, did so on the basis of a "reasonable man" test which imbues the subjective decision in the doctrine with an element of paternalistic objectivity, which rather defeats the object of the exercise, and appears to equate more with a best interest approach than a true substituted judgement. However, in theory the doctrine in its inception called upon the court to "don the mental mantle of the incompetent" as was stated in the American case of *In Re Carson* 39 Misc.

2d. 544, but whereas in the medical context, the English courts have subsumed an incompetent individual's right to self determination within the best interests doctrine, the American courts have attempted to retain self determination by the incompetent, by the substituted judgement doctrine of English trust law.

However, it is not altogether clear what the substituted judgement should be, since there does appear to be some confusion as to whether it should reflect actual or supposed "reasonable" wishes ,and there is a clear distinction between those incompetents who are able to express wishes and those unable to do so.

The Alberta Report describes the test as:

> "An attempt... to ascertain the mentally incompetent person's actual preference"[30]

The American *courts* on the other hand have clearly decided cases on the basis of what the incompetent *would have* decided if sane, rather than an actual preference, which rather begs the question as to whether the incompetent would have made an irrational decision even if sane, or if it must be assumed that, with the benefit of sanity, his decision would be more likely to be rational.

It may be of interest to note that in the context of the variation of trusts, in*Re C. L.*[31] , the English court took the view that the mentally incompetent beneficiary's wishes were considered purely on the basis of what she would have wanted if sane. However since it is in the American courts that in the context of medical treatment the doctrine has been developed, it is to those courts that we must look both for the underlying principles, and for the criteria on which to ascertain the wishes of the particular incompetent.

In America, the doctrine has developed largely in the context of terminally ill patients although it has found application in decisions on behalf of the mentally incompetent whether to undergo or forego medical treatment. However substituted judgement has been employed in the context of some of the more controversial medical procedures such as sterilisation and organ donation (*Strunk v Strunk*)[32].

In some early US cases then, the principle of substituted judgement was considered the appropriate method of upholding the constitutional rights of the mentally incompetent. However, the paradigm case for its use as regards comatose patients that is patients who had once been competent, is the case of *Quinlan*[33].

At the age of twenty-one Karen Quinlan suffered two episodes of respiratory failure as the result of which she suffered extensive brain damage and was placed on a respirator. She was later diagnosed as being in PVS with no reasonable hope of recovery to a cognitive and sapient state, and her father, as her official guardian, applied to the court for authorisation to withdraw the artificial ventilation on the basis that this was what Karen herself would have wished. It was the unanimous opinion of her doctors that Karen would die if she was taken off the respirator. The court nonetheless held that the constitutional right of privacy which would allow refusal of medical treatment, was not lost on incompetency, and could be exercised by a guardian on behalf of the incompetent. Thus, in the present case, subject to certain conditions, Karen's father could assert this right so as to have artificial ventilation withdrawn. The conditions to be satisfied were firstly, that the doctors in charge of Karen and the Hospital Ethics Committee were in agreement that there was no reasonable possibility of a return to a cognitive and sapient state, and secondly, that the doctors agreed with the father and family in the proposed course of action.[34]

Two points are significant. Firstly, the criteria apply only to comatose patients (PVS) and secondly, the agreement of the Ethics Committee pertains solely to the medical prognosis, and not to the decision to withdraw.

Thus, *Quinlan* dealt specifically with patients in persistent vegetative state and although the question of whether the principles set out in that case might be applicable for patients suffering similar types of terminal medical situations was mooted, at that time the issues were not addressed.

However, a few months after *Quinlan,* suitability of the use of substituted judgement in the case of those incompetents who unlike Karen Quinlan had never been competent was explored in the case of *Saikewicz*[35].

In *Saikewicz* the question arose as to whether to administer life-saving chemotherapy to a mentally incompetent cancer patient. Unlike Karen Quinlan, Joseph Saikewicz lacked the capacity either to understand his predicament, or to express a view as to his treatment. Whilst reaffirming the substituted judgement approach, the court conceded that for the never competent adult, greater reliance must be placed on more objective criteria. Thus American courts continued to pay lip service to substituted judgement whilst at the same time shifting the emphasis to that of the reasonable man test. However seven years after *Saikewicz,* the courts recognised the limitations of the

substituted judgements approach, and in *Conroy*[36] set out the criteria for not employing it in some circumstances. Claire Conroy was in the category of patients who had once been incompetent, but whose competence had been lost permanently. The courts reaffirmed the doctrine of substituted judgement and rejected the "reasonable man" test.

> "the question is not what a reasonable or average man would have chosen... but what the particular patient would have done if able to choose for himself"[37]

However, the court added that the patient's intentions must be evidenced clearly, and that in the absence of adequate proof, the subjective test must give way to a more objective approach. To this end the Court set out the three *Conroy* tests to be employed in decision making for the withdrawal of life-sustaining treatment. These are:-

1. The subjective test — when it is clear that the patient would have refused treatment.
2. The limited objective test — where there is no clear unequivocal expression of wishes prior to incompetence, treatment may nonetheless be withdrawn if there is some trustworthy evidence that the patient would have refused treatment AND it is clear that the burden of pain and suffering of continued life with the treatment outweighs the benefits of that treatment.

The court added:-

> "by this we mean that the patient is suffering, and will continue to suffer, unavoidable pain throughout the expected duration of his life"[38]

3. The objective test — where the pain and suffering of life with the treatment *clearly* and *markedly* outweigh the benefits, AND, the patient is suffering so much pain that the prolonging of life is inhumane.

The objective test is clearly most like the best interests test in English law. Although the decision in *Conroy* was limited expressly to nursing home patients in PVS whose life expectancy is less than one year, two additional points may be made. Firstly, pain appears to have been the critical factor in the second and third tests, and secondly, where no actual choice can be determined, resort must be had to the "best interest" of the patient. Thus although the court in *Conroy* still paid lip service to the doctrine of substituted judgement, in reality, the third *Conroy* test differs little from the English test.

A trilogy of cases decided on the same day in 1987 add a further gloss to the doctrine of substituted judgement as it applies in the USA. In the cases of *Re Jobes*[39], *Re Peter*[40] and *Re Farrell*[41], the court formulated guidelines and procedures under which life-sustaining treatment may be withdrawn in circumstances where the limitations of *Conroy* do not exist. In *Farrell* the court merely confirmed the right of a competent patient to refuse treatment. In *Peter*, the court was asked to determine which, if any, of the *Conroy* tests was applicable in the case of a patient with *PVS* who was not expected to die within a year. The court held that since it is impossible to assess benefits and burdens for such a patient, neither the subjective, nor the limited objective tests are applicable, and the court must look "primarily to *Quinlan*" for guidance [a reasonable possibility of a return to a cognitive state][42]. However, where, as in the present case, there is clear evidence of the patient`s previously expressed wishes, the first, subjective test is the first recourse. In *Jobes* there was no such evidence. Judge Handler declared that although the substituted judgement approach is the ideal, in some cases it is unworkable, and as regards the never competent, is inapplicable, and that therefore the courts must look to more objective factors such as "age, terminal illness, imminent death and the extent of bodily intrusion and consequent lost of personal dignity".

Several, more recent cases have added further to the resile from substituted judgement. In *Storar*[43], the court overruled a proxy decision not to administer a life-saving blood transfusion to a never competent patient on the grounds that such decisions should not be made merely by a close relative feeling that "this is best"[44]. In *Cruzan*[45], even the first *Conroy* test was called into question when, in the face of clear evidence of previously expressed wishes, the US Supreme Court upheld a decision of the Supreme Court of Missouri that the State of Missouri could dictate the degree of evidence required. In *Moorhouse*[46], the court followed *Jobes*[47] and, in considering withdrawal of treatment for a never competent patient, focused on best interests.

Thus it would appear that in the American courts, the doctrine of substituted judgement must now sit alongside the principle of best interests, which corresponds for the most part to the best interests tests employed by the English courts. However, in contrast to the English courts, the American courts will still look first to clear and convincing evidence of the patient`s wishes expressed when competent ,(subject to State requirements) ,but in the absence of such evidence, recourse must be had to a test of best interests.

Best Interests v Substituted Judgement

Both the doctrine of substituted judgement and the best interests test have advantages and drawbacks. The main advantage of substituted judgement is that, where the proxy is sure, (and has sufficient evidence to prove), what the incompetent would have wished, the proxy decision will approximate the patient's wishes more so than a best interests decision, which presupposes that those wishes would be those of"the reasonable man" (or more at present likely, those of the doctor).

However, the best interests test has the advantage of certainty in that whereas substituted judgement can never be certain what the patient's wishes would be in the present situation. If competent, the best interests test is determined by the certain view of the decision maker as to what *he* considers are the best interests of the patient under the present circumstances.

Criticism may be levelled at both the substituted judgement, and best interests approaches. the former chiefly on the grounds of uncertainty, the latter because it inclines to outmoded medical paternalism. The doctrine of substituted judgement requires clear and convincing evidence of the incompetent's wishes, but no matter how much evidence we have or how well the surrogate thought he knew the patient's wishes, there will always be some doubt. In many cases this doubt may be minimal. but as the certainly diminishes other factors weigh more heavily in the decision making process. Furthermore, whilst a close family member or friend may usually be relied on to make an honest appraisal of what the surrogate, supposes the patient would wish, there is no guarantee that all seemingly close relatives would be so altruistic. Even where there is incontrovertible evidence of the incompetent's wishes, there remains some doubt as to its validity. Mrs. Farrell made her decision on her own initiative, when she was of sound mind, and neither clinically depressed, nor under the undue influence of third parties. How often could one be so sure? A further argument may be levelled against proxy decision-making, in that whilst it is impossible to ascertain the present desires of a patient in PVS, other incompetents may be able to express an opinion, and therefore, is it right that the incompetent should be subject to the decision of the proxy, especially if, like Mr. Storar, the lifesaving measure proposed is unlikely to cause more than minimal distress?

In addition to these disadvantages, substituted judgement suffers the obvious drawbacks of being purely a fiction where the patient never has been competent, and unworkable where the patient has no-one who is sufficiently close to the patient as to be able to know what he would have wished.

The drawbacks of the best interests test are clear. Unlike the substituted judgement approach, it relies not on a principle of patient autonomy and self determination. but on the paternalistic premise that some other person knows what is best. Since, in the field of medicine, no less than in any other area, there are legitimate differences of opinion, deciding in the patient's best interests is no more than deciding what the doctor himself *thinks* are his best interests, particularly if *Bolam* is the determinative test.

However, whereas the doctrine of substituted judgement is open to abuse only by the evil intent of the surrogate, the best interest approach holds an insidious but far greater danger. The best interests test opens the way to abuse, not as a result of evil intent, but simply by extension from withdrawing treatment in the best interests of the patient, to giving treatment in, what the decision maker considers are his best interests, even if that will end his life. As Judge Pollock observed in *Jobes*:-

> "We must be aware of the slippery slope that could lead to the unwarranted termination of life"[48]

It appears then, that although the substituted judgement approach has been eschewed by the English courts, and the best interests approach allowed only a supporting role in the USA, the best interests test does seem to be gaining ground, if only in those cases where to employ surrogate decision making is a fiction. Furthermore, whereas the best interests approach can accommodate an element of substituted judgement by taking into account the known, or even supposed views of the patient, in circumstances where the substituted judgement approach is either unworkable or inapplicable, it must give way to the objective best interests approach.,

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[1] *Sub. nom. F v West Berkshire Health Authority* [1989] 2 All ER.

[2] Or since The Children Act 1989, by person(s) with parental responsibility.

[3] This issue is discussed more fully in Chapter 5.

[4] *Re J (A Minor) (wardship: medical treatment)* [1990] 3 All ER 930

[5] *Reg v Arthur* (unreported) 5 November 1981.

[6] *Re B (A Minor) (medical treatment)* (1981) [1990] 3All ER 927

[7] *Re C* [1989] 2 All ER 782

8 *Re J (a minor) (Child in Care:Medical Treatment)* [1992] 4 All ER 614.

9 (unreported) 5 November 1981.

10 *Re C* [1989] 2 All ER 782.

11 *Re J (a minor) (wardship; medical treatment)* [1990] 3 All ER.

12 *Ibid* at 931.

13 *Re B (A Minor) (Wardship: Sterilisation)* [1988] AC 199

14 *Re F (Mental Patient) (Sterilisation)* [1989] 2 All ER 545

15 *Gillick v West Norfolk and Wisbech Area Health Authority* [1986]

16 [1988] A.C. 202

17 *Ibid.* at 207

18 [1990] 2 A.C. at 1

19 *Ibid.* at 52

20 [1988] AC 199

21 *Cresswell v Sirl* [1948] 1 KB 241

22 *Collins vWilcock* -any intentionl touching is a battery

23 [1990] 2 A.C at 17

24 *Ibid. at 18.*

25 [1990] 2 A.C at 55.

26 [1986] 2 All ER 440

27 *Re T: Refusal of Treatment* [1992] 4All ER 649 — Prior refusal of blood transfusion — the court decided that had the patient been competent to consent at the time, the material change in circumstances would have elicited consent.

28 Ex Parte Whitbread, In *Re Hinde* 9 (1816) 2 Mer. 99.878

29 *Ibid. 849*

30 Alberta Report. 1988. Sterilisation Decisions: Minors and Mentally Incompetent Adults

31 *Re C.L* (1969) 1 Ch 587.-variation of trust held fora mentally retared adult aproved on the`basis that the proposed variationwouldhave been what the beneficiary wuld have wanted if sane

32 Strunk v Strunk 445 S.W 2d. 145 (KY. Ct App. 1969) — the removal of a kidney from an incompetent patient in order to effectuate a transplant to a person with whom the donor had a special relationship. The court concluded that both parties would benefit from the transplant, and could thus presume that the incompetent would, if competent, consent.

33 *In the matter of Karen Quinlan, an Alleged Incompetent* 70 N.J 10.

34 In the USA it is usual for a Hospital or Nursing Home to have an Ethics Committee

35 *Superintendent of Belchertown State School and Aother v Joseph Saikewicz* 373 Mass. 728.

36 *In the Matter of Claire Conroy* (1985) 486 A.2d 1209

37 *Ibid* at 1229.

38 *Ibid.* at 1231

39 *Re Jobes* (1987), 529 A, 2d 43A.

40 *Re Peter* (1987) 528 A 2d 419.

41 *Re Farrell* (1987) 529 A 2d. 404

42 *Re Peter* (1987) 528 A 2d, 419

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43 *In Re Storar* 52 NY 2d 363 — the court overturned a proxy decision made by the family of a never competent cancer patient that he should not be given a blood transfusion

44 *Ibid at 382.*

45 *Cruzan v Director, Missouri dept. of Health* (1990) 497 US

46 Re *Moorhouse* (1991)593 A 2d.1256

47 *Re Jobes* (1987) 528 A. 2d 434

48 *Ibid* at 462.

4. The Decision In *Bland*

Albeit on narrow legalistic grounds, the House of Lords in *Bland*, came to the conclusion that it may not be unlawful to discontinue treatment, including artificial nutrition and hydration (ANH), given to a permanently insensate patient, even though the result of such withdrawal would be the death of that patient. In a unanimous ruling, their Lordships held that where a doctor, acting in accordance with a responsible body of medical opinion, reaches a reasonable view that continued invasive treatment would no longer be in his patient's best interests, medical treatment, including ANH may lawfully be discontinued. In his leading judgement, Lord Goff elucidated the legal issues raised, but emphasised that the case itself was determined on its own particular facts. Nonetheless it is apparent that in cases which are four square with *Bland,* such discontinuation will be lawful. However, not only does the case of *Bland* itself raise serious legal anomalies, but any extension of the principle to like cases would drive a coach and horses through the present prohibition on passive euthanasia, and could open the door even to active euthanasia. As it happens the expected rush of cases through the courts has not happened, but the determination of those few cases which have been decided, has done nothing to reduce those fears.

If Anthony Bland had left clear instructions that should he find himself in the circumstances which prevail he did not wish to receive ANH, *Sidaway*[1] determines that those wishes must be respected, always bearing in mind the restriction on *Sidaway* placed by *Re T*[2].

If Anthony Bland had been a child and ward of court, the decision in *Re B* [1988][3], would have facilitated treatment in his best interests. Now *Re F*[4] allows acting in the patient's best interest to apply to adult incompetents also. However *Re J*[5] suggests that where continued life will be one of intolerable pain and deprivation, it is right to balance those factors against that of prolonging life, and thus medical treatment may be withheld. Clearly, since he had neither sapience nor cognisance, Anthony Bland could not suffer and thus did not fall into the *Re J* category, and the courts fell back on the decision in *Re F* and the test of best interests. However, in coming to the decision that it was not in Anthony's best interests to continue treatment, there appears more than a little discrepancy in the bases for that decision, both between the reasoning of the lower courts and the House of Lords, and between their Lordships themselves

The High Court Decision

The High Court Judge, Sir Stephen Brown P., was asked by the plaintiffs (the Trust Hospital), to make declarations to the effect that the physicians in charge of AB might lawfully discontinue all life sustaining measures intended to keep AB alive. and that thereafter need furnish only such treatment designed to allow AB to:-

> "end his life and die peacefully with the greatest dignity, and with the least pain suffering and distress":[6]

In agreeing to those applications, Sir Stephen Brown P, appears to base his decision on three propositions; Futility, the *Bolam* test, and the best interests test of *Re F*, together with the concurrence of Anthony Bland's family in that continued medical treatment would be of no benefit to AB, and that its withdrawal would be in accordance with good medical practice.

The Court of Appeal Decision.

In the Court of Appeal, Sir Thomas Bingham MR, Butler-Sloss, and Hoffman LJJ, were unanimous in their view that the test to be applied was that of best interests of *Re F*, and in their conclusion, that AB's best interests lay in discontinuing treatment. All accepted that the balancing test in *Re J*[7] was apposite notwithstanding that in that case the court was acting in its parens patriae jurisdiction, and notwithstanding also, that since AB was permanently insensate, the factors to be taken into account in *Re J,* that is a life of intolerable suffering and deprivation, were absent. However, all three judges averred that even in the case of a patient such as AB, there were factors which could rightly be taken into account to balance against the principle of the sanctity of life, which militates in favour of continuing treatment. Butler-Sloss, whilst firmly excluding the application of substituted judgement employed in some other common law jurisdictions, cited the cases of *Cruzan*[8] and The case of Baby Jane Doe[9] to give weight to the argument for widening the factors to be considered, and included the rights to be well remembered and to avoid unnecessary invasions of the body amongst them. Hoffman however, made clear that in his opinion in the present case any basis of (a life not worth living, should be rejected). He declared:-

> "There is no question of his life being worth living or not being worth living because the stark reality is that Anthony Bland is not living a life at all"[10]

Re Acts and Omissions

None of the judges in the Court of Appeal considered the act/omission dichotomy of much relevance. Sir Thomas Bingham was silent on the issue; Hoffman LJ thought the distinction was not between acts and omissions, but between an act *or* omission which allows an existing cause to operate, and the introduction of an external agency of death[11], and in Lord Justice Butler-Sloss" view there was no unlawful act either of commission or omission which required the issue to be debated[12].

Re *Bolam*

All three judges included *Bolam* in their argument, although, unlike their Lordships when the case came to the House of Lords, none considered it determinative. The opinions of the judges at the Court of Appeal as to the applicability of *Bolam* in such cases differed somewhat. Sir Thomas Bingham merely accepted its relevance, Lord Justice Butler-Sloss considered that *Bolam* alone was insufficient to determine issues of futility, and that some monitoring of the medical decision is required[13]. Whilst accepting that a doctor's view is relevant, Hoffman L J registered concern that *Bolam* should be the test in "live or die" decisions[14]. What is most significant about the views of the court of Appeal, is the marked reservations about the use of *Bolam* expressed in two of the judgements here, in contrast to the ready acceptance of its relevance, indeed determinative nature, expressed in the House of Lords. The relevance of *Bolam* is considered more fully in Chapter 5.

Re ANH and Medical Treatment

In the Court of Appeal, none of the judges draw any distinction between ANH and medical treatment, relying on the "wealth of medical expertise", (Butler-Sloss)[15], "Overwhelming consensus" (Bingham)[16], that ANH is included in medical treatment, but Hoffman does draw a clear distinction between ANH and feeding in the normal manner declaring the latter part of the basic obligation of care. However Hoffman also concedes that although ordinarily, to deny the provision of food is to cause suffering and death, here it is justified since AB is insensate and " his condition is such that he should be allowed to die"[17]. Furthermore he makes it very clear that in his view the decision to allow the discontinuance of treatment in *Bland* creates no precedent for future decisions, and he expresses reservations by posing the question of whether it can ever be right to

cause the death of a human being by depriving him of food. A fuller discussion regarding the nature of ANH is undertaken in Chapter 6.

In their unanimous decision, the members of the Court of Appeal base their decision firmly on the best interests tests of *Re F*[18] with some reference to *Re J*[19]. However, in the absence of a prognosis of suffering and deprivation, extend the factors to be considered in assessing what a patient in PVS's best interests are. They concluded that in this case they were best served by discontinuing AB's treatment. None, however went so far as to suggest that it would be unlawful to continue.

The House of Lords

The Decision

Their Lordships were unanimous in their decision, but not in the details of their reasoning.

Lord Goff

In his leading judgement, Lord Goff made clear the narrow grounds of his decision and emphasised that it would be for Parliament and not the courts to provide the framework for any extension of law in this area. Lord Goff started by reiterating the law relating to medical treatment, in that the principle that a person of sound mind may refuse treatment extends the refusal of life sustaining treatment (*Nancy B v Hotel - Dieu de Quebec*[20]*)*, and also to prior refusal (subject to the rule in *Re T*[21]) — which clarifies the legal position of advance directives in English law, and appears to throw doubt on the decision in *Re S*[22]. However, neither of these cases covers the issues in *Bland* where AB had not previously made, and could not now, make any decision as to his care, and Lord Goff agreed that the court must look at the best interests rule in *Re F*[23]. His Lordship went on to observe that although there is no absolute obligation to prolong life regardless of circumstances, there remains nevertheless a clear distinction between taking active steps to bring about death, and a lawful failure to treat, the former being to "cross the Rubicon" of the prohibition on taking life (See *Cox* unreported[24]).

Lord Goff agreed also that the best interests test extends to decisions to initiate or continue life sustaining treatment, but observed that, in these circumstances:-

> "the question is not whether it is in the best interests of the patient that he should die. The question is whether it is in the best interests of the patient that his life should be prolonged by the continuance of this form of medical treatment or care"[25]

Lord Goff avers that put like this, the question can sensibly be answered, but even so he goes on to make a distinction between two categories of patient; viz. those for whom some balancing of benefit and burden can be carried out because they have the capacity to experience some quality of life thereafter, and those patients like AB, for whom no balancing evaluation can sensibly be carried out because the patient is permanently insensate. It might be lawful to withdraw treatment for the former sensate patient on the basis of the decision in *Re J*[26]. but where the patient is unconscious, and with no hope of recovery, medical treatment to prolong life for no therapeutic purpose is futile and inappropriate. His Lordship adds that in such a case, account should be taken of the distress caused to relatives by the invasiveness of the treatment and indignity to the patient, but:-

> "it is the futility of the treatment which justifies termination" [27]

Lord Goff then, upholds the decision of the lower courts in declaring withdrawal lawful but appears to go very much further in stating:-

> "if the justification for treating a patient who lacks the capacity to consent lies in the fact that the treatment is provided in his best interests, it must follow that the treatment may, and indeed ultimately should, be discontinued when it is no longer in his best interests to provide it"[28]

Here then is the crux of their Lordships' decision: not only may the treatment lawfully be discontinued, but that *at some point, it must be.* (See Chapter 7)

Lord Keith of Kinkel

Lord Keith appears to base his decision, not so much on best interests, as futility, for as he observes, unlike the situation in *Re F*, where some benefit could be conferred, or in *Re J* where continued treatment would mean a life of pain and suffering,, to a patient in AB's condition:-

> "Whether he lives or dies is a matter of complete indifference"[29]

He therefore concluded that where a "large" body of informed and responsible medical opinion is to the effect that no benefit at all would be conferred by its continuance, and that continuance in a vegetative state with no prospect of recovery is by that opinion regarded as not being a benefit, there is no obligation to continue treatment[30].

Lord Lowry

Lord Lowry, in agreeing with the decision of his colleagues, endorsed Lord Goff's view that once the doctors have determined that it is no longer in the patient's best interests to undergo further treatment, in the absence of consent, which cannot be obtained, they are no longer entitled to continue treatment. His Lordship however, expressed concern that to a layman, the decision to discontinue artificial feeding might be seen as a decision to bring about AB's death because it would be in his best interests to die, rather than a decision that it would not be in his best interests, and therefore unlawful to continue treatment including artificial feeding[31].

Lord Browne-Wilkinson

Lord Browne-Wilkinson also agreed with his colleagues that following the decision in *Re F,* the right to administer invasive medical treatment to an incompetent adult patient, is wholly dependent on such care being in the best interests of the patient, and once it is no longer in his best interests, lack of consent renders continued intervention unlawful, and furthermore, that unless the doctor reaches a positive conclusion that it would be in the patient's best interests to continue treatment, that treatment must cease[32].

His Lordship however, went further than some, at least, of his colleagues in the role of the doctors in determining best interests, for whereas Lords Keith and Lowry averred that it is essentially for the doctors to determine best interests in accordance with a body/large body of informed medical opinion, but subject to the sanction of the court, Lord Browne-Wilkinson denied the court any role other than to be satisfied that the doctors in charge have followed the *Bolam* test[33]. Lord Browne-Wilkinson was clearly uneasy at the present state of law and declared it imperative that Parliament should consider the issues, for whilst he acknowledged that to sanction withdrawal of treatment is undoubtedly within the law, it may well appear irrational that although it is lawful to allow AB to die slowly (albeit without suffering himself, but causing added distress to his family), to produce immediate death by lethal injection, would not. To emphasise his

concern he made it clear that the decision had been reached on "narrow legalistic grounds which will provide no satisfactory basis for deciding cases not identical"[34], and that thus courts will be faced with cases where there may be slight chance of recovery or the patient slightly sensate. In addition. his Lordship expressed his concern at the many issues which fall to be addressed in the wake of *Bland.*

Lord Mustill

Lord Mustill admitted to having felt profound misgivings about almost every aspect of the case[35] and in particular as regards the present law covering the issues. He stated:-

> "By dismissing this appeal, I fear that your Lordships" House may only emphasise the distortion of a legal structure which is already morally and intellectually misshapen. Still, the law is there and we must take it as it stands"[36]

Strong words indeed.

In, agreeing with the conclusion of his colleague that the declaration of the lower court should stand, his Lordship did admit to some disagreement in the finer detail of how that conclusion had been reached. In addition he queried the acceptance to the lower courts that notwithstanding the decision in *Malcherek*[37] the doctrine of causation excludes the action by AB's doctors, and also raises squarely for the first time the issue of scarce resources and the "best interests" of the community. However, on the latter issue he conceded that that issue and the concomitant issue of mercy killing a *Re F* or Parliament alone to decide, but that "until the nettle is grasped, we must struggle on with the existing law, imperfect as it is"[38]

Lord Mustill employed a slightly different route to reach the conclusion reached by his colleagues, in that whilst they all relied on *Re F* to the extent that best interests provides the justification for medical treatment, and that when it was no longer in AB's best interests to continue treatment that justification (which is in lieu of consent) was vitiated. His Lordship failed to take the next step of saying that treatment should stop, but he averred merely that the duty to provide it had ceased and absent that duty, an omission is not culpable. For Lord Mustill alone was the distinction between acts and omissions "crucial". However in taking this line of argument, he came to a slightly different conclusion; He accepted that the withdrawal of treatment is an omission, and he further accepted that AB's best interests were not that he should die, but where he differed significantly from his colleagues was that whereas they conceded that AB's best interests lay in not continuing with invasive treatment, Lord Mustill stated baldly that the proposed

conduct could not be in his best interests, "for he has no best interests of any kind", and thus since both his best interests in being kept alive and in having his life terminated had disappeared, both the justification for treatment, and the correlative duty to AB had also disappeared. Thus he rested his argument on the fact that since there was no longer a duty, an omission to perform what had previously been a duty could not be culpable: he was silent as to whether, in the absence of the justification to treat, treatment might lawfully be continued.

In reaching this decision, Lord Mustill did however voice reservations about "transferring the already morally and intellectually dubious distinction between acts and omissions into a context where the ethical foundations of the law are already open to question"[39], and although in the present case, he saw no difficulty in categorising the proposed conduct an omission, he warned that more borderline cases would inevitably create greater difficulties. In addition he also questioned the extension of the *Bolam* principle, and the resulting determinative role of the doctor, into an area of criminal law where the legality of a decision rests on ethical rather than medical opinion.

Thus, although in both the Court of Appeal and the House of Lords, the decision turned on best interests, whereas the former relies on some balancing of benefits and burdens to reach its conclusion, the latter denied any interests, and absent them the justification to continue invasive treatment. It appears then, that although their Lordships did uphold the legality of the proposed course of conduct to withdraw all medical treatment to AB, their justification was significantly different from that of the lower courts. However, all voiced concern at the deficiency of the present law in this area.

It is apparent that many issues were raised which merit further exploration but four are of particular concern;

1. The extension of *Bland*
2. The appropriateness of *Bolam* in life or death decisions. See Chapter 5.
3. Their Lordships' unquestioning acceptance that ANH is medical treatment and their evident reluctance to examine the difference between ANH and other forms of feeding. See Chapter 6.
4. Whether *Bland* is good law.

The Issues in *Bland*

Whilst their Lordships' deliberations in *Bland* have clarified the law within the narrow parameters of the judgement, in some other areas the decision has left the law less certain, and has raised more uncertainties. Some issues were not fully addressed. some issues were addressed but only to the extent of acceptance, and many issues were raised, which were rightly considered outside the forum of the court, and thus for which no answers were considered.

In short, this landmark decision poses as many questions as it answers and commentators have not been slow in voicing them.

Clarifications and Endorsements

Substituted Judgement

It seems unlikely that the doctrine of substituted judgement will find a place in English law outside the Court of Protection. It would appear that the door has been closed firmly against its use in the context of medical care although in a diluted sense consideration of what the patient would have wanted, might in some circumstances be included in the assessment of best interests.

In the court of Appeal, although Butler-Sloss L J appeared to dismiss substituted judgement out of hand as having no place in English law other than in the Court of Protection, Hoffman however conceded that the best interests test includes trying "our honest best to do what we think he would have chosen", and further:-

> "Best interests includes not only recovery of the avoidance of vain, but also a dignified death, and would normally include having respect paid to what seems most likely to have been his own views on the subject. To this extent, I think "substituted judgement" may be subsumed within the English concept of best interests"[40].

Hoffman, however was careful to point out that this principle excludes any positive act to end life which he condemns as assisting in suicide.

In the House of Lords, whilst three of their Lordships were silent on the issue, Lords Mustill and Goff did address it, but their views were not absolutely identical. Lord Goff expressly refuted that the principle of substituted judgement is part of English law in relation to consent to medical treatment for incompetent adults and the test to be

employed is that of best interests[41]. However, he then went on to say that "anything relevant to the application of the test (of best interests) may be taken into account", including apparently comfort accorded to the relatives of the patient by coming with what they, the relatives think the patient would have wished[42]. Perhaps Lord Goff allowed just a chink of substituted judgement here.

Lord Mustill in a rather contradictory, and somewhat confusing passage, also appeared to leave room for at least the possibility of employing a surrogate where a sentient patient is unable to communicate a present choice, but for a patient in PVS he declared "the idea is simply a fiction"[43].

It seems then, that notwithstanding the slight ambivalence of Lords Goff and Mustill, their vehement rejection of substituted judgement outweighs their rather timid and limited acceptance, and that for all intents and purposes, substituted judgement has been firmly excluded in this area of law.

Acts and Omissions

Here, their Lordships' deliberations did not so much clarify uncertainty in this area, as highlight the current unsatisfactory state of the law, and Lord Mustill in particular questioned the appropriateness of transferring the legal distinction to an area where, as he put it, "the ethical foundations of the law are already open to question"[44]. *Bland* brings to the fore the disquieting reality in that it apparently leaves us with a with a legal situation in which an act done with the intent to end a life is unlawful, but an omission with exactly the same intent is not. The position is unsustainable and merits further examination.

In *Bland*, in the Court of Appeal, Hoffman was of the opinion that the distinction was not so much between acts and omissions as between either an act *or* an omission which allows an underlying cause to operate. Butler-Sloss averred that there was no unlawful act or omission, thus implying the distinction irrelevant in the circumstances.

In the House of Lords, only Lord Mustill based his decision on the distinction between acts and omissions, but both at the Court of Appeal and in the House of Lords the relevance of the dichotomy was considered, and whilst not relying on the distinction as an integral part of their decision, several of their Lordships emphatically averred that withdrawal of ANH is an omission, so implying that at least the distinction played at least some part in their deliberations. Lord Goff stated that in his view, withdrawal of treatment is clearly an omission, and as such is not unlawful unless it constitutes a breach

of a duty, (the accepted doctrine). He went on to say that the distinction *is* useful in the present circumstances since it can be invoked to explain how a discontinuance of life support can be differentiated from ending a patient's life by lethal injection. However Lord Goff then added that in fact it is not the distinction between act and omission which confers immunity, but the fact that discontinuance may *be consistent* with the doctor's duty, whereas a deliberate act to bring about death, for "*reasons of policy*", (added emphasis), will not[45]. Thus Lord Goff reaffirmed the principle of immunity from liability in the case of an omission, save where there is a duty to act. Lord Browne-Wilkinson however, considered the matter in greater detail. He again confirmed the above principle but unlike his colleagues posited a novel defence to an omission in the face of a duty in the case of a doctor's duty to an incompetent patient. In his view, notwithstanding a duty to his patient. where the omission is to withhold treatment to which the patient because of his incapacity, is unable to give consent, and in the absence of any other person who can give consent on his behalf, that lack of consent confers a defence on a doctor, to an otherwise unlawful omission to act. However, it is difficult to reconcile this defence with the clear duty to act in the best interests of the patient where positive action is required. Unlike Lord Goff, his Lordship made no mention of any distinction between the liability of a positive act, and that of an omission in the face of a duty. However both related liability to the extent of the doctor's duty, on the one hand discontinuance may be the duty, (Goff), and on the other, in the absence of consent, the duty is to act, that is, to treat only when it is in the patient's best interests, (Browne-Wilkinson). Lord Goff said such treatment can never include a positive act to end life, but on this point Browne-Wilkinson was silent. Lord Mustill alone relied almost exclusively on the distinction between acts and omissions to sanction withdrawal, but admitted that the current state of law in this area is "unsatisfactory, both morally and intellectually"[46], and cited the troubling case of *R v Stone*[47], a case which attached liability in manslaughter to an omission to feed, even where there had been no acceptance of a duty, that duty being imposed on the basis of the relationship between the parties, which in that case appeared to be solely that of allowing an infirm relative to share the defendant's home. Lord Mustill admitted that there might be a distinction between an omission to act which brings about a state of affairs, and one which merely allows it to continue, but found the dividing line between a relationship which incurs a duty, and one which does not, is by no means clear. His Lordship also compared the essential facts of *Bland* and *R v Gibbins* and *Proctor*[48], and concluded that although ethically "miles apart", in both cases the death of a helpless individual was brought about by the intentional withholding of nourishment. Thus in contrast to his

colleagues, in Lord Mustill's view, it was because the duty to treat had come to an end with the abandonment of any hope of recovery, that the omission to treat (that is; withdrawal of ANH) no longer incurred liability. Lord Mustill's decision then rested squarely on the distinction between an act and an omission, but he was admittedly unhappy with the result, not least because in less clear cut circumstances it may be much harder to classify the proposed action as an omission and thus impossible to justify on these grounds.

It appears then, that although the distinction between acts and omissions may be hard to determine in the context of medical treatment, it remains the law that absent a duty to act, liability accrues only to a positive act.

The Role of The Courts

There is general agreement by their Lordships that for the time being, a declaration should be sought before ANH may be withdrawn from a patient in PVS. Thus as far as procedure is concerned the present position is clear. What is less clear, is whether best interests determined by a court using its parens patriae jurisdiction in the case of a minor, is likely to differ significantly from best interests as determined by a doctor, and sanctioned by the court using its inherent jurisdiction in the case of an incompetent adult.

The Legal Criterion of Death

Prior to *Bland*, although since *Malcherek*,[49] the implied criterion for determining death had been brain stem death, and the courts apparently content to accept the medical criterion, there had been no explicit ruling on the point. In *Bland*, Lord Goff stated categorically that since AB's brain stem had not been destroyed, he was in law alive[50], and in Lord Browne-Wilkinson's words, "his brain stem is alive and so is he"[51]. This ends any uncertainty as to the accepted legal criterion of death being brain stem death.

The Right to Refuse treatment

Post *Sidaway*[52] the law has recognised the right of a competent adult to refuse medical treatment, regardless of the reasonableness of that decision. The law in this area was slightly muddied by the decisions firstly in *Re T*[53], and more recently in the High Court decision in *Re S*[54]. In *Re T*, a pregnant patient, who had at one time been a devout Jehovah's Witness signed a consent form refusing blood transfusions. However, after undergoing an emergency caesarean section, her condition deteriorated to the extent that she required an immediate transfusion, which in the light of her express refusal, her

doctors felt unable to give without the sanction of the court. On application by her father and boyfriend. Ward J gave that sanctions decision which the Court of Appeal subsequently upheld. Lord Donaldson agreed that *prima facie* every adult has the right to refuse medical treatment, but that that right was rebuttable either by long term incapacity, or by temporary incapacity due to factors such as unconsciousness, confusion or the effects of shock, fatigue, pain or duress, and further, that it was the capacity of the patient at the time the decision was made which was material as to whether refusal was vitiated. Couched in such wide terms, this rebuttal appears to threaten the principle of self determination on which the right of refusal is founded. This autonomy was further weakened by the extraordinary decision in *Re S* which appeared to confirm a possible exception to the right of refusal identified by Lord Donaldson in R*e T* viz. the rebuttal of that right for a woman, the life of whose viable foetus is at risk.

In *Re S* Sir Stephen Brown P overrode the decision made by a thirty year old patient in labour to refuse surgical intervention. The court held that where the lives of both the mother and unborn child are at risk a court may sanction such treatment notwithstanding the refusal of consent. Sir Stephen Brown P appears to have relied heavily on the possible exception, left open by Lord Donaldson in Re *T*, and also in passing on the American case of *In re AC*[55]. Although the urgency of the decision precluded lengthy deliberation, (from initial application to determination taking a mere 48 minutes), the "desperate nature" of the circumstances appeared to have resulted in a decision which drove a coach and horses through the English law of consent, not least because the patient herself was given no opportunity to be heard, and neither were any of the vitiations highlighted in *Re T* called in aid. Thus it appeared that even absent any vitiation of refusal, where the life of an unborn child was at stake, albeit only as regards a viable foetus, the mother's wishes could be overridden with impunity. However, five months later in *Bland,* their Lordships, with the exception of Lord Lowry, clearly and decisively reiterated the right of a competent adult to refuse treatment, and furthermore that that right extends to the right to refuse life saving treatment even when the patient is suffering a disease which providing the present medical regime is continued, is not immediately life threatening, citing with approval the Canadian case of *Nancy B v Hotel- Dieu de Quebec*[56].

Thus since no exceptions other than those of incapacity at the time of the decision, were admitted in *Bland*, and the possible exception of *Re S* was not referred to, it appears that for a competent adult, the right of refusal of medical treatment is restored in its entirety. However, although the position is clear as regards medical treatment itself, it

seems unlikely that public policy would allow discontinuance of basic nursing care of a patient unable to care for himself, and since such care undoubtedly would include feeding, the question as regards ANH must be debatable Chapter 6.

Anticipatory Refusals

In addition to clarifying the law relating to the right to refuse treatment, the House of Lords also endorse the Court of Appeal's view in *Re T* that the right to refuse medical treatment also extends to anticipatory decisions. In *Re T* the Court of Appeal had determined not only that provided it is not vitiated, a competent adult has the right of refusal which extends to life-saving treatment, but also that provided certain conditions pertain, anticipatory refusals are also valid. Those conditions are similar to those which prevent vitiation of present consent; viz. competence on the part of the patient, the absence of undue influence at the time the decision is made, and a medical situation which correlates to that which has been anticipated. Obviously if complete exactitude of anticipation were the criterion of a valid refusal, few if any would pass the test, so robbing the patient of his right to refuse and thus the Court of Appeal made clear that provided the patient is made aware of the consequences of refusal of treatment in the type of situation anticipated, refusal will not be vitiated for want of specific medical details.

In *Bland*, only Lords Mustill, Goff and Keith addressed this particular issue, Lord Goff cited with approval *Re T,* but observed that especial care must be taken to ensure that the prior refusal is still properly applicable,[57] and Lord Keith endorsed this view, adding that a person is "at complete liberty to decline to undergo treatment",[58] and that choice extends to prior refusal, provided that he has given "clear instructions" relating to the eventuality. It seems then that the legality of prior refusal can no longer be in any doubt and in recognition of this the Government asked the House of Lords Select Committee on Medical Ethics to look at, *inter alia,* the practicalities of documentary advance directives.[59] The Law Commission has included a draft Bill, which contains provision for advance directives, in its recent recommendations regarding medical treatment for the mentally incapacitated[60]. The acceptance of advance directives as legally binding has been affirmed in the first instance decision in *Re C (Refusal of medical treatment) [1994]*[61], in which the High Court upheld the right of an adult schizophrenic to make a refusal as regards amputation, at the present, and against possible amputation at any time in the future.

Notwithstanding the above clarifications, the decision in *Bland* has left some areas of the law in even greater uncertainty. Quite apart from these legal uncertainties, the decision in *Bland,* has brought to the forefront social and ethical issues which cry out for wider and deeper discussion in an arena outside that of the courts of law. However, here it is intended to concentrate on only four areas of concerns. Firstly, the extension of *Bland,* secondly, the relevance of *Bolam* in the determination of best interests, thirdly, the legal and moral significance of the distinction between artificial nutrition and basic care, and lastly, whether the decision in *Bland* is correct.

The Extension of *Bland*

In the leading judgement in The House of Lords, Lord Goff clearly indicated the narrow parameters of the Judgement, and Lords Mustill and Browne-Wilkinson went further in doubting the applicability of *Bland* in any other case. However, although the expected flurry of cases reaching the Courts has not materialised, the few cases which have arisen have illustrated some of the shortcoming in *Bland*, and have belied the narrowness of that decision. In particular, the worrying case of *Frenchay*[62] has highlighted fears of a much wider application of *Bland* than their Lordships had appeared to anticipate. The case raised two major concerns. Firstly there was some doubt as to the diagnosis of PVS, and secondly there seemed an unnecessary haste in making the decision. In *Frenchay*, the Court was asked, as a matter of urgency to sanction the non-replacement of a gastrostomy tube used to deliver ANH to a patient who was purported to be in PVS, after it had become dislodged. Apparently it was not medically practical merely to reinsert the tube and replacement therefore would have required a surgical operation. The doctors decided that this would not be in the patient's best interests and sought a declaration from the Court to this effect. The Application was opposed on the grounds that the diagnosis was uncertain. and that the procedures set out in *Bland* had not been followed in that the apparent urgency of the application had precluded a full investigation of the facts and opportunity to obtain independent medical opinions.

The patient S had suffered from oxygen starvation after he had taken a massive overdose of drugs. He had never regained consciousness and remained comatose. As regards the diagnosis of PVS, there must have been at least some doubt since although S was kept heavily sedated, he still exhibited some degree of sentience it not cognisance. Furthermore as evidence of some volitional behaviour, it was conceded that he might have pulled out the gastrostomy tube himself. However, the majority medical opinion was

that he was in PVS, although obviously in not such an extreme condition as Tony Bland. The extreme urgency of the application is open to question, for when the tube became dislodged, even though simple replacement apparently was not a viable option, other methods of ANH, or at least hydration must have been possible, as an interim measure to enable further enquiry. In *Bland* it was made clear that the decision rested on the extreme condition of AB, and doubts were expressed as to whether a similar judgement would be made in less severe cases of PVS. The Court nevertheless sanctioned the non-replacement of the tube, and S died some days later. Since the House of Lords expressly limited *Bland* to like circumstances it is difficult to see how *Bland* and *Frenchay* are on all fours. *Frenchay* cannot be merely an application of *Bland* — it must be an extension. As the first directly related case to come before the English courts in the wake of *Bland, Frenchay* shows such a significant departure from the narrow parameters of that case, that there must be cause for concern. If we can see *Bland* being diluted to encompass less extreme cases of PVS, where there is some, if only minimal consciousness, the alarm belle surely must alert us to the possibility of *Bland* being extended to cover any incompetent patient in receipt of ANH whose life is considered, (by doctors), to be "not worth living".

The Official Solicitor has issued a practice note with regard to applications to withdraw medical treatment from patients in PVS, which requires, *inter alia* that two independent medical reports must be made available to ensure a correct diagnosis, that the views of the relatives should be sought, and that there should be an adequate opportunity for the Official Solicitor to make a full investigation prior to the hearing[63].

However, the two further cases which have reached the courts appear to demand an unequivocal diagnosis of PVS as a prerequisite for withdrawal of treatment from a comatose patient. In *Re G*[64] the court was asked to sanction the removal of a gastrostomy tube from a patient who, eighteen months earlier had suffered severe brain injury. In contrast to *Frenchay*, here, all the medical evidence supported the view that G was in PVS. The issue at point was whether the view of a close relative, (here G's mother), that the withdrawal of artificial feeding was not in the patient's best interests, could outweigh that of doctor in charge, that it was. Sir Stephen Brown P held that since the doctor had taken account of the views of the relatives, (including G's wife and mother), in accordance with the BMA guidelines for the treatment of patients in PVS,[65] the Consultant Surgeon's decision to withdraw treatment could not be vetoed by those views.

In the second of the two cases, *Swindon and Marlborough NHS Trust v S*[66] the question arose as to whether to operate on a patient in PVS to reinsert a gastrostomy tube which had become dislodged. The diagnosis of PVS was in no doubt. The Court held that in treating a patient in PVS, a doctor acting in accordance with the BMA guidelines, will satisfy the *Bolam* test, and may continue to give such treatment as is appropriate, and furthermore, may discontinue life-sustaining measures when to do so would be in accordance with good medical practice. Thus it appears that, subject to *Bolam*, the doctor's decision is to be determinate. For further discussion on this point see Chapter 5.

It seems then, that notwithstanding *Frenchay*, the courts will require an unequivocal diagnosis of PVS, but that nevertheless there may be some "emergency cases", where time is of the essence, where the full requirements of the Practice Statement may yet be circumvented.

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1 *Sidaway v Govenor of Royal Bethlem Hospital* [1985] A.C.871

2 *Re T* [1992] 4 or ER - Refusal of medical treatment vitiated by a change in circumstance from that envisaged at the time of refusal.

3 *Re B (a minor) (wardship: sterilisation)* [1988] A C 199

4 *Re F (mental patient: sterilisation)* [1989] 2 All ER 545

5 *Re J (a minor) (wardship: medical treatment)* [1990] 3 All ER 931

6 [1993] 2 W L R . 320

7 *Re J* [1991] F am. 33

8 *Cruzan v Missouri Dept. of Health* (1990) 497 US at 281

9 *In The Guardianship of Jane Doe* (1992)583 N.E.2d 1263.

10 [1993] 2 W L R 316.

11 *Ibid at 356.*

12 *Ibid* at 349.

13 *Ibid* at 339.

14 *Ibid* at 358.

15 *Ibid.* at 343.

16 *Ibid* at 341.

17 *Ibid* at 357.

18 *Re F* [1989] 2 All ER 545.

19 *Re J* [1991] Fam 33.

20 *Nancy B v Hotel — Dieu de Quebec* (1992) 86 DLR (4th 385).

21 *Re T* [1992] 4 All ER 649 - Change of circumstance vitiates prior refusal.

22 *Re S (Adult: refusal of medical treatment)* [1992] All ER 671 - Caesarian section performed on a mother desite her refusal to the operation, in order to save thè life of her unborn child. Sir Stephen Brown P P, at first instance only.

23 *Re F* [1989] 2 All ER 545

24 *Reg. v Cox (unreported, 18 September 1992)* - the giving of a lethal injection which had no therapeutic purpose.

25 [1993] 2 WLR 371

26 [1991] Fam 33.

27 [1993] 2 WLR 372.

28 *Ibid 370*

29 *Ibid 361*

30 *Ibid 362*

31 *Ibid 379*

32 *Ibid 387.*

33 For further discussion on the relevance of *Bolam,* see Chapter 5

34 [1993] 2 WLR 387

35 *Ibid 400*

36 *Ibid 388*

37 *Reg. v Malcherek* [1981] 2 All ER 422

38 [1993] 2 WLR 397

39 [1993] 2 WLR 394

40 *Ibid 358*

41 *Ibid 374*

42 *Ibid 375*

43 *Ibid 396*

44 *Ibid 387-400*

45 *Ibid 369*

46 *Ibid 394*

47 *Reg. v Stone* [1977] QB 354

48 *Reg. v Gibbins and Proctor* (1918) 13Cr. App. Rep 134 — conviction for murder for intentional killing of a relative by means of starvation.

49 *Reg. v Malcherek* [1981] 2 All ER 422

50 [1993] 2 WLR 367

51 *Ibid 381*

52 *Sidaway* [1985] AC Appeal Court 871

53 *Re T* [1992] 4 All ER 649

54 *Re S* [1992] 4 All ER 671

55 *In Re AC* (1990) 573 A. 2d 1235, 1240

56 *Nancy B v Hotel — Dieu de Quebec* (1992) 86 DLR — The right of a patient suffering Guillain-Barre Syndrome, an incurable neurological disorder, which left her incapable of movement including breathing, but mentally unimpaired, to have life prolonging treatment discontinued).

57 [1992] 3 WLR 782

58 *Ibid 367*

59 Select Committee on Medical Ethics, House of Lords Report. London HMSO, 1994.

60 Law Commission. Mental Incapacity: Law. Com. No. 231 HMSO, 1995.

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61 *Re C (Refusal of medical treatment)* [1994] 1 FLR

62 *Frenchay Healthcare NHS Trust v S* [1994] 2All ER 403

63 The Official Solicitors Practice Note [1993] 3 All ER 222

64 *Re G* [1994] 21 November. (Steven Brown P)

65 Guidelines on Treatment Decisions for Patients in Persistent Vegetative State (1992)

66 *Swindon and Marlborough NHS Trust v S* (1994) 30 November, (Ward J)

5. The Relevance Of *Bolam*

The *Bolam* Test derives from the direction given by McNair J. to the jury in the case of *Bolam v Friern Hospital Management Committee*[1] to determine the standard of the duty of care owed to a patient by his doctor. It dictates that to defeat a claim for medical negligence, the medical practitioner must show that at the relevant time, some, however minor, responsible body of medical opinion, would have considered the given treatment appropriate. It is based on the recognition that there is ample scope for genuine differences of opinion between medical practitioners in the provision of suitable medical treatment. However, this legal standard, resting as it does solely on medical opinion. has engendered no little criticism in legal debate.

The issue at point in *Bolam* was whether a doctor had acted negligently[2]. It is important to note however, that the *Bolam* test is not confined to medical care alone, (*Gold v Haringey Health Authority*)[3], but is the general test of negligence relevant to the duty of care owed by a person professing some special skill, and who thus owes a particular standard of care, towards those persons for whom he has undertaken that duty.

In the medical context, *Bolam* defines a standard of care as adjudged by the medical profession alone below which standard negligence may be imputed. As such, the *Bolam* principle has been guarded jealously by the medical profession to absolve a defendant from a finding of negligence merely because he has acted in accordance with some medical practice accepted by some, albeit responsible, body of medical opinion. That absolution has been accepted by the courts; Lord Scarman for example has observed that the *Bolam* test :-

> "leaves the determination of a Legal duty to the judgement of doctors" *(Sidaway)*[4]

Nevertheless, the *Bolam* test has long been established as the test for medical negligence, and although in *Bolam* itself, the issue lay in the standard of care to be applied in determining medical treatment, the House of Lords has both approved the test again as regards treatment *(Whitehouse v Jordan)*[5], and also as regards diagnosis, *(Maynard v West Midlands RHA*[6]*)*, and disclosure of information, *(Sidaway)*[7].

More recently, in a rather curious decision, the Court of Appeal added issues of causation to that list *(Bolitho)*[8]. At first sight then, it does appear that since the mid-

eighties at any rate, the position in English law has been that as regards medical decisions across the board, providing that it can be supported by at least some responsible body of medical opinion, apparently however minor, a decision of the medical practitioner in charge cannot legally be challenged. However, notwithstanding the apparent ubiquitous acceptance of *Bolam* as the test for professional negligence, in more recent years, judicial opinion has expressed increasing reservations as to its determinative nature, and that opinion appears to have effected a growing groundswell away from *Bolam.* The question must be raised now whether *Bolam* is still the appropriate test in all, or any of the above areas, and for the present purposes, whether it should play any part in the best interests test, particularly where those interests may lie in the discontinuance of treatment.

The essential feature of the *Bolam* test is that it is a test for determining negligence, and as such is the measure by which a breach of duty can be established. However, although *Bolam* became the test for negligence over an increasing sphere of influence, the seeds of caution were sowed relatively early in this development. A brief examination of the landmark case of *Sidaway* illustrates the beginnings of dissent as to the applicability of *Bolam,* even in the field of negligence alone, to all aspects of medical liability.

In *Sidaway*[9] the House of Lords considered whether the *Bolam* test should be applied in cases of alleged negligence in providing sufficient information as regards proposed medical treatment However, notwithstanding the unanimous decision, there was far from unanimity as regards the role of *Bolam,* and examination of their Lordships' judgements reveal significant divergence of opinion. Lord Diplock considered *Bolam* the sole test, Lord Bridge, with whom Lord Keith agreed, considered it slightly less determinative, (to be decided primarily on the basis of medical evidence). Lord Templeman avoided discussing *Bolam* as such whilst accepting the relevance of current medical practice, seemed even less inclined to allow medical opinion to be the arbiter, and Lord Scarman rejected *Bolam* almost entirely as regards disclosure. He declared:-

> "I am satisfied that the trial judge and the Court of Appeal erred in law in holding that in a case where the alleged negligence is a failure to warn the patient of a risk inherent in the treatment proposed, the *Bolam* test is to be applied. In my view, the question whether or not the omission constitutes a breach of the doctor's duty of care towards his patient is to be determined not exclusively by reference to the current state of responsible and competent professional opinion and practice at the time, though both are of course relevant considerations"[10]

With reference to accepting Bolam as the appropriate test, he went on to say:-

> "The implications of this view are disturbing. It leaves the determination of a legal duty to the judgement of doctors."[11]

His Lordship preferred to draw on the transatlantic concept of the "prudent patient", as expounded in *Canterbury v Spence*[12] , and although he accepted that the doctrine of informed consent as such has at present no place in English law, to all intents and purposes, he advocated just that, and in doing so averred that it is for a court to determine whether a doctor has breached his duty, rather than concurrence or not with current medical opinion.

In contrast, Lord Diplock had no hesitation in relying as exclusively on *Bolam* in these circumstances as in those of treatment or diagnosis. He declared in *Sidaway*:-

> "no convincing reason has in my view been advanced before your Lordships that would justify treating the *Bolam* test as doing anything less than laying down a principle of English law that is comprehensive and applicable to every aspect of the duty of care owed by a doctor to his patient in the exercise of his healing functions as respects that patient"[13]

Furthermore, he firmly rejected any reliance on the doctrine of informed consent. Lords Bridge and Keith concurred, and Lord Bridge refuted Lord Scarman's assertion as to the determinative nature of medical opinion if *Bolam* is accepted as the appropriate test. He stated:-

> "whether nondisclosure in a particular case should be condemned as a breach of duty of care is an issue to be decided primarily on the basis of expert medical evidence, applying the *Bolam* test, but I do not see that this approach involves the necessity to hand over to the medical profession the entire question of the scope of the duty of disclosure"[14]

Since Lord Templeman used as his yardstick the "overriding duty to have regard to the best interests of the patient"[15], he appeared to have some reservations as to the determinative nature of a body of medical opinion.

It seems then, that as early as 1985 there was significant disagreement as to the blanket application of *Bolam* to cover all aspects of a doctor's duty of care. Furthermore, Lord Diplock, whilst making clear that no distinction is to be made between differing

categories of therapeutic care, may have intentionally or unwittingly placed a rider on *Bolam,* which may have implications for the present issue when he declared:-

> "no convincing reason has been advanced... that would justify treating the *Bolam* test as doing anything less than laying down a general principle of English law that is comprehensive and applicable to every aspect of the duty of care owed by a doctor to his patient *in the exercise of his healing functions* as respects that patient"[added emphasis][16]

Here then, whilst supporting the *Bolam* test as a general principle, his Lordship does add the phrase highlighted, which would significantly qualify the principle as regards measures which do not fall into that category, and which therefore would exclude decisions of discontinuance of treatment in situations where healing is not an option. However, this advances the argument little further, since in *Sidaway* the issue was still one of a breach of the duty of care, whereas the discontinuance of medical treatment clearly goes far beyond mere negligence. Later cases throw more light, but nonetheless it appears that the use of *Bolam* could have been curtailed at this early juncture so as to devolve decision making other than for therapeutic treatment, into a wider forum than medical opinion alone. However, since the House of Lords in *Sidaway* endorsed *Bolam,* it has remained the test, but it has come under increasing criticism as its inappropriateness has been explored in later cases, both in the English courts and in other common law jurisdictions.

In *Rogers v Whitaker*[17] in 1992 the High Court of Australia resoundingly refuted *Bolam* as the test for negligence as regards disclosure. Both at the Supreme Court of New South Wales, and in the High Court of Australia, the decision by the House of Lords in *Sidaway* that the *Bolam* test extends to disclosure, was deemed wrong. The Court declared:-

> "In Australia, it has been accepted that the standard of care observed by a person with some special skill or competence is that of the ordinary skilled person exercising and professing to have that special skill, but that standard is not determined solely, or even primarily by reference to the practice followed or supported by a responsible body of opinion in the relevant profession or trade"[18]

Thus, the court struck at the very root of *Bolam as* a general principle, However it must be noted that the nature of consent in Australia bears heavily on the duty to disclose. Even so, Judge Gauldren went even further.

She said:-

> "even in the area of diagnosis and treatment there is, in my view, no legal basis for limiting liability in terms of the rule known as 'The *Bolam* Test' "

and,

> " the *Bolam* test may be a convenient statement of the approach dictated by the state of evidence in some cases, As such, it may have some utility as a rule of thumb in some jury cases, but it can serve no other useful function."[19]

So, it would seem that in Australia, the appropriateness *of Bolam* in the field of medical negligence has not only been challenged and found wanting, but has actively been discarded. How then did the house of Lords so enthusiastically embrace it in *Re F* and consequentially in *Bland,* and do later cases show further advance, or retreat into its more apposite arena?

The Transposition of *Bolam*

Bolam* in *Re F

In English law then, the *Bolam* test has long been the unchallenged standard by which medical negligence is judged, but in recent years it has been employed in cases where the issues extended far beyond that of tortious liability. It appears that the scope was first extended in the case of *Re F.* There, in the course of deliberating whether an incompetent female patient should undergo sterilisation, the House of Lords considered the circumstances in which the *prima facie* tortious liability for non-consensual medical treatment is displaced. However, it was Scott-Baker J set the ball rolling in the judgement at first instance when, as regards the liability of doctors when treating an incompetent adult patient, he opined:-

> "I do not think they are liable in battery where they are acting in good faith and reasonably in the best interests of their patients. I doubt whether the test is very different from that for negligence"[20]

For this declaration he was taken to task by all three judges in the Court of Appeal, none of whom thought *Bolam* alone an adequate test for determining whether medical treatment is in a patient's best interests, but equally none denied *Bolam* a role at all. In his leading judgement Lord Donaldson declared:-

> "...just as the law and the courts rightly pay great, but not decisive, regard to accepted professional wisdom in relation to the duty of care in the law of medical negligence... so they equally would have regard to such wisdom in relations to decisions whether or not, and how to treat incompetent patients in the context of the law of trespass to the persons"[21]

Here then his Lordship appeared to accept medical opinion as relevant to liability both in trespass and negligence, but denied its determination of either: a significant departure from *Bolam* even as regards negligence.

Neill L. J. also voiced reservations; whilst accepting that non-consensual treatment may properly be carried out in circumstances of necessity, his Lordship considered *Bolam* alone an insufficiently stringent test to determine necessity, (and thus preclude an action in trespass), but that in this context necessity should be determined by

> "that which the general body of medical opinion in the particular speciality would consider to be in the best interests of the patient"[22]

So here, the *Bolam* "responsible body", is displaced by "the general body", a somewhat imprecise criteria given the diversity of valid medical opinion, or where such opinion is divided into equal, but opposing schools of thought. However, it is clear that this test is considerably more demanding than *Bolam,* but still leaves decision making in the hands of the medical profession.

Butler-Sloss L. J., agreed with Neill L. J. that the negligence test of *Bolam* is too wide and she endorsed her colleague's narrower test, and furthermore, in particular categories of treatment, such as sterilisation, she claimed the final arbiter should be the court.

Thus it seems there was unanimity in the Court of Appeal as to the inadequacy of the *Bolam* test, but no outright rejection of it either, their Lordship's preferring the stricter, but still medically determined test of "the general body of medical opinion" to determine best interests. Of course in *Re F,* the issue of withdrawal of treatment was not addressed, but it is submitted that as are those in sterilisation, the issues are far wider than the merely medical, and that therefore even the "general body of medical opinion" test is insufficient. However, when the case of *Re F* reached the House of Lords, Lords Bridge, Brandon, Griffiths, Goff and Jauncy resiled from the court of Appeal's call for a stricter test for trespass than for negligence.

Lord Bridge rejected any differentiation between the tests for negligence and trespass. He reasoned that the carers of patients lacking the ability to consent would be placed in a dilemma that if they treat, they may be held guilty of trespass, and if they fail to treat, of negligence. Thus his Lordship held that those who undertake treatment of incompetent or unconscious patients should be judged by "one standard, not two" and, provided that have acted in accordance with the *Bolam* test,

> "they should be immune from liability in trespass, just as they are immune from liability in negligence" [23]

Lord Brandon also refused to deny *Bolam* as the sole test. In a rather curious reasoning his Lordship appeared to equate best interests with compliance with *Bolam* in his view, "in order to be lawful, treatment given to incompetent adults must be in their best interests" but added:-

> "If doctor's were to be required... to apply some test more stringent than the *Bolam* test, the result would be that such adults would, in some circumstances at least, be deprived of the benefit of medical treatment which adults competent to give consent would enjoy"[24]

Lord Griffiths agreed that the duty of a doctor is to give such treatment as he considers in the best interests of his patient, "and the standard of care required is that laid down by *Bolam*"[25]

Lord Goff also agreed that best interests again must be the test, but he too added *Bolam* to the decision making formula, although he conceded that in practice there may be occasions when inter-disciplinary team will participate in the decision making process.[26]

Lord Jauncy appeared to endorse his colleagues' views, but in breaking down medical care into the four component stages of diagnosis, whether to treat, how to treat and actually treating, he appears to have muddied the waters somewhat. With reference to those treating the patient he said:-

> "However, if such persons take the decision in relation to the second and third stages solely in his best interests and if their approach to, and execution of, all four stages is such that would be adopted by a responsible body of medical opinion, they will have done all that is required of them and their actions will not be subject to challenge as being unlawful"[27]

It is difficult to reconcile these two assertions, since he both denied and endorsed the use of *Bolam* in the same breath, for whereas, "solely" excludes any other considerations, the implication of the latter assertion, surely is that best interests must be governed, not by what the physician in charge considers to be in his patient's best interests, but whether a responsible body of appropriate medical opinion would concur. However, if the implication is, that if the proposed treatment is in the patient's best interest, then *a fortiori*, some responsible body of relevant medical opinion would consider it appropriate, and the use of *Bolam* is merely superfluous.

Here then, in *Re F,* all three members of the Court of Appeal considered that the *Bolam* test was insufficiently stringent for deciding whether treatment is in a patient's best interests, but in contrast the members of the House of Lords, with the possible exception of Lord Jauncy, held that it is. The decision in *Re F*, set the benchmark of best interests to determine medical treatment of the adult incompetent patient, but having done so with the inclusion of the *Bolam* test, when, in *Bland* (and subsequently in *Frenchay*[28]) the issue turned from whether, and how to treat, to whether to discontinue treatment, their Lordships employed the same formula, that is, best interests in accordance with the *Bolam* principle, although as examined later, the Court of Appeal expressed grave reservations as to the relevance of *Bolam.*

Bland and *Bolam*

At first sight the decision in *Bland* appears wholeheartedly to endorse the juxtaposition of the *Bolam* test and best interests, however, a closer examination of the deliberations in *Bland* reveals a clear discrepancy of view between the Court of Appeal and the House of Lords as regards the role of *Bolam.*

In the Court of Appeal, Butler-Sloss L. J. clearly expressed reservations regarding the adequacy of *Bolam* alone. In considering the extent of the duty of care of a doctor to a patient in PVS, and accepting that the medical team caring for Anthony Bland were of the opinion that his best interests lay in the discontinuance of all medical treatment, she said:-

> "The formulation of the duty of care within the *Bolam* test may not by itself be an adequate basis for this grave decision which requires more than the decision as to the uselessness of future treatment. The principle of best interest of an incompetent patient in the present circumstances encompasses wider considerations including some degree of monitoring of medical decisions"[29]

Hoffman L. J. also took the view that the decision whether to withdraw treatment should not be decided by reference to the views of the medical opinion alone, but rather complicated his judgement by emphasising that the issue for the court was declaratory as to proposed future treatment, rather than judgmental of past conduct. He said:-

> "If the issue was whether such an act had given rise to civil or criminal liability, the fact that the doctor had acted in accordance with responsible professional opinion would usually be determinative. But in this case the plaintiff hospital trust is seeking the opinion of the court as to whether future conduct will be lawful. It has invited the court to decide whether... the termination of life-support would be justified as being in the best interests of the patient. This is a purely legal (or moral), decision which does not require any medical expertise and is therefore appropriately made by the court"[30]

Whether it can be taken that it is the past/future issue, the issue of withdrawal, or both, which makes *Bolam* insufficient is not absolutely clear and thus whether, had the doctors in charge of Anthony Bland terminated treatment without asking for court approval, the test for liability in trespass or negligence would have been that of *Bolam*. However, what is clear, is that for Hoffman, in the determination of best interests when those interests may lie in the withdrawal of treatment, *Bolam* has no relevance.

In the House of Lords, it fell to Lords Keith, Goff, Lowry, Browne-Wilkinson and Mustill to consider the issue. Lord Keith, put a slightly different twist on, (and thus narrow), *Bolam* in circumstances where the issue is withdrawal of treatment. Although his Lordship cited *Bolam,* he altered the principle substantially by requiring "a *large* body of informed and responsible medical opinion" to approve withdrawal. [added emphasis][31]

In his leading judgement, Lord Goff appeared to suffer no such scruples, he firmly reiterated the stance taken by his colleagues in *Re F,* that *Bolam* is as appropriate in decisions either to initiate or withdraw medical treatment, as in those of any other form of treatment. However, his Lordship then went on to add the rider that "it is to be expected that guidance will be provided for the profession", and that this guidance was to be found in the safeguards set out by the ethics committee of the BMA contained in the discussion document "Treatment of Patients in Persistent Vegetative State"[32]. In his Lordship's words:-

> [the] "study of this document, left me in no doubt that if a doctor treating a PVS patient acts in accordance with the practice now being evolved by the medical ethics committee of the British Medical Association, he will be acting with the benefit of guidance from a responsible and competent body of relevant professional opinion, as required by the *Bolam* test".[33]

So here again whilst still paying lip service to the *Bolam* principle, the test itself was shifted from the wide "a responsible body of opinion", to the much more explicit, and thus narrower, body of opinion which formulated the BMA guidelines.

Lord Browne-Wilkinson had no inclination to curtail the *Bolam* test, for not only was he adamant that where a responsible doctor acting in accordance with the *Bolam* test, had come to a reasonable conclusion that continuation of treatment was no longer in his patient's best interests, that treatment must cease[34], but even more alarmingly, on application to a court on the lawfulness of withdrawal in those circumstances, the court's *only* concern would be the reasonableness of the decision and its compliance with *Bolam*[35] (added emphasis).

However he, like Lord Goff made the obvious point that compliance with the BMA Ethical Committee's proposed guidelines, would satisfy *Bolam* without making clear whether the guidelines would be a legal requirement, or whether compliance with *Bolam* alone would be sufficient. If the former is the case, the test is substantially narrowed and, *Bolam* is again superfluous.

This leaves Lord Mustill, who alone of their Lordships clearly expressed reservations as to the "application of the principle of civil liability in negligence laid down in *Bolam* to decisions of best interests in a field dominated by the criminal law"[36]. In his opinion, beyond the areas of diagnosis, prognosis and medical appraisal, the issue is ethical rather than medical and "there is no reason in logic why on such decisions, the opinions of doctors should be decisive". He added that had the decision of the court rested on the *Bolam* test he would have wished to consider the matter further[37].

Bolam in *Frenchay*

Notwithstanding significant factual differences from those in *Bland,* the court in *Frenchay,*[38] applied *Bland.* The Court of Appeal in *Frenchay,* had been asked to uphold a High Court declaration sanctioning the non-replacement of a gastrostomy tube which had become dislodged from the stomach of a comatose young man. Despite some signs

of "glimmering awareness", the patient was nonetheless diagnosed as being in a PVS. The Court of Appeal agreed to the doctors' request, but in doing so. Sir Thomas Bingham MR. made some observations as to the relevance of *Bolam,* and in reserving ultimate decision making for the court he stated:-.

> "It is important that there should not be a belief that what a doctor says is the patient's best interest is the patient's best interests"[39]

However this robust declaration loses much of its force since he then conceded that if the court held a view contrary to that of the doctors, their position would be untenable in that in the instant case they would be obliged to perform a operation on the patient which was against their professional judgement. He did however affirm that there might be cases where there might be "real doubt" about the correctness of the medical opinion, and where the court might therefore demand such action. Notwithstanding this caveat, Julie Stone is of the opinion that far from retreating from *Bolam, Frenchay* extends its use even beyond *Bland*'s narrow parameters.[40]

It is interesting to note that in *T v T*[41], a case predating both *Re F* and *Bland* on facts not dissimilar to those in *Re F,* Wood J. emasculated *Bolam* by posing the question, that in such circumstances, what does medical practice demand? He later refined this further by narrowing it to the demands of "good medical practice", a test much more aligned to the later views of Neill L. J. in *Re F,* "the general body of medical opinion", and Lord Keith in *Bland,* "a large body of medical opinion"

Commentators have shown concern at the apparent transfer of a test for negligence into the wider fields of trespass and/or criminal law. Kennedy and Grubb have commentated on the changing approach taken by the courts in several notable cases over the last few years and have noted the significant shift away from *Bolam* in other jurisdictions, in contrast to the cautious approach taken by the English courts[42 43 44]. They maintain that the reluctance by the Law Lords, to require a stricter test than *Bolam,* stems as much from the desire to employ the same test for both the doctor's duty of care to his patient, as for his defence against non-consensual treatment of him: the "one standard not two", of Lord Bridge's judgement in *Re F.* Both Kennedy and Grubb, take issue with the whole premise of *Bolam* in that, under *Bolam* what should be merely a matter of medical evidence has become determinative.

Commenting on *Rogers v Whitaker,*[45] Grubb contends that the English courts have "taken *Bolam* literally and hence too far"[46], in that just as *Bolam is* not determinative in

other spheres of professional competence, neither should it be in the medical arena. In particular, Grubb denies *Bolam* any role in areas other than those pertaining to medical judgement. With regard to the approach taken by the Court of Appeal in *Bolitho*[47], Grubb reiterates this view that *Bolam* should be confined to questions of a purely medical nature, and furthermore even then it is the reasonableness of the doctor's decision which is determinative. *Bolitho* involved an allegation of negligence in that a Paediatric Registrar had failed to attend a two year old with severe breathing problems. The claim was that had the Registrar attended the child, she would have intubated him, and therefore he would not have died. The question arose as to the relevance of *Bolam* in this issue of causation. The decision was not unanimous, but the majority held that the court should rely on expert medical opinion. Simon-Browne L. J. dissenting, declared *Bolam* inappropriate. Grubb observes that the English courts appear to have lost sight of the distinction between a case which raises a question of professional practice, and one which does not. Only in the former case does *Bolam* have any place, and even there is subject to the test of whether the doctor's conduct is reasonable. The latter case is subject only to the general rule of reasonableness. Grubb, however would not go so far as Dillon L. J. in *Bolitho* and aver that only "*Wednesbury* unreasonableness" provides proof of negligence.

Whilst adding little to the determinative nature of medical opinion, the recent case of *Defreitas v O'Brien and Another*[48] adds a further gloss to *Bolam*, in that the court held that a small number of specialist doctors are sufficient to satisfy "the responsible body of medical opinion" required by *Bolam.*

It is interesting to note that the Australian courts have already upgraded the requirement of reasonableness, and given *Bolam* only a back seat in the finding of medical negligence. In the case of *Darly v Shale,*[49] Wood J held that as regards professional practices, although failure to comply with current practice in the particular field will amount to negligence, the converse does "not necessarily follow", and the test to be applied is that of reasonableness or otherwise of the action taking into account all known risks.

Much has been written as to the extent and parameters of *Bolam,* but in *Re F,* the House of Lords extended the boundaries of the test in an entirely new direction when it transported what is essentially, and arguably should remain, a test for negligence into the realms of the criminal law. Given the level of expertise required to make a sensible medical judgement, whereas it may be right, and probably inevitable, that the standard of care pertaining to medical negligence should be determined largely, even if not solely, by

responsible medical practice or opinion, where the action to be considered has moved away from the purely therapeutic, there are strong arguments to suggest that medical opinion should not be the determinative arbiter. There is a groundswell of opinion to the effect that *Bolam* should be confined to issues of negligence relating to treatment and diagnosis only, and furthermore that a test of reasonableness should be reintroduced to even these areas.

The great problem in transferring *Bolam* outside tortious liability, is that where the issues at hand are not purely medical, current medical practice may, or may not, have some relevance, but it must be accepted that criminal culpability must be left to the lawyers, and in the realms of ethical debate, the opinion of the medical profession should carry no more weight than that of any other professional body.

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1 *Bolam v Friern Hospital Management Committee* [1957] 2All ER 188

2 Injury sustained by a patient undergoing electro-convulsive therapy where the negligence lay in not adequately restraining the unconscious patient resulting in a fracture of the hip.

3 *Gold v Haringey Health Authority* [1987] 2 All ER 888

4 *Sidaway* [1985] 1 All ER at 649

5 *Whitehouse v Jordan* [1981] 1 All ER 267

6 *Maynard v West Midlands Regional Health Authority* [1984] 1 WLR 634

7 *Sidaway v Bethlem Royal Hospital Governors* [1987] 1 All ER 649

8 *Bolitho v City and Hackney Health Authority* [1993] 13 DMLR 111

9 *Sidaway* [1985] 1 All ER 649

10 *Ibid 652*

11 *Ibid 655*

12 *Canterbury v Spence* (1972) 464 F 2d 772 — A doctor must discuss with his patients, all material risks, to be determined by the "prudent patient" test, which allows that a risk is material if a reasonable person in the patient's position would be likely to attach significance to it.

13 [1985] 1 All ER 664

14 *Ibid 669*

15 *Ibid 671*

16 *Ibid 664*

17 *Rogers v Whitaker* [1992 175 CLR] 479

18 *Ibid 407*

19 *Ibid 493*

20 *Re F* [1990] 2 A C 1 at 32

21 *Ibid 18*

22 *Ibid 32*

23 *Ibid 52*

24 *Ibid 68*

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25 *Ibid 69*

26 *Ibid 78*

27 *Ibid 83*

28 *Frenchay NHS Healthcare Trust v S* [1994] 2 All ER 403

29 [1993] 2 WLR 344

30 *Ibid 352*

31 *Ibid 355*

32 Now in Guidelines on Treatment Decisions for patients in Persistent Vegetative State.

33 [1993] 2 WLR 366

34 *Ibid 376*

35 *Ibid 377*

36 *Ibid 399*

37 *Ibid*

38 *Frenchay Healthcare NHS Trust v S* [1994] 2 All ER 403

39 *Ibid 409*

40 Withholding life-sustaining treatment: the ultimate decision, Julie Stone, NLJ Feb 1994 205 at 206

41 *T v T* [1981] Fam 52

42 Ian Kennedy. Commentary: Med. L. Rev. [1994] 108

43 Andrew Grubb. Commentary: Med. L. Rev. [1993] 247

44 I Kennedy & A Grubb: Medical Law 2d Ed 1994 Chapter 5.

45 *Rogers v Whitaker* [1992 175 CLR 479]

46 Med L. Rev. [1993] at 117

47 *Bolitho v City and Hackney* HA [1993] 13 BMLR 111

48 *Defreitas v O'Brien and Another.* Times Feb 16 1995

49 *Darly v Shale. Supreme Court of New South Wales: Wood J.* [1993] 4 Med. L. Rev. 161

6. The Withdrawal Of Artificial Nutrition And Hydration.

Is it Treatment or Basic Care?

The withdrawal of any life support is ethically both controversial and complex, but the withdrawal of artificial nutrition and hydration (ANH) is an especially emotive subject. It is of course not uncommon for healthcare providers to make decisions as to the withdrawal of artificial aids to life support. The debate over the withdrawal of life-support has now focused on the withholding or withdrawal of ANH. Much has been made of the difference between withdrawing ANH as distinct from other life-supporting measures. Whilst the withdrawal of certain types of medical care, in appropriate circumstances, is perceived as justified, some view the termination of ANH as being in a special category, which requires wider considerations. For whereas most people are prepared to accept the discontinuation of the more technical interventions of life support, for the lay person in particular, ANH may be seen as basic care, the withdrawal of which will leave the patient to "die of thirst", or "starve to death", and many clinicians too may feel an unease at the distinction between "artificial" and other means of feeding. Two separate issues must be addressed. Firstly, is there some difference in principle between the withdrawal of ANH and other life supporting measures, and secondly, if there is, on what principle if any, may ANH be withdrawn? In addition, for the present purposes we must examine whether the general legal principles are satisfactory as regards patients in PVS.

Before examining the moral, legal or ethical arguments to support or refute any difference, it is useful to consider briefly the adverse effects of either providing, or withdrawing the various methods of ANH. Here, it is not proposed to detail the means by which artificial nutrition may be administered. Suffice it to say that those means vary in complexity, all are invasive, all cause some discomfort to a sentient patient and all may, and it continued for any length of time invariably will, lead to further medical complications. Furthermore, since none is permanent, if ANH is needed for any length of time, the means of delivery will require renewing and the initial procedure repeated.

Both physicians and commentators have debated the level of pain or discomfort felt when ANH is withdrawn. There is evidence to show, that in some circumstances at any

rate, there is a remarkable lack of discomfort[1]. What is clear however, is that the gruesome picture painted by one of the dissenting judges the American case of *Brophy*[2] is a great exaggeration. (Here the Judge predicted a lengthy and "a painful and gruesome death", whereas in fact the patient died peacefully several days after his nasogastric tube had been removed). Ahronheim and Rose Gasner quote sources of evidence which indicate that for many categories of semi-comatose patients, dehydration results in rapid, but painless further depression of consciousness and that such patients feel no thirst and that in fact their bodies produce an increased amount of natural analgesia[3]. Of course none of this is relevant for a patient in PVS.

The starting point for any treatment decisions must be the premise that a competent patient has the right to refuse any or all medical treatment, including any means of nutrition, and therefore, it is only as regards the incompetent patient, (or following dicta in *Re T*[4] and *Bland,* one who has made no relevant advance directive), that the following examination applies. Furthermore, for the present purposes, the discussion will concentrate on withdrawal from the comatose patient, although some of the principles relied upon have been developed in decisions relating to the incompetent, but conscious patient.

As regards the incompetent there is a general duty owed by a carer to his charge, which includes a duty to provide such basic care as will maintain the health and welfare of that person and thus includes *inter alia,* the provision of food and drink. For an incompetent patient in hospital this duty is owed by the medical and nursing staff who are charged with his care, but for the doctor in charge, this primary duty is overlaid with a duty to render such medical treatment as is in the patient's best interests (*Re F*[5]). A doctor then, has a double duty of care: to furnish basic care, and to treat his patient.

Largely because of technical advances which have made possible the prolongation of life for many gravely ill patients, it has been increasingly accepted, both legally and morally, that whilst continuing to furnish basic nursing care, treatment which is of no benefit to the patient may be withheld or withdrawn. Professor Jennett has recently argued that treatment may be limited for one of three reasons: Firstly, in cases of futility, where life would not be prolonged, secondly, where life might be prolonged for a short period, but the burdens to the patient in so doing would outweigh the benefits, and, thirdly, where the life to be prolonged would be of such poor quality as to be considered of no benefit to the patient. He includes in this third category patients in PVS[6]. However although treatment may be withdrawn, the duty to furnish basic care continues either until

the death of the patient or until the patient recovers or regains competence and refuses such care. It is a moot point however whether a patient may ever refuse basic care whilst remaining a patient and thus subject to the carers' duty of care, since it is possible to argue a right on behalf of the carer not to have his care impugned. Obviously in the vast majority of cases "basic care" includes feeding and can readily be distinguished from medical treatment, but when the method of feeding is other than by mouth do we need to maintain a distinction, or can ANH properly be included as part of medical treatment rather than of basic care?

Medical Opinion

It might be supposed that the distinction between natural and artificial means of nutrition is clear: feeding by mouth being part of basic nursing care, by any other means part of medical treatment. However, the perception of whether the procedure is feeding or treatment, may depend on whether the patient is being cared for at home or in a hospital environment. What is clear is that the medical profession as a whole has no hesitation in classifying ANH as part of overall medical treatment, and thus, the considerations for the withdrawal of ANH or any other type of artificial life-sustaining treatment might be assumed to be one and the same. However, even among medical practitioners there are differences of opinion as to the role of ANH, and it is by no means certain that the withdrawal of ANH or other support is always subject to the same criteria. Studies have indicated that doctors are willing to initiate, or continue, ANH even when it can be shown to have no possible therapeutic effect. Whether this response was a result of conscience salving, fear of litigation, or merely routine practice, is not clear[7].

Other Bodies have made clear their views. In giving evidence to the House of Lords Select Committee on Medical Ethics. The BMA has made the distinction between feeding by natural and artificial treatment and medical care, in that the former is dependent on some proposed benefit for the patient and absent that benefit may be refused or withdrawn[8], and the latter is a continuing function which may not[9]. Furthermore the Association points out that any difference in viewpoint between artificial means of nutrition, and other types of artificial life support, "may be partly due to the fact that by discontinuing nutrition, doctors are making explicit the intention that the patient should die. Withdrawal of other treatments may lack the same explicitness of intention"[10]. It may be noted however, that in an earlier Report, the BMA categorically accepted that "feeding/gastronomy tubes for nutrition and hydration are medical treatments"[11].

Other Bodies disagree with the view of the BMA: the Royal College of Nursing is adamant that the withdrawal of "food and fluid is a different and more complex issue than the decision to stop other forms of medical treatment"[12]. Professor Scarisbrick, giving evidence to the Select Committee on behalf of LIFE and in affirming that he does see distinction between the provision of food by mouth and by artificial means, said :

> "The courts did no service to society by saying that food and drink were a form of medical care"[13]

It appears then that there is some disagreement between medical professionals as to a distinction between ANH and other means of feeding, but that, as was accepted by their Lordships in *Bland,* the majority of doctors at any rate, are content to see it withdrawn on the same basis as other life-support measures. However, whilst the consensus amongst physicians is clear, other opinion, both medical, and non-medical, may be divided, which opens up further debate as to whether the *Bolam* test should play such a significant role (or any role?), in decisions to withdraw ANH.

The Wider Debate

There are various schools of thought on the issue. Gilbert Meilaender disputes the argument that ANH is but one category of life support. He contends that providing food and drink is the sort of care people owe each other, and that since the provision of food and drink is not of itself curative, to withdraw feeding is to withdraw that which sustains life[14]. He quotes The President's Commission[15] which suggests that as regards the permanently unconscious, certain types of care are mandatory nonetheless, giving as an example care to prevent pressure sores. Meilaender argues that it there is no benefit to be gained by feeding these patients, neither should it be seen as harm to discontinue these other types of basic nursing care. He further argues that any analogy with disconnecting a respirator is false since whereas the withdrawal of nutrition has but one certain outcome, there is the possibility of spontaneous breathing in the other case, and in order to make a true analogy, were the patient to start spontaneous breathing, it would be necessary then to smother him. Thus in his view, feeding cannot be likened to medical treatment and thus withdrawn in some circumstances. In Meilaender's view, since PVS is not burdensome to the patient, ANH is not futile since it preserves the life of a non-dying patient. It is ordinary nursing care, not given as treatment and its withdrawal can have only one intent and that is to bring about the death of the patient.

Other commentators are of the view that the withdrawal of ANH and other measures merits no difference in principle; Lynn and Childress "there is no reason to apply a different ethical standard to feeding and hydration"[16]. Likewise Brock in the same publication agrees [17]. However, some commentators agree with Meilander. Ronald Cranford for instance contends that there is a difference for several reasons, including his assertion that feeding is moral imperative, and that withdrawal might be taken to be the cause of death[18].

Thus amongst commentators there seems to be widespread disagreement as to whether ANH can be seen as merely a type of life-supporting medical treatment, or whether it has some added significance which differentiates it from them.

The Legal View

In the USA the question of withdrawal of life-support in general and ANH in particular has been widely debated both in and out of the courtroom English law has been slow to tackle the issue and. debate in England has been more muted, confined largely to the withdrawal of invasive medical care of the terminally ill or congenitally deformed neonates. Until *Bland* the courts had not been asked to determine in what circumstances the withdrawal of ANH is lawful, and even in *Bland* Lord Mustill expressed serious doubts as to its justiciability[19]. Furthermore, given the narrow grounds of the decision in *Bland* the present law appears little more certain. In *Bland* the House of Lords would accept no difference between the withdrawal of artificial nutrition and the withdrawal of other medical procedures. However, to bracket ANH as a treatment to be governed by the same principles as other life-supporting treatment, may be in itself too simplistic and further begs the question as to whether there remains a distinction between ANH and other means of nutrition. What their Lordships failed to make clear, (it not being at issue in *Bland*), was whether there is any distinction to be made between ANH and other medical procedures, and further. whether or not such a distinction is recognised, whether oral feeding may ever be withdrawn.

In *Bland* in the lower courts it had been argued that there is indeed a significant distinction, and that, in part because of that distinction unlike other forms of medical procedure, ANH may never lawfully be withdrawn. The medical witnesses included some of the outstanding authorities in the United Kingdom on the condition of PVS. In his evidence to the Select Committee ,Professor Jennett told the court that in both the United States and in Canada, tube feeding is accepted as medical treatment and that in his own

opinion "naso-gastric feeding may be equated with a ventilator or kidney machine as a means of substituting a natural function which has failed"[20]. This view was echoed by Peter U. Behan. However, evidence was also given by Dr. Keith Andrews expressing the contrary view; viz. that feeding by tube is not medical treatment and "The use of the equipment might be thought to be medical treatment but not the supply of food which is a basic human requirement"[21].

It was submitted for the Trust Hospital, in a rather curious but unchallenged analogy, submitted that the same basic principles should be applied as in *Re F* "because what is proposed by Dr. Howe [the withdrawal of treatment] is effectively medical treatment"[22,23], "and is in the patient's best interests". Were this to be accepted, curiously it would put treatment by withdrawal in exactly the same category as any other treatment in so far as being governed by the principle of best interests — a subtle but essential difference from the ratio in *Bland* where the best interests test related to it *not being* in AB's best interest to continue treatment, rather than it *being in* his best interests not to continue. It is submitted that this would be the very position that would leave the door open to euthanasia that their Lordships went to such pains to avoid. This would indeed lead to "The slippery-slope" which Mr. Munby, for the Official Solicitor feared.

Notwithstanding some contrary evidence, Sir Stephen Brown P. was satisfied that "overwhelming medical evidence" supported the view that artificial feeding, at any rate by means of naso-gastric tube, is medical treatment. This view was echoed both at the Court of Appeal and in the House of Lords. In the Court of Appeal Sir Thomas Bingham MR relied on a Report from the BMA to support the view that ANH is counted as medical treatment[24]. Relying on "a wealth of medical expertise" and the recently decided American case of *Cruzan* all the judges in the Court of Appeal accepted that feeding by means of a naso-gastric tube is medical treatment, although Hoffman L. J. appeared to limit this assertion to the present case[25]. In the House of Lords, Lord Keith agreed that looked at as part of a regime and not merely as a means of nourishment, ANH is medical treatment[26]. Lord Goff, in his leading judgement also accepted that ANH is medical treatment, but he too qualified this to some extent by adding "and even if it is not strictly medical treatment it must form part of the medical care"[27]. He then went on to equate ANH to life support by a ventilator, arguing that therefore both should be governed by the same principles. Reports from medical and Medico-legal bodies, members of the House of Lords also cited the recently decided American Supreme Court case of *Cruzan*[28], but the question had been addressed on previous occasions by State Courts.

Whilst the Courts in England sanctioned the withdrawal of ANH, firstly in *Bland* and subsequently in *Frenchay*, in considering the present position in the UK, it is useful to examine the law in other common law jurisdictions. In the landmark cases of first *Conroy*[29] and later in *Cruzan*[30] , the American Courts considered the issue in depth. The case of *Cruzan* explicitly concerned a patient in PVS, whereas the decision, if not the discussion, in Conroy was limited to elderly patients in nursing homes who have a life expectancy of less than one year. However, in cases earlier than either of these the American courts first faced the issues, and subsequently the question of the withdrawal of life support has been debated widely both in and out of the courtroom. In the US a large number of Apellate Courts have considered the legality of withdrawing ANH.

The first case to consider the issue came before the American Courts in criminal proceedings. In *Barber*[31], murder charges were brought against the two physicians, Negdel and Barber after they had withdrawn ANH from their patient. The charges however, were dismissed at a preliminary hearing. More recently in *Corbett v D'Alessandro*[32] , the court stated that there is no reason to differentiate between the multitude of artificial devices which enable prolongation of life. In a rash of cases in the mid eighties the courts had sanctioned the removal of naso-gastric tubes from both competent and incompetent patients alike, including some patients in PVS (*Jobes, Bouvia*)[33].

In examining the whole area of the withdrawal of treatment, and setting down for the first time the principles that should be applied in allowing cessation of treatment, in *Conroy*[34], The New Jersey Supreme Court was categorical in its finding that ANH is medical care. However, the court did make a clear distinction between ANH and other means of nutrition. Schrieber J. said:

> "Artificial feedings such as naso-gastric tubes, gastronstomies, and intravenous infusions are significantly different from bottle-feeding or spoon-feeding — they are medical procedures with inherent risks and possible side-effects, instituted by skilled healthcare providers." [35]

In 1990 a case reached the US Supreme Court in which it was asked to sanction the removal of a gastrostomy tube from an elderly woman in PVS. In *Cruzan* Justices Brennan and O'Conner both made references to the nature of ANH and both relied on recent medico-legal publications to support their views[36]. Justice O'Conner stated:-

> "Artificial feeding cannot readily be distinguished from other forms of medical treatment"[37]

Justice Brennan was even more convinced that ANH is even more commensurate with other medical treatment:-

> "The artificial delivery of nutrition and hydration is undoubtedly medical treatment"[38]

Both Judges took the view that initiating treatment requires medical or surgical techniques and the patient needs close monitoring, and that therefore such treatment should properly be counted as medical treatment. It seems then that both in the American and English courts, the judiciary is content to accept the consensus of medical opinion that ANH is, or is akin to, medical treatment. However, the same cannot be said about the legislature since many states in America have excluded ANH expressly from measures to allow withdrawal of life-support treatments[39]. However, this takes us to a further issue: even if ANH *is* medical treatment, may, or should, it be withdrawn under exactly the same principles as all other treatments, or are there, or should there be, additional restraints to be placed on its withdrawal?

It seems then, that at present the courts take their lead from the medical profession and do not dispute the latter's view that ANH *is* medical treatment. However, it may be that the medical view is an insufficient basis on which to formulate a legal principle to cover methods of artificial nutrition as diverse as intravenous hydration by vene-puncture, gastrostomy requiring surgical procedure, and the merely mechanical naso-gastric feeding. Neither does, or should it, help in the even more controversial area of the withdrawal of feeding by mouth. The question may be considered in two parts: firstly, should the initial provision, or subsequent withdrawal, of ANH be subject to the same principles as other forms of life-supporting treatment, and secondly, if not, in what circumstances should ANH be withheld or withdrawn?

The Withdrawal of Artificial Nutrition and Hydration — The same Principles as Other Treatments?

The withdrawal of ANH, no less than the withdrawal of food and drink, conjures up the spectre of an emaciated body with parched lips and in the unendurable agony of

starvation. Does this "sloganism of starvation", as Judith Ahronheim and M Rose Gasner have termed it,[40] lie at the root of concern regarding the withdrawal of ANH or are there rational and proper arguments in favour of this natural repugnance?

Even though most commentators do not oppose the withdrawal of most life support treatments, many express reservations about the withdrawal of ANH. Various arguments have been advanced to suggest that even if artificial nutrition and hydration are medical treatments, they do differ significantly from other treatments, and that therefore they should never be withdrawn or, less dogmatically, that there are additional criteria to be satisfied before they may be withdrawn. In a fairly recent publication, Joanne Lynn gathered together the views on the withdrawal of ANH, of a number of eminent American commentators. This collection explores many, but not all, of the arguments relating to the withdrawal of nutrition[41]. It is useful for the present purposes, to examine these arguments, in an endeavour to find both a consensus viewpoint, and a rationale for it.

There is a strong argument to the effect that it is never right to withhold food and drink from the needy, who, perforce include those incapable of feeding themselves. However most commentators contend that this obligation to feed may not be absolute.

Obviously where feeding is by mouth the requirement to feed is strongest, but even then it is it generally felt to be acceptable to forgo feeding where to feed imposes a burden on the patient which is not balanced by any benefit of an improvement in comfort, health, or life expectancy.

The arguments to prohibit the withdrawal of ANH are numerous; that ANH is part or basic nursing care; that it is ordinary as opposed to extraordinary care; that it has symbolic significance which precludes withdrawal; that it is nothing more than deliberate killing; that society will suffer once an absolute duty to feed the needy is breached; that the slippery slope means that what starts out as a possibility will rapidly become an obligation. In addition to the "ordinary treatment" and "symbolic nature" arguments, Childress and Lynn posit two further, but in their view, equally spurious arguments; an obligation to continue treatment once started, and an obligation not to be the unambiguous cause of death[42].

If we take as the starting point the principle that, as regards an incompetent patient both medical treatment and nursing care must be undertaken in the patient's best interests, can it ever be in those interests for him to become dehydrated and

undernourished? Providing adequate nutrition and hydration is vital in the majority of health care regimes, both to provide palliative care and to aid recovery. However, it is not of itself treatment and some commentators have held that it is intrinsically wrongs to deny nutrition to another. Lynn and Childress, writing in by No Extraordinary Means, quote the philosopher G. E. M. Anscombe:-

> "For wilful starvation there can be no excuse. The same can't be said quite without qualification about failing to operate or to adopt some courses of treatment"[43]

Anscombe then is an absolutist, in his view nutrition must never be withdrawn. Childress and Lynn however, argue that this goes too far, and that if the delivery of ANH does not *always* (added emphasis) improve a patient's well-being, it is difficult to defend an absolute bar on its withdrawal. They propose three situations in which withdrawal is morally acceptable. Firstly, where it is unlikely that attempts to nourish and hydrate will achieve that purpose; secondly, where to do so would render no benefit to the patient, and thirdly, where the benefits to the patient, of doing so. are outweighed by the burdens to him[44]. They rely in part on a study on dying cancer patients which showed that some patients were more comfortable when not given artificial hydration[45].

Clearly patients in PVS will mostly fall into the second category of gaining no benefit. It is submitted that these circumstances are those which are relevant to the withdrawal of any medical treatment.

It is interesting to note that, on the Lynn/Childress analysis, for a patient in PVS, the criterion for withdrawal of no benefit for the patient, is subtly different from the best interests test applied by the House of Lords in *Bland* some six years later. It may be argued that were their Lordships to have decided upon *this* principle, (of no benefit), rather than best interests to govern the withdrawal of ANH, much of their obvious legal machinations might have been avoided. However, it is conceded that such a principle might be open to abuse, if not actually opening the door to passive euthanasia or even active euthanasia.

Other commentators are very much more cautious, urging strict criteria for withdrawal of if not an absolute bar on the practice. Callahan only just falls short of demanding such a bar[46]. He welcomes the present widespread repugnance to the withdrawal of ANH as a defence against the slippery slope of the possible becoming the probable, and the consequent general acceptance of withdrawal pressaging the "destruction of society". As yet, it may be argued that there is little evidence of this, nor

is the one, the inevitable concomitant of the other (Childress). Furthermore, providing a presumption in favour of ANH is maintained, the present revulsion to withdrawal can be viewed as mere sentiment rather than a moral imperative. However, even Childress concedes that the similarities of providing nutrition by all means may form the basis of an argument for an absolute bar on the withdrawal on ANH, but maintains nonetheless, that once withdrawal is sanctioned for any one type in particular circumstances, this argument flounders.

Several of their Lordships in *Bland* expressed concern in a principle which might appear to sanction deliberate killing but none would find analogy with either *Gibbins v Proctor*[47] or *Reg v Stone.*[48] Per Mustill:-

> "Of course the cases are miles apart, but where is the difference and the essential facts?"[49]

How does the claim that the withdrawal of ANH amounts to a death sentence stand up to scrutiny? On the one hand, it may be argued that withdrawal of ANH is no different from any other withdrawal of life-supporting measure, and furthermore that any denial that all result in death, is merely and attempt by carers to distance themselves from this inevitable outcome. Similarly, allowing ANH at a rate insufficient to be effective, (as in the administering of IV fluids at a "to keep open" rate), in order to maintain the symbolism of providing food, is likewise self-deception (Childress). Death results when life-supporting measures are withdrawn. Evidence submitted to the Select Committee on Medical Ethics includes the contention that "the withdrawal of treatment in order to end life would be euthanasia — no less than positive intervention".[50] Others are equally adamant whilst limiting the prohibition to nutrition:-

> "It should make no difference whether food is served on a tray, spoon-fed, eaten with the aid of artificial dentures or administered through a tube, the intentional denial of food for non-therapeutic reasons is nothing other than euthanasia"[51]

However, it may be argued that talk by opponents of withdrawal of ANH in terms of killing or starving, paint a false picture and are merely provocative since withdrawal of ANH bears no resemblance to the commonly held view of starvation. Yet it is this commonly held view which makes the withdrawal of ANH such an emotive subject, and almost inevitably more traumatic than other withdrawal for the relatives, if not for the patient himself. This leads us to two arguments not yet considered fully, and which form the basis of many of the calls for the withdrawal of ANH either to be subject to additional

criteria, or indeed subject to an absolute bar. These arguments are firstly, that feeding including ANH, is part of basic care, and secondly, that the symbolism of feeding the helpless precludes withdrawal.

The "Two Most Frequent" Arguments

Here we shall explore the validity of arguments that firstly ANH is basic care and therefore may never be lawfully withdrawn, and secondly that its symbolic significance also precludes withdrawal.

Is ANH Basic Care?

It has been argued that ANH cannot directly be equated with feeding by mouth, but as has been seen, there is no universal agreement that it is merely a category of medical treatment, and indeed many physicians consider that basic humane care requires that patients must always be given food and water. It has further been argued that the emotive portrayal of patients for whom ANH has been withdrawn, as suffering starvation in a similar manner to those depicted in areas of famine, is dishonest,[52] since the medical facts speak otherwise. Of course for the patient in PVS, suffering as such, has no meaning. Could then, we say that the provision of basic care to such a patient is immaterial? Surely not; it is unthinkable not to tend the sick whether the patient has hope of recovery or not, or even whether he can appreciate such care. Not to keep such a patient warm, clean and decently covered would be seen a dereliction of a duty. As regards an incompetent patient who is able to take food and drink orally, feeding would be considered part of this duty to provide basic nursing care. The question we must now ask is, whether the delivery of nutrition and hydration by artificial means alters either the nature of the act or the duty to provide it.

We can all empathise with hunger and thirst and many people feel that ANH should be distinguished from other life-supporting measures because whatever the means of delivery, it still feeding, and as such is basic comfort care in the same category as warmth and personal hygiene. Steinbrook and Lo however, suggest an emerging medical, ethical and Legal consensus that ANH is on a level with other treatments and should not be considered part of either ordinary care or routine nursing care[53]. Nurses may not agree. In *Brophy*, it was the patient's nurse who blew the whistle on the two doctors. She said:-

> "Food is an ordinary means of care, and everyone has a right to ordinary treatment"[54]

Similar sentiments were expressed by the Royal College of Nursing in its evidence to the House of Lords Select Committee considering the withdrawal of life-supporting medical treatment. The college declared that nurses

> "see feeding somebody as very fundamental to our whole practice and that the withdrawal of feeding, in whatever form it is being given, can produce very strange conflicts for us"[55]

The BMA however seems to have taken the most useful approach in making a clear distinction between treatment and care, the former to be withheld in the absence of some anticipated benefit to the patient, the latter to be always available. The BMA emphasised the continuing nature of care:-

> "medical care... is an expression of the doctor's long recognised duty to respond with compassion to the sick and needy"[56]

In a later article, Childress returns to the debate regarding arguments to preclude the withdrawal of ANH[57]. Here, however, he redefines what he considers the two most frequent arguments as firstly, the duty to provide patient comfort and dignity and secondly, the symbolic nature of feeding. However, he uses the same premise against these revised arguments as he and Lynn employed in the earlier piece, albeit in slightly different terms: He asserts that the fundamental principle of best interests establishes a presumption in favour of all life-prolonging treatment, but that the presumption is rebuttable by either futility, the absence of any benefit for the patient, or on a benefit-burden analysis, and furthermore, that these criteria apply to all types of treatment[58]. Thus far he merely rehashes his former position, but he goes on to explore arguments about whether nutrition and hydration should either be excluded from the general position as regards withdrawal of life-supporting treatment, or prohibited altogether. As regards comfort and dignity, and tackling the comfort element first, Childress dismisses this on his previous assertion that the argument fails in circumstances where continuation reduces patient comfort, relying once more on the study of a relatively small number of dying cancer patients[59] and an article in the Nursing Press[60]. Dignity causes Childress a little more difficulty. Here, the argument that routine nursing care is a matter of human dignity and is thus not an option for medical judgement is skated over on the meagre premise that the dignity of the patient can equally be protected by the wetting of parched lips. An alternative argument in favour of dignity could be furnished by emphasising the indignity of the continuation of some, if not all, methods of ANH once one of his stated

thresholds is reached, and that a person's dignity is best upheld by considering the manner of death rather than its timing.

The Symbolic Nature Of Feeding

Whilst the "sloganism of starvation" may militate against rational decision making as regards the withdrawal of ANH, the emotional significance of feeding may do the reverse. Emotions attach to nourishment that do not apply to other life-sustaining measures. Both courts and commentators have recognised this symbolism. In *Conroy*, the New Jersey Supreme Court acknowledged the "emotional significance" of feeding whilst at the same time declaring that ANH is nonetheless medical treatment[61]. Callahan calls it "the most fundamental of human relationships"[62]. Carson declares:-

> "To allay the hunger and slake the thirst of a dying person, is deemed across time and cultures to be not only right but good"[63]

and again

> "To nourish is to nurse; to offer food and water is to tend and regard"

Carson, however concedes that ANH in a medical setting, does not merit the same symbolic significance as it does in ordinary life and that therefore, it should not determine medical options or decisions. Landsman is in agreement with this view "to rely on symbolism... is to acknowledge that the welfare of the individual being treated is irrelevant".[64] If we take this view, the symbolic significance of feeding may be displaced by patient welfare. Furthermore, it is submitted that welfare should include not only physical well-being, but also human dignity. The whole tenor of Childress and Lynn's argument as regards the symbolism of feeding, rejects a sufficient symbolic significance to preclude its withdrawal absolutely. They accept that there is indeed some symbolic significance in providing food and water, which is, for most people, reinforced by a perception of the discomfort normally felt by hunger and thirst, However they argue that the overriding criterion should be net benefit to the patient, and, absent that, the symbolism of feeding is mere sentiment. In his later article, Childress returns to this argument. He challenges Callahan's assertion that feeding the needy is the most fundamental of human relationships, by arguing that Callahan's view is based on assumptions about the benefits of, and preferences for ANH, which, whilst they may be sufficient to establish a presumption in favour of continuation, are insufficient to create

an absolute bar to cessation, and that thus, as a symbol of a patient's interests it may have little to do with his actual interests.

Ronald Carson contends that the symbolic meaning of an act is seldom obvious and is of the view that it is the reciprocity of offering and acceptance which gives symbolic significance. He argues that Callahan's call to cultivate a deep-seated repugnance to the withdrawal of ANH should rightly be balanced by a similar dislike of treating in the face of futility for example. He suggests in those circumstances feeding can properly be replaced with other forms of care such as sips of liquid or ice chips to allay dryness of the mouth. He avers that such forms of care maintain the ritual of tending and non abandonment and are a suitable replacement for futile feeding[65].

Many carers consider that humane care demands that patients must always be given food and drink because it represents love and concern for the helpless. May not this concern be expressed in alternative, but no less symbolic ways such as the wetting of parched lips, touching, stroking or merely talking to, a patient? At the end of the day is the thought of withdrawal of ANH mere squeamishness because it *feels* different from switching off a ventilator? Although it seems morally right to offer food and water, and our hearts tell us to deliver ANH, our heads may suggest that more rational criteria should determine decision making.

Many of the objections to the withdrawal of ANH may be answered fairly by counter arguments such as those forwarded by Childress, and some of Callahan's fears would be countered by a set of guidelines such as those recently published by the BMA. However, even allowing that there are circumstances in which it is right to discontinue ANH, there is still room for debate, because even if ANH is seen as medical treatment and not basic care, and even if the symbolic significance of feeding does not carry to artificial methods of nutrition, there is some deep-seated feeling that ANH is feeding nonetheless and should be subject to stricter, or merely different criteria from the withdrawal of other life-sustaining measures. It is submitted that the BMA's attitude here, of separating treatment with its therapeutic value, from care with its tending but non-therapeutic function, is not only the most practical solution, but also the most moral. Presumably, on this basis, the BMA would classify feeding other than by artificial means as care and therefore never to be withdrawn. This solution would appear to go a long way in answering the argument that the symbolic nature of feeding precludes withdrawal, particularly it one takes note of Ronald Carson's submission that the symbolism of tending may be exhibited by other, but no less symbolic and nurturing care. If we take

this view, it becomes clear that by separating the therapeutic and caring functions of medical care, we can also keep clear what procedures may, in some circumstances be withdrawn, and those which must always be furnished. However the case of *Bland* may have put the withdrawal of ANH in to a particular category even for patients who are not in PVS, for although feeding may be seen as futile if the *goal* is a return to a cognitive state nonetheless it may be seen as worthwhile in terms of the emotional and symbolic benefits to society as a whole and the patient's relatives in particular.

Here we have considered some of the wide-ranging arguments surrounding the withdrawal of ANH. Steinbrook and Lo may claim that there is an "emerging consensus"[66], but it is clear that the debate on may be but in its infancy and to rely on a somewhat dubious claim to consensus does not address entirely the controversy regarding the withdrawal of ANH. There is little doubt that the debate is up and running, that it has far to go and that it is hotting up.[67]

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1 Micetich, Steinecker and Thomasma : "Are Intravenous Fluids Morally Required for a Dying Patient". Quoted in "By No Extraordinary Means" Ed J Lynn at 42.

2 *Brophy v New England Sinai Hospital* (1986) 497 N E 2d 626 (Mass. Sup. Jud. Ct.)

3 The Sloganism of Starvation: Judith Ahronheim and M Rose Gasner. The Lancet Feb 3 1990 278.

4 *Re T* [1992] 4 All ER 649

5 [1989] 2 All ER 545

6 Select Committee on Medical Ethics House of Lords Report HMSO 1994 Vol. III p117

7 Micetich, Steinecker, and Thomasma "Are Intravenous Fluid Morally Required for a Dying Patient?" — Arch. Intern Med. 143:975/8 (1983)), Quoted in "By No Extraordinary Means" at 42.

8 SCME Vol II at 26

9 *Ibid 28*

10 *Ibid 50*

11 BMA Euthanasia Report 1988 p23

12 SCME vol II. at 72

13 *Ibid 101*

14 Gilbert Meilaender "On Removing Food and Water: Against the Stream", Hastings Centre Report 14:11-13 (Dec. 1984)

15 President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioural Research, *Deciding to forego life-sustaining treatment* Washington DC: US Govt Printing Office 1983.

16 Lynn and Childress, "Foregoing Life-Sustaining Food And Water: Is It Killing" in "By No Extraordinary Means".

17 Quoted in By No Extraordinary Means 145

18 In By No Extraordinary Means Ch. 18, p187

19 [1993] 2 WLR 316 at 392

[20] SCME Voll II

[21] [1993] 2 WLR 316 at 326

[22] *Ibid 327*

[23] Dr. Howe was the consultant Gerontologist in charge of Anthony Bland.

[24] [1993] 2 WLR 338

[25] *Ibid 358*

[26] *Ibid 262*

[27] *Ibid 372*

[28] *Cruzan v Director, Missouri Dept of Health* (1990) 110 S. Ct. 2841

[29] *In Re Conroy* (1985) 486 A 2d 1209

[30] *Cruzan* (1990) 110 S Ct. 2841

[31] *Barber v Superior Court of California* (1983) 195 Cal. Rptr.484

[32] *Corbett v D'Alessandro*

[33] *Jobes* (1987) 108 NJ 394, *Bouvia v Sup. Court* (1986) 225 Cal Rptr.

[34] *Re Conroy* (1985) 98 NJ 321

[35] *(1985)* 98 NJ 321 at 373

[36] Council on Ethical and Judicial Affairs, A M A. Withholding or Withdrawing Life Prolonging Medical Treatment. Current Opinions 13 (1989). The Hastings Centre Guidelines on the Termination of Life-Sustaining Treatment and the Care of the Dying. 59 (1987)

[37] (1990) 110 S Ct 2841 at ..

[38] *Ibid*

[39] Eg. Living Wills and Life-prolonging Procedures Act of Indiana

[40] "The Sloganism of Starvation" — J Ahronheim and Rose Gasner. Lancet 1990, 278.

[41] By No Extraordinary Means 1986 Ed. Joanne Lynn

[42] "Must Patients Always be Given Food and Water?", in by No Extraordinary Means at 54

[43] G. E. M. Anscombe, Ethical Problems in the Management of Some Severely Handicapped Children: Commentary 2 Medical Ethics 7: 117-124 (1981)

[44] These are identical to those proposed by Professor Jennett to the Select Committee.

[45] *Joyce V. Zerwekh,* "The Dehydration Question", Nursing 83 47-51.

[46] Daniel Callahan, "Public Policy and the Cessation of Nutrition", in By No Extraordinary Means at 61.

[47] (1918) 13 Cr. App. R. 134.

[48] [1977] Q B 354.

[49] [1993] 2 WLR 395

[50] SCME HMSO 1994 Vol III 124

[51] David Lamb, *Ibid 136*

[52] The Sloganism of Starvation

[53] Artificial Feeding; Solid Ground Not a slippery Slope, "Robert Steinbrook and Bernard Lo, New, Eng. Journal of Med. 1988 318 at 286

[54] *Brophy* (1966) 497 N E 2d 626

[55] SCME Vol III HMSO 1994 151

[56] *Ibid* Vol II 26

57 When Is It Morally Justifiable To Discontinue Medical Nutrition And Hydration? in By No extraordinary Means P70

58 These criteria correspond directly to those set out by Professor Jennett in his evidence to the House of Lords Select Committee on. Medical Ethics Vol. III p117.

59 Smidtz and O"Brien, Observations on Nutrition and Hydration in Dying Cancer Patients" in By No Extraordinary Means p39

60 Joyce Zerwekh, "The Dehydration Question" , in Nursing 83 47-51, Jan 1983

61 (1985) 98 NJ 231 at 373

62 In By No Extraordinary Means at p22

63 *Ibid 85*

64 R N Landsman, terminating food and water: "Emerging Legal Rules" in By No Extraordinary Means, p135, at 144.

65 The Symbolic Significance of Giving to Eat and Drink in By No Extraordinary Means, p84

66 Artificial Feeding; Solid Ground Not a slippery Slope, "Robert Steinbrook and Bernard Lo, New, Eng. Journal of Med. 1988 318 at 286.

7. The Gloss from *Bland*: Is It Good Law?

We have now explored many of the issues raised in *Bland* and have reached the point where the decision in that case may be re-examined in the light of conclusions reached here. We have determined that the majority opinion is that ANH *is* a medical treatment, which, although imbued with some symbolic or philosophical significance, is not a part of such basic care as should never be withdrawn. It appears that, although legislation in many American States does differentiate between the withdrawal of ANH and other medical procedures, for the time being at any rate, the English courts accept the majority view. Thus, as the law stands post *Bland*, ANH may be withdrawn from an incompetent patient who is, or following *Frenchay* may be, in PVS, on a finding by the doctor in charge that in his opinion it is in the patient's best interests that treatment, including ANH, should be withdrawn.

However, whilst there may well be an "emerging consensus" within medical opinion, and although for the time being, the English courts are willing to take their lead from doctors, any common view regarding the withdrawal of ANH is less clear amongst other commentators. Undoubtedly, amongst some of these there remains unease at the thought that for those for whom no therapeutic benefit from further treatment is considered likely, the withdrawal of feeding, albeit confined to ANH, may be an option under the principle of best interests, particularly if those interests are to be decided solely by doctors according to the *Bolam* test. The dilemma left by *Bland* lies in the fact that the cessation of the invasive procedure of ANH that their Lordships saw as against Anthony's best interests, has but one inevitable and unavoidable conclusion, and that is that the patient will die. In the withdrawal of no other treatment is the outcome quite so sure. Aware of this inevitable outcome, the House of Lords in *Bland* nonetheless sanctioned withdrawal. True, several of their Lordships were troubled by the obvious parallel between *Bland* and the murder and manslaughter cases of *Gibbins and Proctor*, and *Stone* respectively. It is submitted rightly so, for the parallel in *principle* between these two cases and *Bland* surely is greater than their Lordships were prepared to admit. As Lord Mustill, whilst claiming the cases "miles apart" ethically, put it, "but where is the difference in the essential facts"[1]. Where indeed is the difference? *Bland* leaves a state of affairs which is far from satisfactory, for now a patient's life may be brought to an end lawfully by ceasing life-sustaining treatment in circumstances which do not appear to accord with established law.

On re-examining their Lordships' deliberations, it appears that several legal strands have become entangled, which when separated out lead to the conclusion that the decision in *Bland* is either flawed, new law, or at best incomplete. By joining the duties of a doctor both to treat in the best interests of the patient and in accordance with the *Bolam* principle, together with a prohibition on non-consensual treatment, their Lordships have come up with an answer which appears to *demand* the intentional ending of a patient's life by prohibiting further treatment. Furthermore, this prohibition may be decided when according to the personal view of a doctor, tempered only by the *Bolam* test when *he* has determined, not a best interest to cease treatment, but a lack of best interest to continue it.

In an endeavour to disentangle the issues in *Bland* it may be useful to re-examine the present law once again. Some things at least are clear. Firstly, no positive act to bring about the death of a patient is lawful. This is so regardless of futility or any burden/benefit analysis. Secondly, a doctor determining treatment for an incompetent patient must act in his best interests. However, all over the world, no less in England than in any other country, life-sustaining treatment is being withdrawn or withheld, both from the competent and incompetent patient, and had been for many years prior to *Bland*. What makes *Bland* significant is that withdrawal here falls into none of the previously acceptable categories. Prior to *Bland*, the law allowed withdrawal of some treatments on the bases of refusal (actual or anticipatory), futility or on a benefit/burden analysis. On this latter point, Lord Goff whilst referring to the case of *Re J*[2] declined to consider the principles which should apply to such determination of best interests. Futility has been taken to mean that the patient will die shortly whatever treatment is given, and that thus further treatment is useless, and that therefore the patient may be "allowed to die". AB was neither dying nor would he have died in the immediate future, had ANH not been discontinued. In *Bland*, Lord Goff pointed to a distinction between cases in which some balancing exercise could properly be carried out, and those such as the present where such an equation is meaningless[3]. Both categories are dependent on the determination of best interests however. In *Bland* then, treatment was not futile in the accepted sense, no balancing exercise could sensibly be carried out, but treatment was allowed to be withdrawn nonetheless on the basis of best interests. Their Lordships however went to great lengths to emphasise that as regards a patient in PVS, the question is not whether it is in the patient's best interests to die, but whether his best interests lie in not continuing treatment. It is submitted that this is where the confusion lies, for if *Bland* was decided on the basis of best interests, it does not go far enough, but *if* as appears more truthfully, on a

basis of no interests, the decision must be either new law or flawed. It is the extent of the doctor's duty to treat and the relationship between this duty and best interests which holds the key.

A brief resume of their Lordships' is useful. Whilst at the same time as professing doubt about saying that best interests *favours* withdrawal, Lord Keith was clearly of the opinion that it was the conferring of no benefit, to be determined by "a large body" of medical opinion which is the key. For Lord Goff, the essence of the issue lay in the futility of further treatment because AB was unconscious with no prospect of recovery: again no benefit analysis, but a novel characterisation of futility. It is of note that he stated categorically that in the absence of any therapeutic purpose, firstly, medical treatment is not appropriate "simply to prolong life", and secondly, that as regards the present case no reason existed to refuse consent to cease treatment "simply because it involves ANH". Lord Lowry put the matter slightly differently relying on "overwhelming" medical opinion to the effect that feeding merely to sustain life is "not necessarily for the benefit of the patient", and the fact that in the present case the doctors considered that "in the patient's best interests they ought not to feed". Again apparently a no-benefit rationale couched in terms of best interests to cease treatment. Lord Browne-Wilkinson also emphasised the withdrawal in terms of not being in the best interests to continue invasive life support.

Lord Mustill employed a different argument, and in doing so perhaps hit the nail on the head. Having asserted that the justification for non-consensual treatment is best interests, he went further in declaring:

> "The distressing truth which must not be shirked is that the proposed conduct is not in the best interests of Anthony Bland, for he has no best interests of any kind"[4]

He thus concluded therefore that the *justification* for further treatment no longer existed. However, he then went on to claim that it *was* in AB's best interests that treatment was not continued. This somewhat contradictory passage may hold the way forward in that perhaps the reason for withdrawal of ANH from a patient in PVS should be that such a patient has no present interests at all.

The essence of the judgements of Lords Keith, Goff, Lowry and Browne-Wilkinson is that further treatment offers no benefit and that the invasive nature of such treatment is therefore not in the best interests of the patient. However, it is difficult to see how the

invasiveness or otherwise of *any* treatment of which the victim is unaware, can be counted as a factor to weigh in favour of discontinuance. Thus, the basis of their Lordships' conclusions was that in the absence of an interest in continuing treatment it was not in AB's best interests; and further, that because it was not in AB's best interests, the duty to treat ceased and the omission to treat became lawful. With respect, this confuses the separate issues of lack of benefit and best interests, and thence the issue of the extent of a doctor's duty in the absence of any interests. Furthermore, whilst the decision absolved AB's doctors of criminal or civil liability, it did nothing to demonstrate AB's best interests. Indeed it could not do so, having declared that he had none.

What then is the real basis of *Bland*? To use the best interest test surely is inappropriate, for it is totally immaterial to a patient in PVS whether his treatment is continued or withdrawn. In these circumstances the notion of best interests is a fiction[5]. What is more, if we go one step further, and take Lord Mustill's view that this patient has *no* best interests of any kind, the dishonesty of best interests being prayed in aid of lawful withdrawal of life-sustaining treatment becomes even more apparent.

Best Interests Revisited

In further exploring the best interests test, we can start by examining the purposes of treatment. The primary purpose is to cure, and obviously in order to effect recovery, life must be maintained in the mean time. Where cure is not possible, treatment is aimed at alleviating symptoms and preventing deterioration. However, once distress has been alleviated, where no recovery is possible, treatment then focuses on maintaining such quality of life as the patient is capable of enjoying. We come now to the crux of the dilemma in *Bland*. Whilst Lord Goff acknowledged a distinction in rationale between the withdrawal of treatment from patients where some balance of benefit against burden may be calculated, and its withdrawal from those patients for whom such an exercise is meaningless, he nonetheless made clear that the best interests tests is the appropriate test in both categories. Can this be so?

The best interests test lends itself to a balancing of benefits against burdens, and it is submitted that best interests may *only* be adduced by the weighing of benefits against burdens: there is no other possible way to determine such interests. That being so, best interests may be the appropriate test to determine which of alternative treatments to provide, and also to decide on the withdrawal or withholding of treatment where *some* balancing is possible, even when that course of action will hasten death, that hastening

being part of the equation, but best interests can have no possible relevance where no balance is possible.

Clearly under present law, no best interest supports positive action to kill, but what interests support withdrawal when death is then inevitable? Whatever interest it might be, it is submitted that the duty to continue treatment cannot lapse in the *absence* of best interests to do otherwise, and therefore it cannot lapse in the absence of *any* interests whatsoever. However, even if AB did have some interests, what possible interests could favour discontinuance and inevitable death? The answer is far from clear and their Lordships' deliberations in *Bland* offer little light. Whilst they pray in aid the principle of best interests, no satisfactory rationale is given for *why* AB's best interests lay in discontinuance rather than continued treatment. The nearest they came was to declare that it was because further treatment afforded no benefit. The pertinent question therefore, is whether absence of benefit alone is sufficient, or whether some positive detriment needs to be demonstrated. It is submitted that the latter is the case, and that AB had no interests that ANH should cease. Can we say that notwithstanding a total lack of sentience or cognisance, continuing treatment imposes some burden of sufficient weight to balance the scales in favour of discontinuance of treatment? Had the only method of keeping AB alive been to involve some gross insult to his body by such bodily intrusion whereby his body or dignity was open to degradation or ridicule, there might be an argument for claiming his interests did not lie in further treatment. However, nothing could have been further from the truth; AB was lovingly tended by a devoted family and medical staff. To claim that this loving care *affronted* the best interests of AB who, their Lordships claimed had no best interests, is too strong? It is of course possible to assert that a patient has the right to die with dignity which outweighs the principle of the sanctity of life and the duty of the doctor to prolong life. Indeed, Wilson claims that there has been a societal shift towards this view notwithstanding that this road may lead to the acceptance of mercy killing and euthanasia.[6]

Absent any cognisance or sapience, does life itself impose a burden of sufficient weight? Clearly not. Only if mere absence of benefit is counted as a detriment, which is, it appears what *Bland* dictates, could there be an interest in ceasing treatment. However, unless there is neither a best interest to continue, nor to cease treatment the duty is to do one or the other, it cannot be optional. Thus, if further treatment *is* in the patient's best interests it *must* continue, but if it is no longer in his best interests it *must* cease. This is the uncomfortable conclusion reached by Lords Goff, Lowry and Browne-Wilkinson, on

the basis that the best interests test for the incompetent is but the justification (of necessity), for non-consensual treatment. Once the best interests of the patient are to cease treatment, the justification for continuing treatment ceases and any further treatment would be an unlawful battery (Lord Browne-Wilkinson). Thus *if* as their Lordships declared, it was in AB's best interests to have treatment withdrawn, so might it be for all patients in PVS with the consequence that all might be denied treatment once an unequivocal diagnosis of that condition had been made. This may not have been the intention of their Lordships in *Bland* but could be the outcome of their decision.

No Interests

However, what is the position if *Bland* has been decided on a basis of no interests at all? Is mere absence of benefit sufficient to justify the withdrawal of life-sustaining treatment? It is submitted that it is not. Firstly, because the test in *Re F* is positive, that is to act in the best interests of the patient, and not negative that is not to act when not in his best interests. Their Lordships declared that because it was *not* in AB's best interests to continue treatment, the duty to do so ceased and with it justification for non-consensual treatment. The argument equally could have run that because it was not in AB's best interests to cease treatment, it *was* therefore in his best interests that treatment continue, together with the justification for doing so. Secondly, it is submitted that without sufficient justification discontinuance offends against the fundamental legal principle of the sanctity of life. This principle raises a presumption in favour of maintaining life, and although Lord Keith maintained that where life confers no benefit, the withdrawal of treatment does no violence to this principle, it is submitted that an absence of benefit is insufficient justification for it to be displaced. Obviously the best interests of the patient will suffice to displace it, but does any other factor carry sufficient weight? Certainly a patient will be allowed to die where further treatment is futile, in that the patient is dying, or will die whatever the treatment offered. However, it is difficult to see how treatment which sustains life can be characterised as futile, unless it is argued that life *per se* is of no benefit. Surely it is the principle that it is which in part militates against both mercy killing and euthanasia? It is submitted that an absence of benefit as a general ground for the withdrawal of treatment is unsatisfactory since it would open the flood gates to widespread abuse and neglect by carers.

Thus even though their Lordships took care to express it in the terms of *not* being in AB's best interests to *continue* treatment, it seems that the basis of the decision in *Bland*

rests on a new category of no interests in continuing treatment, or futility, in the sense that treatment is not conferring, and will never confer any benefit to the patient. This leads to one of two conclusions. Either, *Bland* should have and possibly has been decided on a basis of no interests, which is new law, or the decision is flawed in that an interest has been ascribed where in truth there was none. It is submitted that if *Bland* is right at all, it is only half right. Surely the more logical approach would be to say that where a patient has interests, a doctor must act, that is treat or withhold treatment in the patient's best interests, but that in the absence of any present interests, treatment may be withdrawn, not because the doctor has no further duty, nor on the basis that it is not in the patient's best interests to continue treatment, but simply on the basis that he has no interests at all. However, it might be even more accurate to state that the patient has no interest in being kept alive rather than having no interest at all, for it can be argued that even the patient in PVS may have an interest in having his body treated with dignity.

There is one possible argument however, which would uphold the decision in *Bland* as it stands. That is to accept that the best interests test is not limited to the present interest of the patient himself. As argued above, if best interests *are* to be limited to those of the patient at the present time, it cannot be in his best interest to cease treatment *unless* there is some burden. However if, perhaps more honestly, other factors are included some meaning can be given to best interests even in a case where the patient himself has no present interests. Thus if we say that it was better for AB's family that treatment should cease, or that it is better for society that resources should be better spent, we may be nearer the truth. However, even if it is accepted that the best interests test does encompass additional factors, unless the inclusion of them is strictly limited to patients in PVS, we appear no only to be closer to, but actually on, the slippery slope of saying that the patient's interests are so minimal as to be outweighed by these other factors: one small step from saying not, that it is in the *patient's* best interests that treatment should cease, but merely that it is better that it should.

Instead of trying to mould best interests to fit this category of patients, it would have been preferable if their Lordships had made clear that the best interests test is not suitable in all circumstances, and that for patients in PVS this novel category of futility is more appropriate. However, this would have limited the withdrawal of ANH to patients in PVS, since for all others some balancing exercise is possible, and there is as yet no authority to cover withdrawal in such circumstances.[7] (Lord Goff declined to address the principles to be considered when this balancing exercise is called for.) Thus it would

exclude withdrawal from patient suffering other medical conditions, and incidentally rendered the decision in *Frenchay* dubious, since it is far from clear whether the patient in that case was in PVS.

It must be the case that whereas the best interests test is a useful general principle for the treatment of the incompetent patient, for the withdrawal of treatment for patients in PVS it is wholly inappropriate. In determining that ANH could be withdrawn from AB, their Lordships have muddied what, outwith the moral and ethical dilemmas of the euthanasia debate, had been clear legal principles. It is submitted that by distorting the best interests test to cover patients who in reality have no interests at all, the House of Lords, in an endeavour to achieve what, in the case of AB, was a desirable solution, has set a course which may be hard to reconcile with both previous good medical practise and established criminal law. In any case, it would appear that the decision in*Bland* opens the door to the widespread abuse of that principle. Can we say in all honesty that the distinction between being in a patient's best interests not to continue treatment, and it being in his best interests to die, is sufficient either in principle or practice to avert and open door to mercy killing even if such killing is confined to the questionable withdrawal of life-sustaining measures?

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[1] [1993] 2 WLR 316 at 395

[2] *Re J* [1991] Fam. 33

[3] [1993] 2 WLR 316 at 371

[4] *Ibid* 397

[5] Unless of course one takes the view that the dignity of a patient is best served by cessation of treatment.

[6] William Wilson "Is Life Sacred?" (1995) JSW FL 131

[7] Apart from *Re J* [1991] Fam 33

8. Conclusion: The Way Forward

Whether *Bland* is, or is not, good law, unless and until Parliament acts, it *is* the law and has been followed. However, it is already apparent that the very narrow, if not exclusive (Lords Mustill and Brown-Wilkinson), parameters of *Bland* have been extended, and that we may already have embarked on the "slippery slope" which their Lordships tried so hard to avoid. Notwithstanding a somewhat equivocal diagnosis of PVS and an urgency which seems doubtful, the Court of Appeal in *Frenchay* set the ball rolling with its unwarrantedly hasty decision. However, even conceding urgency and a correct diagnosis, there seems little doubt that S was not in as extreme a condition as Tony Bland. Had *Bland* remained the benchmark, although it would appear that a novel category of futility has been added to the accepted justifications for the withdrawal of medical treatment, at least the door would have remained closed firmly against any extension to patients other than those in a clearly diagnosed PVS. Post *Frenchay* it seems that only statutory measures are likely to prevent a "no benefit" rule from relaxing into a "minimal benefit" rule, thus opening the door to withdrawal of ANH from any patient, (who can be sedated to negate unpleasant side effects of withdrawal), of whom it may be said (at present by the doctors alone), that his life is of such minimal benefit to him that it is not worth living.

Neither the legal nor medical professions appear wholly at ease with the present position, and both have endeavoured to circumscribe withdrawal of treatment with guidelines, but these also are likely, on occasion to be stretched. In *Bland* their Lordships called for Parliament to act. Discussion papers abound but as yet no statutory measures have been forthcoming, although the Law Commission has included a draft Bill for consideration in its recent recommendations relating to medical treatment decisions for the mentally incapacitated adult[1].

The House of Lords Report by the Select Committee on Medical Ethics recommended that a commonly accepted definition of PVS and a code of practice would be helpful[2], including clear diagnostic criteria based on repeated observations over a period of at least twelve months. As regards the withdrawal of ANH however, the Committee appears to have ducked the real issue. It admitted to being unable to reach conclusion save to hope that the withholding of other medical treatment such as antibiotics where further treatment is inappropriate, would resolve the issue and "the question [of the withdrawal of ANH] should not usually be asked except where its

administration is itself burdensome."[3] The Committee supported proposals for a new judicial forum with the power to make treatment decisions for incompetent patients, but would wish to see some mechanism for the inclusion of independent medical and ethical advice.[4] As regards advance directives however, the Select Committee concluded that legislation is unnecessary.[5]

The findings of the Select Committee *inter alia* were taken into account in the Law Commission Report. The Commission proposes that the common law best interests test should be replaced by a statutory power to give such treatment as is in the best interests of the patient, where it isreasonable to do so.. The Commission further proposes the establishment of a new Court Protection to include medical treatment decision-making powers for incompetent adults. In including in its nine recommendations, statutory rules for the withdrawal of ANH from PVS patients and the provision for advance directives, the Commission adopts features of both best interests and substituted judgement approaches. The Commission lists a number of factors to be taken into account in determining best interests; these include *inter alia* the ascertainable past and present wishes of the patient, and factors which the patient might be expected to take into account including life expectancy and dignity. It may be noted that these accord with the considerations suggested by Hoffman L. J. in *Bland.*

Doctors have already received guidance regarding advance directives in a code of practice drafted by the House of Lords Select Committee and the BMA has issued guidelines for the treatment of patients in PVS. The code of practice advises that legally binding advance directives may be made either by specifying the degree of mental disability to trigger withdrawal of all treatment, or by refusing specific medical procedures. In either case an unambiguous advance directive will have the same force as a present refusal by a competent patient. Furthermore, although general preferences have no legal standing, the code makes clear that doctors should respect those wishes where possible[6].

Thus it appears that although at present the law is inadequate, some steps have been taken to clarify the situation, and if indeed Parliament does act to introduce measures recommended by the Law Commission, some at least ,of the inadequacies will be remedied. However, if the proposed legislation merely translates the common law test of best interest into one of statutory best interests which it is reasonable to provide, that in itself will do little if anything to curtail an increase in the circumstances under which ANH may be withdrawn. If the decision to withdraw takes into account such factors as

family preferences and the allocation of resources, decisions may well be taken much earlier. At present in the UK there are upwards of 1500 patients in PVS, and countless numbers suffering from severe mental incapacity. At the moment there is no pressure on doctors or relatives to request withdrawal. That may not always be the case. Unless legislation is able to impose some more definite criteria for withdrawal in all cases, or, alternatively limit withdrawal on a no benefit basis to patients in PVS, and set out the criteria to be met for all other patients on a benefit/burden analysis, statutory footing would appear no less troublesome than the present common law. Problems of accurate and agreed diagnosis dog the differentiation of PVS from other similar conditions but, it is submitted, would be preferable to the thin end of the wedge "quality of life" rationale. However, resources are not infinite and society must decide how best to allocate them. It is submitted nonetheless, that in this particular area a simplistic utilitarian approach may not be appropriate, and that the moral case for maintaining the relatively few patients like Anthony Bland outweighs any utilitarian argument to the contrary.

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[1] Law Commission. Mental Incapacity: Law Com. No. 231 HMSO 1995.

[2] SCME Vol II Para 258

[3] *Ibid para 257.*

[4] *Ibid para 292.*

[5] *Ibid paras 263/4*

[6] Advanced Statements about Medical Treatment, BMA

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