

THE RIGHT TO DIE

J K Mason

There are two Acts of the United Kingdom Parliament which, in my opinion, transform the relationship between society and the medical profession in its Hippocratic commitment to maintain the utmost respect for human life — these are the Suicide Act 1961 and the Abortion Act 1967. By abrogating the crime of suicide, the 1961 Act opened the door to self inflicted euthanasia and, in so creating a right to die, simultaneously confirmed the doctor's duty not to interfere with that right in the absence of consent. The acceptance of the Abortion Act 1967 effectively abolished any remaining suggestion that the doctor's primary concern was to preserve life. It is certainly true that the profession had been applying a productive/non productive test to the treatment of the severely ill for many years prior to this but the Abortion Act opened up a new philosophy which included destruction of life and which was bound to have repercussions in the field of neonatal care, a matter which will be discussed later.

The one major advantage that the Suicide Act bestowed on the doctor/patient relationship was to clarify the nature of medical inactivity in the face of a patient's claim to a right to die. Irrespective of the civil law relating to assault and battery, the doctor was now placed under no obligation to prevent a crime and there was no question of criticism of a doctor who failed to intervene in

**Department of Forensic Medicine
Edinburgh University
Scotland**

J K Mason, CBE, MD, FRCPath, DMJ
Regius Professor

accordance with the patient's wishes; indeed, there are some who would deny the doctor the right to a plea of necessity should he persevere in treatment (1). Given these patients' rights, the doctor seems to be in two consequential difficulties. Firstly, the patient's death is likely to be relatively slow and painful. If we accept that the doctor is barred from treating the underlying disease, is he not directed towards a conclusion that the best interests of his patient would be served correctly by a quick and painless injection? The moral justification for distinguishing between active passive euthanasia is at best tenuous and Rachels (2) has suggested that the decision is simply one of whether death is less an evil than is the patient's continued existence. No matter how attractive such an argument may be, it must, I feel, be resisted. I accept that the competent patient's right to refuse treatment is matched by the doctor's duty not to interfere with that right. But the patient has no comparable right to be killed and it would, therefore, be quite wrong to erect a fictional obligation on the doctor to kill in the name of good medicine. And, in practice, if the intention was to kill, the act would be murder irrespective of the condition of the patient.

The second dilemma is, perhaps, more controversial and rests on the possibility that the patient may request the means to end his or her own life. The doctor may justify what is colloquially known as 'leaving the pills' — and may distinguish this from the lethal injection — on the grounds that, in the former circumstance, the ultimate decision to use the means provided is taken by the patient. Such an argument is no more than a specific extension of the general distinction which is made in the criminal law between acts of commission and omission, a distinction which may be legally useful but which seems to me to have little moral merit. Section 2 of the Suicide Act 1961 actually retains the offence of aiding, counselling, abetting or procuring the suicide of another but whether this would, in practice, encompass the doctor in the circumstances outlined is unclear. My own feeling is that it would, in so far as the courts take the four possibilities in s.2 as a whole. Professor Furmston (3) has suggested that leaving a patient close to the switch of his respirator would not be a criminal act whereas leaving a fatal dose of drugs within his reach would be; if this be so, the offence must be that of counselling — we all know how to use the electrical switch but many would have to be told of the fatal dose of, say, a barbiturate. In fact, no doctor has been prosecuted under s.2 of the Suicide Act. But the unsatisfactory state of the British law is well expressed by two diametrically opposed academic opinions — Furmston (3) is extremely doubtful if an expressed wish by the patient for his respirator to be switched off would protect the doctor against a charge of manslaughter; Kennedy (4) believes, on the other hand, that it would be unlawful to continue treatment in such circumstances provided that the patient was adult, lucid and informed.

This last proviso emphasises the fact that discussion has, thus far, centered on the consenting adult. The problems surrounding the adult who is unable to consent are best exemplified in the case of withdrawal of ventilator support from the brain damaged patient. Although the subject has been widely discussed over the years, I think it worth reiterating that there are two distinct circumstances in which this might be done. The first is when brain stem death has been diagnosed; this poses no problem as to continue treatment is merely to ventilate a corpse. It is still, however, perfectly proper, in my opinion, to remove a patient from support once it becomes clear that the treatment is achieving nothing. The decision may be a hard one

and the patient may die as a result; but it is one which has been taken logically and one which may free a scarce resource for another who is in a clinical position to benefit from treatment. There are, however, other circumstances which may pose even greater difficulties — and these would include patients in what Jennett (5) has described as the persistent vegetative state or those suffering from lesser degrees of cerebral dysfunction.

The moral choice in such conditions is governed by what Pope Pius XII outlined as the ordinary/extraordinary treatment test but which I believe is better described as the productive/non productive test — my preference depends on the fact that this wording concentrates on the individual patient and avoids such irrelevant generalisations as to, say, whether or not the use of antibiotics constitutes extraordinary treatment *per se* (6).

The legal approach is rather less uniform and depends to a large extent on whether the national legal system favours a professional or patient orientated attitude to problems arising in the doctor/patient relationship. Decisions in both Scotland and in England clearly demonstrate that the courts regard these decisions in the United Kingdom as matters of clinical judgement (7). The United States has adopted the alternative stance and has been, to an extent, split between the relatively objective test — the 'best interests' of the patient in a general sense (8) — and the subjective test — an attempt at 'substituted judgement' or 'donning the mental mantle of the individual patient' (9); the resolution of such problems is dominated by the availability or otherwise of an expression of the incompetent's intentions at a time when he or she was competent (10). However, even in those States which have enacted relevant legislation on this issue, the *absolute* right of the patient to choose death in advance of the crisis tends to be qualified in what may, in fact, be a disadvantageous way (11) — this includes, for example, allowing the physician to take other evidence so as to determine whether or not he can justify effectuating the patient's written directions.

Our debate has, however, now moved a stage further into the quality of life arena which is, I suggest, much less firm ground. This sense of instability is expressed in the words of Lord Scarman:

'There are great social problems not only in the life support of the human vegetable but also in the survival of barely sentient people who cannot look after themselves' (12).

If we follow this philosophy a stage further, the right to die is extended from the frankly vegetative state to the senile dement and there may come a point when euthanasia is positively suggested as a therapeutic alternative in patients with stroke (13). The current spotlight in the United States focuses on the provision of intravenous therapy or even of giving food and water to the brain damaged, the question being — is such nutriment a matter of medical treatment or is it standard nursing care? (14). The argument may rest upon the definition of incurable or terminal illness but it is apparent that it is not a difficult transition to move from a patient's right to die to the enforcement of a duty to die (5). I would suggest that the medical profession must be on its guard against what Campbell has described as the too easy acceptance of a philosophy related to the quality of the person which can lead to an undesirable therapeutic inertia (16). The decision to withhold one form of treatment does not constitute grounds for withdrawing all care (17).

A discussion of withdrawal of nutriment leads us logically, by way of the case of *R V Arthur* (18), to consideration of a second group of patients who may have

a right to die but who cannot, of themselves, express a decision as to the exercise of that right — these are the neonates.

The case of Dr Arthur raises a number of interesting points of medical law but, for present purposes, I will concentrate only on the reasons for his being charged with attempted murder. As Consultant in Charge of a hospital paediatric unit, he wrote in the notes of an apparently otherwise normal Downian neonate: 'Parents do not wish it to survive. Nursing care only', by which it was meant that the baby was not to be fed and, additionally, it was given large doses of drugs designed to sedate any hunger pains.

The first controversial issue raised by those hospital notes was, in my opinion, the whole nature of neonatal defect. The majority of articles written in the wake of the trial — and there were a great many — failed lamentably to distinguish between physical and mental abnormalities. When the British Medical Association spoke of selective treatment for handicapped neonates (19) one was tempted to ask 'What treatment?' in the case of simple Down's syndrome and, indeed, a reasonably thorough search of the American literature has failed to disclose any transatlantic writer who would regard such a child as a severely handicapped neonate. Morally, it seems wrong to apply any sort of 'substituted judgement' test to the Down's baby because it is not going to be in pain and, above all, because we have no reason to suppose that the Downian child is not as happy as is any other child within the confines of his own limited world.

Physical defect is, however, a completely different matter but, again, one which is undefinable, ranging in severity from anencephaly to talipes equinovarus; but, since there is a prognosis which can be estimated, it is possible to apply a productive/non productive treatment test. In many cases there can be no doubt that such a child should be accorded its right to die and that the basis for the decision should be the likelihood of pain and suffering (20). The same principles should govern the treatment of physical defects in a Downian infant as would apply to the mentally subnormal child or adult and it is significant that, in the most important British decision, the court ordered an operation for the relief of duodenal atresia in such an infant on the grounds that: 'she should be given the same chance as any other [Downian] child' — a clear indication that the same court would not consider starvation of any physically healthy infant irrespective of its mental state (21).

The second issue follows directly from this — the exercise of any right to die must be by proxy, and the question raised by *R v Arthur* is the nature of that proxy. By and large, the opinion of the British medical profession is that the decision is one for the parents aided by their doctors and there is considerable academic legal support for this view. But I am not convinced that this is acceptable in practice. Parents certainly have a right to consent to treatment on behalf of their minor children but this common law right extends only to procedures which are to the child's advantage. At the same time, the Children Act 1975, s.85 clearly denies any right to a British parent to abandon his or her child; and if there were a right to 'refuse' a neonate, would it not be logical to extend that right to a child who is brain damaged at any age? Above all, parents cannot take what should be a subjective decision on the part of their infant because the parents themselves are significantly concerned in the outcome. 'What better advocate is there than the parents?' asks Campbell (16); 'Parents are bad decision makers' say Ellis (22) and he may well be right. Freeman points out that, while it may be legally possi-

ble to terminate a parental relationship, that does not mean that parents so doing have the right to impose death on their child (23).

The final issue raised is the position of the doctor, particularly as to 'abandoning' the infant to 'nursing care only'. It is true that a doctor is under no obligation to treat a patient simply because he is a doctor, but I submit that, in accepting a delivery into the ward, the physician has acknowledged a duty of care both to the mother and to the resultant neonate. He is then enjoined to apply the standard productive/non productive treatment test to the infant but, equally, he cannot abandon a baby in defiance of that principle. The law is, however, unclear (24) and, since recourse to the courts in individual cases is time consuming and capricious, I would advocate a limited enabling act of legislation in this sphere which should be aimed at preserving the interests and the rights of the neonate — both the right to live and the right to die.

It is clear that such legislation would be, in many ways, an extension of some, but not all, of the Abortion Act. Our journey backwards in time has, thus, brought us to the fetus and to what I regard as a major legal anomaly. In Great Britain we deny the right to life to some 170,000 fetuses annually but we do this at the behest of and to the benefit of the mother; by an extraordinary quirk, we have simultaneously extended our general denial of rights to the fetus to a denial of its right to die. So called 'wrongful life' actions on the part of defective neonates have met with very little success in the United States although this trend may be changing. Only one such case has been tried in the United Kingdom and it is arguable that the Congenital Disabilities (Civil Liability) Act 1976 is so formed that case will also be the last. In it, the judge said:

'An obligation to the fetus to abort [when known to be defective] would mean regarding the life of a handicapped child as not only less valuable than the life of a normal child but so much less valuable that it was not worth preserving... These are the consequences of the necessary basic assumption that a child has the right to be born whole or not at all', (25)

But, by every tenet of the autonomy principle, it is a decision for the handicapped child to take, not for the court. The child is being denied the opportunity of itself assessing the merits of existence while a duty is imposed on the doctor to facilitate abortion on behalf of the mother. For myself, I cannot see any illogicality in granting to a fetus a right which would be strongly upheld the moment it had attained a separate existence. And, going even further back in the train of existence, I would extend the right to die to the embryo — a right which is being, similarly, attacked through the Unborn Children (Protection) Bill currently being debated in the United Kingdom parliament.

We have, thus, considered the right to die from conception to senility and it will have been noted that any such theoretical right is heavily dependent upon good faith in the medical profession. The law should undoubtedly stay its hand but, in protecting life against what a Jesuit philosopher (26) has called 'the danger of technological abuse which threatens its sanctity', both the law and medicine must combine to ensure that the right to die does not become a euphemism for the disposal of those who are arbitrarily defined as being substandard or undesirable.

REFERENCES

1. Kennedy I: The legal effect of requests by the terminally

- ill and aged not to receive further treatment from doctors. *Crim L R* 1976; 271-32.
2. Rachels J: Active and passive euthanasia. *New Engl J Med* 1975; 292: 78-80.
 3. Furmston MP: Is there a right to die? *Police Surg* 1981; 20; 7-12.
 4. Kennedy IM: Switching off life support machines: the legal implications. *Crim L R* 1977; 443-52.
 5. Jennett B, Plum F: Persistent vegetative stage after brain damage. *Lancet* 1972; i: 734.
 6. Kuhse H: Extraordinary means and the sanctity of life. *J Med Ethics* 1981; 7: 74-82.
 7. *Finlayson v HM Adv* 1978 SLT (Notes) 60; *R v Malcherek, R v Steel* [1981] 2 All ER 422.
 8. *Custody of a minor* 434 NE 2nd 601 (Mass, 1982).
 9. *Superintendent of Belchertown State School v Saikewicz* 370 NE 2d 417 (Mass, 1978).
 10. *In Re Storar* 438 NYS 2d 266 (NY 1981); Dunn LJ: *The Eichner/Storar* decision: A year's perspective. *Law Med Hlth Care* 1982; 10: 117-9.
 11. Lappe M: Dying while living: A critique of allowing to die legislation. *J Med Ethics* 1978; 4: 195-9.
 12. Scarman, Lord: Legal liability and medicine. *J Roy Soc Med* 1981; 74: 11-5.
 13. Robertson GS: Dealing with the brain damaged old — dignity before sanctity. *J Med Ethics* 1982; 8: 173-9.
 14. Myers DW: Legal aspects of withdrawing nourishment from an incurably ill patient. *Arch Int Med* 1985; 145: 125-8.
 15. Siegler M, Weisbard AJ: Against the emerging stream. *Arch Int Med* 1985; 145: 129-31.
 16. Campbell AGM: The right to be allowed to die. *J med Ethics* 1983; 9: 136-40.
 17. Dunea G: When to stop treatment. *Br Med J* 1983; 287: 1056-7.
 18. *The Times*, 6th November 1981, pp. 1, 12.
 19. Editorial comment: Paediatricians and the law. *Br Med J* 1981; 283: 1280-1.
 20. Dickens BM: Withholding paediatric medical care. *Canad Bar Rev* 1984; 62: 196-210.
 21. *Re B (Minor)* [1981] 1 WLR 1421 per Dunn LJ at 1425.
 22. Ellis TS: Letting defective babies die: who decides? *Amer J Law Med* 1982; 7: 393-423.
 23. Freeman MDA: Using wardship to save a baby from its parents. *Fam Law* 1982; 12: 73-5.
 24. Munir AE: Perinatal rights. *Med Sci Law* 1984; 24: 31-40.
 25. *McKay and another v The Essex Area Health Authority and another* [1982] 2 WLR 890 per Stephenson LJ at 902.
 26. Paris JJ: Terminating treatment for newborns: a theological perspective. *Law Med Hlth Care* 1982; 10: 120-4.