

End of life decisions: killing and letting die

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Determining whether a patient is competent to make decisions about refusing treatment involves consideration of legal and ethical principles and the available medical evidence.

Two recent high publicity cases in England neatly highlight the distinction in the law, of both England and Australia, between a positive act that kills a terminally ill patient – which is unlawful – and the withdrawal of treatment at the patient's request – which is permissible.

Ms B

Ms B suffered a haemorrhage into the spinal column of her neck in 1999 – she was 41 years old at the time.¹ In February 2001, she suffered a further haemorrhage and was paralysed from the neck down and could not breathe without a ventilator. In March 2001, she had surgery but it was unsuccessful. Between April and August, she made continued requests for the respirator to be turned off.

Several psychiatrists assessed Ms B's mental state and an independent psychiatrist said she was competent to refuse

further treatment. However, her clinicians were reluctant to act on her refusal. Switching off the respirator seemed to them to be an act – killing her – for which they could face criminal prosecution. Ms B applied to the High Court for a declaration that she was competent to refuse the respirator treatment and that it would then be unlawful for the hospital to continue it against her wishes. The Court found her to be competent to refuse this treatment after a hearing at her bedside (the first time this had occurred in England; it was also the first time a patient had applied to a court to rule on the withdrawal of treatment from a competent patient). The hospital had no ethics committee so that form of resolution was not available.

The judge, Dame Elizabeth Butler-Sloss, upheld the long-established right of a competent adult patient to refuse medical treatment, even if the patient will die as a result. She said that 'the doctors must not allow their emotional reaction to their strong disagreement with the decision of the patient to cloud their judgement in answering the primary question whether the patient has the mental capacity to make the decision'. In making the assessment of the patient's mental capacity, commonly called competence, doctors must assess whether the patient understands his or

her condition and the consequences of refusing treatment for it. If the patient does have that understanding, it is irrelevant that the reasons for his or her decision are 'rational, irrational, unknown or even nonexistent'.² However, a patient who refuses treatment for irrational reasons, or for no reason at all, is probably unlikely to be assessed as competent to make such an important decision.

Ms B died after the ventilator was turned off in accordance with her wishes.

Ms Dianne Pretty

The case of Ms B may be contrasted with the earlier case of Dianne Pretty, which went through the full range of Courts in England and Europe – the English High Court, the Court of Appeal, the House of Lords and the European Court of Human Rights.³

Like Ms B, Ms Pretty was paralysed (in her case, by motor neuron disease) and was unable to take her own life. However, although terminally ill (unlike Ms B), she was not dependant on a ventilator so she could not end her life by refusing treatment. She wanted her husband to be allowed to help her die and to be assured in advance that he would not be prosecuted for assisting her suicide (which is a crime in England, as it is in Australia). The English courts refused her request to grant her husband legal immunity and the European Court of Human Rights held that the Court's decision did not violate her human rights. The 'Right to Life' (Article 2 of the European Convention on Human Rights) does not include a 'right to die', it said, and denying her assisted suicide did not amount to 'inhuman or degrading treatment' (Article 3). Ms Pretty died naturally less than two weeks after losing her final appeal.

Australian law

The law in Australia is similar to that outlined in these two cases. It is unlawful for doctors actively to assist a patient to

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die, even if the patient is terminally ill and wants that to happen. Doctors may give increasing doses of pain relief if that is necessary to relieve pain, even if that hastens the patient's death, but cannot deliberately give a lethal dose. If, on the other hand, the patient is competent, the patient is legally entitled, like Ms B, to refuse treatment that he or she does not want, even if the patient will die.

This principle underlies the Medical Treatment Act 1988 (Vic), which was passed to provide a formal means for patients to refuse treatment – a 'Refusal of Treatment certificate'. The form for this certificate can be completed not only by a competent patient in respect of a current condition, but also by an agent appointed by the patient.

The principle that competent patients can refuse even life-sustaining treatment applies throughout Australia, whether under the common law or under statutory provisions similar to the Victorian ones.

Some concerns about the law

Some commentators who have written about the case of Ms B have criticised the legal distinction between acts and omissions. Ms B's doctors were apparently concerned that turning off the respirator was an act for which they would be criminally liable, not an omission for

which they would not. (This is a general proposition; there can be liability for omissions in certain circumstances, such as where a doctor or a hospital is treating a patient and treatment would generally be given to such a patient.) If turning off the respirator were an act, it would be homicide, even if the patient wanted it.

In a different form of critique, two severely disabled US commentators argue that insufficient attention was given to the assessment of Ms B's incompetence.⁴ They suggest that Ms B was more readily found competent than a nondisabled person would have been because of assumptions that people make about life with a disability. A physically healthy individual who refused life-sustaining treatment would be assessed as suicidal and treated despite the refusal. Ms B, on the other hand, was found to be competent, even though her interpersonal relationships had barely been explored (for example, if her loved ones visited her regularly, she might feel that life was worth living regardless of her being paralysed). There was limited consideration of the possibilities for Ms B to be rehabilitated: she had only two brief visits outside the intensive care unit during the year before her death, to show her what was possible. After these visits she said, 'I saw the world from a wheelchair and I saw how people looked at me'. She also thought, despite advice about welfare facilities, that 'I am no Christopher Reeve and can't pay for everything'. There was what the commentators describe, 'taking Ms B's testimony as a whole... [as] a sense of ambivalence, an inevitable characteristic of suicidal feelings'.

These comments are also relevant in Australia when doctors are assessing patients in relation to the withdrawal of treatment.

Series Editor's comment

Most doctors would feel uncomfortable with the concept that turning off a ventilator is not an act but an omission. It

would seem that once a patient is on a ventilator, and is still alive by the current medically accepted definition (i.e., not brain dead) then switching off the ventilator is a positive action, an act of commission that will have the inevitable consequence of ending life. Ms B was not comatose but fully sentient. Her refusal of further ventilation is different from, say, a cancer patient's refusal of chemotherapy. Both decisions will hasten death – but Ms B's involves the staff taking a positive step to cease therapy. Not giving further treatment is passive; switching off current treatment is active.

Like the US commentators, I am uncomfortable with the assessment of Ms B's competence. Although it is not for us to decide whether we agree with a patient's decision, we do have a duty to assess whether the patient is competent to make his or her own decisions, and then to ensure that the decision is properly informed. I think it is now generally accepted by doctors that obtaining (and documenting) informed refusal of treatment is as important as obtaining informed consent. Thus the doctor in an emergency department is in a very difficult position when faced with an intoxicated patient with a head injury who has been advised to stay for observation but starts to walk out. Is such a patient competent to refuse treatment? That was the scenario dealt with in a recent episode of the ABC television series, 'MDA'. The judgment of the Coroner portrayed in that episode ultimately was that the patient had been properly informed of the risk of walking out, and had understood the warning.

We also saw on a current affairs TV program last year a woman in a very similar position to that of Diane Pretty. She was approaching the terminal phase of motor neuron disease and announced her intention to take a lethal overdose of medication while she was still capable of ending her own life without assistance. Some weeks later she tried to end her life



Even if a competent patient or his or her appointed agent completes a Refusal of Treatment certificate, clinicians may be reluctant to act on the refusal.

but did not die as she wished. She was taken to hospital comatose, remained there for some days, and later died at home, reportedly without regaining consciousness.⁵

Ultimately, it is the slippery slope that worries me. Compassionately helping terminal patients to die with dignity is one end of a spectrum that can have Harold Shipman at the other end. Let's look at the gradations along the slippery slope (carefully avoiding Australian cases).

- In May 1999, a Newcastle, England, GP, Dr David Moor was acquitted after giving an elderly, terminally ill patient an overdose of heroin. The decision was seen as supportive of euthanasia.
- In 1992, Dr Nigel Cox, a consultant rheumatologist in the UK, was convicted of the attempted murder of an elderly patient with intractably painful arthritis with an injection of potassium chloride. The only possible intended effect of the injection could be to create an arrhythmia, precipitate a cardiac arrest and cause death. Thus there was no single intent (analgesia) but double effect (analgesia and hastened death), which is the defence offered when death is hastened by entirely appropriate analgesia. However, clearly Dr Cox's intention

was to ease suffering. He was charged with 'attempted murder', and not 'murder', and hence, despite being convicted, the court was able to free him with a suspended sentence.

- In 1957, Dr John Bodkin Adams, a GP in Eastbourne, England, was charged with murder for killing an elderly patient in order to benefit from her will. His defence was that we all have to die sometime, and doctors have a duty to 'ease the passing'. Many press reports at the time suggested that he had 'eased the passing' of a number of elderly nursing home residents shortly after they altered their wills in his favour. However, after a 17-day trial, Dr Adams was acquitted. He had the good sense not to return to practise but he funded his retirement by taking multiple court actions against several newspapers for defamation and seeking to prejudice the outcome of the trial. Lord Devlin, summing up to jury, stated the principle of double effect that has become the law in England (and probably also in Australia, though the issue has not come before the courts): 'if the purpose of medicine – to restore health – could no longer be achieved, there was still much for the doctor to do, and he was entitled to do all that was

proper and necessary to relieve pain and suffering even if the measures he took might incidentally shorten life by hours or perhaps even longer'.⁶

- Dr Harold Shipman, a GP in Manchester, is now thought to be the UK's worst ever serial killer, with a suspected 215 victims. No intent to 'ease the passing' – just murder.

The slippery slope is razor-edged! **MT**

References

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